Mid-term Evaluation Report

Project for Improvement of Health Service with a Focus on Safe Motherhood in Kisii and Kericho Districts

July 2007

Japan International Cooperation Agency
Kenya Office

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Preface

Safe motherhood is an invaluable foundation of people's lives. Regardless of the status in a country's development, the family is the most important unit constituting community and society. Reproductive health should therefore occupy the central place in the health services, which enhance healthy ways of living particularly for realizing sound family life. Safe baby delivery service, systematically supported with reliable perinatal care, should be provided in the possible closest place to community regardless of the geographical location and ethnic background. With equity, people should have a good access to health facilities, which provide fundamental but quality service related to safe-motherhood.

The technical cooperation project on health service improvement with a focus on safe motherhood vibrantly operated in a typical rural area in Kenya for improving availability and access of the above-mentioned services. Multi-disciplinary approaches have been taken to achieve the objective with special foci on technical and managerial capacity development of health professionals and administrators. Community organizations are also targeted in strengthening the capacity of community support to the front-line health facilities particularly of the health centres.

This technical cooperation is not a wide ranged project to cover all geographical areas of the country but a valuable process of detecting localized evidence, that will be useful for the local and central government in the forthcoming policy level decision-making processes. Investment to vitalize front-line health facilities and the human resources serving directly to the people living in rural setting communities are essential, if the government seeks the most efficient and cost-effective operation of health services. Various institutional enforcements are necessary to re-direct the investment toward promotional and preventive services. Those community-based activities should be well synchronized with standardized curative services in accordance with rationalized task sharing among different service delivery points within the local health systems.

This report is not prepared to criticize the shortcomings and negative aspects of the project and counterpart organizations. Having recognized issues for further improvement, constructive recommendations are made in this mid-term evaluation report in line with various policy and strategy level dialogue, that was maintained between and among the project and the relevant Kenyan authorities. The evaluation team traced the processes followed by the so-called “Save Mothers in Kisii and Kericho” (SAMOKIKE) project towards its project purpose realization and revealed that various efforts were jointly made by the project personnel and the counterpart organizations maintaining favourable relationship with due consideration of the external uncontrollable factors.

The authors of this report highly expect that this document will be actively utilized for the forthcoming opportunity of policy dialogue and decision-making regarding modification of the project targets and/or the financing.

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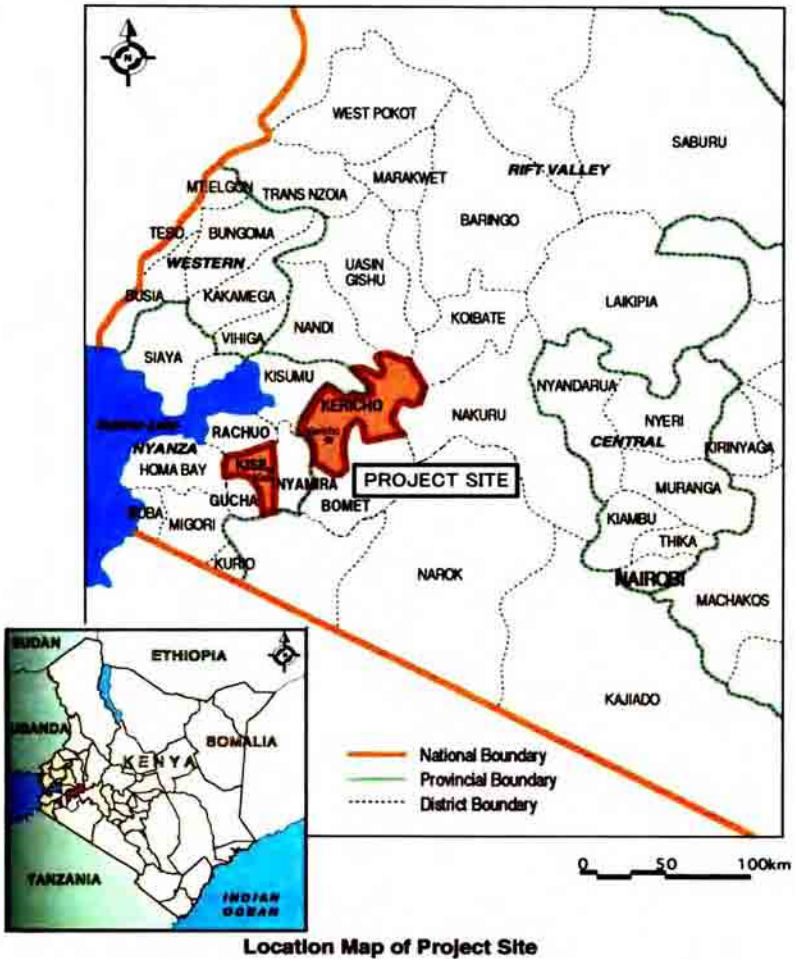
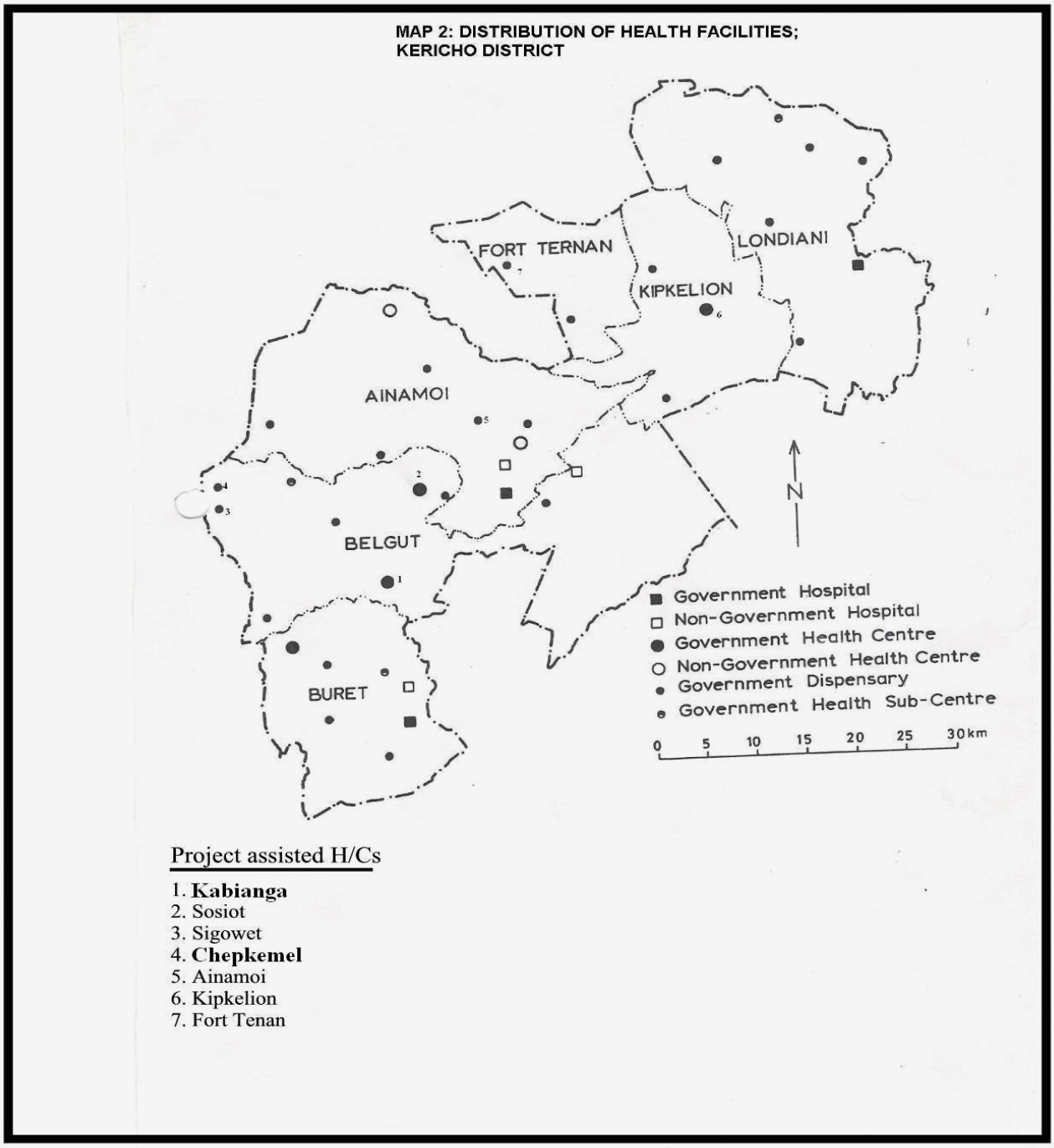
Project Formulation Advisor (Regional)
JICA ReSOESA
Nairobi

Project Location Map

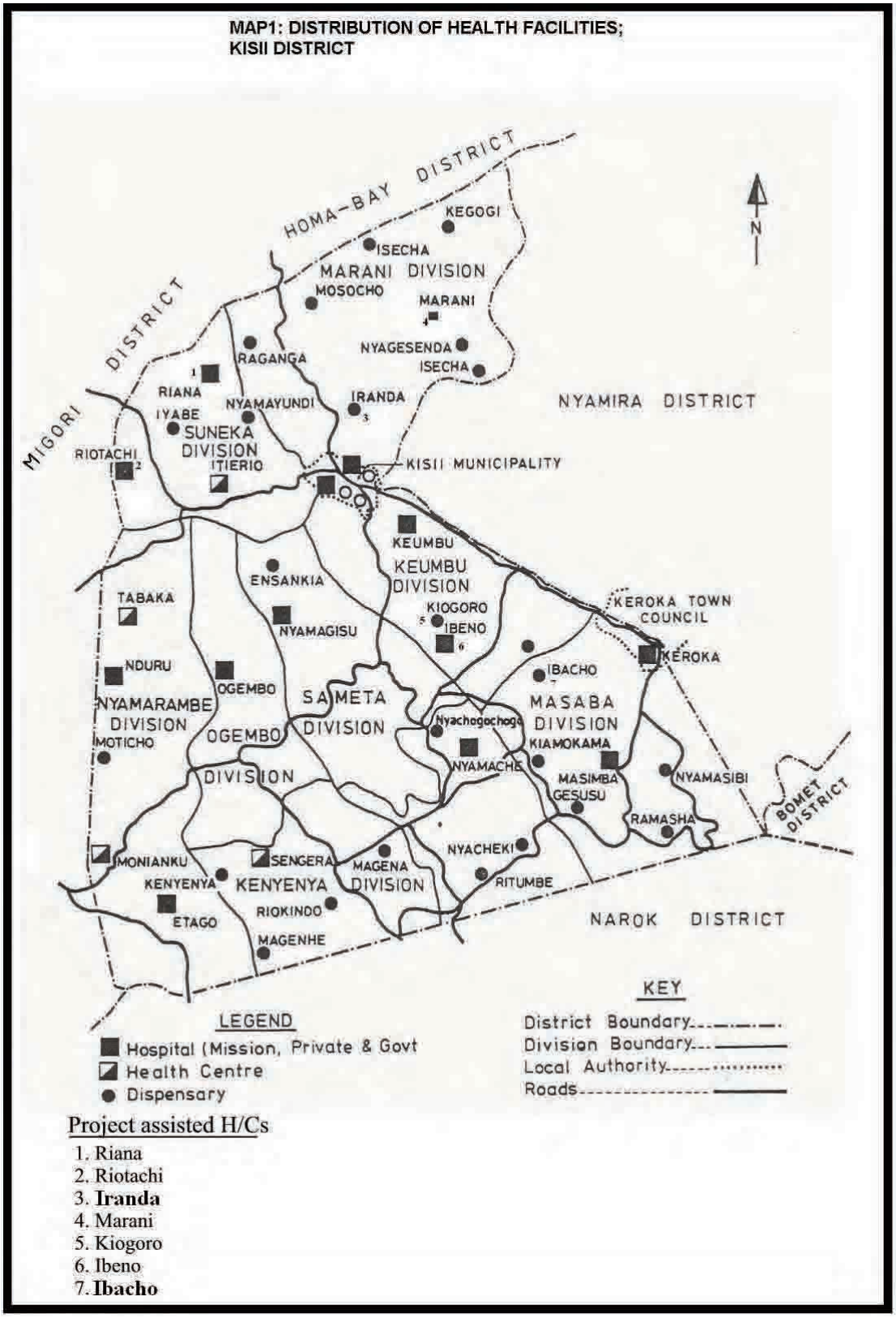


Location Map of Project Site

Map of the Target District (Kericho District)



Map of the Target District (Kisii District)



Project assisted H/Cs

1. Riana
2. Riotachi
3. **Iranda**
4. Marani
5. Kiogoro
6. Ibeno
7. **Ibacho**

Pictures of Project Activities

Maternity Care at Health Centers (HC)
Excavation for water tank construction at Iranda HC with the support of community people

Maternity Care at Health Centers (HC)
Lecture on how to use generator for delivery and attendance to patients at night

Management practice at Health Centers (HC)
Basic research on management of HC with District Health Management Team(DHMT)

Management practice at Health Centers (HC)
Construction of drug store with the support of community people

Supportive Supervision conducted by District Health Management Team (DHMT)
Interview with HC staff for basic survey

Supportive Supervision conducted by District Health Management Team (DHMT)
Joint meeting with Ksii and Kericho DHMT

Community-Based Maternity care
Survey on awareness of maternity care in a community

Community survey in each target area to assess awareness of maternal care
Health education on maternal care for community people

Referral activities between health centres and district hospitals
Handing over ceremony of multi purpose vehicles to Ministry of Health

Referral activities between health centres and district hospitals
Survey on referral at HC by a member of the maternal care specialists team

Abbreviations

DHMT	District Health Management Team
DRH	Division of Reproductive Health
HANDS	Health and Development Service
HC	Health Center
HIS	Health Information System
JICA	Japan International Cooperation Agency
MOH	Ministry of Health
MIS	Management Information System
PCM	Project Cycle Management
PDM	Project Design Matrix
TBA	Traditional Birth Attendant

Evaluation Summary Sheet

<table>
<tr><td colspan="3">I. Outline of the Project</td></tr>
<tr><td colspan="2">Country：Kenya</td><td>Project title：Health Service Improvement with focus on Safe Motherhood in Kisii and Kericho Districts</td></tr>
<tr><td colspan="2">Issue/Sector：Health</td><td>Cooperation scheme：Technical Cooperation</td></tr>
<tr><td colspan="2">Section in charge：Health</td><td>Total Cost：KES 105,000,000.00
(as at the time of evaluation)</td></tr>
<tr><td rowspan="2">Period of Cooperation</td><td>Record of Discussions (R/D):

February 2005 to March 2008</td><td>Partner Country’s Related Organization(s)：
The Ministry of Health (MOH)</td></tr>
<tr><td></td><td>Supporting Organization in Japan：Health and Development Service (HANDS)</td></tr>
<tr><td>Related Cooperation</td><td colspan="2">The study on strengthening the district health system in the Western part of Kenya, JICA, December 1998. The study was implemented in Bomet and Kericho districts in Rift Valley province and Nyamira, Gucha and Kisii districts in Nyanza province.
Grant Aid for Improvement of Health Centres in Kisii and Kericho Districts, 2000. The Project targeted 14 Health Centres in the 2 districts</td></tr>
</table>

1. Background of the Project

Japan International Cooperation (JICA) has been involved with the MOH in activities aimed at developing health services in the Western part of Kenya since 1990s making use of several cooperation schemes, such as assignment of Japan Overseas Cooperation Volunteers and Development Study. These have been complemented by Japan’s Grant Aid for facilities construction and equipment provision. In 2005, JICA entrusted this project on safe motherhood in two selected Districts in West Kenya (Kericho and Kisii) to Health and Development Service (HANDS), a Japanese non-profit organization, which has been working in international cooperation in health sector since the year 2000.

2. Project Overview

This project commenced in March 2005 as a three year technical cooperation project between Kenya and Japan with the purpose of tangible improvement of health centre level maternal care in the target two districts.

（1）Overall Goal

Health condition, particularly maternal health, in Kisii and Kericho districts is improved.

（2）Project Purpose

Maternal care in the project area with a focus on health centres (HCs) and communities is improved.

（3）Outputs

1）Maternal care services at HCs are upgraded.
2）Maternal care in community level is improved.
3）A referral system is arranged and functioning between communities, HCs and District Hospital
4）Health Information System (HIS) and record keeping system in place at HCs is functioning and is utilized for their service and management at the HCs
5）Management capability of drugs and medical supplies at HCs are improved.
6）District Health Management Team’s (DHMT) system for supportive supervision for HCs is strengthened.

（4）Inputs (as at the Project’s mid term)

Japanese side：

1）Local Cost: KES 89,000,000.00

2） Experts: 80.13 Man – months (7 Persons)
3） Training Courses: 5 Courses and 3 Study Tours;
4） Equipment: Assorted
Kenyan Side：
Counterparts: 28; MOH HQ, DRH, DHMTs, District Hospitals; Equipment: N/A; Operational Budget: KES 1,092,000.00; Land and Facilities: DRH HQ, Kisii and Kericho District Hospital Grounds, Meeting and Training Rooms

II. Evaluation Team

Members of Evaluation Team	MOH/JICA Joint Mid Term Evaluation Team JICA Team Leader: Prof. Yujiro HANDA MOH Team Leader: Dr. Josephine KIBARU JICA Team: Mr. Elijah Kinyangi JICA Team: Ms.Yumiko Igarashi MOH Team: Mr.Daniel Sande	
Period of Evaluation	21/ November/ 2006～28/ November/ 2007	Type of Evaluation：Mid Term Evaluation

III. Results of Evaluation

1. Summary of Evaluation Results

（1） Relevance

This Project was designed as an intervention to improve the capability of Kenyan stakeholders (both in community organizations and district level health service delivery system) in planning, implementation, monitoring, and evaluation related to routine health service with emphasis on safe motherhood. In this regard, the objectives of this project were “relevant”. The target was absolutely in line with the national policy advocated in the National Health Sector Strategic Plan.

（2） Effectiveness

The Project intended to improve the capabilities of communities, health centres, and particularly of DHMT, in order to enhance supervision activities as a part of routine work of local health authorities. In the Project areas of Kericho and Kisii Districts, community-based organizations (CBOs), health centres, and the district health service administrators improved technical and managerial capacities to a standard, where they can plan and implement community programmes for improving working conditions and facilities at respective HC.

It was revealed in the mid-term evaluation visit to sampled health centres that the utilization of HCs by the community people was improved particularly at HC, where service was started for normal deliveries. District hospitals staff s serving for maternity care was also trained to update their skill and knowledge through training courses provided by the Project. There were positive indications of effectiveness of maternity care particularly both at HCs and district hospitals.

（3） Efficiency

Safe motherhood and improved maternity care in the project areas were achieved with relatively high efficiency as a well organized package of training, equipment inputs, mobilizing DHMT monitoring function and community involvement. HCs’ facilities and equipment were substantially improved making maximal use of community support and project input. Construction of some physical facilities was conducted by the community people. The activities related to uplifting HC function in the Project areas were designed and implemented in an efficient manner.

The training component related to simple but essential health informatics were well-designed and regarded as an activity with high efficiency for HCs, where computerized clinical recording and

patient registration system was not introduced. It is, however, obvious that the extension of the improved practice to other facilities in the referral ladder is mandatory if the Project intended to monitor the improvement of the referral system in the district through this information system.

（4） Impact

No major negative impacts to the community, health centre, DHMT or other stakeholders were found. At the moment of mid-term evaluation, positive impacts were found primarily related to the practice of maternity care particularly of normal deliveries, which was extended to at least 13 HCs out of 14 in the Project area, whereas before the starting point of the Project only 9 conducted the service of deliveries. It was also recognized that increase of clients coming for antenatal care at most of the HCs, resulted from the provision of deliveries.

（5） Sustainability

The Project was sensitive to the importance of achieving sustainability of ongoing activities since the planning stage. The involvement of central / local government and health authorities was properly done to pursue tangible outcomes of project activities and also to ensure the sustainability of the project outputs.

Finance is the key to ensure sustainability even for successful activities. The most sensitive issue for sustainability is recurrent costs. MOH and DHMT are aware of the demand for allowances and incentives seemingly needed for continued engagement of various health personnel including volunteers. It is not easy to maintain credibility for funding such allowances and incentives

2. Factors that prompted realization of effects

The good working relationship between counterparts of the district ministry of health, staff at HCs and experts prompted realization of effects. The Experts encouraged the participation of community people in the management of HCs, which promoted cooperation between staff at HC and community people to improve service at HCs.

3. Factors that impeded realization of effects

（1） Factors concerning to Planning

The referral system of the health service in the districts targeted in this Project was too extensive to be adequately addressed by the Project as one of the “output” components. The issue was multi-factorial and required strategies both from bottom-up and top-down in the existing referral system. The referral system improvement activity in relation to emergency obstetric care in the Project was not well organized due to difficulty in logistics and lack of tangible outcome.

（2） Factors concerning to the Implementation Process

Dispatch of the Project Manager from Japan to this Project was supposed to be well planned to retain an assignment period long enough to maintain the stable managerial condition for the entire project. Due to several reasons, Project Manager was, however, changed a few times. It impacted on the managerial condition for the project.

4. Conclusions

Institutional and capacity building related to “safe motherhood” particularly on maternity care in the target areas enabled a community participatory approach to achieving the benefits of the project

The financial credibility of the recurrent costs and human resources necessary to sustain the improved standards of care is an issue for the central and district health authorities to tackle through involvement of the policy and strategy level decision makers from a long term perspective

The project will be a model to provide evidence to the central health authorities and development partners alike who are responsible for maintaining policy coherence for such international development initiatives and also rationalizing resource mobilization, allocation and effective utilization

5. Recommendations

HCs with improved utilization by the community people should further be monitored regarding the work environment improvement and quality of service.

Referral activities among HCs and district hospitals should further be looked into by the Project with foci on triage and communication.

The Project should maintain the existing policy to make maximal use of community participation.

The situation of congestion in the maternity wards at district hospitals in the Project areas should be continuously monitored together with relevant and gradual intervention on the work environment and service contents improvement.

Introduction of work environment improvement concept to the HCs will be a good entry point of work efficiency improvement and further improvement of the quality of service.

Assignment of the project manager from Japan to this Project should be well planned to retain periods as long as possible to maintain the stable managerial condition for the entire project.

6. Lessons Learned

Empowerment of the community in collaboration with local technical and administrative personnel is a decisive condition to ensure the activation of maternity care activities particularly in the communities and HCs. To guarantee the sustainability, participatory approach should be employed, with coherence, both in the planning and implementation strategies.

Strategies to strengthen health education on maternity, should be combined with uplifting quality of care at HCs as the supply of safe and obtainable best maternity care including baby delivery.

The components of the referral system should be implemented on a larger scale and in depth if the substantial outcomes are to be achieved. These are the topics with multi-factorial background to be tackled as independent projects.

Executive Summary

01…The Project was so far successful and indicated various positive developments, in which capacities of the stakeholders were adequately built in terms of the management and implementation of maternity care. Targets for the improvement were properly selected by means of participatory approach on (1) maternity care at health centres, (2) management practice at health centres (3) supervision conducted by district health management team (DHMT), (4) community-based maternity care and (5) referral activities between health centres and district hospitals. The District Health Management Team (DHMT) played a major role as the direct counterpart of the Japanese expert team.

(1) Maternity Care at Health Centres (Output 1)

With regard to health centre-based maternity care, 14 health centres were targeted for uplifting quality of service both by equipment and technical standards. Managerial aspects were also taken care of achieving well standardized maternity care by managerial training on drug supply, record keeping and so on. Delivery equipment and kits were provided to 12 health centres for improving physical work environment for the attending health staffs.

(2) Management Practice at Health Centres (Output 4, Output 5)

Capacity of the front-line health staff serving in 14 health centres was further strengthened through variety of training courses under the stipulation that technical training should always be accompanied by managerial training. Topics, such as record keeping, in-house pharmaceutical management, case management, and so on, were elaborated among the training programme participants in collaboration with resident and visiting Japanese experts. The training courses conducted were all designed with community orientation and participation of relevant communities. Monitoring was periodically done jointly with the counterpart organizations making use of the existing supervision system. It is possible to mention that the managerial standard was, in a way, uplifted during the project period, although there are further needs in improving work environment and standardization of health service package as well as the planning exercise maintaining logical linkage with annual budget planning.

(3) Supervision conducted by District Health Management Team 【DHMT】(Output 6)

Through periodic supervision, the function of health centres was intended to be maintained by DHMT. Despite the existence of supervision system, the efficiency and effectiveness of the practice were hampered mainly due to financial constraints in providing transport costs and allowances for the supervision team members, who have to cover several facilities scattered over the wide areas in each district. Supervision guidelines and the correlation with existing health information system (HIS) and management information system (MIS) were thoroughly discussed among the Project office and DHMT during the project implementation. Those discussions were useful to uplift the standard of supervisory work, although the complete solution on financial issues was beyond the capacity of the Project.

(4) Community-based Maternity Care (Output 2)

Attempts at strengthening community-based maternity care in 14 health centre catchments were made with specific objectives to improve the capacity of non-professional community health workers undertaking house-to-house service of maternity care. Efforts were also made in participatory learning opportunities offered by the Project to motivate clients and the family members to participate in the activities by learning more about safe motherhood and the related child health care.

(5) Referral activities between health centres and district hospitals (Output 3)

Referral Hospitals in the two districts under the Project target areas so far maintains in function as the key referral health facilities receiving maternity related referral cases from the catchments. By the on-going strengthening processes at HC level maternity care, particularly on normal deliveries there is an impression among the health personnel in charge that the congestion at maternity wards and out-patient departments are in the process of reduction. In-service training opportunities for middle level health professionals such as nurses, technicians and clinical officers should further be expanded with appropriate training targets.

02…Personal and institutional capacity building related to the safe motherhood at Kericho and Kisii Districts in Western Kenya enabled the residents to achieve effective control of emergencies in maternity care as the successful results of the intervention of community-based reproductive health activities and functional improvement of the front-line health facilities.

03…Participatory approaches were taken for community mobilization by the Project in collaboration with local health authorities in order to involve community people both in decision-making and routine facility management at front-line health facilities.

04…Communication among service-providers, clients and decision-makers was found to have improved as the result of various activities including clients' participation in empowerment seminar for health staff. The unique attempts to share fundamental but crucial health information among health staff and the community people contributed to uplifting the confidence both of care-providers and clients in terms of utilization of nearest health centres for post-natal / antenatal care and also for normal deliveries.

05…Renewal and/or additional supply of fundamental but essential equipment for delivery were well done by the Project in conjunction with technical / managerial trainings. In combination with above-mentioned improvement in communication, the result of this input created visible effects in betterment of clients' utilization of health centres.

06…Tangible outcomes in increase of normal deliveries were seen in two district hospitals in Kericho and Kisii at respective maternity department as the result of the mentioned improvement in utilization of health centres by the catchments people. This change positively affected to reduce congestion at maternity

wards of those district hospitals, where the health professionals are supposed to concentrate on emergency and complicated cases.

07…It is highly expected that managerial practice of front-line health staffs at health centres are further improved for better service provision of safe and well standardized delivery and peri-natal care. For this purpose, bi-lateral efforts of top-down and bottom-up are needed. Supportive supervision will be a target that should be further enhanced from top-down direction for vitalizing the existing administrative function of the district level health authorities. In responding to the supervision, health centres are expected to work on day-to-day work environment improvement using a simple management tool such as 5-S Principles as bottom-up efforts to make maximal utilization of the existing resources. The service contents at health centres must gradually be uplifted on technical and managerial standards only after achieving obtainable best work environment.

08…MOH and DHMT should further elaborate and provide training opportunities, with priority, for health personnel working close to the community and health centre. Additional allocation of cadre especially for middle level health professionals should be considered with priority to DHMT to strengthen technical and management capability of the team.

09…This project on safe motherhood should further gather evidence based on the ground work at the target districts, where there are absolute needs of health services to protect maternity health, an important asset of the people. Together with frequent and timely policy dialogue among the Project and MOH, the evidence is analyzed and hopefully published in an influential mode of publicity, such as scientific journal in collaboration with relevant MOH officials. By doing so, the government both of Kenya and development partners will be able to make maximally use of the project outcomes in policy level decision-making.

Contents

I Definition of Evaluation and Targets

1. Definition

10…Evaluation is an assessment, as systematic and objective as possible, of an ongoing or completed project, programme or policy, on its design, implementation and results. The aim is to determine the relevance and fulfilment of the objectives, effectiveness, development efficiency, impact and sustainability. An evaluation should provide information that is credible and useful, enabling the incorporation of lessons learned into the design making progress of both recipients and donors.

2. Evaluation targets

11…The evaluation target includes all activities in Technical Cooperation on Community Health improvement for Western Kenya Provinces with emphasis on “Safe-Motherhood”, (hereinafter referred to as “the Project”) commenced in March 2005. The status of the Project’s collaboration with local health authorities related to the service, training and surveys were also looked into in order to know the advancement of capacity building of the counterpart organizations. In addition to that, the evaluation team studied, with interests, how the coordination was carried out by the Project and the counterpart organizations in order to extend project impact to the entire health sector of the country.

3. Evaluation team

12…This evaluation was conducted as a mid-term exercise in line with the Record of Discussions on the Project. In order to assure the coherency, transparency and logicality, all the evaluation processes were monitored both by Japanese and Kenyan professionals assigned to the evaluation.

II Background

1. Introduction – from project formulation to the current status –

13…Kenya, a Sub-Saharan African country, is a country with the highest maternal mortality rate (MMR) (Kenya; 1,000, whereas the average of developing countries; 440). In the year 2000, it was reported that over 10,000 women in reproductive age lost their lives with pregnancy-related diseases and complications. This fact is mainly due to unfavourable living condition in rural communities, where most women of reproductive age live. According to the Kenya Demographic and Health Survey, discrepancy in health indicators between urban and rural areas is vast.

14…Ministry of health (MOH) of Kenya has, therefore, been working on the promotion of safe motherhood in collaboration with various development partners paying more atte ntion to the women living in rural setting communities.

15…Japan International Cooperation (JICA) has been involved with the MOH in activities aimed at developing health services in Western part of Kenya since 1990s making use of several cooperation schemes, such as assignment of Japan Overseas Cooperation Volunteers and Development Study. In relation to these efforts, the Japanese government is now considering the rehabilitation of district hospitals in the region through a Grant Aid Project.

16…In 2004, JICA entrusted this project on safe motherhood in two selected Districts in West Kenya (Kericho and Kisii) to Health and Development Service (HANDS), a Japanese non-profit organization, which has been working in international cooperation in health sector since 2000.

17…This project commenced in March 2005 as a three year technical cooperation project between Kenya and Japan with the project purpose of tangible improvement of health centre level maternal care in the mentioned two districts. In order to achieve this project purpose and to lead the entire project to reach the overall goal with improvement of health condition focusing on maternity care, two main approaches were set at the beginning of the project. Those were (1) improvement of the service contents of maternity care itself at HCs (at the point of service delivery) and at each communities (directly to the clients) and (2) managerial betterment of HCs, which are the front-line of the service delivery. Based on the above conceptual framework, the project design was made with 5 outputs and various activities, by which project intended to attain the respective output.

18…The present mid-term evaluation intended to monitor and progress of the Project and summarized both advancement and constraints. By this M&E activity in the mid-term, the Project and other stakeholders are expected to adjust the ongoing implementation process of the Project in the latter part of the Project period until termination in Mar 2008.

2. Methodology of evaluation

19…Project Cycle Management (PCM) method was applied for the evaluation. The evaluation is conducted by comparing design and outcomes of the Project using the 5 evaluation criteria: relevance, effectiveness, efficiency, impact and sustainability. In this method, Project Design Matrix (PDM) represents the project design. The previous PDMs, documents and reports were reviewed to produce a PDM for evaluation that describes the project design in the 5-year cooperation period, which was similar to the PDM produced in March 2005.

20…To compare the outcomes of the Project with its design, an evaluation grid was produced. For each of the above criteria, evaluation questions were set, and method of data collection was decided. In addition to that, Information related to indicators in the PDM collected by the project team prior to the arrival of the evaluation team. Some field survey results compiled by the team were also used for the evaluation. This report was produced based on the data collected that was then analysed from the view points of 5 evaluation criteria

3. Criteria for evaluation

21…

Relevance

An overall assessment of whether the project purpose and overall goal are in keeping with donor and recipient policy and with local needs and priorities.

Effectiveness

A measure of whether the project purpose has been achieved. This is then a question of the degree to which the outputs contribute towards achieving the intended project purpose.

Efficiency

A measure of the production of outputs (results) of the Project in relation to the total resource inputs. In other words, how economically the various inputs were converted into outputs.

Impact

The positive and negative changes produced directly and indirectly as the result of the Project, which is foreseen and unforeseen consequences for society.

Sustainability

An overall assessment of the extent to which the positive changes achieved by the Project can be expected to last after the completion of the Project.

Ⅲ Record of Evaluation Procedures

1. Preparation of PDM for evaluation

22…Assessment of the latest PDM was carried out through discussion with resident experts of the Project. This process is an exercise to improve the PDM content to meet the demand for the evaluation processes.

23…The narrative summary of the Project was prepared from the PDM for evaluation as below to devise evaluation questions along the five evaluation criteria as shown in attachment 1:

Overall Goal:
Health condition, particularly the maternal health, was improved.

Project Purpose:
Maternal care, provided at health centres (HCs) and communities, was improved.

Outputs:
(1) Maternal care services at HCs are upgraded.
(2) Maternal care in community level is improved.
(3) A referral system arranged and functioning between communities, HCs and District Hospital
(4) HIS and record-keeping system in place at HCs is functioning and is utilized for their service and management at the HCs.
(5) Management capability of drugs and medical supplies at HCs are improved.
(6) District Health Management Team (DHMT)' system for their supportive supervision for HCs is strengthened.

Inputs
- Japanese side -

Dispatch of Japenese Experts	80.13 M/M (7 persons)
Provision of Equipment	2 Cars, office equipment, computers, clinical equipment etc
Provision of local cost	

- Kenyan side -

Allocation of Counterparts	- Counterparts from DHMT District Hospitals (Kericho and Kisii), HC Staffs and members of community organizations

Provision of land and facilities	- Office space and construction of a room for JICA experts - Infrastructure for trainings and meetings - Provision of human resource for trainings
Appropriation of operational cost	- Cost sharing for “middle-level manpower training” - Cost sharing of allowance for DHMT staff for the Project activities

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2. Evaluation questions and assessment results

24…Based on the above summary of the content of PDM and actual activities conducted in details, the assessment was carried out on relevance, effectiveness, efficiency, impact and sustainability of the Project. Referring to the indicators set up in the PDM and evaluation criteria, various evaluation questions were set for information collection and compiled as questionnaires. Interviews, site visits for direct observation were also conducted by the Team to verify the collected response by the questionnaires.

25…The results were thereafter summarized and assessed by the Team. The information related to the above five criteria of evaluation were then extracted from the collected data and summarized as the “Evaluation based on the Five Criteria” combined with the result of field survey.

3. Evaluation based on the Five Criteria

3-1. Relevance

26…It may go without saying that an effective project would be on high demand in a developing country context, particularly if it is oriented toward rural and suburban communities with low income earners. This Project was designed as an intervention to improve the capability of Kenyan stakeholders (both in community organizations and district level health service delivery system) in planning, implementation, monitoring, and evaluation related to routine health service with emphasis on safe motherhood. In this regard, the objectives of this project were “relevant”. The target was absolutely in line with the national policy advocated in the National Health Sector Strategic Plan. The function of HCs was successfully highlighted as an important target of the Project with various challenges to uplift the quality of services. This target, particularly on initiation of normal delivery at HCs, where there was no service as such in the past, was well set in advance.

27…In the conceptual framework of the Project, there was a clear principle that the services should be extended directly to the community and households, as close to families as possible. Five main areas were accordingly described in the original PDM as the expected outputs of the Project. However, the Project actually spanned with foci on three distinctive working areas; (1) improvement of maternal care at HCs particularly on normal deliveries, (2) performance improvement of DHMT particularly on the supervision to HCs, (3) awareness creation at the community for safe motherhood. In relation to the said areas,

challenges were vigorously done for the capacity and institution building of the organizations of different level in the referral ladder. The diversity of these areas and the extent of the workload should have been assessed in the planning stage, where more details may have been sought via a more thorough planning exercise. The volume of work shouldered by the project office was unexpectedly large.

3-2. Effectiveness

28…The Project intended to improve the capabilities of communities, health centres, and particularly of DHMT, in order to enhance supervision activities as a part of routine work of local health authorities. In the Project areas of Kericho and Kisii Districts, community-based organizations (CBOs), health centres, and the district health service administrators improved technical and managerial capacities to a standard, where they can plan and implement community programmes for improving working conditions and facilities at respective HC.

29…It was revealed in the mid-term evaluation visit to sampled health centres that the utilization of HCs by the community people was improved particularly at HC, where service was started for normal deliveries. District hospitals staff s serving for maternity care was also trained to update their skill and knowledge through training courses provided by the Project. There were positive indications of effectiveness of maternity care particularly both at HCs and district hospitals.

30…It was intended that awareness be further enhanced in the community in the Project. Case detection and management related to maternity in the community should be improved. For achieving those targets, well-planned seminar and in-service training, involving care providers and community representatives, were provided by the Project and DHMT partnership. The scope of the project activities, however, did not have enough time-frame for in-depth monitoring and follow-up of the seminar participants at health centres to fully evaluate their effectiveness. This can be further elaborated in the next phase of the Project.

31…Workload for DHMT staff seemed to exceed their capacity due to the chronic shortage of personnel, although the participation of the staff was favourable both in managerial and technical training. In addition to that, funding for the supervisory visits covering all HCs in the districts was a big issue. Recurrent budget of DHMT was not sufficient enough to meet the supervisory requirement.

3-3. Efficiency

32…Safe motherhood and improved maternity care in the project areas were achieved with relatively high efficiency as a well organized package of training, equipment inputs, mobilizing DHMT monitoring function and community involvement. Those activities were in line with the principle of promoting community participation and collaboration with the local health centre. The attendance at HCs in the project areas demonstrated an increase corresponding to the progress of project activities guided by health centre staff and project office staff.

33…HCs' facilities and equipment were substantially improved making maximal use of community

support and project input. Construction of some physical facilities was conducted by the community people. The activities related to uplifting HC function in the Project areas were designed and implemented in an efficient manner. It should be noted that for the extension of this approach to the entire region and further to entire Kenya, a strong initiative by MOH with appropriate funding is necessary.

34…The referral system of the health service in the districts targeted in this Project was too extensive in addressing by the Project as one of the "output" components. The issue was multi-factorial and required strategies both from bottom-up and top-down in the existing referral system. The referral system improvement activity in relation to emergency obstetric care in the Project was not well organized due to logistics difficulty and lack of tangible outcome.

35…It was, however, replaced in a programme to improve triage at HCs and care provision at the District Hospitals for receiving referral patients. By skill training of case management, the Project recognized the increase of referral cases, which were sent from the HCs under the Project area. The purpose of this activity does not directly complement other project components.

36...The training component related to simple but essential health informatics were well-designed and regarded as an activity with high efficiency for HCs, where computerized clinical recording and patient registration system was not introduced. It is, however, obvious that the extension of the improved practice to other facilities in the referral ladder is mandatory if the Project intended to monitor the improvement of the referral system in the district through this information system.

37...It was recognized that the activity of technical and managerial improvement commenced in the early phase of the Project was the improvement of the guidance and educational materials. This was carefully initiated by the Project in collaboration with DHMT. It was assumed that the developed materials contributed to the efficiency of the activities conducted thereafter. Some HCs were properly selected as pilot venues for pre-tests of the materials with subsequent confirmation of the utilities by participation of Kenyan counterparts. The health staffs used them efficiently in the activities of delivering messages on maternity care to the clients.

38…In-service training for HC staffs was conducted with the participation of representatives of communities, which occasionally provided funds for facility improvement of HCs. In order to inform the communities about HCs' efforts in uplifting the quality of service, the training programme opened to non-professional people of the communities was a unique and efficient approach.

3-4. Impact

39...No major negative impacts to the community, health centre, DHMT or other stakeholders were found. At the moment of mid-term evaluation, positive impacts were found primarily related to the practice of maternity care particularly of normal deliveries, which was extended to at least 13 HCs out of 14 in the Project area, whereas before the starting point of the Project only 9 conducted the service of deliveries. It

was also recognized that increase of clients coming for antenatal care at most of the HCs, resulted from the provision of deliveries.

40…Principle of community participation and self-help activities for improving HCs were properly adopted by various communities in the Project areas. This enabled the residents of these communities to continue challenges of better maternity care in their own places. The motivated stakeholders in these communities (health centre staff, community health workers and environmental health promoters and so on) are responsible for the successful results of renovation and cleanness improvement of each HC.

41…Traditional birth attendants (TBA) are still instrumental at home deliveries being conducted in the Project areas. Although there was no visible conflict among TBA and HCs, as a negative impact, future involvement of TBA in this Project is an issue that should be well looked into in conjunction with the Project's community activity component.

3-5. Sustainability

42...The Project was sensitive to the importance of achieving sustainability of ongoing activities since the planning stage. The involvement of central / local government and health authorities was properly done to pursue tangible outcomes of project activities and also to ensure the sustainability of the project outputs.

43…For the establishment of a standardized practice related to conducting normal delivery at HCs, the collaboration among the Project, DHMT and other superior authorities such as MOH was effective enough to standardize the inputs such as instruments and equipment. This was an example of sustainable approach in this project, which was designed to assure the continuing commitment of local health authorities even after the completion of the Project.

44…The development targets were too diversified when the initial project design was looked at in retrospect. The components of the referral system should have been implemented on a larger scale and in more depth than the present allowed conditions, if the substantial outcomes were to be achieved. These were the topics that could have been independent projects. Sustainability of the Project should, therefore, be carefully monitored by the related parties to secure the substantial outcomes promised by these initial inputs.

45…Finance is the key to ensure sustainability even for successful activities. The most sensitive issue for sustainability is recurrent costs. MOH and DHMT are aware of the demand for allowances and incentives seemingly needed for continued engagement of various health personnel including volunteers. It is not easy to maintain credibility for funding such allowances and incentives.

46…Road system connecting most of the HCs and the higher classes of paved roads was not properly maintained. This causes tremendous difficulties of the physical access of the community residents to HC particularly in rainy season. In addition to that, muddy and slippery road with many potholes hinder

smooth and speedy transport of the referral patients during emergency. It is obvious that this situation causes life-threatening condition of the patients. This is an existing constraint, which is rather outside of Project's control, although under a separate JICA scheme, a small pilot project for maintaining connecting roads to HCs has been commenced recently within Project areas.

4. Conclusion

47…Capacity and institution building, related to "safe-motherhood" particularly on maternity care at community, HCs and district hospitals in the Project areas of Kericho and Kishii Districts enabled the community people to walk along the right track for receiving improved maternity care with the intervention of this Project funded by JICA and implemented by HANDS in a participatory approach. Also the Project initiated a movement in work environment improvement at HCs in relation to maternity care managed by health centre staff getting support from community based organizations.

48…Financial credibility particularly of recurrent costs for maintaining the uplifted standard of care is an issue for the central and local health authorities as well as staffing matters to fill the all cadres and also to allocate additional health staffs. Of course those issues are not pieces of cakes and should be tackled involving policy / strategy level decision-makers with long term perspective.

49…This Project will be a mode of evidence provision to the central health authorities and donor community, which are responsible to maintain policy coherence to the internationally accredited development initiative and also to rationalize resource mobilization, allocation and effective utilization. For that purpose, the Project are highly expected to enhance policy dialogue based on the evidences collected in the project activities of the remaining time-frame.

5. Recommendation

50…HCs with improved utilization by the community people should further be monitored regarding the work environment and quality of service. Increase in the number of client visits to the HCs was recognized in the rural setting communities as an outstanding positive indication of the project activities. Most of the health centres, which worked together with the Project for the functional improvement, showed gradual increment of the clients particularly those seeking antenatal care in the past 1 year, since the commencement of various project activities conducted jointly with District Health Management Team (DHMT). The Project takes the above progress as anther starign point to make further betterment in quality of service.

51…Referral activities among HCs and district hospitals should further be looked into by the Project.with foci on triage and communication. The referral system from health centres to the district hospitals were gradually utilized, which is positive indication of the project activities. Through the various project activities especially trainings on maternal care services, nurses gained knowledge on what constitutes signs of

emergency/complicated cases that require referral of a patient to the district hospital. Despite lack of institutional telephone facilities, the health workers' personal mobile phones have been used in most of the HCs to communicate with staff at the referral facilities, and this seems to be working well. The multi-purpose vehicles provided by the project are well utilized in the referral system. It, however, is necessary to improve the means of communication between health centres and district hospitals to better handle referral cases.

52…The Project should maintain the existing policy to make maximal use of community participation. Community mobilization and support activity for improvement of HCs' facilities were actively in progress. It was reported by the DHMT and Project Office that this activity exists in every health centre, although there is diversity in the magnitude of involvement among the respective catchments' population. It was also recognized by the Team that in every community, HC management committee is keen to improve the HC's function particularly that of normal delivery and the related maternal care. This desirable development was created by the active collaboration between the Project, DHMT and HC staff in training and information exchange with community leaders and volunteer health workers. The Involvement of those key persons within communities to the process, which uplifts the quality and efficiency of the HC services, should further be carefully and properly done in this Project by means of various training opportunities for health staff. Even technical skill training for midwives and community health workers were partly shared with non-professional community leaders for better calibration of the information and mutual understanding of constraints, which had to be tackled jointly with HC and community. The Project office consisted of capable national and Japanese personnel working effectively as a link between local health authorities and the communities.

53…The situation of congestion in the maternity wards at district hospitals in the Project areas should be continuously monitored together with relevant and gradual intervention on the work environment and service contents improvement. Reduction in congestion is being realized through the increased use of HC's following recent capacity strengthening of the HCs to provide services for normal deliveries. This was actually repeatedly mentioned by the DMHT members in Kericho and corroborated by the team's observation at the maternity ward at Kericho District Hospital. In addition to that, the M&E team was informed that normal deliveries conducted by the Department of Obstetrics and the maternity ward showed slight decline in number due to the present task sharing with HCs, that received training and equipment through this Project.

54…Although the mentioned positive change in terms of congestion at district hospital was not a dramatic change, it should be noted that the visible improvement came to be tangible in one and half year after commencement of this Project. The M&E team regards this change as a sort of rapid changes, which is normally not so easy development in rural setting districts in other parts in Africa. It is possible to expect further development in this aspect, if all the 12 focus HCs under this Project vigorously work in the latter phase of the Project on enhancing service provision of delivering babies in responding to the demand in the catchments communities.

55…Introduction of work environment improvement concept to the HCs will be a good entry point of work efficiency improvement and further improvement of the quality of service. As a simple managerial tool for realizing the above, *5-S + 1K initiatives* has been promoted by the Project Office, since a short term technical advisor on pharmaceutical management at HC was assigned to this Project for 3 months in2006. The said initiatives are set for the betterment of the work environment at the HCs in terms of removing unnecessary items and clatters from the work areas, setting orderliness in the areas, maintaining the cleanness in HCs, making the mentioned three actions a part of routine work and improving staff' attitude to better work. The progress on this issue is seen only at a few HCs at the moment, two months after the training workshop featuring this topic. The potential of rolling out and sustaining this relatively simple concept is enormous considering that with minimal input, very conspicuous positive changes can be realized in making working environment better. It is therefore worthy to note that the Project will make further elaboration on this topic in the latter part of the Project period.

56…Assignment of the project manager coming from Japan to this Project should be well planned to retain period as long as possible to maintain the stable managerial condition for the entire project. In this Project, technical experts from HANDS are contracted and assigned on relatively short term basis as compared to the former conventional technical cooperation project of JICA. Since the topics handling in the Project is diversified including community based activity, assignment of the project manager and his or her oversight of the entire activities are extremely vital for sustaining the standard of work. Repetition of short-term assignments was efficient in terms of technology transfer and training programmes, which were conducted by the Project.

57…Staffing at HCs is an issue that should be further improved by health authorities at all levels including MOH. It is, however, not an easy thing to achieve considering the magnitude of financial resources required by an already constrained MOH to attain the minimum level of facility staffing defined to provide essential health care services. Attempts have been made by several HC's to cooperate with the respective target communities in mobilizing the necessary financial resources to locally hire some staff of the lower cadres. Hospital user fees and HC registration fees have provided some opportunities for fund raising for this approach to the staffing solution. However, the district health authorities still need to review the present staff deployment pattern and possibly re-distribute the available staff based on each facility needs.

58…Managerial practice at HCs and HIS require to be strengthened. It seems that most HC in-charges have not received what can be termed as management training. The use of HC data for management decision making is hardly visible as this is merely forwarded to the district health office to fulfill the reporting requirements. The district health authorities should therefore envisage providing management training suitable to each level of health facility.

59…Advocacy is further needed for improvement of road condition in relation to referral activities between HCs and district hospital. It was indicated that patient referral from some HC's is sometimes

negatively affected by the poor road conditions especially during the rainy season. It takes long for patients to arrive at the HC from their homes and to the District Hospitals upon referral. The district health authorities need to engage other related Government departments and advocate for resource mobilization and allocation to improving rural access roads. Funding sources such as the road maintenance levy, local authority transfer fund and constituency development fund would be better explored for this purpose.

60…Communication and supportive supervision by the DHMT should be regularized especially for those off-road HC's and should aim to provide interactive management guidance to the health workers. Constant communication between HC's and the DHMT is necessary as it provides mechanisms for feed back to HC's on their periodic reporting issues. It may also further enhance the motivation of the health workers. In the present circumstances, it may seem appropriate that each HC be equipped with a mobile phone set with some monthly credit of airtime at the disposal of the HC in-charge to facilitate communication with the key district level staff.

6. Lessons learned

61…Empowerment of the community in collaboration with local technical and administrative personnel is a decisive condition to ensure the activation of maternity care activities particularly in the communities and HCs. To guarantee the sustainability, participatory approach should be employed, with coherence, both in the planning and implementation strategies. Sensitization of the existing organizations and groups to tackle the constraints are, therefore, essential after appropriate stakeholder analysis.

62…Utilization of HCs for normal deliveries is one of the essential components of safe motherhood movement in the rural and suburban setting Project areas. Strategies to strengthen health education on maternity, should be combined with uplifting quality of care at HCs as the supply of safe and obtainable best maternity care including baby delivery.

63…The components of the referral system should be implemented on a larger scale and in depth if the substantial outcomes are to be achieved. These are the topics with multi-factorial background to be tackled as independent projects. This topic can be handled with separate project.

7. Acknowledgements

64…The Project Evaluation Team would like to extend its gratitude to DHMT staff, and health centre staff and members of community organizations for their generous cooperation to the evaluation activities under the tight schedule. The Team would also like to thank the resident Japanese expert team for their enormous efforts in data collection and coordination related to this mid-term evaluation process. We would like to say good luck for the successful advancement of the rest of your activities until the ending point of the project.

ANNEX

1. Project Design Matrix (PDM)
2. List of Evaluation Questions
3. Main Interviewees
4. Minutes of Meeting on the Report of the Joint Evaluation Team

Project Design Matrix
Project Name: Project for the Improvement of Health Service with a focus on Safe Motherhood in the Kisii and Kericho Districts
Project Period: March 2005 to 2008 (3 years)
Implementing Organisations: District Health Management Teams (DHMTs), Division of Reproductive Health (DRH), Department of Preventive and Promotive Health Service, Ministry of Health
Target Groups: DHMTs, Health care providers, HC administration staff, and communities in the Kisii and Kericho Districts
Beneficiaries: People in the Kisii and Kericho Districts, particularly women of reproductive age.

PDM 0 (April 2005, Project Document)

Narrative Summary	Objectively Verifiable Indicators *1	Means of Verification	Important Assumptions
[Overall Goal] Health condition, particularly the maternal health, in the Kisii and Kericho Districts is improved.	Maternal mortality (rate) in the District Case fatality rate due to maternal complications Infant mortality rate and malaria fatality rate	Census (DHS), MDR, Health Statistics	
[Project Purpose] Maternal care in the Project area with a focus on health centres and communities is improved.	Skilled birth attendance rate in District Delivery rate and ANC rate at HCs Success rate in meeting the needs of women with maternal complications HC utilization rate and client satisfaction	Patient charts at hospitals and HCs, DHS, Health Statistics, Community Surveys, Exit Interviews	No significant changes in the pattern of disease, MOH policy, or economic or political conditions.
[Outputs] **Component 1. Maternal care in the Project area is improved.** 1. Maternal care services at the HCs are upgraded.	1 % of HCs providing skilled birth attendance (SBA) % of clinical staff meeting the definition of SBA 1-1 Completion of training workplan, No. of staff trained (in total and by HC), No. of follow-ups for training, No. of staff receiving the follow-ups, Evaluation of work performed by trained staff, Clients satisfaction with the quality of care. 1-2. No. of HCs maintaining facility and equipment provided 1 and 2 years after installation, No. of staff trained for maintenance.	Training records, Reports by trainees Records on meetings , Training records and reports, Monitoring records Monitoring records, Community survey, Maintenance records	Recurrent costs are provided for hospitals, HCs, and communities by the Kenyan side.
2. Maternal care at the community level is improved.	2 No. of CORPs trained, No. of CORPs attending ANCs and deliveries in pilot communities No. of Health learning sessions, No. of participants, Changes in awareness and health behaviour among people. For scaling-up to other communities, No. of peer learning workshops and exchange visits No. of communities replicating activities	Patient charts at HCs and Hospitals Training records/report Community survey	

Component 2. Management support in the HCs is improved.				
3. A referral system is arranged and functioning between communities, HCs and District Hospitals.	3	No. of proper referral cases of maternal complications Use of communication & transportation No. of training sessions for referral and No. of participants Use of referral guideline No. of meetings for reviewing referral cases	Case review record Patient chart (Hospital, HC)	
4. Health Information System (HIS) and record keeping system at HCs is functioning and is utilised for service and management at the HCs.	4	No. of training sessions for HIS and trainees Redundancy of records and reporting Use of HIS for care and management at HCs Use of HIS for monitoring and evaluation	Community surveys Case review meetings Administration records at HCs Monitoring records Training records/reports	
5. Management capability for drugs and medical supplies at the HCs are improved.	5	Stock-out drugs and medical supplies Use of logbooks for inventory and prescription Frequency of drug delivery to HCs Rational use of medicines based on guidelines at HCs	Stock/inventory records Delivery records Logbooks Training records/reports Patient charts at HCs Prescription records	
6. District Health Management Teams (DHMTs)' system for their supportive supervision for HCs is strengthened.	6	No. of DHMT members supervising HCs. Quality of supervision Quality assurance of HC management	DHMT reports DHMT meeting records HCC, HFMT meeting records	

(Activities) **Outcome 1. Maternal care services in the HCs are upgraded.** A) To institute a training system for maternal care 1. Preparation 1) Organizing training team within DHMT 2) Reviewing information on training needs for HC staff 3) Establishing curricula 4) Selecting health staff to be trained. 5) Formulating training work-plan 2. Implementation Training in maternal care for HC staff, including essential& emergency obstetric care, ANC, PAC with client-centred care. 3. Follow-up or Monitoring 1) Follow-up for the trained staff with on-the-job training and re-training utilizing Critical Incidence Analysis *2 2) Conducting Maternal Death Review (MDR) B) To establish a system for renovating facilities and providing equipment with their maintenance. 1. Preparation 1) Investigating the current status of the facilities and equipment at each HC. 2) Determining the required renovation and selecting equipment for maternal care. 2. Implementation 1) Renovating facilities and providing equipment 2) Developing manuals for operation and maintenance. 3. Following-up and Monitoring Conducting regular maintenance for equipment and facilities	(Inputs) Japanese side [Human Resources] (Long-or short term experts or consultants) 1. Chief Advisor or Technical Advisor 2. Project Manager 3. Project Coordinator 4. Midwifery 5. Community-based health [Provision of Equipment] 1. Equipment for Maternal care at HCs 2. Maternal care equipment for training at Hospitals 3. Leaning materials necessary for training 4. Communication equipment 5. Equipment for Project Operation [Facility Renovation] i.e. Water supply facility at HC, Solar system for HC *Decisions on renovation and equipment provision will be made based on further surveys, including an assessment of the condition of equipment provided by Japanese Grant Aid.* [Counterpart training] Training in Japan and/or third countries, Acceptance of trainees 1. Midwifery 2. District Health Management 3. Others [Project Operational Cost] 1. Training 2. Employment of local consultants (including sub-contracting)	(Inputs) Kenyan side [Assignments of counterparts] Ministry of Health DRH Other relevant departments DHMT (Kisii & Kericho) PMO HC staff HFMT (HCC) [Accomodations] Salary for the staff Facilities Project Office Office secretaries Drivers Training sites Recurrent costs for items such as vehicle fuel and equipment

Outcome 2. Maternal care at the community level is improved. 1. Preparation 1) Conducting community and household surveys at candidate communities 2) Selecting a pilot community in each District 3) Identifying CORPs*3 and HCMC*4 members in the community and formulating the workplan. 2. Implementation 1) Training PHT and nurses at the nearby health centre and developing IEC for awareness and referral 2) Training CORPs and HCMC members for community awareness and referral for maternal care 3) Supporting CORPs and the community to organize health learning groups and a transportation system with community funds 3. Follow-up or Monitoring 1) Facilitating visits by other communities and peer learning as pilot community activities. 2) Monitoring the community health activities and formulating models for best practices. 3) Supporting and following up for the scale-up of activities in other areas in Districts **Outcome 3. Referral system is systemized and functioning** 1. Preparation 1) Assessing the current referral system 2) Formulate a referral system improvement plan a) Formulating a communication and transportation plan for referral a District Hospitals and HCs b) Formulating referral guidelines for the HCs and District Hospitals 2. Implementation 1) Setting up communication equipment at District Hospitals and HCs. 2) Assisting in securing transportation by repairing existing vehicles o providing new vehicles at DHs 3) Training HC staff in the guidelines 3. Following up and Monitoring 1) Conducting maintenance for communication and transportation 2) Conducting regular audits of referral cases	3. Others

Outcome 4. HIS for monitoring and evaluation aiming at improved HC services and management 1. Preparation 1) Assessing the current status of the HIS at the HCs and District Hospitals 2) Formulating a HIS improvement plan at the HCs 2. Implementation 1) Training District MRIO for improvement plan for HIS 2) Training HC staff in record-keeping 3. Following up and Monitoring Continuously improving the quality of record-keeping at the District and HC levels	
Outcome 5. Provision, storage, management, and prescription of drugs and medical supplies at the HCs are improved. 1. Preparation 1) Surveying drugs and medical supplies with a focus on the adequacy of provision (delivery), stock, and prescription 2) Formulating a drug management improvement plan at the HCs 2. Implementation 1) Introducing logbooks for inventory, store-keeping and prescription; training HC staff to use the log books 2) Training HC staff on the case management guidelines at the HCs to ensure the rational use of drugs 3) Maintaining and strengthening the logistics system for drug delivery in coordination with HIS 3. Following up and Monitoring Continuously improving the quality of drug management.	
Outcome 6. Strengthened capacity of the DHMTs in supervising the HCs. 1. Preparation 1) Assessing the DHMT's current system for supervising the HCs 2) Formulating their plan for HC supervision 2. Implementation Implementing the supervisory plan 3. Following up and Monitoring Monitoring the DHMT's supervision of the HCs with feedback.	

*1 The objectively verifiable indicators used for the purpose and outputs are accorded to those established in the District Plan. Otherwise, efforts will be made to determine important indicators suc as Maternal Mortality (rate) in the area by baseline s

*2 Critical Incidence Analysis: To assess the effects of training by examining records on the management of cases handled by the trainees after the training.

*3 CORPs include community leaders, traditional birth attendants (TBAs) and community health workers (CHWs).

*4 The Heath Centre Management Committee (HCMC) is a community-based committee responsible for management of the HCs.

2. List of Evaluation Questions

Key: RE..relevance, EY…efficiency, ES…effectiveness, IM…impact, SU…sustainability

01…EVQ in Goal level

IM-G…Do you recognize the declining tendency of maternal death in the catchments of your district hospital after the commencement of SAMOKIKE Project? If, YES, please let us know the numerical data on the death cases of referral patient (mothers) in JAN-JUN 2006 with control data (the number before Project, maybe in JAN-JUN 2004)
(Q to district hospital directors in Kericho and Kisii and to SAMOKIKE Project Office)

If Yes, please fill the table below.

IM-G…Was the quarterly, bi-annual and annual number of the received referral patients or clients of maternal care particularly in relation to pregnancy increased in JAN-JUN 2006 in comparison with the same months in 2005 and 2004? Please provide the information by numerical data based upon the available clinical records. If the record is not available, please notify that and give your impression on the change by description.
(Q to Division Head or Head Nurse in charge of emergency obstetric care or equivalent section of the two district hospitals and also to Project Office)

SU-G…Were data collection, analysis and the feed-back practice of the analysis result to the health centres and other facilities, which send referral clients of maternal health improved at District Hospitals in the project area after commencement of the project activities? Please briefly report if you have already recognized the positive change. In case that there is no improvement or set-back, please discuss the background factors and the most important reason.
(Q to Project Office)

RE-G…Were health centres' physical facilities (buildings) in the Project area durable or useful enough for enhancing maternal care particularly of delivery and antenatal care? Please notify by writing if major problems in buildings were left unattended due to the limitation of fund or due to unavailability of fund.
(Q to Project Office and District Medical Officers in the project area)

IM-G-Ass….Were other health problems than safe motherhood and reproductive health came to be extremely serious in the past 2 years in the catchments of your health facility? If you recognized, in the past 2 years, any disease or conditions, which made your facility extremely busy and full of patients except for maternal child health care, please notify them.
(Q to health centre managers in the project area. Please randomly select at least 5 centres and send this question and retrieve the answers.)

RE-G…Was Maternal health (in a broader sense—Safe motherhood) recognized by residents of the Project area as a prioritized health problem? Please show the awareness level of the general public before the starting point of the Project and the positive change, if it was detected, by showing the result of qualitative observation.
(Q to Project Office)

02…EVQ in Project Purpose Level

ES-PP…How many health centres are capable to provide services on normal delivery at the moment of this evaluation survey? Please give the number. (It was reported that only 9 health centres are instrumental to care provision on delivery in MAR 2005.)
(Q to District Medical Officers of two districts and also to Project Office)

ES-PP….Does your health centre accept the clients for normal delivery? If YES, please notify the number of deliveries carried out at your health centre in JUL, MAY, APR 2006 respectively together with the number of the same months in 2005.
(Q to all health centre managers in the Project area.)

ES-PP…How many instrument kits for normal delivery is available at your health centre at this moment? Please answer this question with relevant number of the kits.
(Q to staff attending to delivery at delivery room of respective health centre, Please select randomly at least 5 health centres, which were donated the mentioned instrument kit by the Project, for collection information by this Q.)

ES-PP…How many health centres are functionally uplifted to the condition, where they accept clients for normal delivery after the starting point of the Project at the Project area?
(Q to Project Office)

SU-PP…(1) How many cadres of midwives was your health centre allocated? (2) How many midwives are in operation at this moment at your health centre?
(Q to health centre managers of all health centres in the Project area.)

SU-PP…In the Project area, was growth monitoring of the under 5 children conducted at each community with out-reach activities run by health centres or systematically conducted at health centre?
(Q to Project Office)

ES-PP…(1) What is the core activities in community-based maternal care, which is now in operation with standardization?, (2) What was the detectable positive change in attitude of care-seekers (pregnant women in the communities) during project period to date in terms of health behaviours related to safe motherhood? If there was no change detected, please notify the background and reason as your speculation.
(Q to Project Office)

ES-PP…(1) What was the most difficult obstacle, which hindered effectiveness of house to house maternal care service in the Project area? (2) Was the implementation status of house to house visit for maternal care improved in terms of frequency and service contents? Please briefly explain the recent development by writing.
(Q to randomly selected 5 health centre managers and Project Office)

ES-PP…What are the most important clinical signs, by which you determine to refer the pregnant patients or clients to district hospital?
(Q to health centre clinical officers serving for randomly selected 5 health centres.)
Danger signs: APH, Pre-, Anaemia, Obstructed labour. The SHC, said recognition of danger signs server bleeding, footling, dryness and hotness of vagina, excess bleeding per vagina, excessive moulding, bindles ring, maternal and foetal distances, premature rupture of membranes more than four hours are the most important clinical signs by which one determines to refer the pregnant patients/clients to district hospital.

03…EVQ in Outputs level

ES-OP1…Was diagnostic skill of the health centre staffs attending to pregnant clients and delivery was standardized after training opportunities provided by the Project? Please provide the current achievement of clinical officers, midwives, and nursing staffs by questionnaire or post-training test. If there is no improvement in the diagnostic skills and knowledge of the above mentioned staffs, please discuss the reasons and major obstacles.
(Q to Project Office)

ES-OP1…What is the expecting feature of the well organized record keeping at health centres? After defining the expecting standard of facility-based record keeping practice, please notify the number of health centres out of the total number of health centres in the Project area, which recently uplifted the past unfavourable practice to the improved practice.
(Q to Project Office)

SU-OP1…Do health centre staff, generally, review and analyze the collected data every month or quarter prior to sending data to the superior office?
(Q to Project Office)

SU-OP1…Do you site the collected data on the clinical statistics at the time of budget planning and request raising on fund, which are made at the end of every fiscal year?
(Q to health centre managers. Please select at least 10 health centres in the Project area for answer collection.)

ES-OP1…Was client satisfaction on the health centre staff performance particularly on communication confirmed after training opportunities provided by the Project? If a survey results of client satisfaction at health centre, please submit the result highlighting the outcomes on staffs' communication skill and practice.
(Q to Project Office)

ES-OP1…Does clinical officers of the health centre you often visit talk to you n nicely and explain your condition at the visit with understandable words and phrases?
(Q to 10 clients visiting at 5 health centres in the Project Area. The quick and informal interview is highly expected to be conducted for this evaluation process by Project Office Kenyan staff by native language. Thanks.)

ES-OP1…How often in a week do you use the Doppler device for your diagnostic service to the clients?
(Q to clinical officers and midwives at least 5 health centres, which was selected randomly from the centres belonging to the Project area)

ES-OP1…Please define the most important technical skill to handle Doppler apparatus for health centre staff attending to diagnostic service to the pregnant clients. Having had that, notify the achievement of that technical point shown by the health centre staffs at the training course, which was conducted by the Project at the equipment donation.
(Q to Project Office)

ES-OP1…Were all health staffs, who are supposed to use the Doppler, enrolled a training course taken place at the Project Area? Please notify the percentage of enrollment of the existing health staff, who are supposed to use Doppler in their practice.
(Q to Project Office)

SU-OP1…How many percentages of the introduced Doppler apparatus is now functional?
(Q to Project Office)

SU-OP1…How much does it cost for the replacement of the Doppler apparatus, if it is functionally impaired after guaranteed period of durability?
(Q to Regional Medical Officer and to Project Office)

ES-OP2…How many percentages of health centres in the Project area submit monthly and annual report related to health information and management information periodically and in time to the superior organization?
(Q to District Medical Officer' s Office and Project Office)

ES-OP2…How many percentages of health centres in the Project area utilize inventory record of the equipment? Please select health centres in the Project area randomly at least 10 in number and collect the information.
(Q to Project Office)

ES0OP2…Was job satisfaction level of nurses and midwives serving at health centers improved in work environment? Please clarify the change of work environment in terms of care-provider friendliness by a simple questionnaire to the nurses and midwives of the selected 5 health centres, which received support from the Project.
(Q to health centre nurses and midwives through Project Office.)

ES-OP3…(1) Please define the District Health Management Team and its supervisory task ,which has to be conducted periodically to health centres in the district. (2) How often can you visit health centres in a year for supervision purpose under the given circumstances?
(Q to District Medical Officer)

SU-OP3…How much does it cost for one supervisory trip to some health centres in your territory? Please show a rough figure in KSH.
(Q to District Medical Officer)

RE-OP3…What is the most important element of supportive supervision, which has to be regularly conducted by DHMT only with implicitly available finance?
(Q to any member of DHMT, which is related to the Project and Q to the Project Office)

ES-OP3…How frequently multi-purpose vehicles introduced to DHMT by the Project were used for supportive supervision, in which DHMT officials physically visited for supervision purpose in the duration of JAN 2006 - JUN 2006?
(Q to DHMT of the two districts in the Project area)

ES-OP3…Did managers of health centres comply to the DHMT' s instruction in preparatory work for the supervision visit? Please notify the evaluation result by DHMT to selected 5 managers of health centres by qualitative statement.
(Q to district medical officers of the two districts through Project Office)

ES-OP3…Was DHMT supervision visit in the year 2005 and 2006 useful to you? If YES please mention the most important suggestion, which you got from the visited team on the management practice. If NO, please notify the points that should be improved in terms of implementation of supervision by DHMT.
(Q to Health centre managers of the selected 10 health centres in the Project area)
SU-OP4…What is the most important component of community-based maternal care, which has to be further improved in the coming year for the betterment of quality of the service at community?
(Q to selected 5-10 community health nurses, who are responsible to control the community activity in catchments of health centres)

ES-OP4…How many Community Resource Persons (CORPS) per community in the Project area were trained by short-term course by the Project in the duration of 2005-2006.
(Q to Project Office)

ES-OP4…How often did you have meeting with CORP at your catchments in APR, MAY, and Jun in 2006?
(Q to community health nurses belonging to the selected 5-10 health centres in the Project area.)

ES-OP4…Please notify by responding to the inquiry of Project Office on the recent improvement of consultation-seeking attitude of reproductive women in your working territory. Were health centre clients for reproductive health education including sex education increased in JAN-JUN 2006, comparing to the same period in 2005? If the increment was visible in statistics, please provide the data. If it was NOT increased, please discuss the background factors and the causes in your written report.
(Q to all health centres and to Project Office)

ES-OP5…Please notify the current trend in referral patients related to maternal health from the health centres in your catchments by writing. Is it increased in number or decreased? What is your speculation of the reason of the change, which has been observed by you in the past 1 year?
(Q to doctors, clinical officers or midwives in charge of receiving referral patients for Obst-Gyne care at the two district hospitals in Project area / Please select multiple interviewees at each hospital and interview informally but directly by the Project Office staff. Thanks in advance for the cooperation.)

ES-OP5…Training Programmes, offered by the Project, were expected to make the diagnosis for sending out referral patients (in relation to maternal care) at health centres. What were the most important knowledge and the technical tips for rationalized decision-making for sending out referral patients to the district hospital?
(Q to Project Office)

ES-OP5…What was the most useful training outcomes that you attained at training courses related to maternal care for making proper diagnosis with confidence in relation to referral activities?
(Q to clinical officers at health centres in the Project area. Please sample, 5- 10 health centres and collect answers from the relevant personnel.)

SU-OP5…(1) Is a vehicle available all the time without charge for transporting patients with urgent needs for care at district hospital? (2) If you had to ask to shoulder the cost of the vehicle to the patient, please let us know the average price for one way trip to the nearest hospital?
(Q to health centres in Project area)

3. Main Interviewees

Ministry of Health (HQ)

1. Dr. Hezron Nyangito, Permanent Secretary, Ministry of Health (MOH)
2. Dr. Shanaz Sharif, Head, Preventive & Promotive Health Services
3. Dr. Jane Kibaru, Head, Division of Reproductive Health, MOH
4. Mr. Daniel Sande, Staff, DRH, MOH

District Health Management Team, Kisii

5. Dr. E.S. Abunga, DMoH, Kisii District
6. Dr. Wycliffe Mogoa, Medical Superintendent, Kisii District Hospital
7. Mr. James Amenya, District Health Administration Officer
8. Ms. Joyce Atinda, District Nutrition Officer
9. Ms. Mary Mosoti, District Health Records Information Officer
10. Mr. James Kirwa, District Health Education Officer
11. Ms. Agnes Monayo, Nursing Officer, KDH
12. Nurse, Iranda Health Centre (H/C)
13. Nurse, Riotanchi H/C

District Health Management Team, Kericho

14. Dr. C.K. Kemboi, DMoH, Kericho District
15. Dr. Betty Langat, Medical Superintendent, Kericho District Hospital
16. Mr. Toroitich, District Public Health Nurse
17. Nurse, Chepkemel H/C
18. Nurse, Kabianga H/C
19. Nurse, Sosiot H/C
20. Nurse, Kiptere Dispensary
21. Mr. John Nyatome, Divisional Public Health Officer, Sigowet
22. Mr. Douglas Koech, Clinical Officer, Sigowet Nyayo H/C
23. Ms. Chemiron, Nurse, Sigowet Nyayo H/C
24. Mr. Z. Mbongoch, Chairman, Health Facility Committee, Sigowet Nyayo H/C
25. Ms. Lily Langat, Treasurer, HFC, Sigowet Nyayo H/C

HANDS Project Office

26. Mr. M. Shimamoto, Chief Advisor, JICA-HANDS Project
27. Ms. Y. Kitagawa, Technical Advisor on Maternal Care
28. Ms. Kato, Project Co-ordinator
29. Ms. Kawai, Staff, Tokyo Office
30. Mr. Uchida, Intern
31. Mr. Leonard Mauti, Project Assistant
32. Mr. Patrick Areri, Project Assistant

4. Minutes of Meeting on the Report of the Joint Evaluation Team

REPORT OF THE JOINT EVALUATION TEAM
ON THE MID TERM EVALUATION
OF THE TECHNICAL COOPERATION FOR
THE PROJECT ON HEALTH SERVICES IMPROVEMENT
WITH A FOCUS ON SAFE MOTHERHOOD
IN KISII AND KERICHO DISTRICTS

The JICA Evaluation Team (hereinafter referred to as "the JICA Team") led by Prof. Yujiro HANDA and the Kenyan Evaluation Team (hereinafter referred to as "the Kenyan Team") led by Dr. Josephine KIBARU formed a Joint Evaluation Team (hereinafter referred to as "the Team") and conducted the mid term evaluation of the technical cooperation project on health services improvement with a focus on safe motherhood in Kisii and Kericho districts (hereinafter referred to as "the Project") between 24th July 2006 and 31st March 2007. The Team evaluated the performance and achievements of the Project.

During the evaluation period, the Team conducted field visits, interviews and held a series of discussions in respect of desirable measures to be taken by the Governments of Kenya and Japan for the successful implementation of the Project.

The Team agreed on the contents of the Mid - Term Evaluation Report as described in the document attached hereto. Further, the Team agreed to recommend to their respective organizations the matters referred to in the attached document.

Nairobi, July 17th, 2007

Prof. Yujiro HANDA
Leader
JICA Evaluation Team
Japan International Cooperation Agency

Dr. Josephine KIBARU
Leader
Kenyan Evaluation Team
Ministry of Health

ATTACHMENT

1 Introduction

1-1. The Evaluation Team

The Team jointly organized by Japan International Cooperation Agency (hereinafter referred to as "JICA") and the Ministry of Health (hereinafter referred to as "the MOH") jointly evaluated the implementation process, performance and achievements of the Project based on the R/D Annex (1).

The Team and the relevant authorities of the Government of Kenya jointly analyzed and discussed the achievement of the Project in terms of the evaluation criteria described herein and the Project's future direction.

1-2. Methodology of Evaluation

The Team examined the Project Design Matrix (hereinafter referred to as "PDM") (Annex 2). The PDM is a narrative summary of the overall description of the Project, its purpose, outputs, indicators, activities and implementation environment. The Team assessed the PDM and improved its content to meet the demand for the evaluation process. The resultant PDM for evaluation (PDMe) was then prepared. The narrative summary of the PDMe was used to devise evaluation questions in line with the evaluation criteria.

The Team confirmed the achievements of the Project in terms of its purpose, outputs, activities and inputs as stated in the PDMe. The Team conducted the evaluation based on the five criteria described in the following section.

1-3. Evaluation Criteria

The evaluation was conducted based on the following five criteria adopted by JICA from the Development Assistance Committee (DAC) of the Organization of Economic Cooperation and Development Countries (OECD).

1) Relevance:
This is a measure for determining whether the outputs, the Project purpose and the overall goal are still consistent with the priority needs and concerns at the time of evaluation.

2) Effectiveness:
This is a measure of the extent to which the Project purpose has been achieved in relation to the outputs.

3) Efficiency:
Is a measure of the productivity of the Project implementation process; assesses the level of conversion of the various inputs into outputs.

4) Impact:
This refers to the intended or unintended, direct or indirect, positive or negative changes that occur as a result of the Project.

5) Sustainability:
This is a measure for determining whether or not the Project benefits are likely to continue after termination of the external assistance.

1-4. Sources of Information for Evaluation
The following sources of information were utilized for the evaluation

(1) The R/D signed in Nairobi in February 2005
(2) The previous versions of PDM
(3) The records of inputs from the JICA and the Kenyan sides and activities of the Project
(4) Project monitoring reports

2 Background and Summary of the Project

2-1. Project Background
The Project commenced on 25th March 2005 with a three – year cooperation period. It is being implemented in Kisii and Kericho districts in the Western part of Kenya. The Overall Goal and Project Purpose were agreed upon as follows;

Overall Goal: Health condition particularly maternal health in Kisii and Kericho districts is improved.
Project Purpose: Maternal care in the Project area with a focus on Health Centres (HCs) and communities is improved.

2-2. Duration of Technical Cooperation
The duration was agreed to be 3 years from 25th March 2005.

2-3. Outputs of the Project
(1) Maternal care services at HCs are upgraded.
(2) Maternal care in community level is improved.
(3) A referral system arranged and functioning between communities, HCs and District Hospital
(4) HIS and record-keeping system in place ay HCs is functioning and is utilized for their service and management at the HCs.
(5) Management capability of drugs and medical supplies at HCs are improved.
(6) District Health Management Team (DHMT)' system for their supportive supervision for HCs is strengthened.

2-4. Implementing Agency
The Project is implemented by the Ministry of Health of the Government of the Republic of Kenya.

3 Project Achievements

3-1. Inputs
(Inputs by JICA)
(1) Dispatch of JICA Experts Annex (3)
(2) Training Courses and Study Tour Annex (4)

(3) Provision of Equipment Annex (5)
(4) Local Activity Cost for the Project

(Inputs by the Government of Kenya)
(1) Counterpart Personnel for the Project Annex (6)
(2) Land, Buildings and Facilities
(3) Budget for Operational Expenses

3-2. Progress of Achievement of Project Purpose and Outputs
The progress towards achievement of the Project Purpose and Outputs is being monitored by the Project in collaboration with the respective District Health Management Teams (DHMTs). Details of the progress made are contained in the Mid - Term Evaluation Report.

4 Summary of Results of Evaluation

4-1. Relevance
This Project was designed as an intervention to improve the capability of Kenyan stakeholders (both in community organizations and district level health service delivery system) in planning, implementation, monitoring, and evaluation related to routine health service with emphasis on safe motherhood. In this regard, the objectives of this project were “relevant”. The target was absolutely in line with the national policy advocated in the National Health Sector Strategic Plan.

4-2. Effectiveness
The Project intended to improve the capabilities of communities, health centres, and particularly of DHMT, in order to enhance supervision activities as a part of routine work of local health authorities. In the Project areas of Kericho and Kisii Districts, community-based organizations (CBOs), health centres, and the district health service administrators improved technical and managerial capacities to a standard, where they can plan and implement community programmes for improving working conditions and facilities at respective HC.

It was revealed in the mid-term evaluation visit to sampled health centres that the utilization of HCs by the community people was improved particularly at HC, where service was started for normal deliveries. District hospitals staff s serving for maternity care was also trained to update their skill and knowledge through training courses provided by the Project. There were positive indications of effectiveness of maternity care particularly both at HCs and district hospitals.

4-3. Efficiency
Safe motherhood and improved maternity care in the project areas were achieved with relatively high efficiency as a well organized package of training, equipment inputs, mobilizing DHMT monitoring function and community involvement. HCs’ facilities and equipment were substantially improved making maximal use of community support and project input. Construction of some physical facilities was conducted by the community people. The activities related to uplifting HC function in the Project areas were

designed and implemented in an efficient manner.

The training component related to simple but essential health informatics were well-designed and regarded as an activity with high efficiency for HCs, where computerized clinical recording and patient registration system was not introduced. It is, however, obvious that the extension of the improved practice to other facilities in the referral ladder is mandatory if the Project intended to monitor the improvement of the referral system in the district through this information system.

4-4. Impact

No major negative impacts to the community, health centre, DHMT or other stakeholders were found. At the moment of mid-term evaluation, positive impacts were found primarily related to the practice of maternity care particularly of normal deliveries, which was extended to at least 13 HCs out of 14 in the Project area, whereas before the starting point of the Project only 9 conducted the service of deliveries. It was also recognized that increase of clients coming for antenatal care at most of the HCs, resulted from the provision of deliveries.

4-5. Sustainability

The Project was sensitive to the importance of achieving sustainability of ongoing activities since the planning stage. The involvement of central / local government and health authorities was properly done to pursue tangible outcomes of project activities and also to ensure the sustainability of the project outputs.

Finance is the key to ensure sustainability even for successful activities. The most sensitive issue for sustainability is recurrent costs. MOH and DHMT are aware of the demand for allowances and incentives seemingly needed for continued engagement of various health personnel including volunteers. It is not easy to maintain credibility for funding such allowances and incentives

5 Lessons Learned

① Empowerment of the community in collaboration with local technical and administrative personnel is a decisive condition to ensure the activation of maternity care activities particularly in the communities and HCs. To guarantee the sustainability, participatory approach should be employed, with coherence, both in the planning and implementation strategies.

② Strategies to strengthen health education on maternity, should be combined with uplifting quality of care at HCs as the supply of safe and obtainable best maternity care including baby delivery.

③ The components of the referral system should be implemented on a larger scale and in depth if the substantial outcomes are to be achieved. These are the topics with multi-factorial background to be tackled as independent projects.

6 Recommendations

① HCs with improved utilization by the community people should further be monitored regarding the work environment and quality of service.
② Referral activities among HCs and district hospitals should further be looked into by the Project with foci on triage and communication.
③ The Project should maintain the existing policy to make maximal use of community participation.
④ The situation of congestion in the maternity wards at district hospitals in the Project areas should be continuously monitored together with relevant and gradual intervention on the work environment and service contents improvement.
⑤ Introduction of work environment improvement concept to the HCs will be a good entry point of work efficiency improvement and further improvement of the quality of service.
⑥ Assignment of the project manager coming from Japan to this Project should be well planned to retain period as long as possible to maintain the stable managerial condition for the entire project.

Annex:

(1) R/D
(2) PDM
(3) List of Japanese Experts dispatched
(4) List of Training Courses
(5) List of Equipment provided
(6) List of Project Counterparts

RECORD OF DISCUSSIONS
BETWEEN JAPAN INTERNATIONAL COOPERATION AGENCY AND AUTHORITIES CONCERNED OF THE GOVERNMENT OF THE REPUBLIC OF KENYA
ON JAPANESE TECHNICAL COOPERATION
ON PROJECT FOR IMPROVEMENT OF HEALTH SERVICE WITH A FOCUS ON SAFE MOTHERHOOD IN KISII AND KERICHO DISTRICTS

The Japan International Cooperation Agency (hereinafter referred to as "JICA") ,through its Resident Representative of JICA Kenya Office, exchanged the views and had a series of discussions with the Kenyan authorities concerned with respect to desirable measures to be taken by JICA and the Government of the Republic of Kenya for the successful implementation of the above-mentioned Project.

As a result of the discussions, and in accordance with the provisions of the Agreement on Technical Cooperation between the Government of Japan and the Government of the Republic of Kenya, signed in Nairobi on April 29, 2004 (hereinafter referred to as "the Agreement"), the Resident Representative of JICA Kenya Office and the Kenyan authorities concerned agreed to recommend to their respective Governments the matters referred to in the document attached hereto.

Nairobi, February 2005

Mr. Yoshiaki KANO
Resident Representative
Kenya Office
Japan International Cooperation Agency
JAPAN

Mr. Patrick S. KHAEMBA
Permanent Secretary
Ministry of Health
REPUBLIC OF KENYA

THE PERMANENT SECRETARY
MINISTRY OF FINANCE,
P. O. Box 30007,
NAIROBI.

Countersigned by

Mr. Joseph K. KINYUA
Permanent Secretary
Ministry of Finance
REPUBLIC OF KENYA

Dr. Yasuhide NAKAMURA
President
Health and Development Service
(HANDS), JAPAN

THE ATTACHED DOCUMENT

I. COOPERATION BETWEEN JICA AND GOVERNMENT OF THE REPUBLIC OF KENYA

1. The Government of the Republic of Kenya will implement the Project for Improvement of Health Service with a focus on Safe Motherhood in Kisii and Kericho Districts (hereinafter referred to as "the Project") in cooperation with JICA.

2. The Project will be implemented in accordance with the Master Plan which is given in Annex I.

II. MEASURES TO BE TAKEN BY JICA

In accordance with the laws and regulations in force in Japan and the provisions of Article III of the Agreement, JICA, as the executing agency for technical cooperation by the Government of Japan, will take, at its own expense, the following measures according to the normal procedures of its technical cooperation scheme.

1. DISPATCH OF JAPANESE EXPERTS
JICA will provide the services of the Japanese experts as listed in Annex II. The provision of Article V of the Agreement will be applied to the above-mentioned experts.

2. PROVISION OF MACHINERY, EQUIPMENT AND MATERIALS
JICA will provide such machinery, equipment and other materials (hereinafter referred to as "the Equipment") necessary for the implementation of the Project as listed in Annex III. The provision of Article VII of the Agreement will be applied to the Equipment.

3. TRAINING OF KENYAN PERSONNEL IN JAPAN AND THIRD COUNTRIES
JICA will provide the technical training for the Kenyan personnel connected with the Project in Japan and third countries.

III. MEASURES TO BE TAKEN BY THE GOVERNMENT OF REPUBLIC OF KENYA

1. The Government of the Republic of Kenya will take necessary measures to ensure that the self-reliant operation of the Project will be sustained during and after the period of Japanese technical cooperation, through full and active involvement in the Project by all related authorities, beneficiary groups and institutions.

2. The Government of the Republic of Kenya will ensure that the technologies and knowledge

acquired by the Kenyan nationals as a result of the Japanese technical cooperation will contribute to the economic and social development of Republic of Kenya.

3. In accordance with the provisions of Article V of the Agreement, the Government of the Republic of Kenya will grant in Kenyan privileges, exemptions and benefits to the Japanese experts referred to in II-1 above and their families.

4. In accordance with the provisions of Article VII of the Agreement, the Government of the Republic of Kenya will take the measures necessary to receive and use the Equipment provided by JICA under II-2 above and equipment, machinery and materials carried in by the Japanese experts referred to in II-1 above.

5. The Government of the Republic of Kenya will take necessary measures to ensure that the knowledge and experience acquired by the Kenyan personnel from technical training in Japan will be utilized effectively in the implementation of the Project.

6. In accordance with the provision of Article V of the Agreement, the Government of the Republic of Kenya will provide the services of Kenyan counterpart personnel and administrative personnel as listed in Annex IV.

7. In accordance with the provision of Article V of the Agreement, the Government of the Republic of Kenya will provide the buildings and facilities as listed in Annex V.

8. In accordance with the laws and regulations in force in the Republic of Kenya, the Government of the Republic of Kenya will take necessary measures to supply or replace at its own expense machinery, equipment, instruments, vehicles, tools, spare parts and any other materials necessary for the implementation of the Project other than the Equipment provided by JICA under II-2 above.

9. In accordance with the laws and regulations in force in the Republic of Kenya, the Government of the Republic of Kenya will take necessary measures to meet the running expenses necessary for the implementation of the Project.

IV. ADMINISTRATION OF THE PROJECT

1. The Director of Medical Services of Ministry of Health, as the Project Director, will bear overall responsibility for the administration and implementation of the Project.

2. The Head of Department of Preventive and Promotive Health Services, as the Project Manager, will be responsible for the managerial and technical matters of the Project.

3. The Japanese Project Manager will provide necessary recommendations and advice to the Kenyan Project Director and the Project Manager on any matters pertaining to the implementation of the Project.

4. The Japanese experts will give necessary technical guidance and advice to the Kenyan counterpart personnel on technical matters pertaining to the implementation of the Project.

5. For the effective and successful implementation of technical cooperation for the Project, a Joint National Project Steering Committee, National Technical Working Committee, and District Project Coordination Committee will be established whose functions and composition are described in Annex VI.

V. JOINT EVALUATION

Evaluation of the Project will be conducted jointly by JICA and the Kenyan authorities concerned, at the middle and during the last six months of the cooperation term in order to examine the level of achievement.

VI. CLAIMS AGAINST JAPANESE EXPERTS

In accordance with the provision of Article 6 of the Agreement, the Government of the Republic of Kenya undertakes to bear claims, if any arises, against the Japanese experts engaged in technical cooperation for the Project resulting from, occurring in the course of, or otherwise connected with the discharge of their official functions in Republic of Kenya except for those arising from the willful misconduct or gross negligence of the Japanese experts.

VII. MUTUAL CONSULTATION

There will be mutual consultation between JICA and Government of the Republic of Kenya on any major issues arising from, or in connection with this Attached Document.

VIII. MESURES TO PROMOTE UNDERSTANDING OF AND SUPPORT FOR THE PROJECT

For the purpose of promoting support for the Project among the people of the Republic of Kenya, the Government of the Republic of Kenya will take appropriate measures to make the Project widely known to the people of the Republic of Kenya.

IX. TERM OF COOPERATION

The duration of the technical cooperation for the Project under this Attached Document will be three years from 25 March, 2005.

X. IMPLEMENTATION OF THE PROJECT

To implement the Project efficiently and effectively, JICA will entrust actual execution of the Project to Japanese Non-profit Organization namely Health and Development Service (HANDS), based on a contract to be signed by both parties. JICA will supervise the overall implementation of the Project.

ANNEX _

Master Plan

1. Overall Goal:

Health condition, particularly the maternal health in the Kisii and Kericho Districts is improved.

2. Project Purpose:

Maternal care in the Project area with a focus on health centers (HCs) and communities is improved.

3. Project Outputs:

Component 1. Maternal care in the Project area is improved

(1) Maternal care services at HCs are upgraded

(2) Maternal care in community level is improved

Component 2. Management support in the HCs is improved.

(3) A referral system is arranged and functioning between communities, HCs and District Hospital

(4) Health Information System (HIS) and record-keeping system in place at HCs is functioning and is utilized for their service and management at the HCs

(5) Management capability of drugs and medical supplies at HCs are improved

(6) District Health Management Team (DHMT)' system for their supportive supervision for HCs is strengthened

4. Project Activities

Output 1. Maternal care services at HCs are upgraded.

A) To institute a training system for maternal care

1. Preparation

1) Organizing training team within DHMT

2) Reviewing information on training needs for HC staff

3) Establishing curriculum

2. Implementation

Training in maternal care for HC staff, including essential & emergency obstetric care (life-saving skill), ANC, PAC with client-centered care

3. Follow-up or Monitoring

1) Follow up for the trained staff with on-the-job training and re-training utilizing Critical Incidence Analysis

2) Conducting Maternal Death Review

B) To establish a system for renovating facilities and providing equipment with their maintenance

1. Preparation

1) Investigating the current status of the facilities and equipment at each HC

2) Determining renovation and selecting equipment for maternal care based on a survey

2. Implementation

1) Investigating the current status of the facilities and equipment at each HCs
2) Developing manuals for operation and maintenance

3. Following-up or Monitoring
1) Conducting regular maintenance for equipment and facilities

Output 2.Maternal care at community level is improved.

1. Preparation
1) Conducting community and household surveys at candidate communities
2) Selecting a pilot community in each District
3) Identifying Community Resource Persons (CORPs) and Health Center Management Committee (HCMC) members in the community and formulating the work plan

2. Implementation
1) Training PHT and nurses at the nearby HC and developing IEC for awareness and referral
2) Training CORPs and HCMC members for community awareness and referral for maternal care
3) Supporting CORPs and the community to organize health learning groups and a transportation system with community funds

3. Following up or Monitoring
1) Facilitating visits by other communities and peer learning as pilot community activities.
2) Monitoring the community health activities and formulating the models of best practices.
3) Supporting and following up for the scale-up of activities in other areas in Districts.

Output 3. Referral system is systemized and functioning.

1. Preparation
1) Assessing the current referral system
2) Formulate a referral system improvement plan
a) Formulating a communication and transportation plan for referral at District Hospitals and HCs.
b) Formulating referral guidelines for the HCs and District Hospitals

2. Implementation
1) Setting up communication equipment at District Hospitals and HCs
2) Assisting in securing transportation by repairing existing vehicles or providing new vehicles at District Hospitals.
3) Training HC staff in the guidelines

3. Following up and Monitoring
1) Conducting maintenance for communication and transportation
2) Conducting regular audits of referral cases

Output 4. HIS is functioning and is utilized for efficient monitoring and evaluation.

1. Preparation
   1) Assessing the current status of the HIS at the HCs and District Hospitals
   2) Formulating a HIS improvement plan at the HCs
2. Implementation
   1) Training DHMT District Medical Record Information Officer for improvement plan for HIS
   2) Training HC staff in record-keeping
3. Following up and Monitoring
   1) Continuously improving the quality of record-keeping at District and HC levels.

Output 5. Provision, storage, management, and prescription of drugs and medical supplies at the HCs are improved.

1. Preparation
   1) Surveying drugs and medical supplies with a focus on the adequacy of provision (delivery), stock, and prescription
   2) Formulating a drug management improvement plan at the HCs
2. Implementation
   1) Introducing logbooks for inventory, store-keeping and prescription; training HC staff to use the logbooks
   2) Training HC staff on the case management guidelines at the HCs to ensure the rational use of drugs
   3) Maintaining and strengthening logistics system for drug delivery in coordination with HIS
3. Following up and Monitoring
   1) Continuously improving the quality of drug management.

Output 6. DHMTs' capacity for support and supervision for HCs is strengthened.

1. Preparation
   1) Assessing the current DHMT's current system for supervising the HCs.
   2) Formulating their plan for HC supervision.
2. Implementation
   1) Implementing the supervisory plan.
3. Following up and Monitoring
   1) Monitoring DHMT's supervision of the HCs with feedback.

ANNEX II

LIST OF JAPANESE EXPERTS

1. Long-term experts: 3 persons
   (1) Project Manager
   (2) Expert in Midwifery
   (3) Project Coordinator

2. Short-term experts
   Short-term experts will be dispatched when the necessity arises for the smooth implementation of the Project.
   (1) Expert in Primary Health Care/ Health Management
   (2) Expert in Community Health
   (3) Expert in Referral System
   (4) Expert in Health Information System(HIS)
   (5) Expert in Drug Management
   (6) As required

ANNEX Ⅲ

LIST OF MACHINERY, EQUIPMENT AND MATERIALS

The following equipment necessary for the implementation of the Project will be provided by the Government of Japan within budgetary limitations.

1. Equipment for training activities.
2. Other equipment and materials necessary for the implementation of the Project.

ANNEX IV

LIST OF KENYAN COUNTERPART AND ADMINISTRATIVE PERSONNEL

For the effective and successful implementation of the Project, following counterparts will be assigned.

Project Director:

Director of Medical Service (DMS) of Ministry of Health

Project Manager:

Head of Department of Preventive and Promotive Health, Ministry of Health

Assistant Project Manager:

Head of Reproductive Health (DRH), Ministry of Health

Counterpart personnel will be assigned to as follows.

(1) National Level

- Officers in Division of Reproductive Health

(2) District Level (See table 1)

- District Medical Officers in Kisii and Kericho Districts
- Medical Superintendent in Kisii and Kericho District Hospitals
- DHMT members in Kisii and Kericho Districts

Supporting Staff

(1) Administrative Staff

(2) Secretaries

(3) Drivers

ANNEX V

LIST OF BUILDINGS AND FACILITIES

1. Buildings and facilities necessary for the implementation of the Project

2. Office space and necessary facilities for the Japanese experts

3. Electricity and communications facilities

ANNEX VI

CORDINATING COMMITTEES

<JOINT NATIONAL PROJECT STEERING COMMITTEE>

1. Function

The Joint National Project Steering Committee will meet quarterly and whenever necessity arises, and work:

(1) To formulate the annual work plan of the Project;
(2) To review the overall progress of the Project as well as the achievements of the above-mentioned annual work plan;
(3) To review and exchange views on major issues arising from, or in connection with, technical cooperation; and
(4) Other relevant issues relating to the implementation of the project.

2. Composition

Chairperson: Permanent Secretary, Ministry of Health

Kenyan Member:

Ministry of Health:

Director of Medical Services (DMS), Project Director
Head, Department of Preventive and Promotive Health Services, Project Manager
Head, DRH, Deputy Project Manager
Head, Policy and Planning Division
Head, Health Sector Reform Secretariat
Provincial Medical Officer, Nyanza
Provincial Medical Officer, Rift Valley
District Medical Officer of Health, Kisii
District Medical Officer of Health, Kericho
Representative of Kenya Medical Supplies Agency

Ministry of Finance: Representative

Japanese Member

Resident Representative, JICA
Japanese Experts assigned to the Project

Observer

Representative, Embassy of Japan
Other personnel invited by the Chairperson

<NATIONAL TECHNICAL WORKING COMMITTEE >

1. Function

The National Technical Working Committee will be organized to deal with all technical issues.

2. Composition

Chairperson: Head, Department of Preventive and Promotive Health Services

Kenyan Member:

Head, DRH
Head, Health Sector Reform Secretariat
Head, Policy and Planning
Project Coordinators, Central level

Japanese Member:

Japanese Experts assigned to the Project
JICA Kenya Office representative

Other personnel invited by the Chairperson

<District Project Coordination Committee>

1. Function

A District Project Coordination Committee will be organized to discuss project activities on monthly basis.

2. Composition

Chairpersons: DMOs of Kisii and Kericho Districts (in turn)

Kenyan Member:

DHMT members
Medical Superintendents of District Hospitals
Officers in charge of the HCs.

Japanese Member

Japanese Experts assigned to the Project

Other personnel invited by the Chairpersons

Other Personnel invited by the Chairperson

Project Design Matrix

Project Name: Project for the Improvement of Health Service with a focus on Safe Motherhood in the Kisii and Kericho Districts

Project Period: March 2005 to 2008 (3 years)

Implementing Organisations: District Health Management Teams (DHMTs), Division of Reproductive Health (DRH), Department of Preventive and Promotive Health Service, Ministry of Health

Target Groups: DHMTs, Health care providers, HC administration staff, and communities in the Kisii and Kericho Districts

Beneficiaries: People in the Kisii and Kericho Districts, particularly women of reproductive age.

PDM 0 (April 2005, Project Document)

Narrative Summary	Objectively Verifiable Indicators *1	Means of Verification	Important Assumptions
[Overall Goal] Health condition, particularly the maternal health, in the Kisii and Kericho Districts is improved.	Maternal mortality (rate) in the District Case fatality rate due to maternal complications Infant mortality rate and malaria fatality rate	Census (DHS), MDR, Health Statistics	
[Project Purpose] Maternal care in the Project area with a focus on health centres and communities is improved.	Skilled birth attendance rate in District Delivery rate and ANC rate at HCs Success rate in meeting the needs of women with maternal complications HC utilization rate and client satisfaction	Patient charts at hospitals and HCs, DHS, Health Statistics, Community Surveys, Exit Interviews	No significant changes in the pattern of disease, MOH policy, or economic or political conditions.
[Outputs] **Component 1. Maternal care in the Project area is improved.**			
1. Maternal care services at the HCs are upgraded.	1 % of HCs providing skilled birth attendance (SBA) % of clinical staff meeting the definition of SBA	Training records, Reports by trainees	Recurrent costs are provided for hospitals, HCs, and communities by the Kenyan side.
	1-1 Completion of training workplan, No. of staff trained (in total and by HC), No. of follow-ups for training, No. of staff receiving the follow-ups, Evaluation of work performed by trained staff, Clients satisfaction with the quality of care.	Records on meetings , Training records and reports, Monitoring records	
	1-2. No. of HCs maintaining facility and equipment provided 1 and 2 years after installation, No. of staff trained for maintenance.	Monitoring records, Community survey, Maintenance records	
2. Maternal care at the community level is improved.	2 No. of CORPs trained, No. of CORPs attending ANCs and deliveries in pilot communities	Patient charts at HCs and Hospitals	
	No. of Health learning sessions, No. of participants, Changes in awareness and health behaviour among people.		
	For scaling-up to other communities, No. of peer learning workshops and exchange visits No. of communities replicating activities	Training records/report Community survey	

Component 2. Management support in the HCs is improved.				
3. A referral system is arranged and functioning between communities, HCs and District Hospitals.	3	No. of proper referral cases of maternal complications Use of communication & transportation No. of training sessions for referral and No. of participants Use of referral guideline No. of meetings for reviewing referral cases	Case review record Patient chart (Hospital, HC)	
4. Health Information System (HIS) and record keeping system at HCs is functioning and is utilised for service and management at the HCs.	4	No. of training sessions for HIS and trainees Redundancy of records and reporting Use of HIS for care and management at HCs Use of HIS for monitoring and evaluation	Community surveys Case review meetings Administration records at HCs Monitoring records Training records/reports	
5. Management capability for drugs and medical supplies at the HCs are improved.	5	Stock-out drugs and medical supplies Use of logbooks for inventory and prescription Frequency of drug delivery to HCs Rational use of medicines based on guidelines at HCs	Stock/inventory records Delivery records Logbooks Training records/reports Patient charts at HCs Prescription records	
6. District Health Management Teams (DHMTs)' system for their supportive supervision for HCs is strengthened.	6	No. of DHMT members supervising HCs. Quality of supervision Quality assurance of HC management	DHMT reports DHMT meeting records HCC, HFMT meeting records	

(Activities)	(Inputs)	(Inputs)
Outcome 1. Maternal care services in the HCs are upgraded.	Japanese side	Kenyan side
A) To institute a training system for maternal care	[Human Resources]	[Assignments of counterparts]
1. Preparation	(Long-or short term experts or consultants)	Ministry of Health
1) Organizing training team within DHMT	1. Chief Advisor or Technical Advisor	DRH
2) Reviewing information on training needs for HC staff	2. Project Manager	Other relevant departments
3) Establishing curricula	3. Project Coordinator	DHMT (Kisii & Kericho)
4) Selecting health staff to be trained.	4. Midwifery	PMO
5) Formulating training work-plan	5. Community-based health	HC staff
2. Implementation	[Provision of Equipment]	HFMT (HCC)
Training in maternal care for HC staff, including essential& emergency obstetric care, ANC, PAC with client-centred care.	1. Equipment for Maternal care at HCs 2. Maternal care equipment for training at Hospitals	[Accomodations]
3. Follow-up or Monitoring	3. Leaning materials necessary for training	Salary for the staff
1) Follow-up for the trained staff with on-the-job training and re-training utilizing Critical Incidence Analysis *2	4. Communication equipment	Facilities
2) Conducting Maternal Death Review (MDR)	5. Equipment for Project Operation	Project Office
B) To establish a system for renovating facilities and providing equipmen with their maintenance.	[Facility Renovation] i.e. Water supply facility at HC, Solar system for HC *Decisions on renovation and equipment provision will be made based on further surveys, including an assessment of the condition of equipment provided by Japanese Grant Aid.*	Office secretaries Drivers Training sites Recurrent costs for items such as vehicle fuel and equipment
1. Preparation	[Counterpart training]	
1) Investigating the current status of the facilities and equipment at eacl HC.	Training in Japan and/or third countries, Acceptance of trainees 1. Midwifery	
2) Determining the required renovation and selecting equipment fo maternal care.	2. District Health Management	
2. Implementation	3. Others	
1) Renovating facilities and providing equipment	[Project Operational Cost]	
2) Developing manuals for operation and maintenance.	1. Training	
3. Following-up and Monitoring	2. Employment of local consultants (including sub-contracting)	
Conducting regular maintenance for equipment and facilities		

Outcome 2. Maternal care at the community level is improved. 1. Preparation 1) Conducting community and household surveys at candidate communities 2) Selecting a pilot community in each District 3) Identifying CORPs*3 and HCMC*4 members in the community and formulating the workplan. 2. Implementation 1) Training PHT and nurses at the nearby health centre and developing IEC for awareness and referral 2) Training CORPs and HCMC members for community awareness and referral for maternal care 3) Supporting CORPs and the community to organize health learning groups and a transportation system with community funds 3. Follow-up or Monitoring 1) Facilitating visits by other communities and peer learning as pilo community activities. 2) Monitoring the community health activities and formulating models for best practices. 3) Supporting and following up for the scale-up of activities in other areas in Districts **Outcome 3. Referral system is systemized and functioning** 1. Preparation 1) Assessing the current referral system 2) Formulate a referral system improvement plan a) Formulating a communication and transportation plan for referral at District Hospitals and HCs b) Formulating referral guidelines for the HCs and District Hospitals 2. Implementation 1) Setting up communication equipment at District Hospitals and HCs. 2) Assisting in securing transportation by repairing existing vehicles or providing new vehicles at DHs 3) Training HC staff in the guidelines 3. Following up and Monitoring 1) Conducting maintenance for communication and transportation 2) Conducting regular audits of referral cases	3. Others

Outcome 4. HIS for monitoring and evaluation aiming at improved HC services and management	
1. Preparation	
1) Assessing the current status of the HIS at the HCs and District Hospitals	
2) Formulating a HIS improvement plan at the HCs	
2. Implementation	
1) Training District MRIO for improvement plan for HIS	
2) Training HC staff in record-keeping	
3. Following up and Monitoring	
Continuously improving the quality of record-keeping at the District and HC levels	
Outcome 5. Provision, storage, management, and prescription of drugs and medical supplies at the HCs are improved.	
1. Preparation	
1) Surveying drugs and medical supplies with a focus on the adequacy of provision (delivery), stock, and prescription	
2) Formulating a drug management improvement plan at the HCs	
2. Implementation	
1) Introducing logbooks for inventory, store-keeping and prescription; training HC staff to use the log books	
2) Training HC staff on the case management guidelines at the HCs to ensure the rational use of drugs	
3) Maintaining and strengthening the logistics system for drug delivery in coordination with HIS	
3. Following up and Monitoring	
Continuously improving the quality of drug management.	
Outcome 6. Strengthened capacity of the DHMTs in supervising the HCs.	
1. Preparation	
1) Assessing the DHMT's current system for supervising the HCs	
2) Formulating their plan for HC supervision	
2. Implementation	
Implementing the supervisory plan	
3. Following up and Monitoring	
Monitoring the DHMT's supervision of the HCs with feedback.	

*1 The objectively verifiable indicators used for the purpose and outputs are accorded to those established in the District Plan. Otherwise, efforts will be made to determine important indicators such as Maternal Mortality (rate) in the area by baseline surveys. The adequacy of indicators should be reviewed and revised when the PDM is revised.
*2 Critical Incidence Analysis: To assess the effects of training by examining records on the management of cases handled by the trainees after the training.
*3 CORPs include community leaders, traditional birth attendants (TBAs) and community health workers (CHWs).
*4 The Heath Centre Management Committee (HCMC) is a community-based committee responsible for management of the HCs.

LIST OF JAPANESE EXPERTS DISPATCHED

NAME	FIELD	TERM
Naoko FUJITA	Chief Advisor	15.4.2005-20.11.2005
	Health Management	22.1.2006-22.3.2006
Yasuhiko KAMIYA	Health Management	31.3.2005-23.9.2005
Yoko CHIBA	Midwife	10.4.2005-20.11.2005
		22.1.2005-22.3.2006
Masayo NONOGUCHI	Coordinator	31.3.2005-20.11.2005
	Community Health	22.1.2006-22.3.2006
Mamoru SHIMAMOTO	Community Health	01.6.2005-31.8.2005
	Chief Advisor	22.1.2006-22.3.2006
	Chief Advisor	19.6.2006-27.12.2006
Hajime MATUNAGA	Coordinator	22.1.2006-22.3.2006
Mai FUJII	Coordinator	13.2.2006-25.3.2006
Kyoko ARAKI	Health Management	27.7.2006-24.9.2006
Keiko TAKAHASHI	Community Health	11.9.-2006-9.11.2006
Yumiko KITAGAWA	Midwife	19.6.2006-28.2.2007
Akiko MATUMOTO	Health Management	02.10.2006-28.2.2007
Jyunko KATO	Coordinator	27.6.2006-28.2.2007
Kiyomi YAMAMOTO	Coordinator/	19.6.2007-28.2.2007/
	Acting Chief Advisor	28.12.2006-28.2.2007

List of Training Courses (As at September 2006)

Name of Activity	Phase of Activity	Period	Place	Contents of the Activity	Target	Total number of Participants
Training	2nd Phase	Five-day	Two (Kisii and Kericho)	Community Safe Mohterhood Orientation	Midwives / Nurses at targeted HCs and District Hospital in Kisii and Kericho	24
		Three-day	Two (Kisii and Kericho)		Community of Catchments areas in Kisii and Kericho	42
	3rd Phase	Ten-day	One (Kisii)	Essential Obstetric Care	Midwives / Nurses at targeted Health Centres (HCs) and District Hospital in Kisii and Kericho	24
	3rd Phase	Three-day	Two (Kisii and Kericho)	Health Centre Drug Management	Clinical Officers / Midwives / Nurses at targeted HCs and District Health Management Team (DHMT) in Kisii and Kericho	16
					Total trained persons	**106**

LIST OF EQUIPMENT PROVIDED

JFY	Approximate Amount (Jap. Yen)	Main Items of Equipment
2005	7,601,000	Vehicles
2005	7,326,000	Vehicles for multi purpose
2005	7,511,000	- Assorted Medical Equipment [Delivery Set, Diagnostic Set, Machines, Infection Prevention] - Training Model - Books - Journal Subscription - Registers - Record Keeping - Drug Management

List of Project Counterparts (As at September 2006)

	Position	Station	Name
1	Director of Medical Services	MOH	Dr. James W. Nyikal
2	Head, Preventive & Promotive Health	MOH	Dr. Ambrose O. Misore
3	Head, Division of Reproductive Health	DRH	Dr. Josephine Kibaru
4	Project Officer of Reproductive Health	DRH	Mr. Daniel Sande
5	Provincial Medical Officer	Nyanza	Dr. James Gesami
6		Rift Valley	Dr. Ibrahim Amira
7	District Medical Officers of Health	Kisii	Dr. Eric Abunga
8		Kericho	Dr. Christopher Kemboi
9	Medical Superintendents	Kisii	Dr. Wycliffe Mogoa
10		Kericho	Dr. Betty Langat
11	District Obstetrician Gynecologists	Kisii	Dr. Silas Onyango
12		Kericho	Dr. Philemon Letting
13	District Pharmacy Technologists	Kisii	Mr. Wilson Onduso
14		Kericho	Mr. John Koech
15	District Public Health Nurses	Kisii	Ms. Christine Momanyi
16		Kericho	Mr. Laban Toroitich
17	District Public Health Officers	Kisii	Mr. Francis Makau
18		Kericho	Mr. David Koech
19	District Clinical Officers	Kisii	Mr. Joseph Morema
20		Kericho	Mr. Stephen Tuei
21	District Medical Records and Information Officers	Kisii	Ms. Mary Mosoti
22		Kericho	Mr. Franklin Songok
23	District Health Education Officers	Kisii	Mr. James N. Kirwa
24		Kericho	Mr. Amos Kemei
25	District Health Administrative Officers	Kisii	Mr. James Amenya
26		Kericho	Mr. Julius Ringera
27	District Project Coordinators	Kisii	Ms. Mary Isena
28		Kericho	Mr. Alfred Langat