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PDM (ORIGINAL, July 2009)

Project Design Matrix

Project Title: Strengthening Management for Health in Nyanza Province, Kenya)

Duration: 4 years

Version

Date:

Target Group : Direct beneficiaries: Department of Primary Health Care Services (MoPHS), members of PHMT, DHMTs
Indirect beneficiaries: health staff working in health facilities, community people (estimated population of 5.2M)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATIONS	IMPORTANT ASSUMPTIONS
OVERALL GOAL Quality of primary health care services is improved in Nyanza province	1. Customer satisfaction 2. Proportion of health workers using existing appropriate guidelines in their service delivery	Survey Report Supervision Report	1. There are no major tribal conflicts after the project 2. There are no major outbreaks of epidemic diseases in after the project 3. The supply of drugs and health commodities does not experience major interruption after the project 4. There are no major changes of the national policy and strategies in the health sector after the project
PROJECT PURPOSE Individual capacity of health managers and institutional capacity of health management teams (Provincial and district levels) are improved in Nyanza Province	Following indicators evaluated by self and externally; 1. Qualitative and quantitative individual capacity of health managers evaluated by checklist 2. Qualitative and quantitative institutional capacity of health management teams evaluated by checklist1	Checklist Checklist	1. There are no major tribal conflicts that happen during the project period. 2. There are no major outbreaks of epidemic diseases in the project area 3. The supply of drugs and health commodities does not experience major interruptions 4. Changes of the national policy and strategies in health sector does not affect implementation of the project activities
OUTPUTS			
1 Core management capacity of health management teams (Provincial Health Management Team, PHMT and District Health Management Team DHMTs)is strengthened in Nyanza Province	1. Institutional capacity of health management team on core management evaluated by checklist 2. Health workers ' satisfaction	Checklist Survey Reports	Any major tribal conflicts do not happen during the project period. Any major outbreaks of epidemic diseases do not occur in the project area.
2 Capacities of health management teams on operational cycle process (planning, implementation, M&E) are strengthened in Nyanza Province	1. Annual Operational Plan (AOP) implementation rate 2. Reporting rate for routine health information and finance 3. Result of AOP evaluation reflected in the next AOP	AOP review report and AOP document Supervision report AOP document	Drugs and health commodities supply do not experience major interruptions
3 Capacities of health management teams to provide supportive supervision is improved in Nyanza Province	Proportion of facilities received standardised supervision	Supervision report	
4 Lessons learnt and good practices from output 1-3 are shared with other provinces and national level and networking among health managers is strengthened through the process	1. Number of workshop sharing project information 2. Number of documents and other ways of information materials to disseminate lessons learnt and best practices in the project 3. No of best practices / lessons influencing on decision making	Workshop reports Products of dissemination materials Policy document, Project evaluation	
			1. The available personnel involved in the Project are retained 2. Positive collaboration with other partners and stakeholders is maintained

PDM (ORIGINAL, July 2009)

ACTIVITIES	INPUTS		
1. Core management capacity of health management teams (PHMT, DHMTs) is strengthened in Nyanza Province 1.1. Organise workshop to identify areas that needs to be improved among PHMT and DHMTs on core management skills 1.2. Through the workshop above, develop tools for evaluation of management capacity (by self and externally) and determine the baseline of health management capacity in the province by using the developed tools 1.3. As a part of workshop, conduct exchange visit to learn from good practices in other geographic region/ country. 1.4. Through the workshop above, develop plans to improved the identified areas through 1.1 1.5. Implement the plans in 1.4	**Japanese side** JICA expert *Long term (Chief Advisor, System strengthening/ Training development, Coordinator/ Documentation) *Short term (M&E, Health Information System, Public Relations etc.) Counterpart training Equipment (vehicles, ICT equipment etc) Local activity cost (training, workshop etc.)	**Kenyan side** Counterpart staff (National, provincial and district levels) Office spaces and utilities Counterpart budget for operational cost Cost for support staff (drivers, secretary etc.)	Inputs for Project activities and secured and timely delivered by both the Kenyan and Japanese sides
2. Capacities of health management teams on operational cycle process (planning, implementation, M&E) is strengthened in Nyanza province 2.1 Conduct needs assessment for training on operational cycle process 2.2 Develop training plan 2.3 Conduct training on operational cycle process according to the plan 2.4 Using the skills acquired through the training above, develop and appraise Annual Operational Plans (AOPs) 2.5 Review existing health information system related to AOPs and its operations 2.6 Develop training / workshop plan to address gaps identified on health information system 2.7 Conduct training / workshop on health information system and develop appropriate tools and its operation through the training /workshop 2.8 Conduct support supervision visits by DHMTs at district level monthly basis 2.9 After the visits, hold monthly meetings to review implementation of AOPs and plan for the next step at district level 2.10 Implement quarterly monitoring to DHMTs and health facilities by PHMT 2.11 After quarterly monitoring visits, hold a meeting to review the results of the activity so that they will be reflected on plan of implementation of AOP and establishing the next AOP			
3. Capacities of health management teams to provide supportive supervision is improved in Nyanza province 3.1 Review and revise supervision system and practices in light of quality of management and health services through project among project staff at national, provincial and district level managers 3.2 Conduct trainings for health managers at district and provincial level on effective system and practices of supportive supervision 3.3 Conduct regular supervision 3.4 Give feedbacks to district and health facility levels on their performance, quality, processing and utilisation of health information through supervision visits 3.5 Hold regular meetings between health facilities and DHMTs to give feedback of supervision and to discuss suggestions in terms of in-service training, skill development, and other management issues such as drug commodities, health information, and financing at district level 3.6 Hold regular meeting between DHMTs and PHMT at provincial level to discuss finding of supervision and the meeting above to improve quality of services 3.7 Conduct quarterly quality audit by PHMT and DHMT regarding facility supervision conducted			PRECONDITIONS
4. Lessons learnt and best practices from Output 1-3 are shared with other provinces and national level, and health management system networking is strengthened through the process. 4.1 Set up a mechanism to review and share project activities, results, and lessons learned from the project implementation of output 1-3 with other provinces and stakeholders in the health sector 4.2 Set up a mechanism of reflecting project results on policy at national level 4.3 Document all lessons learnt, best practices and challenges of the project 4.4 Conduct workshops with other provincial management teams to share the project findings 4.5 Through the workshops, existing health management system is reviewed to be standardize through incorporating the project findings 4.6 Conduct exchange visits to Nyanza from other provinces to disseminate the project models 4.7 Hold regular meetings with national level managers			The security and safety measures in the project target areas are maintained to allow implementation of Project activities.

[1] Checklist will be developed through project workshop and baseline capacity will be assessed and the target will be set within the first 3 months.
[2] This includes basic comprehensive management skills such as leadership, human resource management, financial management, improvement of work place environment, team building, facilitation, coordination, information sharing and communication etc.
[3] A part of checklist for the project purpose will be used.
[4] Health care providers who are working health facilities within the province for DHMTs, and health care providers and DHMT members for PHMT
[5] The workshop is composed of 3 parts; in the first part, tools for capacity assessment are developed and capacity evaluation is conducted, in the second part exchange visit is conducted, and in the third part, tools and evaluation conducted in the first part are reviewed and work plan on core management skills is developed.

PDM (Modified, March 2011)

Project Design Matrix

Project Title: Strengthening Management for Health in Nyanza Province, Kenya

Duration: 4 years (July 2009 -June 2013)

Version: Proposed Version 1.0

Target Group :
Direct beneficiaries: Health managers of Provincial Health Management Team (PHMT) and District Health Management Teams (DHMTs) in Nyanza Province, Department of Primary Health Services (MOPHS: Ministry of Public Health and Sanitation)
Indirect beneficiaries: health service providers, communities in Nyanza province (estimated population of 5.8 Million)

Date: 25th March 2011

Narrative Summary	Objectively Verifiable Indicators and Targets	Means of Verifications	Important Assumption
OVERALL GOAL			
Quality of primary health care services is improved in Nyanza Province	1. Customers satisfaction rates in health facilities are increased to 90% by 2015 (Benchmark in March 2011). 2. Health managers'/providers' work satisfaction rates are increased to 90% by 2015 (Benchmark in March 2011). 3. Health service performance indicators for priority High Impact Interventions (HIs) increased to 80% and above by 2015 (Benchmark in AOP 4 and 5).	Health Leadership and Management Survey report Customer Satisfaction Survey report Health Leadership and Management Survey report Annual Operational Plan (AOP) Performance Review Report	Administrative devolution does not affect project implementation negatively. Security and safety measures in Kenya are maintained. Major outbreaks and epidemics are not emerged to affect the overall performance of the health status of the people. Human resource for health is well maintained and promoted.
PROJECT PURPOSE			
Management capacity of health management teams at Provincial and District levels in Nyanza Province is strengthened. * * Eight management capacities are identified: leadership and governance, team management, planning and M&E, health policy management, supportive supervision/coaching/mentoring, health information management, resource management, customer relationship management.	1. Grand average score of the capacity assessment in PHMT and DHMTs in Nyanza Province is increased to 4.0 by June 2013 (Benchmark in January 2010 for pilot teams and in March 2011 for other teams). 2. Grand average of the behavioral change assessment in PHMT and DHMTs in Nyanza Province is increased to 4.0 by June 2013 (Benchmark in March 2011).	Health Leadership and Management Survey report Health Leadership and Management Survey report Health Sector Performance report	Infrastructure is are well maintained. Referral systems is adequately functioned. Supplies for drugs and commodities are ensured and maintained. Availability of health providers is secured and maintained.
OUTPUTS			
1 Health leadership and management trainings are modeled and promoted in Nyanza Province	1. A operational model of health strategic leadership and management training is established by June 2011 (Benchmark is zero in July 2009). 2. Coverage of PHMT and DHMTs in Nyanza Province receiving the model training program is increased to 100% by June 2013 (Benchmark is zero in July 2009).	Training model in place Training Completion and Evaluation report	Workplace environment for PHMT/DHMT is well maintained and promoted at least it meets the minimum requirement. Mobility of health managers including transport, competing tasks and personal issues is well secured and maintained. Conflict resolution and disciplinary action under code of conduct are esteemed and functioned well.
2 Health promotion activities are modeled and mainstreamed in Health Systems Strengthening in the pilot districts*. * The Pilot districts include PHMT and DHMT in Siaya, Kisumu and Ugenya.	1. An operational model of health promotion activities is established by April 2012 (Benchmark is zero in July 2009). 2. Execution rate of health promotion activities budgeted in AOP of the pilot districts is increased to at least 5 activities per district by June 2013 (Benchmark is zero in AOP4 and 5). 3. Grand average score of the capacity assessment on health promotion in the pilot districts is increased to 4.0 by June 2013 (Benchmark in March 2011).	Health promotion model in place AOP Performance Review report Health Promotion Capacity Assessment report	Collaboration between health managers and development partners are well coordinated and organized under mutual vision and mission. All the stakeholders are involved in health management activities to strengthen health systems.
3 Supportive supervision and related management activities by DHMTs for health facilities and communities are modeled and promoted in the pilot districts*. * The Pilot districts include PHMT and DHMT in Siaya, Kisumu and Ugenya.	1. An operational model of supportive supervision is established by April 2012 (Benchmark is zero in July 2009). 2. Number of health facilities in the pilot districts receiving Integrated Management Supportive Supervision (IMSS) is increased to 80% of facilities in every district by June 2013 (Benchmark is zero in July 2009).	Supportive supervision model in place IMSS report Health Sector Performance report	
4 Evidence-based practices and lessons-learned demonstrated by the Project implementation are promoted to all the districts in Nyanza province and other provinces and enhance national health policies/guidelines and international networks.	1. Number of seminars, workshops and conferences shared project achievement is continuously increased until June 2013 (Benchmark is zero in July 2009). 2. No of scientific papers, documents and publications concerning to the project activities and achievements is continuously increased until June 2013 (Benchmark is zero in July 2009).	Minutes of the meetings, abstracts, conference proceedings, journal articles Scientific papers, documents and publications	

PDM (Modified, March 2011)

ACTIVITIES	INPUTS		Important Assumption
	Japanese Side	Kenyan Side	
1 **Health leadership and management trainings are modeled and promoted in Nyanza Province:** 1.1 To establish Community of Practices (COPs) as institutional networking to spearhead and support health management training. 1.2 To organize a training management working group (TMWG) consisting of training focal persons from PHMT and DHMTs, JICA Experts, and technical advisors from COPs. 1.3 To hold regular meeting to identify training needs and develop training plans, courses, modules and tools. 1.4 To implement core management training program to the pilot teams as initial modeling process for packaging. 1.5 To review, develop and package core management training program for scaling-up to cover all the DHMTs in Nyanza Province. 1.6 To scale-up core management training program to all the DHMTs in Nyanza province with randomized Control Trial (RCT) method. 1.7 To support DHMTs to conduct health management training at health facility and community level in the pilot districts. 1.8 To support DHMTs to enhance health management training into AOP in the pilot districts. 1.9 To evaluate and document health leadership and management training Program as evidence-based practice.	**(1) JICA expert and project staffs** a. long-term expert (Chief Advisor, Human Resource Development Advisor, Project Coordinator/IEC Material Development/Health Promotion Advisor, Health Administration Management Advisor) b. Short-term expert (Health Management Information System etc.) c. Project staffs (National expert, project assistant, driver etc.) **(2) Management trainings/related activities** **(3) Project operational cost** **(4) Office equipment, furniture and vehicle** **(5) Counterpart training in Japan**	**(1) Counterpart members (Ministry, Provincial and District levels)** **(2) Management support staffs** **(3) Office space, equipment and utilities** **(4) Counterpart budget for operational costs (cost-sharing)** **(5) Sector coordination and arrangements**	Knowledge and information acquired by the Project activities are adequately shared by all the DHMT members and stakeholders. Partnership with other implementing donors, agencies and institutions is maintained. Availability of counterpart members (PHMT/DHMTs) is retained and maintained.
2 **Health promotion activities are modeled and mainstreamed in Health Systems Strengthening in the pilot districts** 2.1 To organize and operate a working group on health promotion (UCAN WG: Unity, Communication, Advocacy and Networking Working Group). 2.2 To conduct needs assessment on health promotion both at PHMT/DHMT level and Health Facility/Community level. 2.3 To conduct capacity assessment on health promotion for the pilot districts. 2.4 To conduct management training/workshops on health promotion at PHMT/DHMT level. 2.5 To support DHMTs to conduct health promotion activities at health facility and community level. 2.6 To support DHMTs to promote health promotion activities to be incorporated into AOP. 2.7 To conduct study/exchange visits for sharing good practices and networking with other teams. 2.8 To support DHMTs to develop IEC materials suitable to the local contexts. 2.9 To evaluate and document health promotion activities as evidence-based practice.			
3 **Supportive supervision and related management activities by DHMTs for health facilities and communities are modeled and promoted in the pilot districts.** 3.1 To establish and operationalize Field Support Working Group to strengthen capacity development of district health systems. 3.2 To review supervision system and checklist in light of quality of management and standardized health services. 3.3 To develop Integrated Management Supportive Supervision(IMSS) checklist and implementation, on-site training and feedback mechanism. 3.4 To operationalize implementation, on-site training, feedback and dissemination of IMSS. 3.5 To support DHMT to incorporate IMSS into budget and action plan of AOP. 3.6 To support PHMT/DHMT to promote Health Management Information System (HMIS), Community Health Strategy (CHS) and other related communication management to strengthen district health systems. 3.7 To support PHMT/DHMT to strengthen project management in AOP. 3.8 To support PHMT/DHMT to hold Technical Assistance Committee and Stakeholder Forum at provincial and district level. 3.9 To evaluate and document IMSS and other related management activities as evidence-based practice.			**Preconditions** Security and safety measures in the Project working areas are maintained. Major policies and guidelines are maintained at the ministerial level. Health sector reform and local government reform are maintained.
4 **Evidence-based practices and lessons-learned demonstrated by the Project operational models are promoted to all the districts in Nyanza Province and other provinces and enhance national health policies/guidelines and international networks.** 4.1 To design and conduct operational research for evidence-based practices concerning to the project interventions. 4.2 To document and publish research results, operational models and lessons-learned to a wider public audience. 4.3 To support sustainable mechanism to disseminate evidence-based practices demonstrated by the Project in scientific journals, conferences and stakeholders' forums. 4.4 To promote institutional networking with development partners, academic institutions and other organizations (NGOs, CBOs, FBOs etc.). 4.5 To conduct forums and study visit to exchange information and experiences to enhance evidence-based practices. 4.6 To support Department of Primary Health Services and other departments in MOHS for their organizational capacity development. 4.7 To support the development and review of health policy/guidelines based on the Project activities and achievements. 4.8 To spearhead international collaborative network for health systems strengthening with neighboring countries and beyond.			

Annex 3: Process matrix (Project activity implemented in July 2009 - June 2011)

活動実績表

		Narrative Summary	Progress	Challenge/Bottleneck
Output 1		Health leadership and management trainings are modelled and promoted in Nyanza Province		
	Activity 1-1	To establish Community of Practices (COPs) as institutional networking to spearhead and support health management training.	Community of Practices (COPs) was formulated in December 2009 with 4 academic/training institutes. The number of the institutes, ministries, international organizations and private firms collaborating with the project as COPs has been expanded to 24 as of June 2011.	Administrative issues including payment and logistic were sometime raised from a few of institutes/private firm. Also some members from Nairobi have difficulty to collaborate with the project continuously since most project activities were conducted in Kisumu.
	Activity 1-2	To organize a training management working group (TMWG) consisting of training focal persons from PHMT and DHMTs, JICA Experts, and technical advisors from COPs.	Training Management Working Group (TMWG) was formulated in November 2009 with 5 core members from JICA, PHMT and the pilot DHMTs. 4 members from COPs also joined in the TMWG as Technical Advisors from December 2009. In concert with scaling-up the training, the number of members has been expanded to 18 (13 core members & 5 technical advisors) as of June 2011.	Technical advisors, especially those from out of Kisumu had sometimes difficulty to join the TMWG meeting conducted in Kisumu due to completing tasks in their workstation.
	Activity 1-3	To hold regular meeting to identify training needs and develop training plans, courses, modules and tools.	The Project has organised a series of regular TMWG meetings in Kisumu (10 times from November 2009 to June 2011). Training curriculum/facilitators' guide and operational plan for the pilot teams were developed through the meetings.	
	Activity 1-4	To implement core management training program to the pilot teams as initial modelling process for packaging.	Core Management Training Programme consisting of 7 training courses had been developed and implemented to the pilot teams(PHMT, Kisumu West, Siaya and Ugenya) since January 2010 to December 2010. In addition, IT trainings (3days course: beginners, intermediate and advance) were conducted for all the pilot teams. Gross number of participants receiving the trainings is 432 as of June 2009.	It was observed that the PHMT members were often out of the training to attend to other duties when training were organized in Kisumu limiting their concentration
	Activity 1-5	To review, develop and package core management training program for scaling-up to cover all the DHMTs in Nyanza Province.	The training programme for the pilot teams were carefully reviewed by TMWG members based on the evaluation report submitted in March 2010, and Operational Plan and Training Curriculum/ Facilitators' Guide for the scale-up to cover all DHMT in Nyanza were developed by June 2012. Process of developing training materials including text book and lecture slides for the scale-up is in the initial stage as of June 2011.	The assumption here is that the authors will respond and put their sections together within the required time.

Activity 1-6	To scale-up core management training program to all the DHMTs in Nyanza province with randomized Control Trial (RCT) method.	Training Mechanism and Operational Plan including the matching of the target DHMTs were discussed and developed through the TMWG meeting by May 2011. IT Trainings targeting DHMTs will be implemented in July 2011, and the Core Management Training Programme for the scale-up will start from August 2012.	The discussion of whether to use capacity or knowledge as the indicator for matching was quite an enriching experience.
Activity 1-7	To support DHMTs to conduct health management training at health facility and community level to the pilot districts.	The cascading process for DHMT training health facility management level is still in the preparatory stage as of June 2011. However, facilitators' guide and training materials of "Service Quality Management" will be developed through the TMWG by the end of July 2011, and the training will be delivered to the pilot DHMTs in August 2011. After this training, the project will support members of the pilots DHMT members to conduct on-site service quality management training for their health facilities.	It is assumed that DHMTs members have to manage their completing tasks well to organize and conduct trainings for the Health facilities management staff.
Activity 1-8	To support DHMTs to enhance health management training into AOP in the pilot districts.	Kisumu West (pilot team) incorporated plan of the health leadership and management training into their AOP6 as JICA supported activities. For the next AOP, the project will encourage all the pilot district teams to incorporate plan of the follow-up activities (including demand driven trainings and on-site trainings to health facilities) into their AOP with cost-sharing.	Siaya DHMT did not incorporate any health leadership and management training into their AOP6. Further sensitization and needs identification for the leadership and management will be necessary for the team.
Activity 1-9	To evaluate and document.health leadership and management training Program as evidence-based practice.	15 evaluation/completion reports for the pilot trainings were submitted by June 2011, and a completion report of the baseline survey on health leadership and management for all DHMTs in Nyanza was submitted in May 2011.	The baseline survey data was quite massive hence a challenge of including everything in the report, this led to a consensus on the most important indicators for the way forward.
Output 2	**Health promotion activities are modeled and mainstreamed in Health Systems Strengthening in the pilot districts.**		
Activity 2-1	To organize and operate a working group on health promotion (UCAN WG: Unity, Communication, Advocacy and Networking Working Group)	UCANWG was established in December 2009 with 12 members. The number of members is 12 core members and 9 co-opted members/groups as of June 2011. As of 1st June 2011, 16 UCANWG workshops were conducted. UCANWG has a chair, vice-chair, coordinator and secretary. Venues for workshops are rotational in pilot districts.	Competing tasks amongst PHMT/DHMTs in organizing and coordination of meetings
Activity 2-2	To conduct needs assessment on health promotion both at PHMT/DHMT level and Health Facility/Community level.	A local consultant conducted situation analysis on health promotion at PHMT and pilot DHMTs in March 2010. The Project has compiled Resource Directories on health facilities (HFs) in Kisumu West and Siaya with basic information of all HFs in the areas in 2010. UCANWG has conducted baseline survey on IEC materials at randomly selected health facilities and communities in pilot districts between June to November 2010.	1) It is necessary to conduct other surveys in order to decide details on health promotion interventions. 2) Lack of knowledge and skills in conducting surveys amongst UCANWG members.
Activity 2-3	To conduct capacity assessment on health promotion for the pilot districts.	Capacity assessment on health promotion was conducted among 1) health managers in Nyanza Province, and 2) UCANWG members. Both were done in March 2011.	The assessment should be monitored and evaluated in 2011/2012.

Activity 2-4	To conduct management training/workshops on health promotion at PHMT/DHMT level.	1) 4 day Basic Health Promotion Training was conducted in June 2010 targeting health managers in pilot districts in collaboration with Department of Health Promotion (DHP)/ MoPHS. Total 42 participants attended the training. Facilitators were from DHP/MoPHS, University of Nairobi, KMTC etc. 2) Print Media Training was conducted between December 2010 and June 2011 with 6 workshops, total 12 days. Total 17 participants attended the training.	1) Because of competing tasks especially amongst PHMT, some participants could not participate in Basic Health Promotion training or some went back to the office during the training. 2) Competing tasks made some participants difficult in attending the workshops consistently in Print Media Training.
Activity 2-5	To support DHMTs to conduct health promotion activities at health facility and community level.	This has not been done yet. As of June 2011, planning of this activity is taking place.	It is necessary to conduct detailed survey to decide health promotion interventions at HFs and community level.
Activity 2-6	To support DHMTs to promote health promotion activities to be incorporated into AOP.	After three (3) UCANWG members participated in Health Promotion Re-orientation workshop conducted by DHP/MoPHS and WHO in August 2010, UCANWG encouraged all the pilot districts to come up with the health promotion plans for 2011. All the pilot districts made plans, presented them in UCANWG and revised them in late 2010. Health Promotion Officers and focal persons in pilot districts will incorporate these plans in AOP7.	1) Resource mobilization to realize health promotion activities in pilot districts. 2) Health promotion being neglected in some districts results in not allocating budget to health promotion activities.
Activity 2-7	To conduct study/exchange visits for sharing good practices and networking with other teams.	UCANWG has organized and conducted study visit to Bondo districts in February 2010. UCANWG members observed waste management system, community units and youth group activities.	UCANWG members are interested in observing best practices in particular areas, e.x.) health promotion, income generation for villagers, community mobilization. It is difficult to spot a place with best practices in those areas.
Activity 2-8	To support DHMTs to develop IEC materials suitable to the local contexts.	In Print Media Training stated in Activity 2-4, knowledge and skills to develop print IEC materials were transferred to the participants. In June 2011, UCANWG has established Task Production Groups (TPG) including Print Media TPG, Electronic Media & Website Development TPG. With support by JICA expert, these TPGs will develop, monitor and revise IEC materials suitable to local contexts.	Sharing gained knowledge and skills to other members/teams.
Activity 2-9	To evaluate and document health promotion activities as evidence-based practice.	1) Minutes of meeting for all the UCANWG workshops, 2) Report on exchange visit to Bondo, 3) Situation Analysis Report, 4) UCANWG report in March 2011, 5) Completion report on Basic Health Promotion Training, 6) Health Promotion Baseline Survey Report, 7) Capacity Assessment on Health Promotion for health managers and for UCANWG core members	UCANWG needs to develop M&E tools for health promotion activities.

Output 3		Supportive supervision and rerated management activities by DHMTs for health facilities and communities are modeled and promoted in the pilot districts.		
	Activity 3-1	To establish and operationalize Field Support Working Group to strengthen capacity development of district health systems.	In stead of Field Support Working Group, District Think Tank (Siaya including Gem, Kisumu West and Ugenya) will be formed on 13th June. Under DTT, Transformative Action Group (Supportive Supervision, HMIS and CHS) will be formed on the same day.	DTT is expected to operate independently (without Project financial support) from June 2011. TAG is operatinozed by the Project support from June 2011.
	Activity 3-2	To review supervision system and checklists in light of quality of management and standardized health services.	Between June 2010 and Octorber 2010, the representatives from PHMT and Pilot DHMTs, keypersons from MOPHS HQ and other partners reviewed supervision system and developed the Intergrated Management Supportive Supervision Checklists (IMSS).	There is a lack of autonomous funding to facilitate Supervison mechanism.
	Activity 3-3	To develop Integrated Management Supportive Supervision(IMSS) checklist and implementation, on-site training and feedback mechanism.	From June 2010 to Octber 2010, the same stakeholders as Activity 3-2 developed Integrated Management Supportive Supervision checklist.	IMSS should be more intergrated, summarized and harmoized in line with service quality management.
	Activity 3-4	To operationalize implementation, on-site training, feedback and dissemination of IMSS.	IMSS checklist (draft version) has been in practice at the Pilot districts since Janurary 2011. In Siaya distroct, IMSS has been introduced and practised by 19 health facilities among total 32 health facilities. In Ugenya district, IMSS has been introduced and practiced by 14 health facilities among total 24 health facilities.	IMSS checklist will be reviewed by SS TAG and finalized by PHMT and DTTs. SS management handbook will be developed by SS TAG, in which IMSS checklist and its operation will be incorporated. It will take more time.
	Activity 3-5	To support DHMT to incorporate IMSS into budget and action plan of AOP.	The Project has not achieved anything in this area yet.	AOP planning will be taken place in February and March every year.
	Activity 3-6	To support PHMT/DHMT to promote Health Management Information System (HMIS), Community Health Strategy (CHS) and other related communication management to strenglhen district health systems.	HMIS: The Project welcomed JICA Short-term expert to conduct situational analysis, sensitization workshop and networking with Department of HMIS in MOPHS. There are consecutive effort to support District Health Information System (DHIS), newly introduced HMIS tool. CHS: The Project hosted the first Provincial CHS Forum in October 2010 and elected provincial best community unit (Saro CU, Migori). The Project demonstrated the Project activities in national CHS Convention and the provincial best CU was laureate as the national best CU in December 2010.	1) There are competing tasks and shortage of health managers to facilitate smooth operation in management support at DHMT level. 2) The fluctuation in the policy and guidance of management systems from MOPHS hinders also effective implementation of district health management activities. 3) Data collection for CHS survey will be challenge bacause of door to door survey. Donor coordination is difficult.

Activity 3-7	To support PHMT/DHMT to strengthen project management in AOP.	The Project supported day-to-day management in AOP development and monitoring at the provincial and district level. Especially, the Project supported Marginal Budgeting for Bottleneck Analysis (MBB) to facilitate financial analysis and allocation in AOP 6 development.	1) There is immature team spirit and capacity to share the workload for AOP development and monitoring among PHMT and DHMT members. 2) There is no autonomous funding mechanism to implement activities planned in AOP.
Activity 3-8	To support PHMT/DHMT to hold Technical Assistance Committee and Stakeholder Forum at provincial and district level.	The Project supported total 16 workshops and forums for AOP6 and 7 development in pilot districts to conduct AOP sensitization meeting, district stakeholder meeting and health facility in-charge meeting.	There is no autonomous funding mechanism to support AOP development and review mechanism. All the incidentals depend on the partners' contribution.
Activity 3-9	To evaluate and document IMSS and other related management activities as evidence-based practice.	The Project has not achieved anything in this area yet.	To conduct impact survey with control sites will require more time and resources.
Output 4	**Evidence-based practices and lessons-learned demonstrated by the Project operational models are promoted to all the districts in Nyanza Province and other provinces and enhance national health policies/guidelines and international networks.**		
Activity 4-1	To design and conduct operational research for evidence-based practices concerning to the project interventions.	The Project has took one operational research on health systems management training in pilot teams using capacity assessment tool between January 2010 and December 2010. The project is going to undertake four major operational researches on (1) quasi-controlled study on scaling-up health systems management training, (2) health promotion intervention, (3)supportive supervision intervention and (4) community health management intervention between March 2011 and June 2012.	The project is facing challenges in research institutions, which can provide quality research activities. However, the Project was recently able to conduct data collection and statistical analysis supported by GLUK supervised by Mr Kawakatsu.
Activity 4-2	To document and publish research results, operational models and lessons-learned to a wider public audience.	There are no published research results and operational models until June 2011. However, there are two research papers submitted to academic journals. The Project will promise to build four models (health systems management, health promotion activities, service quality management and community health management) before June 2012.	There are competing tasks among the Project members to allocate enough time to conduct research activities and documentations.
Activity 4-3	To support sustainable mechanism to disseminate evidence-based practices demonstrated by the Project in scientific journals, conferences and stakeholders' forums.	The Project has demonstrated and disseminated the Project achievements in total 69 seminars, conferences and forums until June 2011.	The challenge here is an inadequate capacity for health managers (PHMT, DHMT) to conduct operational research to facilitate evidence-based practice. Otherwise the development partner gave the information about High Impact Interventions (HIIs) to the counterpart teams.

	Activity 4-4	To promote institutional networking with development partners, academic institutions and other organizations (NGOs, CBOs, FBOs etc.)	The Project is working closely with UNICEF, EHS(DFID), USAID (KEMRI/CDC, APHIA+, ICAP, FACES, IMPACT etc.), WHO, DANIDA and International NGOs (Plan International, CARE, AMREF, World Vision etc.). The Project has developed Communities of Practices (local institutional technical network)with Mzumbe University-Tanzania, GLUK, Maseno University, KIA, KCA, KIM, MSH, AMREF and etc.	There are several organizations, which have not been transparent to work with the government. However, since January 2011, it is a great opportunity that the Global Health Initiative (GHI) by US government was commenced to seek more synergetic effects with partners.
	Activity 4-5	To conduct forums and study visit to exchange information and experiences to enhance evidence-based practices.	The project conducted and showed the achievements in five major forums (GLUK International Conference 2010 and 2011, Provincial and National Community Health Strategy Forums 2010, Provincial Scientific and Good Practice Forum 2010). And the Project conducted six study visits to Bondo District (UCAN), Nairobi (UCAN), Mombasa (CHS), Uganda (PHMT, DHMT) and Tanzania (PHMT, DHMT).	There were very few occasions to exit good practices by partners, however the Provincial stakeholder meeting will be quarterly held to demonstrate the ground efforts. The Project is assigned as assistant secretariat for this sector wide coordination mechanism.
	Activity 4-6	To support Department of Primary Health Services and other departments in MOPHS for their organizational capacity development.	The project conducted four major contributions to DPHS/MOPHS in (1)Department AOP6 development (April 2010), (2) Department Business Plan development (June 2010), (3)Team building retreat (November 2010) and (4)Health systems management training (December 2010).	There are several challenges in ineffective coordination between MOPHS and the Provincial office, communication gap between the MOPHS and the Project and geographic gap between Nairobi and Kisumu.
	Activity 4-7	To support the development and review of health policy/guidelines based on the Project activities and achievements.	The Project has not achieved anything in this area yet.	There are critical challenges in policy implications at the provincial level due to immature decentralized system in health sector (ultimate centralized system).
	Activity 4-8	To spearhead international collaborative network for health systems strengthening with neighboring countries and beyond.	The Project has developed international collaborative network with Uganda (January 2011), Tanzania (February 2011) and Somaliland (April 2011).	There is great willingness to work together beyond the frontier, however the official arrangement and communication means have to be promoted.

4．専門家派遣実績表

List of Japanese Experts assigned to the Project
専門家派遣実績表

Long term Expert

Designation	Name	Duration	M/M
Chief Advisor チーフアドバイザー	Tomohiko SUGISHITA 杉下　智彦	30 September 2009 – 29 June 2013	45 M/M
Project Coordinator/ Education Material Development 業務調整/IEC 教材	Chie MURAKAMI 村上　千恵	1 July 2009 – 14 July 2011	24.5 M/M
System Strengthening/ Training Management 組織強化/研修マネージメント	Mikihiro TODA 戸田　幹洋	30 July 2009 – 29 June 2013	47 M/M
Health Administration Management 保健行政マネージメント	Kaori SAITO 斎藤　佳央里	9 April 2011 – 1 July 2013	26.77 M/M
Project Coordinator/ Health Promotion 業務調整/保健プロモーション	Naoko KITAZAWA 北澤　菜穂子	29 June 2011 – 29 June 2013	24 M/M

Short term Expert

Designation	Name	Duration	M/M
Health Information Management 保健情報システム	Naoki TAKE 竹　直樹	9 September 2010 – 23 December 2010	2.5 M/M

機材供与実績表

Serial	Date Supplied (YYYY-MM-DD)	Item	Specification	Currency	Price	Procured From	Remarks
1	2009-08-17	Inkjet Printer	Canon iP100	Ksh	38,280	Compulynx Nyanza	
2	2009-08-26	Toyota Hilux	KUN25R-PRMDHN (DLX)	USD	26,485	Toyota East Africa Ltd.	供与機材
3	2009-08-26	Toyota Prado	KZJ120R-GKMETQ	JPY	3,862,600	Toyota East Africa Ltd.	供与機材
4	2009-09-09	External Universal Laptop Battery	Promate	Ksh	19,500	Bloomerg	
5	2009-10-01	Fax Machine		Ksh	33,500	Compulynx Nyanza	
6	2009-10-01	HP Scanner	CN87DTH0M7	Ksh	40,000	Compulynx Nyanza	
7	2009-10-06	Toneau Cover for Toyota Hilux		Ksh	168,200	Sai Raj	
8	2009-10-15	Dell Laptop Computer 1	751S4K1	Ksh	65,000	Electronics Technology Ltd	供与機材
9	2009-10-15	Dell Laptop Computer 2	CP85606	Ksh	65,000	Electronics Technology Ltd	供与機材
10	2009-10-15	Dell Laptop Computer 3	361S4K1	Ksh	65,000	Electronics Technology Ltd	供与機材
11	2009-10-15	Dell Laptop Computer 4	V7HS4K1	Ksh	65,000	Electronics Technology Ltd	供与機材
12	2009-10-15	HP LaserJet 5200dtn		Ksh	134,000	Electronics Technology Ltd	供与機材
13	2009-10-15	SHARP Photocopier AR-M318		Ksh	430,000	Electronics Technology Ltd	供与機材
14	2009-10-15	Sony LCD Projector 1 VPL-CX150		Ksh	170,000	Electronics Technology Ltd	供与機材
15	2009-10-15	Sony LCD Projector 2 VPL-CX150		Ksh	170,000	Electronics Technology Ltd	供与機材
16	2009-10-15	Projecting Screen "95x"95		Ksh	78,000	Electronics Technology Ltd	供与機材
17	2009-10-15	MS Office 2007 software 1		Ksh	23,400	Electronics Technology Ltd	供与機材
18	2009-10-15	MS Office 2007 software 2		Ksh	23,400	Electronics Technology Ltd	供与機材
19	2009-10-15	MS Office 2007 software 3		Ksh	23,400	Electronics Technology Ltd	供与機材
20	2009-10-15	MS Office 2007 software 4		Ksh	23,400	Electronics Technology Ltd	供与機材
21	2009-12-02	Adobe Acrobat 1		Ksh	23,000	Compulynx Nyanza	
22	2009-12-02	Adobe Acrobat 2		Ksh	23,000	Compulynx Nyanza	
23	2009-12-02	Adobe Acrobat 3		Ksh	23,000	Compulynx Nyanza	

24	2009-12-02	Adobe Acrobat 4		Ksh	23,000	Compulynx Nyanza	
25	2009-12-16	Office Desk 1		Ksh	20,783	Compulynx Nyanza	
26	2009-12-16	Office Desk 2		Ksh	20,783	Compulynx Nyanza	
27	2009-12-16	Office Desk 3		Ksh	20,783	Compulynx Nyanza	
28	2009-12-16	Office Desk 4		Ksh	20,783	Compulynx Nyanza	
29	2009-12-16	Conference Table		Ksh	33,620	Compulynx Nyanza	
30	2009-12-16	White Board 6ft x 4ft		Ksh	15,000	Compulynx Nyanza	
31	2009-12-16	Bookshelf with door & lock		Ksh	16,810	Compulynx Nyanza	
32	2010-02-10	Security Alarm System		Ksh	158,708	G4S	
33	2010-03-03	Toyota Prado		Ksh	3,165,468	Toyota East Africa Ltd.	
34	2010-03-15	Conference Table (Small)		Ksh	21,000	Compulynx Nyanza	
35	2010-03-15	Conference Table (Large)1		Ksh	33,620	Compulynx Nyanza	
36	2010-03-15	Conference Table (Large)2		Ksh	33,620	Compulynx Nyanza	
37	2010-03-15	Coffee Table		Ksh	18,000	Compulynx Nyanza	
38	2010-03-15	Office Desk 1		Ksh	20,783	Compulynx Nyanza	
39	2010-03-15	Office Desk 2		Ksh	20,783	Compulynx Nyanza	
40	2010-03-15	White Board		Ksh	15,000	Compulynx Nyanza	
41	2010-03-18	HP Compaq 6000 Pro MT, Keyboard, Mouse, Monitor, Win7 Pro, ESET		Ksh	108,000	Total Solutions	供与機材
42	2010-03-18	APC Smart 1kVA UPS		Ksh	62,640	Total Solutions	供与機材
43	2010-03-18	HP Compaq 6530b Notebook1		Ksh	108,580	Total Solutions	供与機材
44	2010-03-18	HP Compaq 6530b Notebook2		Ksh	108,580	Total Solutions	供与機材
45	2010-03-18	Adobe CS4 Master Collection- User License		Ksh	257,082	Total Solutions	供与機材
46	2010-03-18	70"x70" Tripod Projector Screen 1		Ksh	18,360	Total Solutions	供与機材
47	2010-03-18	70"x70" Tripod Projector Screen 2		Ksh	18,360	Total Solutions	供与機材
48	2010-03-18	HP Officejet Pro 6500 AiO DW		Ksh	19,980	Total Solutions	供与機材、Kisumu West譲渡済
49	2010-03-18	Kyocera Mita Photocopier		Ksh	544,970	MFI, Procured by JICA Kenya	供与機材

50	2010-03-25	Office Blind		Ksh	306,608	Vitendi	
51	2010-03-29	Office Desk 1		Ksh	20,783	Compulynx Nyanza	Siaya譲渡済
52	2010-03-29	Office Desk 2		Ksh	20,783	Compulynx Nyanza	Siaya譲渡済
53	2010-03-29	Office Desk 3		Ksh	20,783	Compulynx Nyanza	Siaya譲渡済
54	2010-03-29	Whiteboard		Ksh	15,000	Compulynx Nyanza	Siaya譲渡済
55	2010-03-29	PVC Tent for 100 people		Ksh	125,000	Compulynx Nyanza	Siaya譲渡済
56	2010-03-29	Office Desk		Ksh	20,783	Compulynx Nyanza	Kisumu West譲渡済
57	2010-03-29	Whiteboard		Ksh	15,000	Compulynx Nyanza	Kisumu West譲渡済
58	2010-03-29	Bookshelf with glass doors		Ksh	17,600	Compulynx Nyanza	Kisumu West譲渡済
59	2010-03-29	PVC Tent for 100 people		Ksh	125,000	Compulynx Nyanza	Kisumu West譲渡済
60	2010-03-31	Sawafuji Generator ELEMAX SH3200EX	SADN 1012023 / VSW3GCAAK-1649815	Ksh	86,000	Davis & Shirtliff	Kisumu West譲渡済
61	2010-03-31	Sawafuji Generator ELEMAX SH3200EX	SADN 1012028 / VSW3GCAAK-1649816	Ksh	86,000	Davis & Shirtliff	Siaya譲渡済
62	2010-03-31	Peavey ESCORT Portable Audio System	Escort OGIH0028 00511812	Ksh	65,000	Credible Sounds	Kisumu West譲渡済
63	2010-03-31	Peavey ESCORT Portable Audio System	Escort OGIH0009 00511812	Ksh	65,000	Credible Sounds	Siaya譲渡済
64	2010-03-31	SEKAKU Wireless Microphone System WR-202R	9052235	Ksh	16,000	Credible Sounds	Kisumu West譲渡済
65	2010-03-31	SEKAKU Wireless Microphone System WR-202R	9052049	Ksh	16,000	Credible Sounds	Siaya譲渡済
66	2010-03-31	SONY DSC - W350 Digital Camera	8686628	Ksh	13,480	Total Solutions	PHMT譲渡済
67	2010-03-31	SONY DSC - W350 Digital Camera	8696890	Ksh	13,480	Total Solutions	Kisumu West譲渡済
68	2010-03-31	SONY DSC - W350 Digital Camera	8696883	Ksh	13,480	Total Solutions	Siaya譲渡済
69	2010-03-31	SONY Handycam DCR-HC54	707608	Ksh	18,875	Total Solutions	供与機材
70	2010-03-31	Tripod for SONY Handycam		Ksh	15,085	Total Solutions	供与機材
71	2010-03-31	Plastic tables & chairs		Ksh	46,200	Compulynx Nyanza	Kisumu West譲渡済
72	2010-03-31	Plastic tables & chairs		Ksh	51,000	Compulynx Nyanza	Siaya譲渡済
73	2010-05-07	GPS device	GARMIN eTrex	Ksh	30,290	Swiss Products Ltd.	
74	2010-08-14	Projector	SONY VPL MX-20	Ksh	170,000	Procured by JICA Kenya Office	Kisumu West譲渡済
75	2010-08-14	Projector	SONY VPL MX-20	Ksh	170,000	Procured by JICA Kenya Office	Siaya用

76	2010-10-13	Laptop computer	TOSHIBA Satellite Notebook 7A092551H	Ksh	95,300	Compulynx Nyanza	ナショナルスタッフ用
77	2010-10-13	Laptop computer	TOSHIBA Satellite Notebook 7A088685H	Ksh	95,300	Compulynx Nyanza	ナショナルスタッフ用
78	2010-12-20	Laptop computer	TOSHIBA Satellite R630-105 7A089375H	Ksh	95,000	Compulynx Nyanza	Ugenya District用
79	2010-12-20	Laptop computer	TOSHIBA Satellite R630-105 7A088465H	Ksh	95,000	Compulynx Nyanza	Gem District用
80	2011-01-05	Digital camera	SONY DSC HX5V	Ksh	31,585	Nakmatt Holdings Ltd.	Ugenya District用
81	2011-01-05	Digital camera	SONY DSC H55	Ksh	31,585	Nakmatt Holdings Ltd.	Gem District用
82		Toyota Prado			3,676,565	Procured by JICA Kenya Office	

6. C/P リスト

カウンターパートリスト

No.	Name	Designation	Team	Organization	Station
1	Dr. John Odondi	Head, DPHS	DPHS	MoPHS	Nairobi
2	Dr. Jackson K. Kioko	PDPHS	PHMT-Nyanza	MoPHS	Kisumu
3	Dr. Peter O. Okoth	PDPCO	PHMT-Nyanza	MoPHS	Kisumu
4	Clementine Gwoswar	SNO (PPHN)	PHMT-Nyanza	MoPHS	Kisumu
5	A. N Omukuba	PHRM	PHMT-Nyanza	MoPHS	Kisumu
6	Norah Bett	PRHC	PHMT-Nyanza	MoPHS	Kisumu
7	Isaiah Ogwalo	P.Pharm	PHMT-Nyanza	MoPHS	Kisumu
8	Charles Ngetich	PHO-NAS	PHMT-Nyanza	MoPHS	Kisumu
9	Matthews Odiango	D/PHRIO	PHMT-Nyanza	MoPHS	Kisumu
10	Tom O. Andebe	PPHO	PHMT-Nyanza	MoPHS	Kisumu
11	Blasto A. Kwanya	PPHO	PHMT-Nyanza	MoPHS	Kisumu
12	Dr. Ibrahim Shiwalo	PCBHS Co	PHMT-Nyanza	MoPHS	Kisumu
13	Charles Ngwalla	PCO/ACCO	PHMT-Nyanza	MoPHS	Kisumu
14	Monica Omondi	PHAO	PHMT-Nyanza	MoPHS	Kisumu
15	Elly Nyambok	PDSC	PHMT-Nyanza	MoPHS	Kisumu
16	Jared Miyombe	PMET	PHMT-Nyanza	MoPHS	Kisumu
17	Monica Owour	PHBC	PHMT-Nyanza	MoPHS	Kisumu
18	Dr. Beatrice Oyando	PMCC	PHMT-Nyanza	MoPHS	Kisumu
19	Gamaliel Omondi	D/PPHO	PHMT-Nyanza	MoPHS	Kisumu
20	Lillian Ousa	PHO I/C Port	PHMT-Nyanza	MoPHS	Kisumu
21	J.W Odera	Ag. PPHN/PLO	PHMT-Nyanza	MoPHS	Kisumu
22	Oscar Kambona	PNO	PHMT-Nyanza	MoPHS	Kisumu
23	James Onsongo	M&E	PHMT-Nyanza	MoPHS	Kisumu
24	Nell Odira	Secretary	PHMT-Nyanza	MoPHS	Kisumu
25	Edward Oloo	DVBD&NO	PHMT-Nyanza	MoPHS	Kisumu
26	Yuster Ronoh	Lab/Epi	PHMT-Nyanza	MoPHS	Kisumu
27	Linda Odanga	D/PHRIO	PHMT-Nyanza	MoPHS	Kisumu
28	Dr. Kadondi Kasera	PTLC	PHMT-Nyanza	MoPHS	Kisii
29	Dr. Lusi Ojwang	PDMS	PHMT-Nyanza	MoMS	Kisumu
30	Margaret Odhiambo	PNO	PHMT-Nyanza	MoMS	Kisumu
31	Evans Nyakundi	PCSO	PHMT-Nyanza	MoMS	Kisumu
32	Barnabas Getanda	PHAO	PHMT-Nyanza	MoMS	Kisumu
33	Patrick Lumumba Okamo	PPNO	PHMT-Nyanza	MoMS	Kisumu
34	Samuel Oginga Okun	POT	PHMT-Nyanza	MoMS	Kisumu
35	Ismael Musindalo	Radiograph	PHMT-Nyanza	MoMS	Kisumu
36	Peter Nyaberi	P/OT	PHMT-Nyanza	MoMS	Kisumu
37	Morris Senghor	Nursing Coordinator	PHMT-Nyanza	MoMS	Kisumu
38	Dr. Elizabeth Okoth	DMOH	DHMT-Kisumu West	MoPHS	Kombewa
39	Hesbon Olang'	HAO	DHMT-Kisumu West	MoPHS	Kombewa
40	Herman Nyobambo	DMLT	DHMT-Kisumu West	MoPHS	Kombewa
41	George S. Odhiambo	DRHIO	DHMT-Kisumu West	MoPHS	Kombewa
42	Sylvia Olal	DRHC	DHMT-Kisumu West	MoPHS	Kombewa
43	Asher Ragumbi	NO	DHMT-Kisumu West	MoPHS	Kombewa
44	Monica Musyoka	DPHN	DHMT-Kisumu West	MoPHS	Kombewa
45	Nicholas Pule	DCO	DHMT-Kisumu West	MoPHS	Kombewa
46	Dr. Festus Ogada	D.Pharm	DHMT-Kisumu West	MoPHS	Kombewa
47	Dr. J. O Okumu	Medsup	DHMT-Kisumu West	MoMS	Kombewa
48	Hilda Ayieko	DPHO	DHMT-Kisumu West	MoPHS	Kombewa
49	Peter Anyona	DDSC	DHMT-Kisumu West	MoPHS	Kombewa

50	Joan Chepkemboi	DNO	DHMT-Kisumu West	MoPHS	Kombewa
51	Jonathan Mutua	HAO	DHMT-Kisumu West	MoPHS	Kombewa
52	Timothy M. Malika	DTLC	DHMT-Kisumu West	MoPHS	Kombewa
53	Yuanita Hongo	DASCO	DHMT-Kisumu West	MoPHS	Kombewa
54	Emma Mogere	CO	DHMT-Kisumu West	MoPHS	Kombewa
55	Florence Aneya	METechno	DHMT-Kisumu West	MoPHS	Kombewa
56	Millicent Obinge	NO I	DHMT-Kisumu West	MoPHS	Kombewa
57	Anne A Okado	PHO	DHMT-Kisumu West	MoPHS	Kombewa
58	Millicent Oloo	NOI	DHMT-Kisumu West	MoPHS	Kombewa
59	Oscar Munambo	D/DPHO	DHMT-Kisumu West	MoPHS	Kombewa
60	Peter Anyona	DDSC	DHMT-Kisumu West	MoPHS	Kombewa
61	Dr. Nickson Shango	Medsup	DHMT-Kisumu West	MoMS	Kombewa
62	Dr. Samuel Onditi	DMOH	DHMT- Siaya	MoPHS	Siaya Town
63	Caroline Ayieko	NO III	DHMT- Siaya	MoPHS	Siaya Town
64	Millicent Okwach	DPHN	DHMT- Siaya	MoPHS	Siaya Town
65	Ali Asuman	DCO	DHMT- Siaya	MoPHS	Siaya Town
66	Everlyne Achieng	DHPO	DHMT- Siaya	MoPHS	Siaya Town
67	Janet Mule	DPHO	DHMT- Siaya	MoPHS	Siaya Town
68	James Odiga	DHRIO	DHMT- Siaya	MoPHS	Siaya Town
69	Anne Omollo	NO II	DHMT- Siaya	MoPHS	Siaya Town
70	Samuel K. Mugoh	DHAO	DHMT- Siaya	MoPHS	Siaya Town
71	Dr. Jackton Omoto	Medsup	DHMT- Siaya	MoMS	Siaya Town
72	James Okoth	NO I/C	DHMT- Siaya	MoPHS	Siaya Town
73	William Mayi	HRIO	DHMT- Siaya	MoPHS	Siaya Town
74	Dr. Ernest Ollando	Ag. Medsup	DHMT- Siaya	MoPHS	Siaya Town
75	Lillian Omungi	NO	DHMT- Siaya	MoPHS	Siaya Town
76	Gilbert Oyugi	DMLT	DHMT- Siaya	MoPHS	Siaya Town
77	Geofrey Odhiambo Otieno	Div PHN	DHMT- Siaya	MoPHS	Siaya Town
78	Joyce Nabwire	DNO	DHMT- Siaya	MoPHS	Siaya Town
79	Ezekiel Ojwang	DRHIORD	DHMT- Siaya	MoPHS	Siaya Town
80	Dr. Mwai O.G	Pharmacist	DHMT- Siaya	MoPHS	Siaya Town
81	Kennedy Genga	DTLC	DHMT- Siaya	MoPHS	Siaya Town
82	Maxwell Omondi	Records Technician	DHMT- Siaya	MoPHS	Siaya Town
83	Hillary Okumu	DDPHO	DHMT- Siaya	MoPHS	Siaya Town
84	Samuel Juma	DDSC	DHMT- Siaya	MoPHS	Siaya Town
85	Luke Opondo	DASCO	DHMT- Siaya	MoPHS	Siaya Town
86	Paul M. Tikolo	DPHO- Gem	DHMT- Siaya	MoPHS	Siaya Town
87	Fredrick Opee Owino	DCO/DASCO-Gem	DHMT- Siaya	MoPHS	Siaya Town
88	Joshua Ondiege	DPHN -Gem	DHMT- Siaya	MoPHS	Siaya Town
89	Dr. Jacqueline Ngeny	DMOH (*until Aug 10)	DHMT- Ugenya	MoPHS	Ukwalla
90	Dr. Charles Chege	DMOH (*since May 11)	DHMT- Ugenya	MoPHS	Ukwalla
91	Victor Odhiambo	DRHC	DHMT- Ugenya	MoPHS	Ukwalla
92	Dr. Omamo K. Ndai	Medsup	DHMT- Ugenya	MoMS	Ukwalla
93	Benter Rieko	DPHN	DHMT- Ugenya	MoPHS	Ukwalla
94	Edward G. Ochieng	DCO	DHMT- Ugenya	MoPHS	Ukwalla
95	Peter J. Osalla	EPI Coordinator	DHMT- Ugenya	MoPHS	Ukwalla
96	Victor Odhiambo	Ag. DPHN	DHMT- Ugenya	MoPHS	Ukwalla
97	David Ochilo	Ag. DPHO	DHMT- Ugenya	MoPHS	Ukwalla
98	Dr. Mogeni Adams	Pharmacist	DHMT- Ugenya	MoPHS	Ukwalla
99	Ntoitha Baimirongo	DPHO	DHMT- Ugenya	MoPHS	Ukwalla
100	Steve Wakhule	CS Coordinator	DHMT- Ugenya	MoPHS	Ukwalla

7．ローカルリソース及びインスティチューションリスト

ローカルリソース及びインスティチューションリスト

1	Prof. Dan Kaseje	Great Lakes University of Kisumu(GLUK)	Vice Chancellor	Lecturer (governance)	01/2010
2	Prof. Richard Muga		Deputy Vice Chancellor	Lecturer (Srtategic planning, Health policy)	02/2010, 04/2010
3	Prof. Stephen Okeyo		Dean, Faculty of Health Sciences	Lecturer & TMWG	12/2009~ (TMWG)
4	Dr. Joyce Owino		Lecturer	Lecturer (Health Policy)	04/2010, 12/2010
5	Mr. Patrick Ojera	Maseno University	Head, DEBS	Lecturer (Communication)	01/2010
6	Ms. Scholastica Odhiambo		Lecturer	Lecturer & TMWG	12/2009~11/2010 (TMWG)
7	Mr. Nelson Obange		Lecturer	TMWG	11/2010~ (TMWG)
8	Mr. Alphonse Odondo		Lecturer	Lecturer (Communication)	01/2010
9	Ms. Jackline Opande	KCA University	Head, ICD-Kisumu	Lecturer (Communication)	01/2010
10	Mr. Peter Halwenge		Lecturer	TMWG	01/2010~ (TMWG)
11	Mr. Wilfred Owalla		Lecturer	Lecturer (Resource mgt)	11/2010, 12/2010
12	Ms. Judith Raburu	UNICEF	Senior Project Officer	Lecturer (Supervision)	06/2010, 07/2010
13	Dr. Kennedy Ongwae		Health Specialist	Lecturer (Supervision)	07/2010
14	Prof. Miriam Were	Uzima Foundation	Co-Founder	Lecturer (Health Policy)	04/2010
15	Ms. Rachel Ngesa	KIA	Lecturer	TMGW	12/2010~ (TMWG)
16	Prof. Elisante Ole Gabriel	Eden Consultants/ Mzumbe University	CEO/Professor	Main Lecturer & TMWG	12/2009~ (TMWG)
17	Ms. Devota Elisante	Eden Consultants	Consultant	Lecturer (Team building)	11/2010
18	Mr. Charles Oyaya	IIHDPAR-Africa	Executive Director	Lecturer (Health Policy)	04/2010, 12/2010
19	Ms. Joan Mutero	AMREF	Training Specialist	TMWG	12/2010
20	Dr. Edwin Nyutho	University of Nairobi	Lecturer	Lecturer (Supervision)	07/2010, 12/2010
21	Theresa Odero		Lecturer	Lecturer (Health promotion)	06/2010
22	Ms. Teresa Samita Okeyo	Price Waterhouse Coopers	Consultant	Lecturer (Supervision)	07/2010
23	Mr. Waki Netsanet	World Bank	Senior Economist	Lecturer (MBB)	09/2010
24	Mr. Micheal Ochieng	APHIA II Nyanza	Senior Programme Officer	Lecturer (M&E)	09/2010, 12/2010
25	Mr. Geoffrey Alumila	KEMSA	Depot Manager-Kisumu	Lectuerer (Resource mgt)	11/2010
26	John Mukui Kariri	KMTC	Lecturer	Lecturer (Health promotion)	06/2010, 08/2010
27	Dr. Christine Kisia	WHO	Health Promotion Expert	Lecturer (Health promotion)	08/2010
28	Francis Namisi	AMREF Italy	Programme Officer	Lecturer (Print media)	08/2010
29	Meble Birengo	Kenya Competences Trust	Share Facilitator	Lecturer (Facilitation skill)	11/2010
30	Onesmus Mlewa	Kenya Competences Trust	Share Facilitator	Lecturer (Facilitation skill)	11/2010
31	Dr. Catherine Lengewa	AED	Programme Officer	Lecturer (Print media)	12/2010
32	Bill Okaka	-	Consultant	Consultant (Health promotion)	03/2010
33	Eulalia Namai	-	Communication/Media Consultant	Lecturer (Health promotion)	06/2010
34	Benjamin Nyangoma	-	Designer	Lecturer (Print media)	12/2010
35	Dr. Esther Ogara	Ministry of Medical Services(MOMS)-HQ	Head, Division of e-Health	Lecturer (Health information)	09/2010
45	Dr. Isabel Maina		Officer, Division of Technical Planning	Lecturer (Strategic planning)	02/2010
36	Dr. Samuel Were	Ministry of Public Health and Sanitation(MOPHS)-HQ	Head, Technical Planning & Performance Monitoring	Lecturer (Resource mgt)	11/2010, 12/2010
37	Mr. Wanjala Pepela		Officer, Division of Health Information System	Lecturer (Health information)	09/2010, 11/2010
38	Mr. George Ochieng		Head, Division of Standards & Quality Assurance	Lecturer (Supervision)	06/2010, 07/2010
39	Dr. Ayub Manya		Officer, Division of Health Information System	Lecturer (Health information)	09/2010, 11/2010
40	Ms. Hannah Kimemia		Head, Division of Human Resource Development	Lecturer (HRH)	11/2010
41	Mr. David Njoroge		Head, Division of Human Resource Development	Lecturer (HRH)	11/2010, 12/2010
42	Mr. Edward Were		Head, Accounting Unit	Lecturer (Resource mgt)	11/2010
43	Dr. Otipo Shikanga		Officer, Division of Disease Surveillance and Response	Lecturer (Health information)	09/2010
44	Dr. Ruth Kitetu		Officer, Department of Technical Planning & Performance Monitoring	Lecturer (Strategic planning)	02/2010

46	Dr. Salim Hussein		Head, Department of Health Promotion	Lecturer (Health promotion)	06/2010, 08/2010
47	Susan Nyerere		Deputy Head, Department of Health Promotion	Lecturer (Health promotion)	06/2010
48	Samson Thuo		Health Promotion Officer, Department of Health Promotion	Lecturer (Health promotion)	06/2010, 12/2010
49	Dr. Jackson K Kioko	MOPHS/PHMT-Nyanza	Provincial Director of Public Health and Sanitation	Lecturer & TMWG	8/2009~
50	Dr. Peter Okoth		Provincial Disease Prevention and Control Officer	Lecturer & TMWG	11/2009~ (TMWG)
51	Mrs. Clementine Gweswar		Provincial Public Health Nurse	TMWG	11/2010~ (TMWG)
52	Dr. Elizabeth Okoth	MOPHS/DHMT-Kisumu West	District Medical Officer of Health	TMWG	8/2009~
53	Ms. Hilda Ayieko		District Public Health Officer	TMWG	11/2009~ (TMWG)
54	Dr. Onditi Samuel	MOPHS/DHMT-Siaya	District Medical Officer of Health	TMWG	10/2009~
55	Ms. Milicent Okwach		District Public Health Nurse	TMWG	11/2009~ (TMWG)
56	Mr. David Ochilo	MOPHS/DHMT-Ugenya	District Public Health Officer	TMWG	9/2010~ (TMWG)
57	Dr. Julius Nyerere	MOPHS/DHMT-Bondo	District Medical Officer of Health	TMWG	1/2011~ (TMWG)
58	Dr. Magara Jack	MOPHS/DHMT-Nyamira	District Medical Officer of Health	TMWG	1/2012~ (TMWG)
59	Dr. S. J. Bongo	MOPHS/DHMT-Kuria	District Medical Officer of Health	TMWG	1/2013~ (TMWG)
60	Dr. Omondi Owino	MOPHS/DHMT-Suba	District Medical Officer of Health	TMWG	1/2014~ (TMWG)
61	Dr. Dan Otieno	MOPHS/DHMT-Nyando	District Medical Officer of Health	TMWG	1/2015~ (TMWG)
62	Dr. Crypus Nyongesa	MOPHS/DHMT-Kisii Central	District Medical Officer of Health	TMGW	1/2016~ (TMWG)

DEBS:Department of Economics and Business Studies
ICD: Institute for Capacity Development
KIA: Kenya Institute of Administration
KEMSA: Kenya Medical Supply Agency
IIHDPAR: International Institute of Health and Development Policy and Research
AMREF: African Medical and Research Foundation
KMTC: Kenya Medical Training College
PHMT: Provincail Health Management Team
DHMT: District Health Management Team

本邦研修参加者リスト（合計9名）

No.	Name	Course Title	Designation	Position	Counterpart	Period (From)	Period (To)
1	Dr. Peter Okoth	Health Systems Management(保健衛生管理)	PHMT-Nyanza	PDSC	MoPHS	5th May 2010	10th July 2010
2	Clementine Gwoswar	Health Administration for Regional Health Officer for Africa(地域保健担当官のための保健行政)	PHMT-Nyanza	PPHN	MoPHS	29th June 2010	14th August 2010
3	Benter Rieko	Maternal and Child Health Promotion in Public Health for Africa(公衆衛生活動による母子保健強化(アフリカ地域))	DHMT-Ugenya	DPHN	MoPHS	18th August 2010	9th October 2010
4	Mathews Odiango	Information, Education and Communication in Health Sector(保健医療分野におけるIEC活動)	PHMT-Nyanza	D/PHRIO	MoPHS	7th September 2010	18th December 2010
5	Dr. John Odondi	Community Health Management (コミュニティヘルスマネージメント)	DPHS-MOPHS	Head	MoPHS	29th November 2010	25th December 2010
6	Dr. Kioko Jackson K.	Community Health Management (コミュニティヘルスマネージメント)	PHMT-Nyanza	PDPHS	MoPHS	29th November 2010	25th December 2010
7	Tom Andebe	Community Health Management (コミュニティヘルスマネージメント)	PHMT-Nyanza	PPHO	MoPHS	29th November 2010	25th December 2010
8	Florence Atieno Owuor	Community Health Management (コミュニティヘルスマネージメント)	DHMT-Rachuonyo	DPHN	MoPHS	29th November 2010	25th December 2010
9	Hilda Ayieko	Health Systems Management(保健衛生管理)	DHMT-Kisumu West	DPHN	MoPHS	5th May 2011	9th July 2011

９．プロジェクト運営費

プロジェクト運営費 (JFY 2009 - JFY 2011): Kenya Shilling (Ksh)

		Period	Budget	Expenditure	Expenditure (%)
JFY 2009	1st Quarter	Apr 2009 - Jun 2009	0	0	0%
	2nd Quarter	Jul 2009 - Sep 2009	1,276,500	716,087	56%
	3rd Quarter	Oct 2009 - Dec 2009	3,564,366	3,007,972	84%
	4th Quarter	Jan 2010 - Mar 2010	7,495,126	8,562,572	114%
	Total	**Apr 2009 - Mar 2010**	**12,335,992**	**12,286,631**	**100%**
JFY 2010	1st Quarter	Apr 2010 - Jun 2010	8,018,082	4,925,394	61%
	2nd Quarter	Jul 2010 - Sep 2010	5,896,645	6,773,698	115%
	3rd Quarter	Oct 2010 - Dec 2010	7,964,455	8,714,043	109%
	4th Quarter	Jan 2011 - Mar 2011	7,423,453	8,889,500	120%
	Total	**Apr 2010 - Mar 2011**	**29,302,635**	**29,302,635**	**100%**
JFY 2011	1st Quarter	Apr 2011 - Jun 2011	12,283,550	TBD	TBD
	2nd Quarter	Jul 2011 - Sep 2011		0	0%
	3rd Quarter	Oct 2011 - Dec 2011		0	0%
	4th Quarter	Jan 2012 - Mar 2012		0	0%
	Total	Apr 2011 - Mar 2012			

Project Performance Review (Group A)

	Input		Output		Activities			
	Contributing Factors	Constraining Factors	Contributing Factors	Constraining Factors		Contributing Factors	Constraining Factors	Criteria of Operation Model by Participants
					Were activities impremented as planned?			
Output1	>Good coordination and organization by JICA >Participatory planning by DHMT/PHMT/JICA >Good will from the province >Commitment by participants and organization	>Lack of facilitators guide and text materials prioritization of activities >Need for facilitators >Limited number of participants due to funding >Limited financial resources >Inadequate resources to cover all facilities	>Willingness and understanding from participants	>Competing tasks >Vertical task activities assigned from headquarters	Output1	Not discussed.	Not discussed.	>Relevant participants identified >Participatory contribution at all levels of activity >Training in line with policy guideline >Pre and post test evaluation carried out >Identification of local persons >developing models to be covered >Training curriculum developed >Adequate content of curriculum >Standardize training and on-going support >Standard training of identified personnel >Identification and training of facilitators
Output2	>Proper utilization of IEC materials >Development of curriculum on health promotion >Interest to improve on health indicators >Capacity of some DHMT members >Collaboration with other stakeholders	>Devolution of IEC production >Too many materials being produced by central level >Align the product with national guideline		>Media training workshop too frequent should be merged	Output2	Not discussed.	Not discussed.	>Baseline survey >Identification of social cultural factors before producing IEC materials >Training Needs assessment on gaps among members >Production of IEC materials that are relevant to area >Identification of health promotion focal person >Distribution and dissemination of IEC materials >Training of identified personnel on IEC material development >Pre test in IEC materials before production
Output3	>Resources available in order to accomplish the pre-designed supervision task >Supportive supervision core function of DHMT >Basic supervisory tools were already existing	>Very few member in the team has basic knowledge of IMSS >Conflict of interest from the partners supporting this area	>Follow up on action points identified during supervision >Realistic action plan between facilitator and PHMT after supervision >production of checklist in time	>IMSS checklist not user friendly for our partners >Production of IMSS is time consuming	Output3	Not discussed.	Not discussed.	>Identification of SS focal person >Evidence based checklist filed >Planning and carrying out visits to all facilities/supervision sites >Development of checklist >Improved uptake of services >Written feedback to facilities on SS >Orientation of staff members on SS checklist >Coaching and mentoring of the staff during SS
	Progress in Action	Contributing factors	Challenges		Is the project structure appropriate? And How appropriate?			
Project Purpose	Siaya:There was improvement except in planning M&E KW: showed improvement in all areas except some improvement required in team management and health policy management PHMT: No much fairly average -Improvement in PME and infor MGT Baseline survey: all DHMT with different criteria Ugenya was part of Siaya Jan –Dec 2010	KW-Team having the desire to change in their way they do things - Visionary leadership - Accountability - Commitment - Reliability - Prioritizing staff to take lead - Maintenance of dignity Siaya-team spirit and cohesiveness of the team - Good facilitators	Siaya-lack of team work - Inadequate knowledge - Insufficient funds - Inconsistent members attendance to the training - Staff turnover leading to inconsistent performance e.g DMOH Ugenya - Inconsistent attendance of training sessions among PHMT members could have contributed to all round low performance. KW- the prioritized staff going overboard without consulting - Inadequate resources to scale up training to lower level facilitiesx2 - Utilization of knowledge and skills acquired to attain maximum points - No assessment was done after the training of DHMT - Loss of institutional memory due to staff movement		Output1	Appropriate	Reasons were not discussed.	
					Output2	Appropriate	Reasons were not discussed.	
Important Assumptions	Not discussed.				Output3	Appropriate	Reasons were not discussed.	

List of Internship Student from Japan (Total 22 people)

No.	Name	School/Organization	Affiliation	Period (Month/Year)
1	Yuki Yamamoto (山本有記)	National Nursing college (国立看護大学校4年)	Jaih-s(日本国際保健医療学会学生部会)	2010/2/24 - 2010/3/9
2	Haruko Yokote (横手春子)	National Nursing college (国立看護大学校4年)	Jaih-s(日本国際保健医療学会学生部会)	2010/2/24 - 2010/3/9
3	Jyunko Takenaga (武長純子)	ICU (国際基督教大学4年)	Jaih-s(日本国際保健医療学会学生部会)	2010/2/24 - 2010/3/9
4	Moe Ozawa (小澤萌)	School of Med, Miyazaki-U (宮崎大学医学部3年)	Jaih-s(日本国際保健医療学会学生部会)	2010/3/13 - 2010/3/24
5	Yuri Hamashima (濱島ゆり)	School of Med, Ikashika-U (東京医科歯科大学医学部2年)	Jaih-s(日本国際保健医療学会学生部会)	2010/3/13 - 2010/3/24
6	Hitomi Ishida (石田瞳)	School of Med, Shiga-U (滋賀医科大学医学部2年)	Jaih-s(日本国際保健医療学会学生部会)	2010/3/13 - 2010/3/24
7	Kanako Kikuchi (菊池可奈子)	Graduate School, Nagasaki-U(長崎大学熱帯医学研究科)	長崎大学MPHインターンシップ	2010/4/12 - 2010/7/9
8	Yoshito Kawakatsu (川勝義人)	Graduate School, Nagasaki-U(長崎大学熱帯医学研究科)	長崎大学MPHインターンシップ	2010/4/12 - 2010/8/3
9	Jyunko Morinushi (森主順子)	Registered Nurse, St. Luke's Nursing school (聖路加看護大学)	聖路加国際病院	2010/6/17 - 2010/6/23
10	Yu Takasugi (高杉友)	Graduate School, Shiefield-U (英国シェフィールド大学)	Jaih-s(日本国際保健医療学会学生部会)	2010/6/21 - 2010/7/17
11	Hiroshi Tsukamoto (塚本裕)	School of Med, Kyoto-U (京都大学医学部2年)	Jaih-s(日本国際保健医療学会学生部会)	2010/8/14 - 2010/8/28
12	Chiho Miyake (三宅千穂)	School of Med, Ikashika-U (東京医科歯科大学医学部2年)	Jaih-s(日本国際保健医療学会学生部会)	2010/8/14 - 2010/8/28
13	Mihoko Suzuki (鈴木美穂子)	National Nursing college (国立看護大学校4年)	Jaih-s(日本国際保健医療学会学生部会)	2010/8/25 - 2010/9/10
14	Shogo Kubota (窪田祥吾)	JICA Expert, Lao PDR(元聖路加国際病院)	ラオス国地域保健専門家(医師)	2010/11/21 - 2011/11/26
15	Sayaka Horiuchi (堀内清華)	小児科医師(国立成育病院)	国立成育病院(医師)	2010/11/21 - 2011/11/26
16	kensuke Tashiro (田代健介)	小児科医師(名戸ヶ谷病院)	名戸ヶ谷病院(医師)	2011/2/8 - 2011/2/9
17	Yuri Nakamura (中村有里)	School of Med, Saga-U (佐賀医科大学医学部4年)	Jaih-s(日本国際保健医療学会学生部会)	2011/2/21 - 2011/3/2
18	Aya Tamiya (田宮彩)	School of Med, Yamaguchi-U (山口大学医学部1年)	Jaih-s(日本国際保健医療学会学生部会)	2011/2/21 - 2011/3/2
19	Kyoko Masuda (増田響子)	Graduate School, Tokyo-U (東京大学国際保健大学院)	Jaih-s(日本国際保健医療学会学生部会)	2011/3/3 - 2011/3/14
20	Sachi Fukui (福井沙知)	School of Med, Asahikawa-U (旭川医科大学5年)	Jaih-s(日本国際保健医療学会学生部会)	2011/3/3 - 2011/3/14
21	Asako Saji (佐治朝子)	School of Med, Sapporo-U (札幌医科大学5年)	Jaih-s(日本国際保健医療学会学生部会)	2011/3/15 - 2011/3/24
22	Tomohiro Ujikawa (氏川智皓)	School of Med, Osaka-U (大阪大学医学部5年)	Jaih-s(日本国際保健医療学会学生部会)	2011/3/15 - 2011/3/24

Counterpart Budget and Execution

	Period	Budget	Expense	Execution rate (%)
JFY 2009	Apr 2009 - Mar 2010	0	0	0%
JFY 2010	Apr 2010 - Mar 2011	0	0	0%
JFY 2011	Apr 2011 - Mar 2012	TBD	TBD	N.A.

【補足】 ケニアにける地方自主財源については、保健バスケットファンドが2010年7月に開始されたばかりであり、その使途も現在まではパイロットとして選抜された保健センターに限定的に拠出されているのが現状である。2011年7月からは可及的に使途が拡大する予定であるが、州および県保健行政分野でどの程度配分されるのかについては全く未定である。現時点では、州および県レベルの保健予算はすべてAIE (Authority Inquired Expenditure)と言われる小規模の財源しかなく、疎に使途についても極めて限定的でプロジェクトへのCost-sharingは極めて困難な状況である(中央でプロジェクト専用のバジェットラインを作らなければ現時点での共同出資は不可能である)。そのために、いくつかの活動においては、他のパートナー(UNICEF、CDC, USAID/APHIA+など)とのジョイント・ファンディング(協賛出資)を行ってきている。

Project Performance Review (Group B)

	Input		Output			Activities		
	Contributing Factors	Constraining Factors	Contributing Factors	Constraining Factors		Contributing Factors	Constraining Factors	Criteria of Operation Model by Participants
					Were activities implemented as planned?			
Output1	>Knowledgeable facilitator. >Learning environment was conducive especially for DHMTs.	>As for KW, frequent change of Med-Sup. >As for Ugenya, change /absence of DMOH.	>The use of mixed facilitators with different backgrounds. >Supportive Supervision training had practice sessions. >Development and updating resolution matrix	>Some contents such as in Knowledge Management, Health Policy, Governance were too academic and too bulky for time to be delivered. >Although those contents were relevant, it was difficult to apply what was presented into practice. >The method of delivery was not suitable for adult learning in some courses. >Not all the staff received the complete package of training due to their competing tasks (especially in PHMT) >Some partners such as EHS felt that they were side lined.	Output1	In general, the Project has stick to the schedule.	Early planning and sharing of plan of activities. Resources from JICA are availed on time. Joint activity planning.	JICA expert explained the Operation Model.
Output2	>Identification and addressing of gaps in pilot districts.	>Generally health workers have not grasped the concept of HP to integrate it to their routine works. >HP policies are not well informed at lower levels. >Divergence HP policies from the national programmes. >Inadequate skills and knowledge among HP officers >Inadequate HP staffing	>UCANWG has done a lot to strengthen HP activities. >Support received from JICA such as cameras, PA system made pilot districts easy to work in communities.		Output2		Some activities have delayed such as Print Media Training due to competing tasks and slow pace of learning by some participants.	JICA expert explained the Operation Model.
Output3	>Learning environment was conducive especially for DHMTs. >Logistics support other partners to carry out SS. >Human resource input by other partners such as ICAP.	>Weakness in using previous SS reports.	>Training on SS, Coaching & Mentoring was very good. >Repair of vehicles in districts by JICA.	>Documentation of resolution matrix is weak in some districts.	Output3			JICA expert explained the Operation Model.
	Progress (Action Taken)	Contributing Factors	Challenges		Is the project structure appropriate? And How appropriate?			
Project Purpose	Not discussed.	Not discussed.	>Orientation of PDM (UCANWG members were orientated, Dr. Sugi shared the concepts of PDM but not this document itself) >Devolution of Nyanza Province and its implication of Project target area.		Output1 Output2 Output3	Appropriate.	>The structure provides proper and efficient coordination. >Decisions are made by Kenyan CPs. >The structure provides adequate consultation in terms of decision making and feedback. >structure provide for regular meetings	
Important Assumptions	>Workplace environment for Ugenya and Gem is inadequate in terms of security, space, electricity >Inadequate staffing for Gem and Ugenya >Mobility: Transport is a problem in Gem and Ugenya							

Project Performance Review (Group C)

	Input		Output			Activities		Criteria of Operation Made by Participants
	Contributing Factors	Constraining Factors	Contributing Factors	Constraining Factors		Contributing Factors	Constraining Factors	
					Were activities implemented as planned?			
Output1	>Well planned logistics and training modules >good choice of knowledgeable facilitators >Well monitored and supported >Key DHMT member involved >JICA funded the training fully >reference materials were provided in terms of hard and soft copy >Consultation on next venue of training done and communicated early	>not all member were trained in all the 6 module >Many district health workers scrambling for the training yet not in DHMT >Governmence top'c was not adequately tackled >Limited training period	>Members practicing SS using IMSS tool >Improve communication >Capacity to mobilize resources/support from partners based on community needs >Referral system improved data available >member equiped with new management skill (Leadership,Computer skill, SS skill) >Evidence based planning and practice >Vision and mission was developed >policy corner available >A great level of mindset change	>Skill from DHMT were not been rolled down >Limited logistics to cascade training to the lower cadres >Competing task, many activities running parallel >some DHMT member did not participate in all training	Output1	>Additional teams were involved where districts requested >time was managed satisfactorily >training was timely and implemented as planned	Duration of some training was too short >Some facilitator did not cover their topic well >Selection of participant was not fair >Competing task made some members to miss some module >too many activities are running parallely	Not discussed.
Output2	>Training of DHMT uder UCAN successful and ongoing >the choice of the facilitator acting in 'SIRT was appropriate >PA, tent, generator, Laptop, CD projector and chairs very useful >UCAN member have developed IEC materials >Printmedia training is very usedul and successful.	>only few member gained the skill >Not all member were involved	>new focus on health promotion is now enhanced by DHMT >Development of IEC materials >Song developed by each district >UCAN WG has developed IEC materials >High impact indicators were summarised and used in health facilities during Malezi bora	>Limited feedback from UCAN member >Health promotion activities not all inclusive >Limited resource and man power >Poor communication from HP office on activities >M&E tool health promotion was not available >limited logistics to develop IEC materials	Output2	>Planned activities done despite of delay in funding. >Malezi bora, ITNs distibution activities carried out >News letter circulated in district >Good overuw for demand creation >Basic health promotion training done	>Activities were not well planned >More needs to be done in health promotion in terms of involving more DHMT members >Health promotion basic training not well planned >many competing task	Not discussed.
Output3	DHMT was trained on SS >IMSS tool is good and useful for supervision >Formation of DIT and TAG is good >Development of DIT and TAG will be great help	>the roll out of tool is too slow >TAG should comprise a few DHMT members and not all the members >The tool need to improve because of too long >Training were limited to few DHMT	IMSS tool was developed and in use >Resolution matric is a very useful tool to be used in SS >District motivated to conduct SS >AOP 7 well planned at the district level >Facilities are abled to develop resolution matrix >MIC students taken through SS using IMSS tool >Funds sourced for SS	>Inadequate funding for SS at the district level >Draft IMSS tool is not addressing specific program areas >the use of the RM tool limited to DHMT ad not well utilised >Partners Supporting supervision be brought on board early enough at the DHSRF	Output3	>It was produce in time >Training of SS was well choice	>Planned activities delayed due to competing task >Slow-follow-up of SS progress after training >Left some department out	Not discussed.
	Progress in Action	Contributing Factors	Challenges		Is the project structure appropriate? And How appropriate?			
Project Purpose	Not discussed.	Not discussed.	Not discussed.		Output1	>Good coordination system >Organization/structure is good >Lectures friendly and good >Project took cognisance of the level of the trainees and involved higher levels of training instructors >Rich Academic facilitation >Project working group was an good idea. >Good venue, panning adequate logistics >Communication between project and DHMT is good	>Specifically computer training was too short >some training venue was not user friendly >Need to involve participant out of the DHMT >Activities are limited to DHMT only
					Output2	>The UCAN structure is appropriate >The Task Group structure is very good	>Structure is not well known >Improve on existing structure by adding more member >No knowledge about structure >Am not confortable with people leaving their core training to be purely health promoters
Important Assumptions	Not discussed.				Output3	>Structure is good because districts participated in their choice >IMSS tool being used during supervision >The structure of DIT and TAG for specific duties is good	>new structure not very friendly too many meeting >The structure of DIT and TAG not well understand

Effectiveness (All Groups)

Effectiveness	Sub Question				
	Is it likely that the project purpose achieved by the end of the project as expected?	**1.Has the indicators for the project purpose progressed sufficiently?How much is the level of the achievement oat the time of the mid-term**	**2. Are all output fully contribute to achieve the progect purpose? Does each output contribute to the achievement of the project purpose?**	**3. Are there any contributing factor that influenced the achievement of the outcome?**	**4. Are there any constraining factor that influenced the achievement of the outcome?**
Group A	>Yes Individual indicators to target district behavior change • Coaching and mentoring during support supervision • Use of integrated checklist instead of service specific checklist Support facilities noting their strength	>Yes Capacity development • 121% • Scale up to other districts • Pilot districts baseline capacity of 3.09 (2009/2011) • Grand average capacity of 3.4 • Pilot district capacity of 3.75 (Dec 2010)	Output 1: Direct contribution to project purpose (training/Capacity development) Output 2:Resource mobilization skills, Improved communication skills, Skills in IEC. Enhanced advocacy skills Output 3:Enhanced skill in communication, Coaching and mentoring, Documentation skills. Enhanced feedback mechanism Output 4:Resource corner, Implementation scale up is evidence based, Networking enhanced, Production of newsletter, Regional presentation of lessons learnt	Improved planning and coordination at DHMT level • Good leadership • Good organization • Dignity maintenance • Development of vision and mission statements • Leadership and management training	>Level of staffing if not included in AOP >Delayed start of the project >Competing tasks >Lack of sharing information >Inadequate information on knowledge of individual staff >Many training without enough time to practice
Group B	>Yes Sufficient progress has been made in the 8 capacities	>Yes • Average improvement of the pilot teams 121% • DHMTS improved in health policy management 3.7 • Siaya marked improvement in LM&G, achieved target of 4.0 • PHMT have stagnated in planning & M&E • Coaching, mentoring was well articulated in the S.S training • Training model targets the 8 capacities • Kisumu west exceeded the target in information management • Siaya achieved 4.0 in S.S • Siaya has declined in M&E from 3.5 to 3.4	Not discussed	>KW improved in information sharing through emails & Monday morning briefs >Support from other partners >Support from MOMS (HSSF) >Feedback from District Stakeholders Forum & in charges meetings	>M&E was scattered per program, not centrally coordinated >Adhoc activities from the national level >Absence of district strategic plan >Competing tasks >Disruptions of PHMT plans by national office >Weakness in documentation >Insufficient human resource
Group C	>Yes, the commitment and enthusiasm is great >Yes, Because staff have been trained and equiped with leader skill for management >Yes, Project activities are going as planned and on schedule >Yes, pilot dhas already been done >Yes, because I did manage to attend 95% of the intended capacity development >Yes, There are plans to role out the training to other district >No, I hace not attended any training >NO, the scale down from DHMT to other staff is slow and resource are limited. >No, inadequate infrastructure, staffs, materials and stationery at HF and District	>No, We can improve more because most of us have not been trained >Yes, there is remarkable improvement on key indicators within a short period >Yes, because the member are showing willingness to work together >Yes, because all planned activities are being carried out despite constrains. >No, all tam players did not yet trained >No, because there are key member still missing in out DHMT >No,because training was not yet rolled down to grassroot. >Satisfactory but more management support is needed to enhanc service delivery >No, if we plan not to CB, we plan to fail >No, some key members are trained and do not remain to implement. >No, We can improve more because most of us have not been trained	>Yes, 4 factors are contributing because they is a lot of owarness to community. >Yes, all output are relevant to the attainment of the project project >Yes,They form the bulk of management support system >Yes, all the outpus are well elaborated and urged. >No, the community is not fully sensitized though CS to access care >No, give another chance for a under range >No, Nyanza populationis big and the indicators are more challenging >No, Community linkage still weak hence participation and involvement low >No, the community component still missing	>Yes, the high level of commitment from both team >Yes, HIS department has been enhanced >Yes, Stakehoder involvement during impremementation >The current constitution is likely to enforce mindset change the more. >Yes, the project works in collaboration with other stakeholdersand synergises the work of the government	>Low level of awareness among community member >Limited resources, lack of human resource, inadequate accountability >high turnover of staff >slow uptake intervention to community >Red tapes in following finances at the district treasury >Inequity in distributing resources >lack of office space >Nepotism >Political system within the community >Corruption

Effectiveness (All Groups)

Effectiveness	Is it likely that the project purpose achieved by the end of the project as expected?	Sub Question: 1.Has the indicators for the project purpose progressed sufficiently?How much is the level of the achievement oat the time of the mid-term review?	2. Are all output fully contribute to achieve the progect purpose? Does each output comtribute to the achievement of the project purpose?	3. Are there any comtributing factor that influenced the achievement of the outcome?	4. Are there any constraining factor that influenced the achievement of the outcome?
Group A	-Yes Individual Indicators to target district behavior change • Coaching and mentoring during support supervision • Use of integrated checklist instead of service specific checklist Support facilities noting their strength	-Yes Capacity development • 121% • Scale up to other districts • Pilot districts baseline capacity of 3.09 (2009/2011) • Grand average capacity of 3.4 • Pilot district capacity of 3.75 (Dec 2010)	Output 1: Direct contribution to project purpose (training/Capacity development) Output 2:Resource mobilization skills, Improved communication skills, Skills in IEC, Enhanced advocacy skills Output 3:Enhanced skill in communication, Coaching and mentoring, Documentation skills, Enhanced feedback mechanism Output 4:Resource corner, Implementation scale up is evidence based, Networking enhanced, Production of newsletter, Regional presentation of lessons learnt	Improved planning and coordination at DHMT level • Good leadership • Good organization • Dignity maintenance • Development of vision and mission statements • Leadership and management training	-Level of staffing if not included in AOP -Delayed start of the project -Competing tasks -Lack of sharing information -Inadequate information on knowledge of individual staff -Many training without enough time to practice
Group B	-Yes Sufficient progress has been made in the 8 capacities	-Yes • Average improvement of the pilot teams 121% • DHMTS improved in health policy management 3.7 • Siaya marked improvement in LM&G, achieved target of 4.0 • PHMT have stagnated in planning & M&E • Coaching, mentoring was well articulated in the S.S training • Training model targets the 8 capacities • Kisumu west exceeded the target in information management • Siaya achieved 4.0 in S.S • Siaya has declined in M&E from 3.5 to 3.4	Not discussed	-KW improved in information sharing through emails & Monday morning briefs -Support from other partners -Support from MOMS (HSSF) -Feedback from District Stakeholders Forum & in charges meetings	-M&E was scattered per program, not centrally coordinated -Adhoc activities from the national level -Absence of district strategic plan -Competing tasks -Disruptions of PHMT plans by national office -Weakness in documentation -Insufficient human resource
Group C	-Yes, the commitment and enthusiasm is great -Yes, Because staff have been trained and equiped with leader skill for management -Yes, Project activities are going as planned and on schedule -Yes, pilot dhas already been done -Yes, because I did manage to attend 95% of the intended capacity development -Yes, There are plans to role out the training to other district -No, I hace not attended any training -NO, the scale down from DHMT to other staff is slow and resource are limited. -No, inadequate infrastructure, staffs, materials and stationery at HF and District	-No, We can improve more because most of us have not been trained -Yes, there is remarkable improvement on key indicators within a short period -Yes, because the member are showing willingness to work together -Yes, because all planned activities are being carried out despite constrains. -No, all tam players did not yet trained -No, because there are key member still missing in out DHMT -No,because training was not yet rolled down to grassroot. -Satisfactory but more management support is needed to enhanc service delivery -No, if we plan not to CB, we plan to fail -No, some key members are trained and do not remain to implement. -No, We can improve more because most of us have not been trained	-Yes, 4 factors are contributing because they is a lot of awarness to community. -Yes, all output are relevant to the attainment of the project project -Yes.They form the bulk of management support system -Yes, all the outpus are well elaborated and urged. -No, the community is not fully sensilized though CS to access care -No, give another chance for a under range -No, Nyanza populationis big and the indicators are more challenging -No, Community linkage still weak hence participation and involvement low -No, the community component still missing	-Yes, the high level of commitment from both team -Yes, HIS department has been enhanced -Yes, Stakehoder involvement during impremention -The current constitution is likely to enforce mindset change the more. -Yes, the project works in collaboration with other stakeholdersand synergises the work of the government	-Low level of awareness among community member -Limited resources, lack of human resource, inadequate accountability -high turnover of staff -slow uptake intervention to community -Red tapes in following finances at the district treasury -Inequity in distributing resources -lack of office space -Nepotism -Political system within the community -Corruption

11. 主要面談者リスト

主要面談者リスト

【公衆衛生省】

Dr. S. K. Shariff, Director , Public Health and Sanitation, Ministry of Public Health and Sanitation (MoPHS)

Mr. Ibrahim Maalim, Senior Deputy Secretary, MoPHS

Dr. John Odondi, Head Department of Primary Health Service, MoPHS

Dr. Rael Mutai, Monitoring and Evaluation Coordinator, Head Department of Primary Health Service, MoPHS

Nyanza PHMT

Dr. Jackson Kioko, Provincial Director of Public Health and Sanitation, Nyanza PHMT (Provincial Health Management Team)

Dr. Peter Okoth, Provincial Disease Prevention and Control Officer, Nyanza PHMT

Kisumu West DHMT

Dr. Elizabeth Okoth, District Medical Officer of Health

Nicolus Pule, District Clinical Officer

Monica Musyoka, District Public Health Nurse

George S. Odhiambo, District Health Records and Information Officer

Joan Chepkemboi, District Nursing Officer/ District Health Promotion Officer

Herman Nyobambo, District Medical Laboratory Technologist

Siaya DHMT

Dr. Samuel Onditi, District Medical Officer of Health

Millicent Okwach, District Medical Officer of Health

James Odiga, District Health Records and Information Officer

Gilbert Oyugi, District Medical Laboratory Technologist

Ali Asuman, District Clinical Officer

Kennedy Genga, District Tuberculosis and Leprosy Coordinators

Dr. Mwai O. G., Pharmacist

Everlyne Achieng, District Health Promotion Officer

Janet Mule, District Health Promotion Officer

Samuel Mugoh, District Health Administration Officer

Joyce Namwire、District Nursing Officer

【パートナー】

Margaret Gwada, Programme Specialist, Emergency & Field Operations Section

Prof. Stephan Okeyo, Great Lake University of Kisumu (GLUK)

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杉下　智彦、チーフアドバイザー

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斎藤　佳央里、保健行政マネージメント

村上　千恵、業務調整/IEC教材開発

川勝　義人、フィールド能力開発アドバイザー

【JICAケニア事務所】

加藤　正明、所長

河澄　恭輔、次長

MINUTES OF MEETINGS
BETWEEN
THE JAPANESE MID-TERM REVIEW TEAM
AND
OFFICIALS CONCERNED OF THE GOVERNMENT OF
THE REPUBLIC OF KENYA
ON
JAPANESE TECHNICAL COOPERATION PROJECT
FOR
STRENGTHENING MANAGEMENT FOR HEALTH IN NYANZA PROVINCE

The Mid-Term Review Team (hereinafter referred to as "the Team") organized by Japan International Cooperation Agency (hereinafter referred to as "JICA") and the Ministry of Public Health and Sanitation (hereinafter referred to as "MoPHS"), conducted the mid-term review of the Project for Strengthening Management for Health in Nyanza Province (hereinafter referred to as "the Project"), from 14 June to 24 June, 2011, for the purpose of reviewing its performance and monitoring the Project activities.

During the review mission in the Republic of Kenya, the Team collected relevant data and information, evaluated the achievement of the Project, and held a series of discussions with the officials concerned of the relevant authorities of the Government of Kenya to confirm the results of the mid term review.

Accordingly, both the Japanese and Kenyan sides agreed upon the issues referred to in the document attached hereto.

Nairobi, 24 June, 2011

Mr. Ikuo Takizawa
Team Leader,
The JICA Mid term Review Team,
Japan International Cooperation Agency,
JAPAN

Mark K. Bor, CBS
Permanent Secretary
Ministry of Public Health and Sanitation
Republic of Kenya

JOINT MID-TERM REVIEW REPORT
ON JAPANESE TECHNICAL COOPERATION
FOR

STRENGTHENING MANAGEMENT FOR HEALTH

NYANZA PROVINCE

Japan International Cooperation Agency

and

Ministry of Public Health and Sanitation, Republic of Kenya

June 2011

CONTENTS

Annexes

Annex 4: List of Japanese Experts assigned to the Project
Annex 5: List of Equipment Provided by the Project
Annex 6: List of Counterparts
Annex 7: List of Counterpart Trainees
Annex 8: Project Operational Cost
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(including the list of participants)

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante natal care
AOP	Annual Operational Plan
CDC	Center for Disease Control and Prevention
DHMT	District Health Management Team
DMOH	District Medical Officer of Health
DPHS	Department of Public Health and Sanitation
DSS	Demographic Surveillance Survey
DTT	District Think Tank
GLUCK	Great Lake University Kisumu
GOK	Government of Kenya
HF	Health Facility
HIIs	High Impact Interventions
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
IMSS	Integrated Management Supportive Supervision
ICC	Inter-agency Coordinating Committee
IEC	Information, Education & Communication
JCC	Joint Coordination Committee
JFY	Japanese Fiscal Year
JICA	Japan International Cooperation Agency
KDHS	Kenya Health Demographic Survey
KEMRI	Kenya Medical Research Institute
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MoPHS	Ministry of Public Health and Sanitation
MSH	Management Sciences for Health
NHSSP	National Health Sector Strategic Plan
ODA	Official Development Assistance
PDM	Project Design Matrix
PDPHS	Provincial Director of Public Health & Sanitation
PHMT	Provincial Health Management Team
PO	Plan of Operation
PSC	Project Steering Committee
R/D	Record of Discussions
TAG	Transformative Action Group
TICAD	Tokyo International Conference on African Development
TWG	Technical Working Group
UCAN	Unity, Communication, Advocacy and Networking
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WG	Working Group
WHO	World Health Organization

1. Outline of the Mid-term review

1-1 Background of the Mid-term review

The Mid-term review Team (hereinafter referred to as "the Team") dispatched by Japan International Cooperation Agency (JICA) visited the Republic of Kenya for the purpose of the joint Mid-term review with Kenyan side on the Project for Strengthening Management for Health in Nyanza Province (hereinafter referred to as "the Project") at the middle of 4 year cooperation term. The Project has been implemented since 1 July 2009 and will terminate on 30 June 2013 based on the Record of Discussions (R/D) signed on 22 April, 2009.

1-2 Objectives of the Mid-term review

The Mid-term review is an opportunity to revise the Project Design Matrix (PDM) if necessary based on the results. Considering the fact that the original PDM (PDM0) was recently revised by the Project Team and approved in the 2nd JCC meeting in March 2011, the joint review team determined that it would not further modify the basic structure of the Project. The main focus of the Mid-term review is:

1) to review the Project performance (achievements and implementation process) for the past one year and eight months, and assess on the Project performance based on the five evaluation criteria with focus on relevance, efficiency and effectiveness,.
2) to draw recommendations to the Project for the rest of the Project period.
3) to build the consensus among stakeholders on the direction of the Project for the rest of the Project period. This includes:
    a) up to which level should the Project Purpose and the Outputs be achieved within the Project period (reviewing the scope of the Project, paying attention to its contents and indicators)?
    b) what should be done in each Outcome for the rest of the Project period (setting efficient number of appropriate activities to reach each Output effectively)?

1-3 Methodology of the Mid-term review

1-3-1 Process of Mid-term review

In accordance with the JICA Project Evaluation Guideline of June 2011, the Mid-term review of the Project was conducted in the following process:

Step 1: Based on the PDM, analysis was conducted on the factors that promoted or inhibited the Project's achievement levels including matters relating to both the project design and project implementation process (See 1-4).

Step 2: An assessment of the Project results was conducted based on the five evaluation criteria: "relevance", "effectiveness", "efficiency", "impact", and "sustainability".

Step 3: Recommendations for the Project stakeholders was formulated.

1-3-2 Five Criteria of Review

The definition of the five criteria that were applied in the analysis for the Mid-term review is given

in Table 1 below.

Table 1: Definition of the Five Criteria for the Mid-term review

Five Criteria		Definitions as per the JICA Evaluation Guideline
1.	Relevance	Relevance of the Project is reviewed by the validity of the Project Purpose and Overall Goal in connection with official development assistance policies of Japan, development policies of the Government of Kenya and the needs of the target group and/or ultimate beneficiaries in Kenya
2.	Effectiveness	Effectiveness is assessed to what extent the Project has achieved its Project Purpose, clarifying the relationship between the Project Purpose and Outputs.
3.	Efficiency	Efficiency of the Project implementation is analysed with emphasis on the relationship between Outputs and Inputs in terms of timing, quality and quantity.
4.	Impact	Impact of the Project is assessed in terms of positive/negative, and intended/unintended influence caused by the Project.
5.	Sustainability	Sustainability of the Project is assessed in terms of institutional, financial and technical aspects by examining the extent to which the achievements of the Project will be sustained after the Project is completed.

1-3-3 Data Collection Method

Both quantitative and qualitative data were gathered and utilized for analysis. Data collection methods used for the review were as follows:

- Literature/Documentation review:
- Key informant interviews:
- Participatory Project Review Workshop (See Annex 9)
- Direct observations

1-4 Adoption of the PDM as the framework for Mid-term review

The original PDM (PDM0) was revised by the Project Team and approved in the 2nd JCC meeting in March 2011, 2 months before the Mid-term review. The joint exercise between the Japanese experts and the counterparts started in February 2011 to clarify the indicators which enable the reviewers to measure Project performances, to spell out key activities which were not included in the PDM0, and to restructure the logical framework.

The Evaluation Team adopted the PDM1 as a basis of the Mid-term review because the PDM1 more addresses actual activities implemented under the Project for one year and eight months than the PDM0. Both PDM0 and PDM1 are attached as Annex 1 and Annex 2 respectively.

1-5 Reviewers

The following are the members of the joint review team.

(1) Kenyan side

Name	Designation	Position/Organization
Dr. John Odondi	Team Leader	Head, Department of Primary Health Service, MoPHS
Mr. Ibrahim Maalim	Reviewer	Senior Deputy Secretary, MoPHS
Dr. Rael Mutai	Reviewer	Monitoring &Evaluation Coordinator, Department of Primary Health Service , MoPHS

(2) Japanese side

Name	Designation	Position/Organization
Mr. Ikuo Takizawa	Team Leader	Director, Health Division 1, Health Group 1, Human Development Department, JICA Head Quarter
Mr. Elijah Kinyangi	Health Management	Programme Officer, JICA Kenya
Ms. Yasuyo Kawamura	Cooperation Planning	Representative, JICA Kenya
Ms. Yumiko Nakahara	Cooperation Planning	Project Formulation Advisor, JICA Kenya
Ms. Keiko Kita	Review/analysis	Senior Consultant, Global Link Management Co.

1-6 Schedule of the Mid-term review

Date	Day	AM/PM	Schedule
14, June	Tue	0900	Internal Meeting (JICA Kenya Office)
		1100	Meeting with DoPHS (MOPH) to explain the evaluation objectives and procedures
15, June	Wed	0900	Courtesy call to PDPHS
		0930	Project Internal Meeting (Presentation for Overview Progress and Challenges)
		PM	Interview with Japanese experts, Project Staffs and PHMT
16, June	Thu	1100	Ugenya DHMT Meeting and Interview
		1400	Siaya DHMT Meeting and Interview

17, June	Fri	0900	Interview (UNICEF, GLUK)
		1100	Kisumu West DHMT Meeting and Interview
		PM	Meeting with the Project and PHMT members
18, June	Sat		Additional interviews with Japanese expert team Drafting review report
19, June	Sun		Further collection of information Drafting review report
20, June	Mon	0830	Mid-term review Participatory Work Shop
		17:00	Imperial Hotel (35 people)
		13:30	Meeting with DoPHS (MOPHS)
		1900	Internal meeting (Mission team)
21, June	Tue	0830	JICA HSS Program meeting: Imperial Hotel (45 people)
		1500	Interview with JOCV and Grass roots Technical Cooperation Project Internal meeting (Mission Team & the Project)
22, June	Wed	0800	Visitation to Kisumu West District, health facility and community Final discussion with the Project team Final analysis, review and report writing (Mission team)
		1400	Tentative Review result dissemination and final dialogue (the Mission Team, PDPHS, DMOH, WG Chairperson and the Project)
23, June	Thu	1100	Meeting with MOPHS to review the draft report (apart from DoPHS, other departments may be invited if necessary)
		PM	Finalizing Joint Review Report (Study Team)
24, June	Fri	0900	Mission Reporting to MOPHS (Joint Review Report)
		1100	Signing M/M on Joint Mid Term Review (PS and Team Leader)
		1330	Reporting to JICA Kenya office

2. Outline of the Project

2-1 Background of the Project

Nyanza is one of the most challenging provinces in Kenya. More than 5.8 million people inhabit in the second smallest province in Kenya. The province has 38 districts and there are 30 District

Health Management Teams (DHMTs) functioning under the oversight by Provincial Health Management Team (PHMT). The Province faces a vast range of health challenges such as HIV/AIDS, malaria, tuberculosis and childhood illnesses.

According to the Kenya Demographic and Health Survey (KDHS) 2003, Nyanza province had some of the worst health indicators among all provinces in Kenya. However, according to the KDHS of 2008/09, the trend of health indicators recently showed accelerated improvement as compared to other provinces. However these indicators are still among the worst in the country. Also HIV/AIDS prevalence in adult is highest (13.9%) in the country.

According to the data from DSS by KEMRI/CDC in Siaya County in 2010, malaria and related anemia account for 80% of morbidity and 32% of mortality of under-five children. Pneumonia accounts for 20% of morbidity and HIV/AIDS accounts for 15% of mortality of under-five children. Maternal mortality is mainly caused by postpartum hemorrhage (30%) and puerperal sepsis (15%). However indirect causes of maternal mortality are such as HIV/AIDS (40%) and malaria (15%) are also important.

To accelerate the achievement of MDGs by 2015, NHSSPII (2005－2010) clearly described that the government would devolve the task of health services and administration to province/ district level. In line with this strategy, province/ district have to make annual plan, set the target and priorities, and implement according to their priority. In this regard, PDPHS and DMOH are required to have capacity for planning, implementation, monitoring and evaluation.

With the forgoing consideration, MoPHS in collaboration with JICA, initiated the Project as a four-year technical cooperation. The Project is based in Nyanza Province. It aims at strengthening management capacities of PHMT and DHMTs in Nyanza through catalytic support of JICA, with a vision to strengthen overall health systems in a self-reliant manner to ensure quality primary health services.

The Project focused initially on the PHMT and the two pilot District Health Management Teams (DHMTs; Siaya and Kisumu West) and would ultimately pursue expansion of the activities throughout the whole DHMTs in Nyanza Province and impacting on others.

2-2 Project Design Matrix

Goal, Project Purpose, Outputs and Activities of the Project in the latest PDM (PDM1) are as follows[1]:

1) Overall Goal

Quality of primary health services is improved in Nyanza Province.

2) Project Purpose

Management capacity of health management teams at Provincial and District levels in Nyanza Province is strengthened.

(Management capacity includes: leadership and governance, team management, planning and M&E, health policy management, supportive supervision/coaching/mentoring, health information management, resource management, customer relationship management)

[1] Super Goal of the Project: Health status of the people in Nyanza Province is improved.

3) Outputs and Activities

Output 1: Health leadership and management training are modeled and promoted in Nyanza Province.

1.1 To establish Community of Practices (COPs) as institutional networking to spearhead and support health management training.

1.2 To organize a training management working group (TMWG) consisting of training focal persons from PHMT and DHMTs, JICA Experts, and technical advisors from COPs.

1.3 To hold regular meeting to identify training needs and develop training plans, courses, modules and tools.

1.4 To implement core management training programme to the pilot teams as initial modeling process for packaging.

1.5 To review, develop and package core management training programme for scaling-up to cover all the DHMTs in Nyanza Province.

1.6 To scaling-up core management training program to all the DHMTs in Nyanza province with randomized Control Trial (RCT) method.

1.7 To support DHMTs to conduct health management training at health facility and community level to the pilot districts.

1.8 To support DHMTs to enhance health management training into AOP in the pilot districts.

1.9 To evaluate and document health leadership and management training Program as evidence-based practice.

Output 2: Health promotion activities are modeled and mainstreamed in Health System Strengthening in the pilot districts.

2.1 To organize and operate a working group on health promotion (UCAN WG: Unity, Communication, Advocacy and Networking Working Group).

2.2 To conducts needs assessment on health promotion both at PHMT/DHMT level and Health Facility/Community level.

2.3 To conduct capacity assessment on health promotion for the pilot districts.

2.4 To conduct management training/workshops on health promotion at PHMT/DHMT level.

2.5 To support DHMTs to conduct health promotion activities at health facility and community level.

2.6 To support DHMTs to promote health promotion activities to be incorporated into AOP.

2.7 To conduct study/exchange visits for sharing good practices and networking with other teams.

2.8 To support DHMTs to develop DHMTs to develop IEC materials suitable to the local contexts.

2.9 To evaluate and documents health promotion activities as evidence-based practice.

Output 3: Supportive supervision and related management activities by DHMTs for health facilities and communities are modeled and promoted in the pilot districts.

3.1 To establish and operationalize Field Support Working Group to strengthen capacity

development of district health systems.

3.2 To review supervision system and checklists in light of quality of management and standardized health services.

3.3 To develops Integrated Management Supportive Supervision (IMSS) checklist and implementation, on-site training and feedback mechanism.

3.4 To operationalize implementation, on-site training, feedback and dissemination of IMSS.

3.5 To support DHMT to incorporate IMSS into budget and action plan of AOP.

3.6 To support PHMT/DHMT to promote Health Management Information System (HMIS), Community Health Strategy (CHS) and other related communication management to strengthen district health systems.

3.7 To support PHMT/DHMT to strengthen project management in AOP.

3.8 To support PHMT/DHMT to hold Technical Assistance Committee and Stakeholder Forum at provincial and district level.

3.9 To evaluate and document IMSS and other related management activities as evidence-based practice.

Output 4: Evidence-based practice and lessons-learned demonstrated by the Project operational models are promoted to all the districts in Nyanza Province and other provinces and enhance national health policies/guidelines and international networks.

4.1 To design and conduct operational research for evidence-based practices concerning to the project interventions.

4.2 To document and publish research results, operational models and lessons-learned to a wider public audience.

4.3 To support sustainable mechanism to disseminate evidence-based practices demonstrated by the Project in scientific journals, conferences and stakeholders' forums.

4.4 To promote institutional networking with development partners, academic institutions and other organizations (NGOs, CBOs, FBOs etc.).

4.5 To conduct forums and study visit to exchange information and experiences to enhance evidence-based practices.

4.6 To support Department of Primary Health Services and other departments in MoPHS for their organizational capacity development.

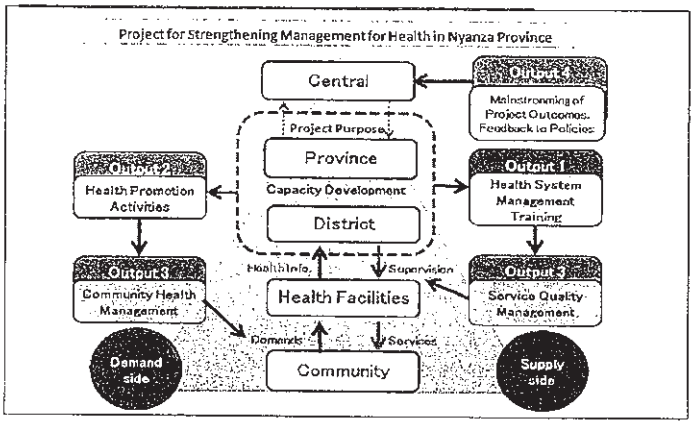
4.7 To support the development and review of health policy/guidelines based on the Project activities and achievements.

4.8 To spearhead international collaborative network for health systems strengthening with neighboring countries and beyond.

2-3 Cooperation Scenario of the Project

The cooperation scenario of the Project is illustrated in Figure 1. It shows how each Output is interrelated each other within the Project toward the achievement of the Project Purpose.

Figure 1: Cooperation Scenario



Output 1, 2 and 3 aim at developing an operational models of health systems management through verification of their effectiveness and disseminating the models in Nyanza Province. Output 4 is set to (a) design operational researches for Output 1, 2 and 3, (b) mainstream the models to the national level, (c) feedback Project's experiences to national guidelines/strategies, (d) develop/strengthen international networking for Nyanza. How each Output contributes to the achievement of the Project goal is described in the section of review of effectiveness (See 5-2 Effectiveness).

3. Results and Achievements of the Project

Details of the results and achievement of the Project are described in this section.

3-1 Inputs

3-1-1 Inputs from the Japanese Side

Table 3-1 shows the comparison of the planned (as per R/D of 22 April 2009) and actual inputs from the Japanese side.

Table2: Inputs by the Japanese Side, Planned and Actual

Plan (as per R/D of April 2009)	Actual (as of June 2011)
[Japanese Experts] **Long-term:** One (1) Chief Advisor One (1) Project Coordinator/Documentation One (1) System strengthening/Training **Short-term:** One (1) M&E One (1) Health Information System One (1) Public Relations	[Japanese Experts] **Long-term:** One (1) Chief Advisor One (1) Project Coordination/IEC development (By 30 June 2011) One (1) Project Coordination/Health Promotion (From 1 July 2011) One (1) Institutional Strengthening/Training Management One (1) Health Management **Short-term:** One (1) Health Information System

	[National Expert] Field capacity Development Human Resource Development (See Annex 4)
[Counterpart Training in Japan] Not specified	[Counterpart Training in Japan] A total of nine (9) persons were trained in trainings in Japan (See Annex 7)
[Equipment] Vehicles, ICT equipment and ECT	[Equipment] Total 82 items JFY2009: 6,987,618 Ksh JFY2010: 2,690,096 Ksh (See Annex 5)
[Project Operational Cost] Not mentioned	[Project Operational Cost] JFY2009: 12,286,631 Ksh [2] JFY2010: 29,302,635 Ksh (See Annex 8)

3-1-2 Inputs from the Kenyan Side

Table 3 shows the comparison of the planned (as per R/D of 22 April 2009) and actual inputs from the Kenyan side.

Table 3 Inputs from the Kenyan Side

Plan (as per R/D of April 2009)	Actual (as of June 2011)
[Allocation of Counterpart Personnel] 1. Project Director: Director of Public Health and Sanitation, MoPHS 2. Project Manager: Head of the Department of Primary Health Service, MoPHS 3. Field Manager: Provincial Director of Public Health and Sanitation, Nyanza Province, MoPHS 4. Staff of the Department of Primary Health Service at the Ministry headquarter, MoPHS 5. Members of Provincial Health Management Team, Nyanza Province (PHMT) 6. Members of District Health Management Teams, within Nyanza Province (DHMTs)	[Allocation of Counterpart Personnel] 1. Project Director: Director of Public Health and Sanitation, MoPHS 2. Project Manager: Head of the Department of Primary Health Service, MoPHS 3. Field Manager: Provincial Director of Public Health and Sanitation, Nyanza Province, MoPHS 4. Staff of the Department of Primary Health Service at the Ministry headquarter, MoPHS 5. Members of Provincial Health Management Team, Nyanza Province (PHMT) 6. Members of District Health Management Teams, from Siaya (including Gem), Ugenya and Kisumu West (See Annex 6)

[2] Exchange rate (March 2010) is 1Ksh =1.218 JPY 1USD= 89.25 JPY

[Others] ● Land, buildings and facilities necessary for the implementation of the Project ● Rooms and facilities necessary for the installation and storage of the equipment ● Electricity, water supply and necessary telecommunication services	[Others] ● Land, buildings and facilities necessary for the implementation of the Project ● Rooms and facilities necessary for the installation and storage of the equipment ● Electricity and water supply
Counterpart budget for operational cost Cost for support staff	[Cost-sharing] Personnel: Salary for counterpart staff

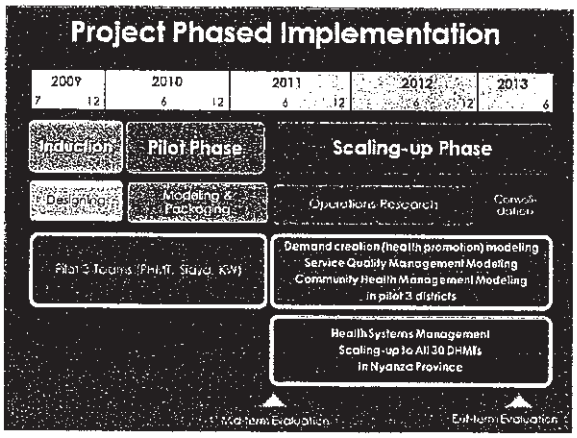
3-2 Activities Implemented

The Project framework of implementation which was revised prior to the Mid-term review is composed of the three phases: Introduction, Pilot and Scale-up as shown in Figure 2.

The Mid-term review covers the period of the introduction and the pilot phases according to the implementation framework.

The main focus of the period before the Mid-term review was on activities related to the core management training program set under the Output 1 in the PDM1. Most of these activities were implemented as planned without much delay.

Figure 2 Project Phased Implementation

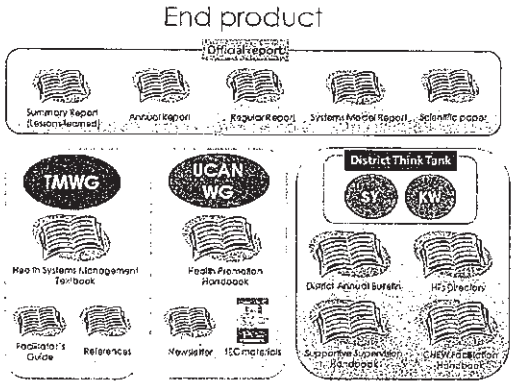


The Project implemented some activities related to health promotion in the pilot districts under the new Output 2 in the PDM1- health promotion activities.

Activities related to the supportive supervision and other related management practices set under the Output 3 in the PDM1 were not fully implemented as planned because most of them are started after the revision of the PDM.

Activities under Output 4 in the PDM1 were implemented as they were originally planned. However, PDM1 introduced new operation researches as an evidence-based practice. They are started but results are yet to be seen.

Most of criteria of the benchmarks to verify the establishment of operational models to be developed under Output 1, 2 and 3 are reflected in the PDM as activities. The end products of Output 1, 2 and 3 were being conceptualized as in Figure 3, yet they were not shared



among project personnel.

The summary of achievement of Activities is shown in Annex 3[3].

3-3 Achievement of Outputs

3-3-1 Achievement of Output 1

Output 1	Objectively Verifiable Indicators
Health leadership and management training are modelled and promoted in Nyanza Province	1. An operational model of health strategic leadership and management training is established by June 2011 (Benchmark is zero in July 2009). 2. Coverage of PHMT and DHMTs in Nyanza Province receiving the model training program is increased to 100% by June 2013 (Benchmark is zero in July 2009)

By the time of the Mid-term review, 73% of model development is completed and 12.9% of the targeted health management teams (4 out of PHMT and 30 DHMTs) received the training. Output 1 is considered achieved when an operational model is developed and all the target PHMT and DHMTs in Nyanza province have received the training. Details are shown in the table below.

Table:4 Progress in Indicators set for Output 1

Objectively Verifiable Indicators and Targets	JFY2009				JFY2010				JFY2011
	Q1 (Apr-Jun)	Q2 (Jul-Sep)	Q3 (Oct-Dec)	Q4 (Jan-Mar)	Q1 (Apr-Jun)	Q2 (Jul-Sep)	Q3 (Oct-Dec)	Q4 (Jan-Mar)	Q1 (Apr-Jun)
1 A operational model of health strategic leadership and management training is established by June 2011 (Benchmark is zero in July 2009).	0.0%	0.0%	0.0%	15.7%	23.6%	39.3%	55.0%	62.5%	73.0%
2 Coverage of PHMT and DHMTs in Nyanza Province receiving the model training program is increased to 100% by June 2013 (Benchmark is zero in July 2009).	0.0%	0.0%	9.7%	9.7%	9.7%	12.9%	12.9%	12.9%	12.9%

The benchmarks to verify establishment of the operational model is composed of five criteria as shown in the table 5. The progress in model development varies according to criteria. Among five criteria, the first criteria (completion of the core training to PHMT/DHMT in the pilot district) has been fully completed while the fifth criteria (scaling up of the training program in the whole province) is a challenges for the rest of the Project period.

[3] The table is based on the revised PDM (PDM1) to which most of the original activities in the PDM0 were incorporated.

Table 5: Progress in Development of Operational Training Model

			Achievement (%)								
			Q1 - 09	Q2 - 09	Q3 - 09	Q4 - 09	Q1 - 10	Q2 - 10	Q3 - 10	Q4 - 10	Q1 - 11
Output 1 Model	1	Core Management Training Programme for PHMT and the pilot DHMTs in Nyanza Province is completed with outstanding satisfaction from the participants.	0.0%	0.0%	0.0%	28.6%	42.9%	71.4%	100.0%	100.0%	100.0%
	2	Facilitators' Guide/Training Curriculum is developed for scaling-up the Programme.	0.0%	0.0%	0.0%	14.3%	21.4%	35.7%	50.0%	50.0%	75.0%
	3	Training Materials including text book and presentation slides are developed for scaling-up the Programme.	0.0%	0.0%	0.0%	14.3%	21.4%	35.7%	50.0%	50.0%	55.0%
	4	Training Implementation Mechanism and Operational Plan is developed for scaling-up the Programme to cover all the DHMTs in Nyanza Province.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	90.0%
	5	Training of Facilitators is conducted in line with the facilitators' guide and other training materials for scaling-up the Programme to cover all the DHMTs in Nyanza Province	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
		Total	0.0%	0.0%	0.0%	15.7%	23.6%	39.3%	55.0%	62.5%	73.0%

Note: The total is calculated as waited average. Criteria 1 is assigned 0.4 and the rest 0.15 each.

3-3-2 Achievement of Output 2

Output 2	Objectively Verifiable Indicators
Health promotion activities are modeled and mainstreamed in Health System Strengthening in the pilot districts.	1. An operational model of health promotion activities is established by April 2012 (Benchmark is zero in July 2009). 2. Execution rate of health promotion activities budgeted in AOP of the pilot districts is increased to at least 5 activities per district by June 2013 (Benchmark is zero in AOP4 and 5). 3. Grand average score of the capacity assessment on health promotion in the pilot districts is increased to 4.0 by June 2013 (Benchmark in March 2011).

Completion rate of the model development is close to 50% at the time of the Mid-term review. Full achievement of the Output 2 requires the development of an operational model of health promotion, execution of budgeted health promotion activities in AOP and self-assessment of capacity on health promotion in the pilot districts, with the satisfactory level of indicators respectively. Challenges are
the areas of training to health promotion officers and health promotion focal persons in the target districts as well as the development/dissemination of health promotion handbooks.

Progress in execution of budgeted health promotion activities in AOP is the most challenging area. Among 3 target districts Kisumu West is most ahead.

The Project exercised self capacity assessment on health promotion to 4 pilot teams in March 2011. The grand average score is 3.5 which was set as the benchmark.

Table 6: Progress in Indicators set for Output 2

Objectively Verifiable Indicators and Targets	Q1-09	Q2-09	Q3-09	Q4-09	Q1-10	Q2-10	Q3-10	Q4-10	Q1-11
1 An operational model of health promotion activities is established by April 2012 (Benchmark is zero in July 2009).	0.0%	0.0%	6.7%	13.3%	30.0%	7.5%	21.6%	23.2%	47.1%
2 Execution rate of health promotion activities budgeted in AOP of the pilot districts is increased to at least 5 activities per district by June 2013 (Benchmark is zero in AOP4 and 5).	0.0	0.0	0.0	0.0	0.0	2.0	2.0	2.0	3.0
3 Grand average score of the capacity assessment on health promotion in the pilot districts is increased to 4.0 by June 2013 (Benchmark in March 2011).	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.5	3.5

Table 7: Progress in Development of Health Promotion Model

			Achievement (%)								
			Q1-09	Q2-09	Q3-09	Q4-10	Q1-10	Q2-10	Q3-10	Q4-11	Q1-11
Output 2 Model:	1	Health promotion working group is established and it conducts meetings monthly.	0.0%	0.0%	33.3%	66.7%	133.3%	33.3%	100.0%	100.0%	66.7%
	2	Basic health promotion training and applied health promotion trainings for health promotion officers and health promotion focal persons in pilot districts are conducted.	0.0%	0.0%	0.0%	0.0%	4.0%	4.0%	8.0%	16.0%	4.0%
	3	Health promotion handbook including policy documents are published. 25%: contents & authors decided, 50%: drafts completed, 75%: drafts revised, 100%: published	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	4	IEC materials suitable for local contexts are developed	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	65.0%
	5	Provincial health promotion stakeholders forums are conducted quarterly.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
		Total	0.0%	0.0%	6.7%	13.3%	30.0%	7.5%	21.6%	23.2%	47.1%

Table8: The details of health promotion activities budgeted and executed which are budgeted in AOP 6.

The details of health promotion activities executed which are budgeted in AOP6	Q1-09	Q2-09	Q3-09	Q4-09	Q1-10	Q2-10	Q3-10	Q4-10	Q1-11
Total	0	0	0	0	0	2	2	2	3
PHMT	0	0	0	0	0	0	0	0	0
Siaya District including Ugenya District	0	0	0	0	0	0	0	0	0
Kisumu West District	0	0	0	0	0	2	2	2	3
The details of health promotion activities budgeted in AOP6	**Q1-09**	**Q2-09**	**Q3-09**	**Q4-09**	**Q1-10**	**Q2-10**	**Q3-10**	**Q4-10**	**Q1-11**
Total	0	0	0	0	0	8	7	7	8
PHMT	0	0	0	0	0	0	0	0	0
Siaya District including Ugenya District	0	0	0	0	0	0	0	0	0
Kisumu West District	0	0	0	0	0	8	7	7	8

3-3-3 Achievement of Output 3

Output 3	Objectively Verifiable Indicators
Supportive supervision and related management activities by DHMTs for health facilities and communities are modeled and promoted in the pilot districts.	1. An operational model of supportive supervision is established by April 2012 (Benchmark is zero in July 2009). 2. Number of health facilities in the pilot districts receiving Integrated Management Supportive Supervision (IMSS) is increased to 80% of facilities in every district by June 2013 (Benchmark is zero in July 2009).

As far as the indicators are concerned, some progress has been made. The development of the operational model is completed only 14 % by the time of Mid-term review. Among 5 criteria, the Project started the development of IMSS checklist a year ago and about 70% was completed at the time of the Mid-term review. The checklist is still in the draft stage and needs to be agreed with the counterparts toward finalization and humanization with national effort. There is little progress in rest of the criteria.

Although it is a draft, 51.5% of the facilities in the pilot districts received supervision using the IMSS checklist by the time of Mid-term review.

Table9: Progress in Indicators set for Output 3

	Objectively Verifiable Indicators and Targets	JFY2009				JFY2010				JFY2011
		Q1 (Apr-Jun)	Q2 (Jul-Sep)	Q3 (Oct-Dec)	Q4 (Jan-Mar)	Q1 (Apr-Jun)	Q2 (Jul-Sep)	Q3 (Oct-Dec)	Q4 (Jan-Mar)	Q1 (Apr-Jun)
1	An operational model of supportive supervision is established by April 2012 (Benchmark is zero in July 2009).		0.0%	0.0%	0.0%	2.0%	6.0%	10.0%	14.0%	14.0%
2	Number of health facilities in the pilot districts receiving Integrated Management Supportive Supervision (IMSS) is increased to 80% of facilities in every district by June 2013 (Benchmark is zero in July 2009).		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	51.5%

Table10: Progress in Development of Operational Supervision Model

			Achievement (%)		
			Jun-09	Jun-10	Jun-11
Output 3 Model	1	IMSS checklist is developed	0.0%	10.0%	70.0%
	2	SS mechanism (plan, prepare, do monitor, evaluate, feedback) is established	0.0%	0.0%	0.0%
	3	SS handbook is developed	0.0%	0.0%	0.0%
	4	IMSS checklist and Resolution matrix are well documented, analysed, stored and shared by DHMTs and stakeholders	0.0%	0.0%	0.0%
	5	The impact of the SS model is verified. (Health workers' satisfaction, Clients' satisfaction, Indicator of HIIs etc)	0.0%	0.0%	0.0%
		Total	0.0%	2.0%	14.0%

Table11: IMSS Checklist Utilization as of May 2011

	Siaya	Ugenya	Gem	Kisumu West	Total
No. of IMSS Checklist kept	28	14	11	7	60
No. of HF received IMSS twice	9	0	0	0	9
Total No. of HF in district	32	24	21	22	99
% of HF received IMSS in district	59.38	58.33	52.38	31.82	51.52

3-3-4 Achievement of Output 4

Output 4	Objectively Verifiable Indicators
Evidence-based practices and lessons-learned demonstrated by the Project operational models are promoted to all the districts in Nyanza Province and other provinces and enhance national health policies/guidelines and international networks	1. Number of seminars, workshops and conferences shared project achievement is continuously increased until June 2013 (Benchmark is zero in July 2009). 2. No of scientific papers, documents and publications concerning to the project activities and achievements is continuously increased until June 2013 (Benchmark is zero in July 2009).

The number of seminars/workshops/conferences where Project activities and achievement were presented has increased continuously and the number reached 69 in total by June 2011. The number of project publications also sharply increased from 5 in JFY 2009 to 24 in 2010. The grand total as of June 2011 reached to 33.

Table 12: Progress in Indicators set for Output 4

	JFY 2009				JFY 2010				JFY 2011
	Q1	Q2 (July-Sep)	Q 3 (Oct-Dec)	Q 4 (Jan -Mar)	Q1 (Apr-Jun)	Q2 (July-Sep)	Q 3 (Oct-Dec)	Q 4 (Jan -Mar)	Q1 (Apr-Jun)
1. Number of seminars, workshops and conferences shared project achievement is continuously increased until June 2013 (Benchmark is zero in July 2009).		3	4	6	9	12	13	14	8
2. No of scientific papers, documents and publications concerning to the project activities and achievements is continuously increased until June 2013 (Benchmark is zero in July 2009).		0	0	5	1	3	8	12	4

3-4 Achievement of the Project Purpose

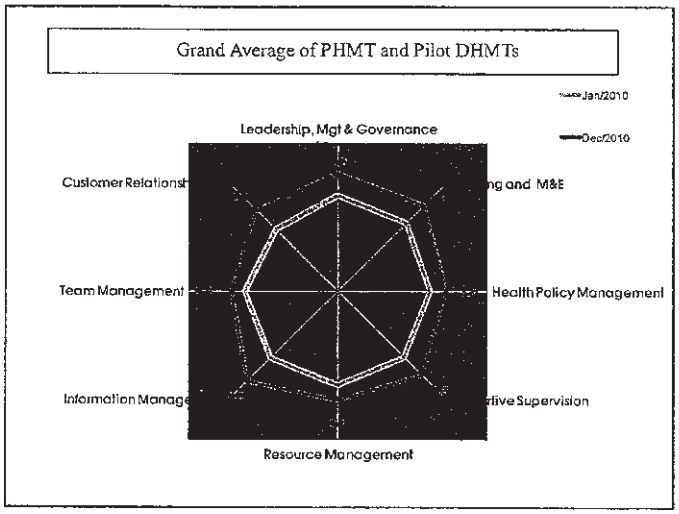
Project Purpose	Objectively Verifiable Indicators
Management capacity of health management teams of Provincial and Districts levels in Nyanza Province is strengthened.	1. Grand average score of the capacity assessment (self-assessment) in PHMT and DHMTs in Nyanza Province is increased to 4.0 by June 2013 (Benchmark in January 2010 for pilot teams and in March 2011 for other teams). 2. Grand average of the behavioral change assessment (self-assessment) in PHMT and DHMTs in Nyanza Province is increased to 4.0 by June 2013 (Benchmark in March 2011). 3. Health service performance indicators for priority High Impact Interventions (HIIs) increased to 80% and above by 2015 (Benchmark in AOP 4 and 5).

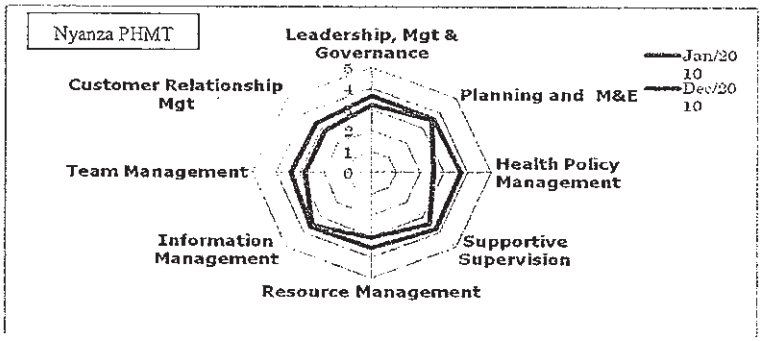
Indicator 1 and 3 have progressed steadily while the progress of Indicator 2 could not be assessed because no benchmark was set till just recently. The baseline survey targeting all 30 districts was conducted in March 2011 (Benchmark is 3.89).

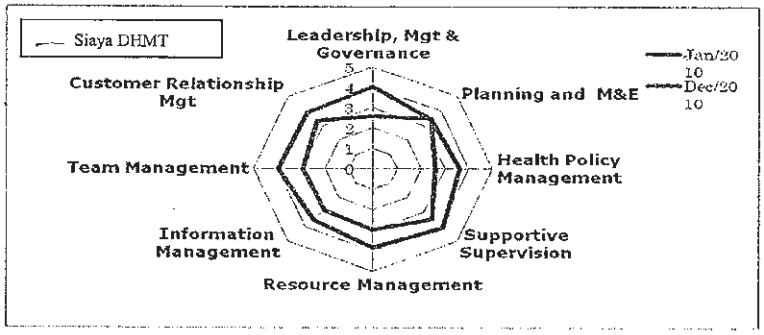
The result of the assessment in management capacities for pilot teams (PHMT and 2 pilot districts -Siaya and Kismu West DHMT) was increased by 121 % in average from the baseline of January 2010 to December 2010. The result disclosed that among eight areas (Leadership, management and governance, Planning and M&E, Health policy management, Supportive supervision, Resource management, Information management, Team management, Customer relations management), capacities in planning and M&E need to be further strengthened in PHMT and Siaya DHMT.

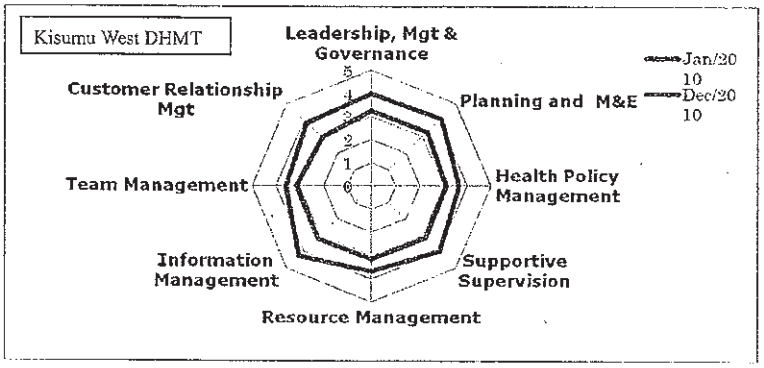
Prior to scale up intervention in July 2011, the Project implemented the baseline survey to all 30 districts in the Province in March 2011.

Figure 3: Progress of Indicator 1: Capacity Assessment









Progress of Indicator 3 is shown in Figure 13. Comparing HIIs indicators in AOP4 (2009) with those in AOP5 (2010), average indicators of the Province and all pilot districts have improved sharply.

Figure4: Progress of Indicator 3 (District Average)

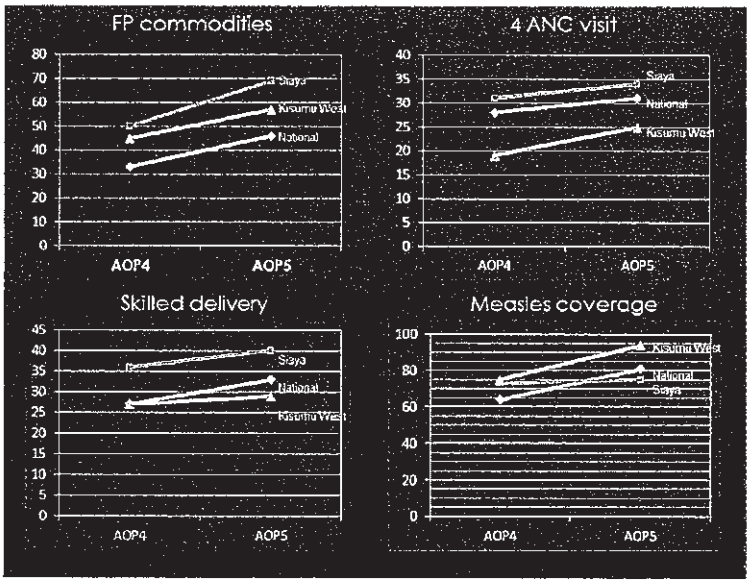
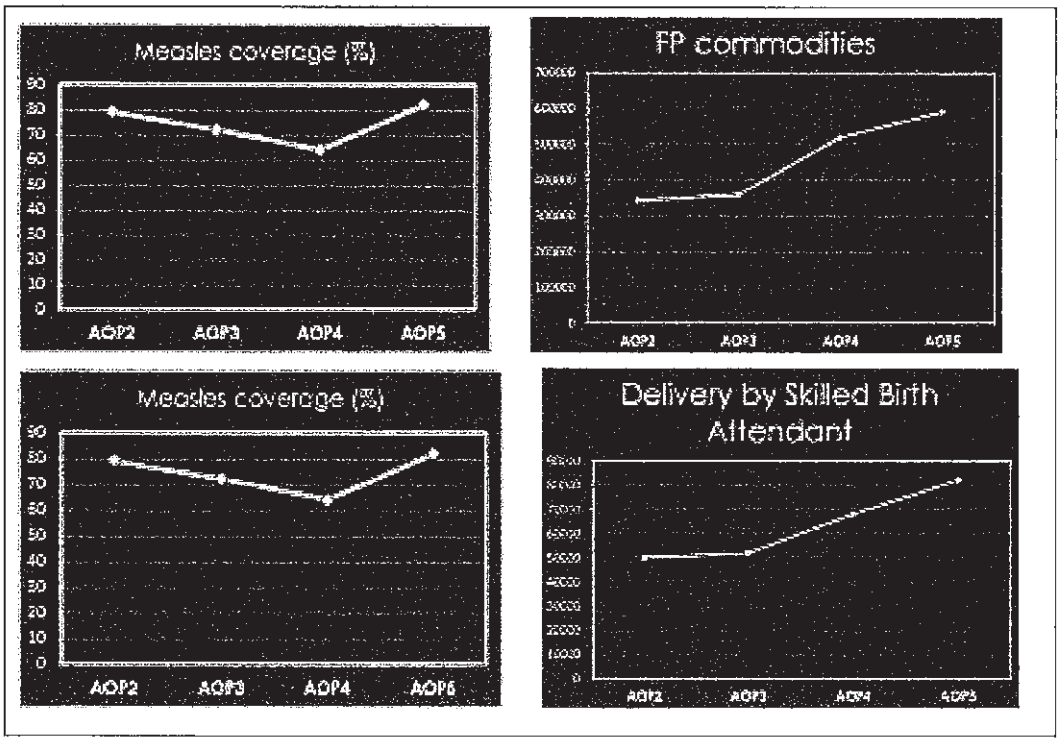


Figure5: Progress of Indicator 3 (Province)



4. Implementation Process

4-1 Issues Stemming from the Project Plan

The indicators in the PDM0 were set with "What" but it did not include measurable targets. No baseline survey was conducted till the PDM was revised three months before the Mid-term review which might minimize function of PDM as a project management tool: building consensus of the direction of the Project among all stakeholders and monitor the progress of the Project performance based on the indicators.

4-2 Issues Relating to the Implementation Process

Based on examination of the PDM 1 of March 2011 that was applied to this evaluation study, the Project activities are in general implemented as planned without major obstacles. Even though there was a slight delay in the placement of the Project Chief Adviser (3 months,) and the Long Term Expert on Institutional Strengthening/Training Management (1 month), the activities progressed as planned in the PO.

The timely assignment as planned of Project Coordinator/IEC Development, Short Term Expert on Health Information System and National Experts on Human Resource Development and Field Capacity Development respectively, contributed to the execution of the related activities as scheduled. In addition, the formation of the three (3) Project Working Groups (Coordination, Training Management and UCAN), with membership from the PHMT and DHMTs of the pilot districts greatly assisted in the planning and timely execution of the Project activities.

At the time of the Mid-term review, the District Think Tanks (DTT) and Transformative Action Group (TAG) for Siaya (including Gem), Ugenya and Kisumu West districts, have been set up for Output 3. It is expected that the DTT will operate independently without financial support from the Project while the TAG will be made operational by the Project support from June 2011 onwards. These new structures are expected to further accelerate implementation of activities for Output 3.

However, it was noted that in the absence of baseline data for most of the indicators set in the PDM, a baseline survey had to be undertaken later in March 2011 to provide for benchmarks for measuring progress in the achievement of the Overall Goal, Project Purpose and Outputs. This process required some level of re-orientation of some activities to align them with the objectively verifiable indicators in the PDM.

An assessment of the important factors that contributed to and/or constrained the implementation process is summarized in the following table.

Key Question	Observation
2-1 Were activities implemented as planned?	In general, all activities were implemented as planned. The only delay cited was that in print media training that was occasioned by competing tasks and the slow pace of learning by some training participants. The baseline survey although not reflected in the PDM and PO was conducted in March 2011 for benchmarking.
2-2 What are the factors contributing to implementation of activities?	A number of factors were cited as contributing to implementation of activities, key among them following; • Early joint planning exercises and sharing of the activity

	plans among the implementing teams • Involvement of additional task teams where the pilot districts requested for the same • Satisfactory time management during implementation • Availability of the necessary resources such as equipment, materials, personnel and finance on time
2-3 What are the factors constraining the implementation of activities?	The following were some of the factors that were reported to be constraining Project activity implementation; • Competing tasks particularly for the PHMT in relation to activities such as working group meetings and trainings conducted in Kisumu • Inability of some external technical advisers particularly those residing outside Kisumu to attend working group activities due to other pressing engagements • Parallel activities particularly those initiated by national programmes and targeted for implementation at district levels (e.g. Malezi Bora campaing, National Immunization Days, ITN distribution to households etc) • Limited follow up for supportive supervision progress after completion of training of the pilot district teams
2-4 Is the Project implementation structure appropriate? If yes, how appropriate is it?	The Project implementation structure was deemed to be appropriate. It allows for proper and efficient coordination, providing a framework for dialogue and consultation in decision making and feedback. The structure also provides a mechanism for regular meetings for members of the implementing teams. However, there were some concerns from some quarters that the Project implementation structure was not well known to some members of the pilot teams. In addition, the new (revised) structure comprising the DTT and TAG in the pilot districts is still not well understood, and there were fears that it would result in too many meetings adding to the woes already exerted by the existing competing tasks.
2-5 If Project implementation structure is not appropriate, why is it not? What should be done to make it appropriate?	Not applicable (N/A)

5. Five Criteria Evaluation

5-1 Relevance

The Project Purpose and Overall Goal are relevant in terms of the needs of the health sector of Kenya, Kenyan national policy and Japanese Official Development Assistance (ODA) policy.

1) Relevance to Kenya's Health Policy/Strategies

Consistency with the Kenya Vision 2030 and the National Health Sector Strategic Plan II

The overall project goal of improving quality of primary health services in Nyanza is consistent

with Kenya Vision 2030 for the Health sector which is to provide equitable and affordable quality health services to all Kenyans. The then Ministry of Health therefore defined a decentralization approach that allocates funds and responsibility for the delivery of health services to district hospitals, health centers and Dispensaries.

Priority areas for intervention

The project goal and purpose are also consistent with the vision and mission of the NHSSPII.

Vision: An efficient and high quality health care system that is accessible, equitable and affordable for every Kenyan.

Mission: To promote and participate in the provision of integrated and high quality promotive, preventive, curative and rehabilitative health care services to all Kenyans.

Among other objectives, the Strategy imperatives outlined in NHSSPII include the following:

1. To improve service quality and responsiveness

Factors related to the achievement of this objective include the performance of health workers on the supply side, and public awareness of client rights on the demand side. These are both addressed during the plan period through improving Health Worker Performance by addressing the competence of service providers through a series of training and performance management initiatives such as

a. Improved supportive supervision and management at all levels.
b. Enhanced service quality by initiating regular clinical audits (in particular for maternal deaths) and building these into the performance management systems

2. To improve Responsiveness to Client Needs

The sector has taken action to strengthen the demand side of the equation, so that clients are attracted to make use of the health facilities. Among other things, the plan calls for training of health workers on client handling and patient centered accountability.

These two imperatives are directly addressed through the Project strategies, especially by the Leadership, Governance and Management training.

2) Relevance to National Needs

The project recognized the importance of the role of the DHMTS and PHMTS in the performance of primary health services. The project designed a baseline survey as a basis for evaluation of the project. The positioning of the Project in Nyanza province was well intended to strengthen the provincial and district health management systems and the successful modeling will then be rolled out to other parts of the country.

Mortality rates particularly among women and children in Kenya still remain high. Mortality rate among under-fives shows marked regional disparities. The overall concern is that if the current national trend continues, the Under-five Mortality related MDG may not be achieved. Recent statistics show that 60 per cent of births in Kenya take place outside health facilities and only 40 per cent of deliveries are attended by skilled personnel. There is therefore an urgent need for high impact interventions at all levels of health care delivery.

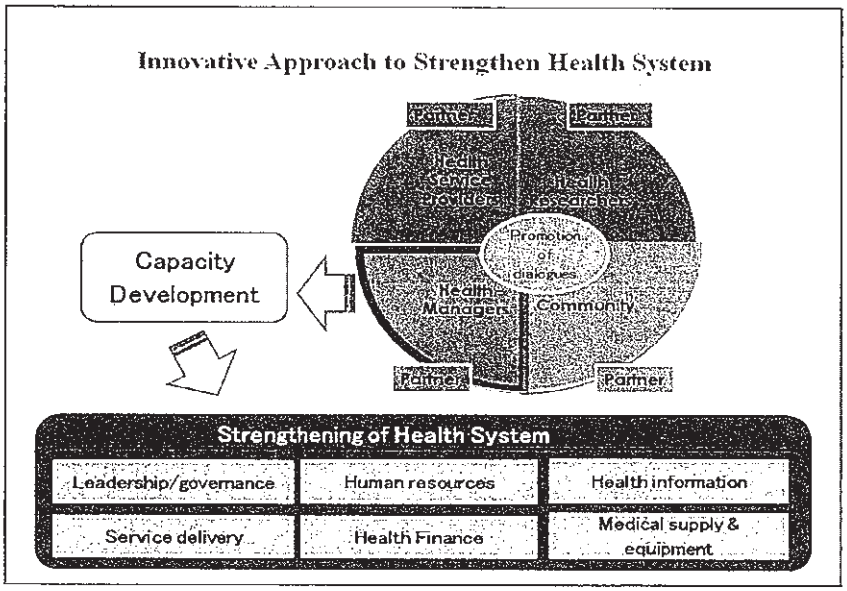
3) Relevance to Japan's Development Assistance Policy

Both the area of intervention and methods adopted by the Project are aligned to Japanese ODA policy in health sector so called "New International Health Policy." Strengthening of capacities of local health managers is identified as a priority area of intervention and development and scale-up of effective models which have been verified by evidence through operation researches is the method for intervention. The Project also responses to TICAD IV Action Plan which addresses training of 100,000 health workers in Africa by 2012.

4) Relevance of Strategies

The Project takes an innovative strategy to demonstrate the assumption that health systems can be strengthened through the management capacity development in local health management teams. Instead of addressing issues related to the individual building block of the health systems separately, i.e., governance and leadership, human resources, health information, service delivery, health finance and medical supply & equipment, the Project focuses on the role of health managers as change agents who can impact on the entire health systems in a sustainable manner.

Figure 6: Project Strategies



5-2 Effectiveness

In line with the progress of the current Outcome and Output indicators, the Project is on track to achieve the Project Purpose by the end of the implementation period. However, critical challenges remain, mainly with Output 2 and Output 3.

The Project is considered to have achieved its goal when it has completed the three stages: (1) the three operational models are developed (2) its effectiveness is examined, and (3) effective operational models are duplicated/mainstreamed. The step (1) and (2) are supported to be completed one year before the termination of the project to facilitate (3).

Among three operational models (Management Training model, Health Promotion model and

Supportive Supervision model), Output 1 (Management Training model) has shown the best progress with recognition by the central government that the training package developed by the Project is more comprehensive targeting all levels than any other training programs. The progress of Output 2 (Health Promotion model) and Output 3 (Supportive Supervision model) is slow compared to that of Output 1 but steady. For all the three Outputs, the second and the third stages are challenges for the rest of the Project period.

5-3 Efficiency

The Project's efficiency is satisfactory with regards to its inputs and the current achievement levels. Focus of activities for the first two years was on the development of the package of training on management and leadership which resulted in the biggest progress among the four Outputs. On the other hand, the results of the participatory workshop suggest that the Project should carefully consider the appropriate number of training for the scale-up period. Another point of concern addressed in the workshop is staff turn- over. The efficiency of Output 1 can be increased toward the end of the Project if collaboration with partners is further strengthened in the mainstreaming process.

Output 2 has kicked into gear with new implementation structure (Unity-Communication-Advocacy-Networking: UCAN). The group has been vigorously worked on production of IEC materials with close collaboration with UNICEF which resulted in increase in efficiency.

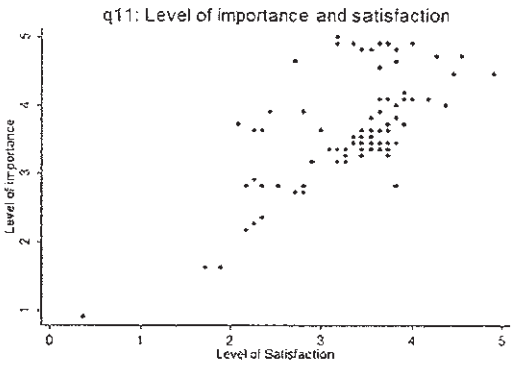
Output 3 is also the component which requires collaboration and coordination with other partners working in line with community strategy, including UNICEF and USAID. The Output is with lower achievement levels at the time of Mid-term review because the Output was just launched upon the new arrival of two Japanese experts in April, 2011. Intensive intervention should be given to the Output 3 toward the end of the Project to produce the expected results, which is crucial to lead the Project to achieve the Project Purpose. Concentration of inputs into the activities under the Output 3 may further enhance the efficiency levels of the Project.

Most procured equipment has been utilized fully by the counterparts which improved working environment and communication among the health management teams. The training opportunities in Japan have been cited in interviews as useful for the Counterparts to obtain new technical capabilities and perspective on health system management. Assignment of Japanese experts and placement of Kenyan counterparts are considered appropriate based on the results of participatory workshop.

5-4 Impact

Overall Goal	Objectively Verifiable Indicators[4]
Quality of primary health care services is improved in Nyanza Province.	1. Customers satisfaction rates in health facilities are increased to 90% by 2015 (Benchmark in March 2011). 2. Health managers'/providers' work satisfaction rates are increased to 90% by 2015 (Benchmark in March 2011).

The baseline survey was conducted prior to the Mid-term review to set the benchmark. According to the survey, customers satisfaction score was 3.35/4.00 and health managers'/providers' work satisfaction score was 3.16/4.00. These scores will be used as benchmarks.



Even through it is too early to analyze the Overall Goal, major positive impact is observed in harmonization among development partners working in Nyanza Province toward the common goal through joint planning on AOP.

5-5 Sustainability

5-5-1 Institutional Sustainability

The Capacity Development approach of the project addresses the entire component of Health Systems strengthening. The project and its positive results so far need to be mainstreamed in the operations of the Department of Primary Health Services, MOPHS so that it is not viewed as an external intervention but that it is part and parcel of DPHS. These Capacity Building trainings should preferably be offered to personnel already working to complement the basic theory captured in pre-service training.

The Ministry of Public Health and Sanitation also recognizes leadership and management as an area of intervention in accelerating progress towards attainment of the halth related MDGs. As such, the Ministry will continuously support efforts towards improvement of staff competencies in leadership, governance and management.

The DPHS needs to continuously engage other development partners to support the health systems strengthening project for realization of the project objectives and the attainment of the goals in the high impact intervention areas, such as skilled birth attendance, four antenatal visits and improved family planning coverage.

The project applies adult learning approach which builds on team spirit and enhances coordination between different teams. This will in turn contribute to institutional sustainability of

[4] Data clearing are necessary.

the project benefits.

5-5-2 Financial Sustainability

The review team noted that the Project is currently well funded by JICA and this funding arrangement will continue throughout the project life cycle. There is therefore a need for the DPHS to look for viable financing options for the sustenance of the results and the roll out once the JICA funding comes to an end. With the overall improvement in health sector planning and budgeting, the review team concluded that the prospect of financial sustainability can be judged to be positive.

One of the contributing factors to increase financial sustainability is availability of devolution funds, including Health Sector Service Fund, Constituency Development Fund and Authority Transfer Fund for health facilities.

5-5-3 Technical Sustainability

At the time of the mid-term review, sustainability from the viewpoints of individual capacity and organizational aspects is rated as satisfactory.

1. There is commitment by GOK to develop individual capacities of public sector managers in general and in particular that for health managers as articulated in the Human Resources for Health (HRH) Strategic Plan (2008 – 2012). The training for public sector managers conducted by the Kenya Institute of Administration is tailored to improve knowledge & skills and impart general management principles to a mix of Government officers drawn from different ministries and agencies. This is an ongoing programme by the Government of Kenya, delivered in three (3) modules over a six (6) week period to complement other sector-specific management training, and is linked to career progression and promotion in the civil service.

2. According to HRH Strategic Plan, Kenya's health sector recognizes that human resources for health constraints are a critical ingredient – possibly "the" critical ingredient –hampering Kenya's health sector planning, service delivery and ultimately national health outcomes. Against this background, the sector has taken on the task of defining long-term strategies for addressing the constraints to human resource development and management so as to effectively improve health service delivery. Its strategic objective 3.1 under Outcome 3 is about improving leadership and management.

3. The Project has continuously fostered the establishment and empowerment of Communities of Practice as providers of technical services at local levels in Nyanza province. The technical skills and capacity developed through these communities will continue to be available for health sector utilization in the region. This is part of the Project's legacy in Nyanza.

4. In addition, the involvement of local training institutions such as public universities and Kenya Medical Training College in the Project, affords them an opportunity to seize opportunities to review their training programs with a view to enrich them with experiences from the Project. This approach will continuously contribute to improvement of training of health workers particularly in the pre – service category.

5. From organizational aspects, the Ministries of Health (MOHs) in Kenya recognize the importance of leadership and management training in health, and as such, have enlisted support of other Partners such as World Health Organization (WHO), USAID – MSH, USAID - Capacity among others to develop curriculum and implement training in this area. The MOHs did recognize the weaknesses inherent in the available training programs arising from unilateral input by national level officers into curriculum development, without adequately considering the actual needs articulated by the target groups at County (provincial & district) levels. As a way forward, the MOHs are keen to harmonize the available training programs including the one implemented through the Project in order to enhance effectiveness of the training and capacity building outcomes.

However, the prospects of the MOHs to mainstream the training operational model developed by the Project is highly dependent on its tested and proven effectiveness, with evidence showing contribution to improvement of health indicators for the High Impact Interventions (HIIs). This appears to be the focus that the Project should take in order to enhance sustainability of the Project from organizational perspectives.

6. Conclusion

The Project is well on the way in achieving the stated goal of strengthening management capacity of health management teams at provincial and district levels in Nyanza Province. The relevance is high in the current and long-term political context of Kenya under the new Constitution, in which further decentralization of administrative authority and responsibility is being elaborated.

The Core Management Training Programme under Output 1 consisting of seven courses has been developed and the PHMT and DHMT members in three pilot districts have already completed the training. The impact of the training is visible in changes of management practices in the pilot DHMTs. The training is envisioned to be scaled up to benefit all DHMTs in Nyanza province starting in July 2011.

Due partly to the success of the Core Management Training Programme which raised awareness about the importance of management, there is an increasing demand from the pilot districts for additional support to expand such training to cover health facility managers and to strengthen management practices of DHMTs. The revised PDM is a response from the Project to such demand and support to modeling of health promotion activities, supportive supervision and other management activities in the pilot districts are now clearly indicated as Outputs 2 and 3. Those models are being conceptualized, but fully shared among project personnel is not sufficient.

The Project is active in publishing and disseminating its achievements through workshops, newsletters and other media corresponding to Output 4. Through such activities and establishment of networks and collaborative relationships with other stakeholders and development partners, the recognition of the Project is being increased. However, contribution of the Project to the health policy discourse in Kenya is still limited and should be further strengthened.

There is no need for major revision of PDM and the project direction. However, more strategic management and proper prioritization of activities will be needed for the rest of the project period in order to ensure achievement of Outputs and Project Purpose.

7. Recommendations

Recommendations on Project Design

The Project revised PDM in order to better reflect the expectations from the Project beneficiaries. The revised PDM was just recently approved by JCC on 25th March 2011. It deemed neither necessary nor appropriate to revise the PDM at this point. However, several issues need to be further clarified in order to provide clear guidance to the people involved in the Project for the rest of the project period.

(1) Indicators for overall goal should be reconsidered to the ones which will be achieved 3-5 years after the completion of the Project, as preliminary analysis of the data collected from baseline survey revealed that level of the current indicators for the overall goal is already high. (Recommendation to the Project)

(2) The current indicators for the project purpose are based on mainly self-assessment. Even though they adequately capture changes in subjective recognition on the level of management capacity by PHMT and DHMTs, they may not reflect changes in management practices. Project should consider adding indicators for tracing changes in management practice. (To the Project)

(3) Models which are to be established under Output 2 and 3, and the related end products need to be clarified further and those ideas should be shared among the people involved in the related activities. Activities leading to the establishment of those models in Output 2 and 3, the indicators for the verification of model establishment and end products for all Output need to be elaborated and reflected in PDM. (To the Project)

Recommendations on Project Implementation

Based on the revised PDM, the Project should be implemented for the rest of the project period in consideration of the following issues. These issues deemed critical in ensuring both effectiveness of the Project and sustainability of its achievements.

(1) Effectiveness of each model established under output 1, 2 and 3 need to be verified through rigorous elaboration. They need to be standardized through consensus building involving relevant stakeholders and development partners. The Project needs to be guided properly by MoPHS on the procedure on how to obtain authorization in various end products to be produced. (To the Project and MoPHS)

(2) Since the Project aims to establish models and demonstrate evidence-based practice and lessons-learnt, the latter half of the project period will focus on scaling up the models and authorization of products. For this reason, there is need to establish a close working relationship with the central ministry to facilitate effective mechanism for project implementation.(To the Project and MoPHS)

(3) In relation to recommendation 7 (1) herein, there is need to further pursue active collaboration with other partners and stakeholders, particularly with respect to rallying them towards achieving targets for MDG 4 and 5 (maternal and child health indicators). Further attention will need to be paid to health promotion and integrated support supervision activities.

(4) The Project Steering Committee (PSC) was established to support coordination and monitoring of the progress of implementation. The functions of the PSC need to be revitalized so that it can effectively undertake its responsibilities as spelt out in the Record of Discussions (R/D) of the Project signed on 22nd April, 2009 (To the Project).

(5) In line with the need to mainstream the Project outputs into the national HSS strategies, a Project promotion strategy should be implemented. In this regard, it is recommended that the Project be encouraged to engage with relevant systems support and technical ICCs in the sector. Presentations and discourse around the experiences and lessons learnt from implementation are invaluable for this course (To the Project, JICA and MoPHS).

PDM (ORIGINAL, July 2009)

Annex 1

Project Design Matrix			
Project Title: Strengthening Management for Health in Nyanza Province, Kenya)			
Duration: 4 years		Version	
Target Group : Direct beneficiaries: Department of Primary Health Care Services (MoPHS), members of PHMT, DHMTs Indirect beneficiaries: health staff working in health facilities, community people (estimated population of 5.2M)		Date:	
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATIONS	IMPORTANT ASSUMPTIONS
OVERALL GOAL Quality of primary health care services is improved in Nyanza province	1. Customer satisfaction 2. Proportion of health workers using existing appropriate guidelines in their service delivery	Survey Report Supervision Report	1. There are no major tribal conflicts after the project 2. There are no major outbreaks of epidemic diseases in after the project 3. The supply of drugs and health commodities does not experience major interruption after the project 4. There are no major changes of the national policy and strategies in the health sector after the project
PROJECT PURPOSE Individual capacity of health managers and institutional capacity of health management teams (Provincial and district levels) are improved in Nyanza Province	Following indicators evaluated by self and externally; 1. Qualitative and quantitative individual capacity of health managers evaluated by checklist 2. Qualitative and quantitative institutional capacity of health management teams evaluated by checklist1	Checklist Checklist	1. There are no major tribal conflicts that happen during the project period. 2. There are no major outbreaks of epidemic diseases in the project area 3. The supply of drugs and health commodities does not experience major interruptions 4. Changes of the national policy and strategies in health sector does not affect implementation of the project activities
OUTPUTS			
1 Core management capacity of health management teams (Provincial Health Management Team, PHMT and District Health Management Team DHMTs)is strengthened in Nyanza Province	1. Institutional capacity of health management team on core management evaluated by checklist 2. Health workers ' satisfaction	Checklist Survey Reports	Any major tribal conflicts do not happen during the project period. Any major outbreaks of epidemic diseases do not occur in the project area.
2 Capacities of health management teams on operational cycle process (planning, implementation, M&E) are strengthened in Nyanza Province	1. Annual Operational Plan (AOP) implementation rate 2. Reporting rate for routine health information and finance 3. Result of AOP evaluation reflected in the next AOP	AOP review report and AOP document Supervision report AOP document	Drugs and health commodities supply do not experience major interruptions
3 Capacities of health management teams to provide supportive supervision is improved in Nyanza Province	Proportion of facilities received standardised supervision	Supervision report	
4 Lessons learnt and good practices from output 1-3 are shared with other provinces and national level and networking among health managers is strengthened through the process	1. Number of workshop sharing project information 2. Number of documents and other ways of information materials to disseminate lessons learnt and best practices in the project 3. No of best practices / lessons influencing on decision making	Workshop reports Products of dissemination materials Policy document, Project evaluation	
			1. The available personnel involved in the Project are retained 2. Positive collaboration with other partners and stakeholders is maintained

PDM (ORIGINAL, July 2009)

ACTIVITIES	INPUTS		
1. Core management capacity of health management teams (PHMT, DHMTs) is strengthened in Nyanza Province 1.1. Organise workshop to identify areas that needs to be improved among PHMT and DHMTs on core management skills 1.2. Through the workshop above, develop tools for evaluation of management capacity (by self and externally) and determine the baseline of health management capacity in the province by using the developed tools 1.3. As a part of workshop, conduct exchange visit to learn from good practices in other geographic region/ country. 1.4. Through the workshop above, develop plans to improved the identified areas through 1.1 1.5. Implement the plans in 1.4	Japanese side JICA expert *Long term (Chief Advisor, System strengthening/ Training development, Coordinator/ Documentation) *Short term (M&E, Health Information System, Public Relations etc.) Counterpart training Equipment (vehicles, ICT equipment etc) Local activity cost (training, workshop etc.)	Kenyan side Counterpart staff (National, provincial and district levels) Office spaces and utilities Counterpart budget for operational cost Cost for support staff (drivers, secretary etc.)	Inputs for Project activities and secured and timely delivered by both the Kenyan and Japanese sides
2. Capacities of health management teams on operational cycle process (planning, implementation, M&E) is strengthened in Nyanza province 2.1 Conduct needs assessment for training on operational cycle process 2.2 Develop training plan 2.3 Conduct training on operational cycle process according to the plan 2.4 Using the skills acquired through the training above, develop and appraise Annual Operational Plans (AOPs) 2.5 Review existing health information system related to AOPs and its operations 2.6 Develop training / workshop plan to address gaps identified on health information system 2.7 Conduct training / workshop on health information system and develop appropriate tools and its operation through the training /workshop 2.8 Conduct support supervision visits by DHMTs at district level monthly basis 2.9 After the visits, hold monthly meetings to review implementation of AOPs and plan for the next step at district level 2.10 Implement quarterly monitoring to DHMTs and health facilities by PHMT 2.11 After quarterly monitoring visits, hold a meeting to review the results of the activity so that they will be reflected on plan of implementation of AOP and establishing the next AOP			
3. Capacities of health management teams to provide supportive supervision is improved in Nyanza province 3.1 Review and revise supervision system and practices in light of quality of management and health services through project among project staff at national, provincial and district level managers 3.2 Conduct trainings for health managers at district and provincial level on effective system and practices of supportive supervision 3.3 Conduct regular supervision 3.4 Give feedbacks to district and health facility levels on their performance, quality, processing and utilisation of health information through supervision visits 3.5 Hold regular meetings between health facilities and DHMTs to give feedback of supervision and to discuss suggestions in terms of in-service training, skill development, and other management issues such as drug commodities, health information, and financing at district level 3.6 Hold regular meeting between DHMTs and PHMT at provincial level to discuss finding of supervision and the meeting above to improve quality of services 3.7 Conduct quarterly quality audit by PHMT and DHMT regarding facility supervision conducted			
4. Lessons learnt and best practices from Output 1-3 are shared with other provinces and national level, and health management system networking is strengthened through the process. 4.1 Set up a mechanism to review and share project activities, results, and lessons learned from the project implementation of output 1-3 with other provinces and stakeholders in the health sector 4.2 Set up a mechanism of reflecting project results on policy at national level 4.3 Document all lessons learnt, best practices and challenges of the project 4.4 Conduct workshops with other provincial management teams to share the project findings 4.5 Through the workshops, existing health management system is reviewed to be standardize through incorporating the project findings 4.6 Conduct exchange visits to Nyanza from other provinces to disseminate the project models 4.7 Hold regular meetings with national level managers			PRECONDITIONS The security and safety measures in the project target areas are maintained to allow implementation of Project activities.

[1] Checklist will be developed through project workshop and baseline capacity will be assessed and the target will be set within the first 3 months.
[2] This includes basic comprehensive management skills such as leadership, human resource management, financial management, improvement of work place environment, team building, facilitation, coordination, information sharing and communication etc.
[3] A part of checklist for the project purpose will be used.
[4] Health care providers who are working health facilities within the province for DHMTs, and health care providers and DHMT members for PHMT
[5] The workshop is composed of 3 parts; in the first part, tools for capacity assessment are developed and capacity evaluation is conducted, in the second part exchange visit is conducted, and in the third part, tools and evalustion conducted in the first part are reviewed and work plan on core management skills is developed.

Annex 2

Project Design Matrix

Project Title: Strengthening Management for Health in Nyanza Province, Kenya

Duration: 4 years (July 2009 -June 2013)		Version	Proposed Version 1.0
Target Group : Direct beneficiaries: Health managers of Provincial Health Management Team (PHMT) and District Health Management Teams (DHMTs) in Nyanza Province, Department of Primary Health Services (MOPHS; Ministry of Public Health and Sanitation) Indirect beneficiaries: health service providers, communities in Nyanza province (estimated population of 5.8 Million)		Date:	25th March 2011
Narrative Summary	**Objectively Verifiable Indicators and Targets**	**Means of Verifications**	**Important Assumption**
OVERALL GOAL			
Quality of primary health care services is improved in Nyanza Province	1. Customers satisfaction rates in health facilities are increased to 90% by 2015 (Benchmark in March 2011). 2. Health managers'/providers' work satisfaction rates are increased to 90% by 2015 (Benchmark in March 2011). 3. Health service performance indicators for priority High Impact Interventions (HIs) increased to 80% and above by 2015 (Benchmark in AOP 4 and 5).	Health Leadership and Management Survey report Customer Satisfaction Survey report Health Leadership and Management Survey report Annual Operational Plan (AOP) Performance Review Report	Administrative devolution does not affect project implementation negatively. Security and safety measures in Kenya are maintained. Major outbreaks and epidemics are not emerged to affect the overall performance of the health status of the people. Human resource for health is well maintained and promoted.
PROJECT PURPOSE			
Management capacity of health management teams at Provincial and District levels in Nyanza Province is strengthened. * * Eight management capacities are identified; leadership and governance, team management, planning and M&E, health policy management, supportive supervision/coaching/mentoring, health information management, resource management, customer relationship management.	1. Grand average score of the capacity assessment in PHMT and DHMTs in Nyanza Province is increased to 4.0 by June 2013 (Benchmark in January 2010 for pilot teams and in March 2011 for other teams). 2. Grand average of the behavioral change assessment in PHMT and DHMTs in Nyanza Province is increased to 4.0 by June 2013 (Benchmark in March 2011).	Health Leadership and Management Survey report Health Leadership and Management Survey report Health Sector Performance report	Infrastructure is are well maintained. Referal systems is adequately functioned. Supplies for drugs and commodities are ensured and maintained. Availability of health providers is secured and maintained.
OUTPUTS			
1. Health leadership and management trainings are modeled and promoted in Nyanza Province	1. A operational model of health strategic leadership and management training is established by June 2011 (Benchmark is zero in July 2009). 2. Coverage of PHMT and DHMTs in Nyanza Province receiving the model training program is increased to 100% by June 2013 (Benchmark is zero in July 2009).	Training model in place Training Completion and Evaluation report	Workplace environment for PHMT/DHMT is well maintained and promoted at least it meets the minimum requirement. Mobility of health managers including transport, competing tasks and personal issues is well secured and maintained. Conflict resolution and disciplinary action under code of conduct are esteemed and functioned well. Collaboration between health managers and development partners are well coordinated and organized under mutual vision and mission. All the stakeholders are involved in health management activities to strengthen health systems.
2. Health promotion activities are modeled and mainstreamed in Health Systems Strengthening in the pilot districts*. * The Pilot districts include PHMT and DHMT in Siaya, Kisumu and Ugenya.	1. An operational model of health promotion activities is established by April 2012 (Benchmark is zero in July 2009). 2. Execution rate of health promotion activities budgeted in AOP of the pilot districts is increased to at least 5 activities per district by June 2013 (Benchmark is zero in AOP4 and 5). 3. Grand average scale of the capacity assessment on health promotion in the pilot districts is increased to 4.0 by June 2013 (Benchmark in March 2011).	Health promotion model in place AOP Performance Review report Health Promotion Capacity Assessment report	
3. Supportive supervision and related management activities by DHMTs for health facilities and communities are modeled and promoted in the pilot districts*. * The Pilot districts include PHMT and DHMT in Siaya, Kisumu and Ugenya.	1. An operational model of supportive supervision is established by April 2012 (Benchmark is zero in July 2009). 2. Number of health facilities in the pilot districts receiving Integrated Management Supportive Supervision (IMSS) is increased to 80% of facilities in every district by June 2013 (Benchmark is zero in July 2009).	Supportive supervision model in place IMSS report Health Sector Performance report	
4. Evidence-based practices and lessons-learned demonstrated by the Project implementation are promoted to all the districts in Nyanza province and other provinces and enhance national health policies/guidelines and international networks.	1. Number of seminars, workshops and conferences shared project achievement is continuously increased until June 2013 (Benchmark is zero in July 2009). 2. No of scientific papers, documents and publications concerning to the project activities and achievements is continuously increased until June 2013 (Benchmark is zero in July 2009).	Minutes of the meetings, abstracts, conference proceedings, journal articles Scientific papers, documents and publications	

Activities		INPUTS		Important Assumption
		Japanese Side	Kenyan Side	
1	Health leadership and management trainings are modeled and promoted in Nyanza Province: 1.1 To establish Community of Practices (COPs) as institutional networking to spearhead and support health management training. 1.2 To organize a training management working group (TMWG) consisting of training focal persons from PHMT and DHMTs, JICA Experts, and technical advisors from COPs. 1.3 To hold regular meeting to identify training needs and develop training plans, courses, modules and tools. 1.4 To implement core management training program to the pilot teams as initial modeling process for packaging. 1.5 To review, develop and package core management training program for scaling-up to cover all the DHMTs in Nyanza Province. 1.6 To scale-up core management training program to all the DHMTs in Nyanza province with randomized Control Trial (RCT) method. 1.7 To support DHMTs to conduct health management training at health facility and community level to the pilot districts. 1.8 To support DHMTs to enhance health management training into AOP in the pilot districts. 1.9 To evaluate and document health leadership and management training Program as evidence-based practice.	(1) JICA expert and project staffs a. Long-term expert (Chief Advisor, Human Resource Development Advisor, Project Coordinator/IEC Material Development/Health Promotion Advisor, Health Administration Management Advisor) b. Short-term expert (Health Management Information System etc.) c. Project staffs (National expert, project assistant, driver etc.) (2) Management trainings/related activities (3) Project operational cost (4) Office equipment, furniture and vehicle (5) Counterpart training in Japan	(1) Counterpart members (Ministry, Provincial and District levels) (2) Management support staffs (3) Office space, equipment and utilities (4) Counterpart budget for operational costs (cost-sharing) (5) Sector coordination and arrangements	Knowledge and information acquired by the Project activities are adequately shared by all the DHMT members and stakeholders. Partnership with other implementing donors, agencies and institutions is maintained. Availability of counterpart members (PHMT/DHMTs) is retained and maintained.
2	Health promotion activities are modeled and mainstreamed in Health Systems Strengthening in the pilot districts. 2.1 To organize and operate a working group on health promotion (UCAN WG: Unity, Communication, Advocacy and Networking Working Group). 2.2 To conduct needs assessment on health promotion both at PHMT/DHMT level and Health Facility/Community level. 2.3 To conduct capacity assessment on health promotion for the pilot districts. 2.4 To conduct management training/workshops on health promotion at PHMT/DHMT level. 2.5 To support DHMTs to conduct health promotion activities at health facility and community level. 2.6 To support DHMTs to promote health promotion activities to be incorporated into AOP. 2.7 To conduct study/exchange visits for sharing good practices and networking with other teams. 2.8 To support DHMTs to develop IEC materials suitable to the local contexts. 2.9 To evaluate and document health promotion activities as evidence-based practice.			
3	Supportive supervision and related management activities by DHMTs for health facilities and communities are modeled and promoted in the pilot districts. 3.1 To establish and operationalize Field Support Working Group to strengthen capacity development of district health systems. 3.2 To review supervision system and checklists in light of quality of management and standardized health services. 3.3 To develop Integrated Management Supportive Supervision(IMSS) checklist and implementation, on-site training and feedback mechanism. 3.4 To operationalize implementation, on-site training, feedback and dissemination of IMSS. 3.5 To support DHMT to incorporate IMSS into budget and action plan of AOP. 3.6 To support PHMT/DHMT to promote Health Management Information System (HMIS), Community Health Strategy (CHS) and other related communication management to strengthen district health systems. 3.7 To support PHMT/DHMT to strengthen project management in AOP. 3.8 To support PHMT/DHMT to hold Technical Assistance Committee and Stakeholder Forum at provincial and district level. 3.9 To evaluate and document IMSS and other related management activities as evidence-based practice.			Preconditions Security and safety measures in the Project working areas are maintained. Major policies and guidelines are maintained at the ministerial level. Health sector reform and local government reform are maintained.
4	Evidence-based practices and lessons-learned demonstrated by the Project operational models are promoted to all the districts in Nyanza Province and other provinces and enhance national health policies/guidelines and international networks. 4.1 To design and conduct operational research for evidence-based practices concerning to the project interventions. 4.2 To document and publish research results, operational models and lessons-learned to a wider public audience. 4.3 To support sustainable mechanism to disseminate evidence-based practices demonstrated by the Project in scientific journals, conferences and stakeholders' forums. 4.4 To promote institutional networking with development partners, academic institutions and other organizations (NGOs, CBOs, FBOs etc.). 4.5 To conduct forums and study visit to exchange information and experiences to enhance evidence-based practices. 4.6 To support Department of Primary Health Services and other departments in MOPHS for their organizational capacity development. 4.7 To support the development and review of health policy/guidelines based on the Project activities and achievements. 4.8 To spearhead international collaborative network for health systems strengthening with neighboring countries and beyond.			

Annex 3: Process matrix (Project activity implemented in July 2009 - June 2011)

	Narrative Summary	Progress	Challenges/Bottlenecks
Output 1	Health leadership and management trainings are modelled and promoted in Nyanza Province		
Activity 1-1	To establish Community of Practices (COPs) as institutional networking to spearhead and support health management training.	Community of Practices (COPs) was formulated in December 2009 with 4 academic/training institutes. The number of the institutes, ministries, international organizations and private firms collaborating with the project as COPs has been expanded to 24 as of June 2011.	Administrative issues including payment and logistic were sometime raised from a few of institutes/private firm. Also some members from Nairobi have difficulty to collaborate with the project continuously since most project activities were conducted in Kisumu.
Activity 1-2	To organize a training management working group (TMWG) consisting of training focal persons from PHMT and DHMTs, JICA Experts, and technical advisors from COPs.	Training Management Working Group (TMWG) was formulated in November 2009 with 5 core members from JICA, PHMT and the pilot DHMTs. 4 members from COPs also joined in the TMWG as Technical Advisors from December 2009. In concert with scaling-up the training, the number of members has been expanded to 18 (13 core members & 5 technical advisors) as of June 2011.	Technical advisors, especially those from out of Kisumu had sometimes difficulty to join the TMWG meeting conducted in Kisumu due to competing tasks in their workstation.
Activity 1-3	To hold regular meeting to identify training needs and develop training plans, courses, modules and tools.	The Project has organised a series of regular TMWG meetings in Kisumu (10 times from November 2009 to June 2011). Training curriculum/facilitators' guide and operational plan for the pilot teams were developed through the meetings.	
Activity 1-4	To implement core management training program to the pilot teams as initial modeling process for packaging.	Core Management Training Programme consisting of 7 training courses had been developed and implemented to the pilot teams(PHMT, Kisumu West, Siaya and Ugenya) since January 2010 to December 2010. In addition, 11 trainings (3days course: beginners, intermediate and advance) were conducted for all the pilot teams. Gross number of participants receiving the trainings is 432 as of June 2009.	It was observed that the PHMT members were often out of the training to attend to other duties when training were organized in Kisumu limiting their concentration
Activity 1-5	To review, develop and package core management training program for scaling-up to cover all the DHMTs in Nyanza Province.	The training programme for the pilot teams were carefully reviewed by TMWG members based on the evaluation report submitted in March 2010, and Operational Plan and Training Curriculum/ Facilitators' Guide for the scale-up to cover all DHMT in Nyanza were developed by June 2012. Process of developing training materials including text book and lecture slides for the scale-up is in the initial stage as of June 2011.	The assumption here is that the authors will respond and put their sections together within the required time.
Activity 1-6	To scale-up core management training program to all the DHMTs in Nyanza province with randomized Control Trial (RCT) method.	Training Mechanism and Operational Plan including the matching of the target DHMTs were discussed and developed through the TMWG meeting by May 2011. 11 Trainings targeting DHMTs will be implemented in July 2011, and the Core Management Training Programme for the scale-up will start from August 2012.	The discussion of whether to use capacity or knowledge as the indicator for matching was quite an enriching experience.
Activity 1-7	To support DHMTs to conduct health management training at health facility and community level to the pilot districts.	The cascading process for DHMT training health facility management level is still in the preparatory stage as of June 2011. However, facilitators' guide and training materials of "Service Quality Management" will be developed through the TMWG by the end of July 2011, and the training will be delivered to the pilot DHMTs in August 2011. After this training, the project will support members of the pilots DHMT members to conduct on-site service quality management training for their health facilities.	It is assumed that DHMTs members have to manage their competing tasks well to organize and conduct trainings for the Health facilities management staff.
Activity 1-8	To support DHMTs to enhance health management training into AOP in the pilot districts.	Kisumu West (pilot team) incorporated plan of the health leadership and management training into their AOP6 as JICA supported activities. For the next AOP, the project will encourage all the pilot district teams to incorporate plan of the follow-up activities (including demand driven trainings and on-site trainings to health facilities) into their AOP with cost-sharing.	Siaya DHMT did not incorporate any health leadership and management training into their AOP6. Further sensitization and needs identification for the leadership and management will be necessary for the team.
Activity 1-9	To evaluate and document health leadership and management training Program as evidence-based practice.	15 evaluation/completion reports for the pilot trainings were submitted by June 2011, and a completion report of the baseline survey on health leadership and management for all DHMTs in Nyanza was submitted in May 2011.	The baseline survey data was quite massive hence a challenge of including everything in the report. this led to a consensus on the most important indicators for the way forward.
Output 2	Health promotion activities are modeled and mainstreamed in Health Systems Strengthening in the pilot districts.		
Activity 2-1	To organize and operate a working group on health promotion [UCAN WG: Unity, Communication, Advocacy and Networking Working Group]	UCANWG was established in December 2009 with 12 members. The number of members is 12 core members and 9 co-opted members/groups as of June 2011. As of 1st June 2011, 16 UCANWG workshops were conducted. UCANWG has a chair, vice-chair, coordinator and secretary. Venues for workshops are rotational in pilot districts.	Competing tasks amongst PHMT/DHMTs in organizing and coordination of meetings
Activity 2-2	To conduct needs assessment on health promotion both at PHMT/DHMT level and Health Facility/Community level.	A local consultant conducted situation analysis on health promotion at PHMT and pilot DHMTs in March 2010. The Project has compiled Resource Directories on health facilities (HFs) in Kisumu West and Siaya with basic information of all HFs in the areas in 2010. UCANWG has conducted baseline survey on IEC materials at randomly selected health facilities and communities in pilot districts between June to November 2010.	1) It is necessary to conduct other surveys in order to decide details on health promotion interventions. 2) Lack of knowledge and skills in conducting surveys amongst UCANWG members.
Activity 2-3	To conduct capacity assessment on health promotion for the pilot districts.	Capacity assessment on health promotion was conducted among 1) health managers in Nyanza Province, and 2) UCANWG members. Both were done in March 2011.	The assessment should be monitored and evaluated in 2011/2012.
Activity 2-4	To conduct management training/workshops on health promotion at PHMT/DHMT level.	1) 4 day Basic Health Promotion Training was conducted in June 2010 targeting health managers in pilot districts in collaboration with Department of Health Promotion (DHP)/ MoPHS. Total 42 participants attended the training. Facilitators were from DHP/MoPHS, University of Nairobi, KMTC etc. 2) Print Media training was conducted between December 2010 and June 2011 with 6 workshops, total 12 days. Total 17 participants attended the training.	1) Because of competing tasks especially amongst PHMT, some participants could not participate in Basic Health Promotion training or some went back to the office during the training. 2) Competing tasks made some participants difficult in attending the workshops consistently in Print Media Training.
Activity 2-5	To support DHMTs to conduct health promotion activities at health facility and community level.	This has not been done yet. As of June 2011, planning of this activity is taking place.	It is necessary to conduct detailed survey to decide health promotion interventions at HFs and community level.
Activity 2-6	To support DHMTs to promote health promotion activities to be incorporated into AOP.	After three (3) UCANWG members participated in Health Promotion Re-orientation workshop conducted by DHP/MoPHS and WHO in August 2010, UCANWG encouraged all the pilot districts to come up with the health promotion plans for 2011. All the pilot districts made plans, presented them in UCANWG and revised them in late 2010. Health Promotion Officers and focal persons in pilot districts will incorporate these plans in AOP7.	1) Resource mobilization to realize health promotion activities in pilot districts. 2) Health promotion being neglected in some districts results in not allocating budget to health promotion activities.
Activity 2-7	To conduct study/exchange visits for sharing good practices and networking with other teams.	UCANWG has organized and conducted study visit to Bondo districts in February 2010. UCANWG members observed waste management system, community units and youth group activities.	UCANWG members are interested in observing best practices in particular areas, e.x.) health promotion, income generation for villagers, community mobilization. It is difficult to spot a place with best practices in those areas.
Activity 2-8	To support DHMTs to develop IEC materials suitable to the local contexts.	In Print Media Training stated in Activity 2-4, knowledge and skills to develop print IEC materials were transferred to the participants. In June 2011, UCANWG has established Task Production Groups (TPG) including Print Media TPG, Electronic Media & Website Development TPG. With support by JICA expert, these TPGs will develop, monitor and revise IEC materials suitable to local contexts.	Sharing gained knowledge and skills to other members/teams.
Activity 2-9	To evaluate and document health promotion activities as evidence-based practice.	1) Minutes of meeting for all the UCANWG workshops, 2) Report on exchange visit to Bondo, 3) Situation Analysis Report, 4) UCANWG report in March 2011, 5) Completion report on Basic Health Promotion training, 6) Health Promotion Baseline Survey Report, 7) Capacity Assessment on Health Promotion for health managers and for UCANWG core members	UCANWG needs to develop M&E tools for health promotion activities.

Output 3		Supportive supervision and rerated management activities by DHMTs for health facilities and communities are modeled and promoted in the pilot disricts.		
	Activity 3-1	To establish and operationalize Field Support Working Group to strengthen capacity development of district health systems.	Instead of Field Support Working Group, District Think Tank (Siaya including Gem, Kisumu West and Ugenya) will be formed on 13th June. Under DTT, Transformative Action Group (Supportive Supervision, HMIS and CHS) will be formed on the same day.	DTT is expected to operate independently (without Project financial support) from June 2011. TAG is operationized by the Project support from June 2011.
	Activity 3-2	To review supervision system and checklists in light of quality of management and standardized health services.	Between June 2010 and October 2010, the representatives from PHMT and Pilot DHMTs, keypersons from MOPHS HQ and other partners reviewed supervision system and developed the Integrated Management Supportive Supervision Checklists (IMSS).	There is stock of autonomous funding to facilitate Supervision mechanism.
	Activity 3-3	To develop Integrated Management Supportive Supervision(IMSS) checklist and implementation, on-site training and feedback mechanism.	From June 2010 to Octber 2010, the same stakeholders as Activity 3-2 developed Integrated Management Supportive Supervision checklist.	IMSS should be more integrated, summarized and harmonized in line with service quality management.
	Activity 3-4	To operationalize implementation, on-site training, feedback and dissemination of IMSS.	IMSS checklist (draft version) has been in practice at the Pilot districts since January 2011. In Siaya district, IMSS has been introduced and practiced by 19 health facilities among total 32 health facilities. In Ugenya district, IMSS has been introduced and practiced by 14 health facilities among total 24 health facilities.	IMSS checklist will be reviewed by SS TAG and finalized by PHMT and DTTs. SS management handbook will be developed by SS TAG, in which IMSS checklist and its operation will be incorporated. It will take more time.
	Activity 3-5	To support DHMT to incorporate IMSS into budget and action plan of AOP.	The Project has not achieved anything in this area yet.	AOP planning will be taken place in February and March every year.
	Activity 3-6	To support PHMT/DHMT to promote Health Management Information System (HMIS), Community Health Strategy (CHS) and other related communication management to strengthen district health systems.	HMIS: The Project welcomed JICA Short-term expert to conduct situational analysis, sensitization workshop and networking with Department of HMIS in MOPHS. There are consecutive effort to support District Health Information System (DHIS), newly introduced HMIS tool. CHS: The Project hosted the first Provincial CHS Forum in October 2010 and elected provincial best community unit (Sare CU, Migori). The Project demonstrated the Project activities in national CHS Convention and the provincial best CU was laureate as the national best CU in December 2010.	1) There are competing tasks and shortage of health managers to facilitate smooth operation in management support at DHMT level. 2) The fluctuation in the policy and guidance of management systems from MOPHS hinders also effective implementation of district health management activities. 3) Data collection for CHS survey will be challenge because of door to door survey. Donor coordination is difficult.
	Activity 3-7	To support PHMT/DHMT to strengthen project management in AOP.	The Project supported day-to-day management in AOP development and monitoring of the provincial and district level. Especially, the Project supported Marginal Budgeting for Bottleneck Analysis (MBB) to facilitate financial analysis and allocation in AOP 6 development.	1) There is immature team spirit and capacity to share the workload for AOP development and monitoring among PHMT and DHMT members. 2) There is no autonomous funding mechanism to implement activities planned in AOP.
	Activity 3-8	To support PHMT/DHMT to hold Technical Assistance Committee and Stakeholder Forum at provincial and district level.	The Project supported total 16 workshops and forums for AOP6 and 7 development in pilot districts to conduct AOP sensitization meeting, district stakeholder meeting and health facility in-charge meeting.	There is no autonomous funding mechanism to support AOP development and review mechanism. All the incidentals depend on the partners' contribution.
	Activity 3-9	To evaluate and document IMSS and other related management activities as evidence-based practice.	The Project has not achieved anything in this area yet.	To conduct impact survey with control sites will require more time and resources.
Output 4		Evidence-based practices and lessons-learned demonstrated by the Project operational models are promoted to all the districts in Nyanza Province and other provinces and enhance national health policies/guidelines and international networks.		
	Activity 4-1	To design and conduct operational research for evidence-based practices concerning to the project intervention.	The Project has took one operational research on health systems management training in pilot teams using capacity assessment tool between January 2010 and December 2010. The project is going to undertake four major operational researches on (1) quasi-controlled study on scaling-up health systems management training, (2) health promotion intervention, (3)supportive supervision intervention and (4) community health management intervention between March 2011 and June 2012.	The project is facing challenges in research institutions, which can provide quality research activities. However, the Project was recently able to conduct data collection and statistical analysis supported by GLUK supervised by Mr Kawakatsu.
	Activity 4-2	To document and publish research results, operational models and lessons-learned to a wider public audience.	There are no published research results and operational models until June 2011. However, there are two research papers submitted to academic journals. The Project will promise to build four models (health systems management, health promotion activities, service quality management and community health management) before June 2012.	There are competing tasks among the Project members to allocate enough time to conduct research activities and documentations.
	Activity 4-3	To support sustainable mechanism to disseminate evidence-based practices demonstrated by the Project in scientific journals, conferences and stakeholders' forums.	The Project has demonstrated and disseminated the Project achievements in total 69 seminars, conferences and forums until June 2011.	The challenge here is an inadequate capacity for health managers (PHMT, DHMT) to conduct operational research to facilitate evidence-based practice. Otherwise the development partner gave the information about High Impact Intervention (HII) to the counterpart teams.
	Activity 4-4	To promote institutional networking with development partners, academic institutions and other organizations (NGOs, CBOs, FBOs etc.)	The Project is working closely with UNICEF, EHSD(DFID), USAID (TEPARU/CDC, APHIA+, ICAP, FACES, IMPACT etc.), WHO, DANIDA and International NGOs (Plan International, CARE, AMREF, World Vision etc.). The Project has developed Communities of Practices (local institutional technical network)with Mzumbe University-Tanzania, GLUK, Moi-mu University, KIA, KCA, KUA, MSH, AMREF and etc.	There are several organizations, which have not been transparent to work with the government. However, since January 2011, it is a great opportunity that the Global Health Initiative (GHI) by US government was commenced to seek more synergetic effects with partners.
	Activity 4-5	To conduct forums and study visit to exchange information and experiences to enhance evidence-based practices.	The project conducted and showed the achievements in five major forums (GLUK International Conference 2010 and 2011, Provincial and National Community Health Strategy Forums 2010, Provincial Scientific and Good Practice Forum 2010). And the Project conducted six study visits to Bondo District (UCAN), Nairobi (UCAN), Mombasa (CHS), Uganda (PHMT, DHMT) and Tanzania (PHMT, DHMT).	There were very few occasions to sell good practices by partners, however the Provincial stakeholder meeting will be quarterly held to demonstrate the ground efforts. The Project is assigned as assistant secretariat for this sector wide coordination mechanism.
	Activity 4-6	To support Department of Primary Health Services and other departments in MOPHS for their organizational capacity development.	The project conducted four major contributions to DPHS/MOPHS in (1)Department AOP6 development (April 2010), (2) Department Business Plan development (June 2010), (3)Team building retreat (November 2010) and (4)Health systems management training (December 2010).	There are several challenges in ineffective coordination between MOPHS and the Provincial office, communication gap between the MOPHS and the Project and geographic gap between Nairobi and Kisumu.
	Activity 4-7	To support the development and review of health policy/guidelines based on the Project activities and achievements.	The Project has not achieved anything in this area yet.	There are critical challenges in policy implications at the provincial level due to immature decentralized system in health sector (ultimate centralized system).
	Activity 4-8	To spearhead international collaborative network for health systems strengthening with neighboring countries and beyond.	The Project has developed international collaborative network with Uganda (January 2011), Tanzania (February 2011) and Somaliland (April 2011).	There is great willingness to work together beyond the frontier, however the official arrangement and communication means have to be promoted.

Annex 4:

List of Japanese Experts assigned to the Project

Long term Expert

Designation	Name	Duration	M/M
Chief Advisor	Tomohiko SUGISHITA	30 September 2009 – 29 June 2013	45 M/M
Project Coordinator/ Education Material Development	Chie MURAKAMI	1 July 2009 – 14 July 2011	24.5 M/M
System Strengthening/ Training Management	Mikihiro TODA	30 July 2009 – 29 June 2013	47 M/M
Health Administration Management	Kaori SAITO	9 April 2011 – 1 July 2013	26.77 M/M
Project Coordinator/ Health Promotion	Naoko KITAZAWA	29 June 2011 – 29 June 2013	24 M/M

Short term Expert

Designation	Name	Duration	M/M
Health Information Management	Naoki TAKE	9 September 2010 – 23 December 2010	2.5 M/M

Annex 5: Equipments Purchased through Project Budget

No.	Acquired Date	Item	Specification	Unit/Cr.	Price	Procured from	Remarks
1	2009-08-17	Inkjet Printer	Canon IP100	Ksh	38,280	Compulynx Nyanza	
2	2009-08-26	Toyota Hilux	KUN25R-PRMDHN (DLX)	USD	26,485	Toyota East Africa Ltd.	供与機材
3	2009-08-26	Toyota Prado	KZJ120R-GKMETQ	JPY	3,862,600	Toyota East Africa Ltd.	供与機材
4	2009-09-09	External Universal Laptop Battery	Promate	Ksh	19,500	Bloomerg	
5	2009-10-01	Fax Machine		Ksh	33,500	Compulynx Nyanza	
6	2009-10-01	HP Scanner	CN87DTH0M7	Ksh	40,000	Compulynx Nyanza	
7	2009-10-06	Topeau Cover for Toyota Hilux		Ksh	168,200	Sai Raj	
8	2009-10-15	Dell Laptop Computer 1	7515S4K1	Ksh	65,000	Electronics Technology Ltd	供与機材
9	2009-10-15	Dell Laptop Computer 2	CP85606	Ksh	65,000	Electronics Technology Ltd	供与機材
10	2009-10-15	Dell Laptop Computer 3	3615S4K1	Ksh	65,000	Electronics Technology Ltd	供与機材
11	2009-10-15	Dell Laptop Computer 4	V7HS4K1	Ksh	65,000	Electronics Technology Ltd	供与機材
12	2009-10-15	HP LaserJet 5200dtn		Ksh	134,000	Electronics Technology Ltd	供与機材
13	2009-10-15	SHARP Photocopier AR-M318		Ksh	430,000	Electronics Technology Ltd	供与機材
14	2009-10-15	Sony LCD Projector 1 VPL-CX150		Ksh	170,000	Electronics Technology Ltd	供与機材
15	2009-10-15	Sony LCD Projector 2 VPL-CX150		Ksh	170,000	Electronics Technology Ltd	供与機材
16	2009-10-15	Projecting Screen 96"x96"		Ksh	78,000	Electronics Technology Ltd	供与機材
17	2009-10-15	MS Office 2007 software 1		Ksh	23,400	Electronics Technology Ltd	供与機材
18	2009-10-15	MS Office 2007 software 2		Ksh	23,400	Electronics Technology Ltd	供与機材
19	2009-10-15	MS Office 2007 software 3		Ksh	23,400	Electronics Technology Ltd	供与機材
20	2009-10-15	MS Office 2007 software 4		Ksh	23,400	Electronics Technology Ltd	供与機材
21	2009-12-02	Adobe Acrobat 1		Ksh	23,000	Compulynx Nyanza	
22	2009-12-02	Adobe Acrobat 2		Ksh	23,000	Compulynx Nyanza	
23	2009-12-02	Adobe Acrobat 3		Ksh	23,000	Compulynx Nyanza	
24	2009-12-02	Adobe Acrobat 4		Ksh	23,000	Compulynx Nyanza	
25	2009-12-16	Office Desk 1		Ksh	20,783	Compulynx Nyanza	
26	2009-12-16	Office Desk 2		Ksh	20,783	Compulynx Nyanza	
27	2009-12-16	Office Desk 3		Ksh	20,783	Compulynx Nyanza	
28	2009-12-16	Office Desk 4		Ksh	20,783	Compulynx Nyanza	
29	2009-12-16	Conference Table		Ksh	33,620	Compulynx Nyanza	
30	2009-12-16	White Board 6ft x 4ft		Ksh	15,000	Compulynx Nyanza	
31	2009-12-16	Bookshelf with door & lock		Ksh	16,810	Compulynx Nyanza	
32	2010-02-10	Security Alarm System		Ksh	158,708	G4S	
33	2010-03-03	Toyota Prado		Ksh	3,165,468	Toyota East Africa Ltd.	
34	2010-03-15	Conference Table (Small)		Ksh	21,000	Compulynx Nyanza	
35	2010-03-15	Conference Table (Large)1		Ksh	33,620	Compulynx Nyanza	
36	2010-03-15	Conference Table (Large)2		Ksh	33,620	Compulynx Nyanza	
37	2010-03-15	Coffee Table		Ksh	18,000	Compulynx Nyanza	
38	2010-03-15	Office Desk 1		Ksh	20,783	Compulynx Nyanza	
39	2010-03-15	Office Desk 2		Ksh	20,783	Compulynx Nyanza	
40	2010-03-15	White Board		Ksh	15,000	Compulynx Nyanza	
41	2010-03-18	HP Compaq 6000 Pro MT, Keyboard, Mouse, Monitor, Win7 Pro, ESET		Ksh	108,000	Total Solutions	供与機材
42	2010-03-18	APC Smart 1kVA UPS		Ksh	82,640	Total Solutions	供与機材
43	2010-03-18	HP Compaq 6530b Notebook1		Ksh	108,580	Total Solutions	供与機材
44	2010-03-18	HP Compaq 6530b Notebook2		Ksh	108,580	Total Solutions	供与機材
45	2010-03-18	Adobe CS4 Master Collection- User License		Ksh	257,082	Total Solutions	供与機材
46	2010-03-18	70"x70" Tripod Projector Screen 1		Ksh	18,360	Total Solutions	供与機材
47	2010-03-18	70"x70" Tripod Projector Screen 2		Ksh	18,360	Total Solutions	供与機材
48	2010-03-18	HP Officejet Pro 6500 AIO DW		Ksh	19,980	Total Solutions	供与機材、Kisumu West譲渡済
49	2010-03-18	Kyocera Mita Photocopier		Ksh	544,970	MFI, Procured by JICA Kenya	供与機材
50	2010-03-25	Office Blind		Ksh	306,608	Vitendi	
51	2010-03-29	Office Desk 1		Ksh	20,783	Compulynx Nyanza	Siaya譲渡済
52	2010-03-29	Office Desk 2		Ksh	20,783	Compulynx Nyanza	Siaya譲渡済
53	2010-03-29	Office Desk 3		Ksh	20,783	Compulynx Nyanza	Siaya譲渡済
54	2010-03-29	Whiteboard		Ksh	15,000	Compulynx Nyanza	Siaya譲渡済
55	2010-03-29	PVC Tent for 100 people		Ksh	125,000	Compulynx Nyanza	Siaya譲渡済
56	2010-03-29	Office Desk		Ksh	20,783	Compulynx Nyanza	Kisumu West譲渡済
57	2010-03-29	Whiteboard		Ksh	15,000	Compulynx Nyanza	Kisumu West譲渡済

58	2010-03-29	Bookshelf with glass doors		Ksh	17,600	Compulynx Nyanza	Kisumu West譲渡済
59	2010-03-29	PVC Tent for 100 people		Ksh	125,000	Compulynx Nyanza	Kisumu West譲渡済
60	2010-03-31	Sawafuji Generator ELEMAX SH3200EX	SADN 1012023 / VSW3GCAAK-1649815	Ksh	86,000	Davis & Shirtliff	Kisumu West譲渡済
61	2010-03-31	Sawafuji Generator ELEMAX SH3200EX	SADN 1012028 / VSW3GCAAK-1649816	Ksh	86,000	Davis & Shirtliff	Siaya譲渡済
62	2010-03-31	Peavey ESCORT Portable Audio System	Escort OGIH0028 00511812	Ksh	65,000	Credible Sounds	Kisumu West譲渡済
63	2010-03-31	Peavey ESCORT Portable Audio System	Escort OGIH0009 00511812	Ksh	65,000	Credible Sounds	Siaya譲渡済
64	2010-03-31	SEKAKU Wireless Microphone System WR-202R	9052235	Ksh	16,000	Credible Sounds	Kisumu West譲渡済
65	2010-03-31	SEKAKU Wireless Microphone System WR-202R	9052049	Ksh	16,000	Credible Sounds	Siaya譲渡済
66	2010-03-31	SONY DSC - W350 Digital Camera	8686628	Ksh	13,480	Total Solutions	PHMT譲渡済
67	2010-03-31	SONY DSC - W350 Digital Camera	8696890	Ksh	13,480	Total Solutions	Kisumu West譲渡済
68	2010-03-31	SONY DSC - W350 Digital Camera	8696883	Ksh	13,480	Total Solutions	Siaya譲渡済
69	2010-03-31	SONY Handycam DCR-HC54	707608	Ksh	18,875	Total Solutions	供与機材
70	2010-03-31	Tripod for SONY Handycam		Ksh	15,085	Total Solutions	供与機材
71	2010-03-31	Plastic tables & chairs		Ksh	46,200	Compulynx Nyanza	Kisumu West譲渡済
72	2010-03-31	Plastic tables & chairs		Ksh	51,000	Compulynx Nyanza	Siaya譲渡済
73	2010-05-07	GPS device	GARMIN eTrex	Ksh	30,290	Swiss Products Ltd.	
74	2010-08-14	Projector	SONY VPL MX-20	Ksh	170,000	Procured by JICA Kenya Office	Kisumu West譲渡済
75	2010-08-14	Projector	SONY VPL MX-20	Ksh	170,000	Procured by JICA Kenya Office	Siaya用
76	2010-10-13	Laptop computer	TOSHIBA Satellite Notebook 7A085251H	Ksh	95,300	Compulynx Nyanza	ナショナルスタッフ用
77	2010-10-13	Laptop computer	TOSHIBA Satellite Notebook 7A088685H	Ksh	95,300	Compulynx Nyanza	ナショナルスタッフ用
78	2010-12-20	Laptop computer	TOSHIBA Satellite R630-10S 7A089375H	Ksh	95,000	Compulynx Nyanza	Ugenya District用
79	2010-12-20	Laptop computer	TOSHIBA Satellite R630-10S 7A088465H	Ksh	95,000	Compulynx Nyanza	Gem District用
80	2011-01-05	Digital camera	SONY DSC HX5V	Ksh	31,585	Nakmatt Holdings Ltd.	Ugenya District用
81	2011-01-05	Digital camera	SONY DSC H55	Ksh	31,585	Nakmatt Holdings Ltd.	Gem District用
82		Toyota Prado			3,676,565	Procured by JICA Kenya Office	

Annex 6 : List of Counterparts (Total 62 people)

No.	Name	Organization	Position	Function in the Project	Period (Duration)
1	Prof. Dan Kaseje	Great Lakes University of Kisumu(GLUK)	Vice Chancellor	Lecturer (governance)	01/2010
2	Prof. Richard Muga		Deputy Vice Chancellor	Lecturer (Srtategic planning, Healh policy)	02/2010, 04/2010
3	Prof. Stephen Okeyo		Dean, Faculty of Health Sciences	Lecturer & TMWG	12/2009~ (TMWG)
4	Dr. Joyce Owino		Lecturer	Lecturer (Health Policy)	04/2010, 12/2010
5	Mr. Patrick Ojera	Maseno University	Head, DEBS	Lecturer (Communication)	01/2010
6	Ms. Scholastica Odhiambo		Lecturer	Lecturer & TMWG	12/2009~11/2010 (TMWG)
7	Mr. Nelson Obange		Lecturer	TMWG	11/2010~ (TMWG)
8	Mr. Alphonse Odondo		Lecturer	Lecturer (Communication)	01/2010
9	Ms. Jackline Opande	KCA University	Head, ICD-Kisumu	Lecturer (Communication)	01/2010
10	Mr. Peter Halwenge		Lecturer	TMWG	01/2010~ (TMWG)
11	Mr. Wilfred Owalla		Lecturer	Lecturer (Resource mgt)	11/2010, 12/2010
12	Ms. Judith Raburu	UNICEF	Senior Project Officer	Lecturer (Supervision)	06/2010, 07/2010
13	Dr. Kennedy Ongwae		Health Specialist	Lecturer (Supervision)	07/2010
14	Prof. Miriam Were	Uzima Foundation	Co-Founder	Lecturer (Health Policy)	04/2010
15	Ms. Rachel Ngesa	KIA	Lecturer	TMGW	12/2010~ (TMWG)
16	Prof. Elisante Ole Gabriel	Eden Consultants/ Mzumbe University	CEO/Professor	Main Lecturer & TMWG	12/2009~ (TMWG)
17	Ms. Devota Elisante	Eden Consultants	Consultant	Lecturer (Team building)	11/2010
18	Mr. Charles Oyaya	IIHDPAR-Africa	Executive Director	Lecturer (Health Policy)	04/2010, 12/2010
19	Ms. Joan Mutero	AMREF	Training Specialist	TMWG	12/2010
20	Dr. Edwin Nyutho	University of Nairobi	Lecturer	Lecturer (Supervision)	07/2010, 12/2010
21	Theresa Odero		Lecturer	Lecturer (Health promotion)	06/2010
22	Ms. Teresa Samita Okeyo	Price Waterhouse Coopers	Consultant	Lecturer (Supervision)	07/2010
23	Mr. Waki Netsanet	World Bank	Senior Economist	Lecturer (MBB)	09/2010
24	Mr. Micheal Ochieng	APHIA II Nyanza	Senior Programme Officer	Lecturer (M&E)	09/2010, 12/2010
25	Mr. Geoffrey Alumila	KEMSA	Depot Manager-Kisumu	Lectuerer (Resource mgt)	11/2010
26	John Mukui Kariri	KMTC	Lecturer	Lecturer (Health promotion)	06/2010, 08/2010
27	Dr. Christine Kisia	WHO	Health Promotion Expert	Lecturer (Health promotion)	08/2010
28	Francis Namisi	AMREF Italy	Programme Officer	Lecturer (Print media)	08/2010
29	Mebie Birengo	Kenya Competences Trust	Share Facilitator	Lecturer (Facilitation skill)	11/2010
30	Onesmus Mlewa	Kenya Competences Trust	Share Facilitator	Lecturer (Facilitation skill)	11/2010
31	Dr. Catherine Lengewa	AED	Programme Officer	Lecturer (Print media)	12/2010
32	Bill Okaka	-	Consultant	Consultant (Health promotion)	03/2010
33	Eulalia Namai	-	Communication/Media Consultant	Lecturer (Health promotion)	06/2010
34	Benjamin Nyangoma	-	Designer	Lecturer (Print media)	12/2010
35	Dr. Esther Ogara	Ministry of Medical Services(MOMS)-HQ	Head, Division of e-Health	Lecturer (Health information)	09/2010
45	Dr. Isabel Maina		Officer, Division of Technical Planning	Lecturer (Strategic planning)	02/2010
36	Dr. Samuel Were	Ministry of Public Health and Sanitation(MOPHS)-HQ	Head, Technical Planning & Performance Monitoring	Lecturer (Resource mgt)	11/2010, 12/2010
37	Mr. Wanjala Pepela		Officer, Division of Health Information System	Lecturer (Health information)	09/2010, 11/2010
38	Mr. George Ochieng		Head, Division of Standards & Quality Assurance	Lecturer (Supervision)	06/2010, 07/2010
39	Dr. Ayub Manya		Officer, Division of Health Information System	Lecturer (Health information)	09/2010, 11/2010
40	Ms. Hannah Kimemia		Head, Division of Human Resource Development	Lecturer (HRH)	11/2010
41	Mr. David Njoroge		Head, Division of Human Resource Development	Lecturer (HRH)	11/2010, 12/2010
42	Mr. Edward Were		Head, Accounting Unit	Lecturer (Resource mgt)	11/2010
43	Dr. Otipo Shikanga		Officer, Division of Disease Surveillance and Response	Lecturer (Health information)	09/2010
44	Dr. Ruth Kitetu		Officer, Department of Technical Planning & Performance Monitoring	Lecturer (Strategic planning)	02/2010

46	Dr. Salim Hussein		Head, Department of Health Promotion	Lecturer (Health promotion)	06/2010, 08/2010
47	Susan Nyerere		Deputy Head, Department of Health Promotion	Lecturer (Health promotion)	06/2010
48	Samson Thuo		Health Promotion Officer, Department of Health Promotion	Lecturer (Health promotion)	06/2010, 12/2010
49	Dr. Jackson K Kioko	MOPHS/PHMT-Nyanza	Provincial Director of Public Health and Sanitation	Lecturer & TMWG	8/2009~
50	Dr. Peter Okoth		Provincial Disease Prevention and Control Officer	Lecturer & TMWG	11/2009~ (TMWG)
51	Mrs. Clementine Gwoswar		Provincial Public Health Nurse	TMWG	11/2010~ (TMWG)
52	Dr. Elizabeth Okoth	MOPHS/DHMT-Kisumu West	District Medical Officer of Health	TMWG	8/2009~
53	Ms. Hilda Ayieko		District Public Health Officer	TMWG	11/2009~ (TMWG)
54	Dr. Onditi Samuel	MOPHS/DHMT-Siaya	District Medical Officer of Health	TMWG	10/2009~
55	Ms. Milicent Okwach		District Public Health Nurse	TMWG	11/2009~ (TMWG)
56	Mr. David Ochilo	MOPHS/DHMT-Ugenya	District Public Health Officer	TMWG	9/2010~ (TMWG)
57	Dr. Julius Nyerere	MOPHS/DHMT-Bondo	District Medical Officer of Health	TMWG	1/2011~ (TMWG)
58	Dr. Magara Jack	MOPHS/DHMT-Nyamira	District Medical Officer of Health	TMWG	1/2012~ (TMWG)
59	Dr. S. J. Bongo	MOPHS/DHMT-Kuria	District Medical Officer of Health	TMWG	1/2013~ (TMWG)
60	Dr. Omondi Owino	MOPHS/DHMT-Suba	District Medical Officer of Health	TMWG	1/2014~ (TMWG)
61	Dr. Dan Otieno	MOPHS/DHMT-Nyando	District Medical Officer of Health	TMWG	1/2015~ (TMWG)
62	Dr. Crypus Nyongesa	MOPHS/DHMT-Kisii Central	District Medical Officer of Health	TMGW	1/2016~ (TMWG)

DEBS:Department of Economics and Business Studies
ICD: Institute for Capacity Development
KIA: Kenya Institute of Administration
KEMSA: Kenya Medical Supply Agency
IIHOPAR: International Institute of Health and Development Policy and Research
AMREF: African Medical and Research Foundation
KMTC: Kenya Medical Training College
PHMT: Provincail Health Management Team
DHMT: District Health Management Team

Annex 7 : List of CP Training in Japan (Total 9 people)

No.	Name	Training Course Title	PHS Station	Position	Training Plan	Training Period (From)	Training Period (To)	Note
1	Dr. Peter Okoth	Health Systems Management	PHMT-Nyanza	PDSC	MoPHS	5th May 2010	10th July 2010	
2	Clementine Gwoswar	Health Administration for Regional Health Officer for Africa	PHMT-Nyanza	PPHN	MoPHS	29th June 2010	14th August 2010	
3	Benter Rieko	Maternal and Child Health Promotion in Public Health for Africa	DHMT-Ugenya	DPHN	MoPHS	18th August 2010	9th October 2010	
4	Mathews Odlango	Information, Education and Communication in Health Secotr	PHMT-Nyanza	D/PHRIO	MoPHS	7th September 2010	18th December 2010	
5	Dr. John Odondi	Community Health Management	DPHS-MOPHS	Head	MoPHS	29th November 2010	25th December 2010	
6	Dr. Kioko Jackson K.	Community Health Management	PHMT-Nyanza	PDPHS	MoPHS	29th November 2010	25th December 2010	
7	Tom Andebe	Community Health Management	PHMT-Nyanza	PPHO	MoPHS	29th November 2010	25th December 2010	
8	Florence Atieno Owuor	Community Health Management	DHMT-Rachuonyo	DPHN	MoPHS	29th November 2010	25th December 2010	
9	Hilda Ayieko	Health Systems Management	DHMT-Kisumu West	DPHN	MoPHS	5th May 2011	9th July 2011	
10								

Annex 8 : Project Operational Cost (JFY 2009 - JFY 2011): Kenya Shilling (Ksh)

		Period	Budget	Expense	Execution rate (%)
JFY 2009	1st Quarter	Apr 2009 - Jun 2009	0	0	0%
	2nd Quarter	Jul 2009 - Sep 2009	1,276,500	716,087	56%
	3rd Quarter	Oct 2009 - Dec 2009	3,564,366	3,007,972	84%
	4th Quarter	Jan 2010 - Mar 2010	7,495,126	8,562,572	114%
	Total	**Apr 2009 - Mar 2010**	**12,335,992**	**12,286,631**	**100%**
JFY 2010	1st Quarter	Apr 2010 - Jun 2010	8,018,082	4,925,394	61%
	2nd Quarter	Jul 2010 - Sep 2010	5,896,645	6,773,698	115%
	3rd Quarter	Oct 2010 - Dec 2010	7,964,455	8,714,043	109%
	4th Quarter	Jan 2011 - Mar 2011	7,423,453	8,889,500	120%
	Total	**Apr 2010 - Mar 2011**	**29,302,635**	**29,302,635**	**100%**
JFY 2011	1st Quarter	Apr 2011 - Jun 2011	12,283,550	TBD	TBD
	2nd Quarter	Jul 2011 - Sep 2011		0	0%
	3rd Quarter	Oct 2011 - Dec 2011		0	0%
	4th Quarter	Jan 2012 - Mar 2012		0	0%
	Total	Apr 2011 - Mar 2012			

Project Performance Review (Group A)

	Input		Output			Activities		Criteria of Operation Made by Participants
	Contributing Factors	Constraining Factors	Contributing Factors	Constraining Factors		Contributing Factors	Constraining Factors	
					Were activities impremented as planned?			
Output1	>Good coordination and organization By JICA >Participatory planning by DHMT/PHMT/JICA >Good will from the province >Commitment by participants and organization	>Lack of facilitators guide and text materials prioritization of activities >Need for facilitators >Limited number of participants due to funding >Limited financial resources >Inadequate resources to cover all facilities	>Willingness and understanding from participants	>Competing tasks >Vertical task activities assigned from headquarters	Output1	Not discussed.	Not discussed.	>Relevant participants identified >Participatory contribution at all levels of activity >Training in line with policy guideline >Pre and post test evaluation carried out >Identification of focal persons >developing models to be covered >Training curriculum developed >Adequate content of curriculum >Standardize training and on-going support >Standard training of identified personnel >Identification and training of facilitators
Output2	>Proper utilization of IEC materials >Development of curriculum on health promotion >Interest to improve on health indicators >Capacity of some DHMT members >Collaboration with other stakeholders	>Devolution of IEC production >Too many materials being produced by central level >Align the product with national guideline		>Media training workshop too frequent should be merged	Output2	Not discussed.	Not discussed.	>Baseline survey >Identification of social cultural factors before producing IEC materials >Training Needs assessment on gaps among members >Production of IEC materials that are relevant to area >Identification of health promotion focal person >Distribution and dissemination of IEC materials >Training of identified personnel on IEC material development >Pre test in IEC materials before production
Output3	>Resources available in order to accomplish the pre-designed supervision task >Supportive supervision core function of DHMT >Basic supervisory tools were already existing	>Very few member in the team has basic knowledge of IMSS >Conflict of interest from the partners supporting this area	>Follow up on action points identified during supervision >Realistic action plan between facilitator and PHMT after supervision >production of checklist in time	>IMSS checklist not user friendly for our partners >Production of IMSS is time consuming	Output3	Not discussed.	Not discussed.	>Identification of SS focal person >Evidence based checklist filed >Planning and carrying out visits to all facilities/supervision sites >Development of checklist >Improved uptake of services >Written feedback to facilities on SS >Orientation of staff members on SS checklist >Coaching and mentoring of the staff during SS
	Progress in Action	Contributing factors	Challenges		Is the project structure appropriate? And How appropriate?			
Project Purpose	Siaya:There was improvement except in planning M&E KW: showed improvement in all areas except some improvement required in team management and health policy management PHMT: No much fairly average improvement in PME and Infor MGT Baseline survey: all DHMT with different criteria Ugenya was part of Siaya Jan –Dec 2010	KW-Team having the desire to change in the way they do things - Visionary leadership - Accountability - Commitment - Reliability - Prioritizing staff to take lead - Maintenance of dignity Siaya-team spirit and cohesiveness of the team - Good facilitators	Siaya-lack of team work - Inadequate knowledge - Insufficient funds - Inconsistent members attendance to the training - Staff turnover leading to inconsistent performance e.g OMOH Ugenya - Inconsistent attendance of training sessions among PHMT members could have contributed to all round low performance. KW- the prioritized staff going overboard without consulting - Inadequate resources to scale up training to lower level facilitiesx2 - Utilization of knowledge and skills acquired to attain maximum points - No assessment was done after the training of DHMT - Loss of institutional memory due to staff movement		Output1	Appropriate	Reasons were not discussed.	
					Output2	Appropriate	Reasons were not discussed.	
Important Assumptions	Not discussed.				Output3	Appropriate	Reasons were not discussed.	

Project Performance Review (Group B)

	Input		Output			Activities		
	Contributing Factors	Constraining Factors	Contributing Factors	Constraining Factors		Contributing Factors	Constraining Factors	Criteria of Operation Model by Participants
					Were activities implemented as planned?			
Output1	>Knowledgeable facilitator. >Learning environment was conducive especially for DHMTs.	>As for KW, frequent change of Med-Sup. >As for Ugenya, change /absence of DMOH.	>The use of mixed facilitators with different backgrounds. >Supportive Supervision training had practical sessions. >Development and updating resolution matrix	>Some contents such as in Knowledge Management, Health Policy, Governance were too academic and too bulky for time to be delivered. >Although those contents were relevant, it was difficult to apply what was presented into practice. >The method of delivery was not suitable for adult learning in some courses. >Not all the staff received the complete package of training due to their competing tasks (especially in PHMT) >Some partners such as EHS felt that they were side lined.	Output1	In general, the Project has stick to the schedule.	Early planning and sharing of plan of activities. Resources from JICA are availed on time. Joint activity planning.	JICA expert explained the Operation Model.
Output2	>Identification and addressing of gaps in pilot districts.	>Generally health workers have not grasped the concept of HP to integrate it to their routine works. >HP policies are not well informed at lower levels. >Divergence HP policies from the national programmes. >Inadequate skills and knowledge among HP officers >Inadequate HP staffing	>UCANWG has done a lot to strengthen HP activities. >Support received from JICA such as cameras, PA system made pilot districts easy to work in communities.		Output2		Some activities have delayed such as Print Media Training due to competing tasks and slow pace of learning by some participants.	JICA expert explained the Operation Model.
Output3	>Learning environment was conducive especially for DHMTs. >Logistics support other partners to carry out SS. >Human resource input by other partners such as ICAP.	>Weakness in using previous SS reports.	>Training on SS, Coaching & Mentoring was very good. >Repair of vehicles in districts by JICA.	>Documentation of resolution matrix is weak in some districts.	Output3			JICA expert explained the Operation Model.
	Progress in Action	Key Contributing factors	Challenges		Is the project structure appropriate? And How appropriate?			
Project Purpose	Not discussed.	Not discussed.	>Orientation of PDM (UCANWG members were orientated. Dr. Sugi shared the concepts of PDM but not this document itself) >Devolution of Nyanza Province and its implication of Project target area.		Output1 Output2	Appropriate.	>The structure provides proper and efficient coordination. >Decisions are made by Kenyan CPs. >The structure provides adequate consultation in terms of decision making and feedback. >structure provide for regular meetings	
Important Assumptions	>Workplace environment for Ugenya and Gem is inadequate in terms of security, space, electricity >Inadequate staffing for Gem and Ugenya >Mobility: Transport is a problem in Gem and Ugenya				Output3			

Project Performance Review (Group C)

	Input		Output			Activities		Clients of Operation Model by Participants
	Contributing Factors	Constraining Factors	Contributing Factors	Constraining Factors		Contributing Factors	Constraining Factors	
					Were activities impremented as planned?			
Output1	>Well planned logistics and training modules >good choice of knowledgeable facilitators >Well monitored and supprted >Key DHMT member involved >JICA funded the training fully >reference materials were provided in terms of hard and soft copy >Consultation on next venue of training done and communicated early	>not all member were trained in all the 8 module >Many district health workers scrumbling for the training yet not in DHMT >Governmence topic was not adequately tackled >Limited training period	>Members practicing SS using IMSS tool >Improve communication >Capacity to mobilize resources/support from partners based on community needs >Referal system improved data available >member equiped with new management skill (Leadership,Computer skill, SS skill) >Evidence based planning and practice >Vision and mission was developed >policy corner available >A great level of mindset change	>Skill from DHMT were not been relied down >Limited logistics to cascade training to the lower cadres >Competing task, many activities running parallel >some DHMT member did not participate in all training	Output1	>Additional teams were involved where districts requested >Time was managed satisfactorily >Training was timely and implemented as planned	Duration of some training was too shorl >Some facilitator did not cover their topic well >Selection of participant was not fair >Competing task made some members to miss some module >too many activities are running parallely	Not discussed.
Output2	>Training of DHMT uder UCAN successful and ongoing >the choice of the facilitator acting in 'SMI' was appropriate >PA, lenti, generator, Laptop, CD projector and chairs very useful >UCAN member have developed IEC materials >Printmedia training is very usedul and successful.	>only few member gained the skill >Not all member were involved	>new focus on health promotion is now enhanced by DHMT >Development of IEC materials >Song developed by each district >UCAN WG has developed IEC materials >High impact indicators were summarised and used in health facilities during Malezi bora	>Limited feedback from UCAN member >Health promotion activities not all inclusive >Limited resource and man power >Poor communication from HP office on activities >M&E tool health promotion was not available >limited logistics to develop IEC materials	Output2	>Planned activities done despite of delay in funding. >Malezi bora, ITNs distribution activities carried out >News letters circulated in district >Good overview for demand creation >Basic health promotion training done	>Activities were not well planned >More needs to be done in health promotion in terms of involving more DHMT members >Health promotion basic training not well planned >many competing task	Not discussed.
Output3	DHMT was trained on SS >IMSS tool is good and useful for supervision >Formation of DIT and TAG is good >Development of DIT and TAG will be great help	>the roll out of tool is too slow >TAG should compile a few DHMT members and not all the members >The tool need to improve because of too long >Training were limited to few DHMT	IMSS tool was developed and in use >Resolution matrix is a very useful tool to be used in SS >District motivated to conduct SS >AOP 7 well planned at the district level >Facilities are able to develop resolution matrix >MTC students taken through SS using IMSS tool >Funds sourced for SS	>Inadequate funding for SS at the district level >Draft IMSS tool is not addressing specific program areas >The use of the RM tool limited to DHMT ad not well utilised >Partners Supporting supervision be brought on board early enough at the DHSHF	Output3	>It was produce in time >Training of SS was well choice	>Planned activities delayed due to competing task >Slow-follow-up of SS progress after training >Left some department out	Not discussed.
	Degree of Achievement	Contributing factors	Challenges		Is the project structure appropriate? And How appropriate?			
Project Purpose	Not discussed.	Not discussed.	Not discussed.		Output1	>Good coordination system >Organization/structure is good >Lectures friendly and good >Project took cognizance of the level of the trainees and involved higher levels of training instructors >Rich Academic facilitation >Project working group was an good idea. >Good venue, penning adequate logistics >Communication between project and DHMT is good	>Specifically computer training was too shor >some training venue was not user friendly >Need to involve participant out of the DHMT >Activities are limited to DHMT only	
					Output2	>The UCAN structure is appropiate >The Task Group structure is very good	>Structure is not well known >Improve on existing structure by adding more member >No knowledge about structure >Am not comfortable with people leaving their core training to be purely health promoters	
Important Assumptions	Not discussed.				Output3	>Structure is good because district participated in their choice >IMSS tool being used during supervision >The structure of DIT and TAG for specific duties is good	>new structure not very friendly too many meeting >The structure of DIT and TAG not well understand	

Annex 9-2 Effectiveness (All Groups)

Effectiveness	Sub Question			
	Is it likely that the project purpose achieved by the end of the project as expected?	1.Has the indicator for the project purpose progressed sufficiently?How much is the level of the achievement oat the time of the mid-term	2. Are all output fully contribute to achieve the progect purpose? Does each output contribute to the achievement of the project purpose?	3. Are there any comtributing factor that influenced the achievement of the outcome?	4. Are there any constraining factor that influenced the achievement of the outcome?
Group A	>Yes Individual indicators to target district behavior change • Coaching and mentoring during support supervision • Use of integrated checklist instead of service specific checklist Support facilities noting their strength	>Yes Capacity development • 121% • Scale up to other districts • Pilot districts baseline capacity of 3.09 (2009/2011) • Grand average capacity of 3.4 • Pilot district capacity of 3.75 (Dec 2010)	Output 1: Direct contribution to project purpose (training/Capacity development) Output 2:Resource mobilization skills, Improved communication skills, Skills in IEC, Enhanced advocacy skills Output 3:Enhanced skill in communication, Coaching and mentoring, Documentation skills, Enhanced feedback mechanism Output 4:Resource corner, Implementation scale up is evidence based, Networking enhanced, Production of newsletter, Regional presentation of lessons learnt	Improved planning and coordination at DHMT level • Good leadership • Good organization • Dignity maintenance • Development of vision and mission statements • Leadership and management training	>Level of staffing if not included in AOP >Delayed start of the project >Competing tasks >Lack of sharing information >Inadequate information on knowledge of individual staff >Many training without enough time to practice
Group B	>Yes Sufficient progress has been made in the 8 capacities	>Yes • Average improvement of the pilot teams 121% • DHMTS improved in health policy management 3.7 • Siaya marked improvement in LM&G, achieved target of 4.0 • PHMT have stagnated in planning & M&E • Coaching, mentoring was well articulated in the S.S training • Training model targets the 8 capacities • Kisumu west exceeded the target in information management • Siaya achieved 4.0 in S.S • Siaya has declined in M&E from 3.5 to 3.4	Not discussed	>KW improved in information sharing through emails & Monday morning briefs >Support from other partners >Support from MOMS (HSSF) >Feedback from District Stakeholders Forum & In charges meetings	>M&E was scattered per program, not centrally coordinated >Adhoc activities from the national level >Absence of district strategic plan >Competing tasks >Disruptions of PHMT plans by national office >Weakness in documentation >Insufficient human resource
Group C	>Yes, the commitment and enthusiasm is great >Yes, Because staff have been trained and equiped with leader skill for management >Yes, Project activities are going as planned and on schedule >Yes, pilot dhas already been done >Yes, because I did manage to attend 95% of the intended capacity development >Yes, There are plans to role out the training to other district >No, I hace not attended any training >NO, the scale down from DHMT to other staff is slow and resource are limited. >No, Inadequate infrastructure, staffs, materials and stationery at HF and District	>No, We can improve more because most of us have not been trained >Yes, there is remarkable improvement on key indicators within a short period >Yes, because the member are showing willingness to work together >Yes, because all planned activities are being carried out despite constrains. >No, all tam players did not yet trained >No, because there are key member still missing in out DHMT >No,because training was not yet rolled down to grassroot. >Satisfactory but more monagement support is needed to enhanc service delivery >No, if we plan not to CS, we plan to fail >No, some key members are trained and do not remain to implement. >No, We can improve more because most of us have not been trained	>Yes, 4 factors are contributing because they is a lot of awarness to community. >Yes, all output are relevant to the attainment of the project project >Yes,They form the bulk of management support system >Yes, all the outpus are well elaborated and urged. >No, the community is not fully sensitized though CS to access care >No, give another chance for a under range >No, Nyanza population's big and the indicators are more challenging >No, Community linkage still weak hence participation and involvement low >No, the community component still missing	>Yes, the high level of commitment from both team >Yes, HIS department has been enhanced >Yes, Stakehoder involvement during impremenitation >The current constitution is likely to enforce mindset change the more. >Yes, the project works in collaboration with other stakeholdersand synergises the work of the government	>Low level of awareness among community member >Limited resources, lack of human resource, inadequate accountability >high turnover of staff >slow uptake intervention to community >Red tapes in following finances at the district treasury >Inequity in distributing resources >lack of office space >Nepotism >Political system within the community >Corruption

Annex 9-2 Efficiency, Impact, and Sustaiability

Efficiency (Group A)	Sub Question			
Sufficient Activities to produce outputs?	Inputs are appropriate?			Factors influenced the efficiency of the Project (Contributing Factors)	Factors influenced the efficiency of the Project (Constraining Factors)
>All activities contribute to produce outputs >The No of training is more than necessary >The Media training should be considered some implementation mechanism as the Core Management Training Programme	>All inputs are appropriate.			>Joint Planning & Monitoring/Evaluation >Collaboration with other partners > Bottom-up Approach	>Difference of Fiscal Calendar between the Partners >Competing Tasks by MOPHS > Staff Turn Over > Many Vertical Activities/Programme without good coordination
	Inputs	Experts	Assignments Kenya O/P to the project	Facilities/Equipments	
	Timing	Excellent	appropriate	appropriate	
	Size	appropriate	appropriate	appropriate, but need for more computer	
	Quality	High	Good	High	

Impact (Group B)	Sub Question		
What is your observation on the Impact by the Project	How is the Project assisting the Province to achieve Nyanza Hlth?	Contributing Factors	Constraining Factors
>Progress in overall goal is mixed picture >Project achieving overall goal >Indicators varies from pilot district	>Customer satisfaction at provincial level at 57% >Customer satisfaction in siaya at 20% >Measles coverage at 98% in siaya >Measles coverage at provincial level at 84% >ANC at provincial level & KW respectively, 39%, 39% >Skilled deliveries at provincial, Siaya & KW respectively 42%, 42%, 47% >Vitamin A at provincial level, siaya & KW respectively 88%, 76%, 75%	>Improved referal system >Hospital reform agenda >Regular SS >Staff reshuffles & redeployment >Training on CRM for HM >Performance contract implementation for HM >Availability of information corner for reference for HM >Partners support in infrastructure, commodity management, Human resource & financial >Revitalized HM committees in HF >National RRI	>Lack of equipment for deliveries especially in KW >Inadequate staffing >Lack of staffing houses >NO electricity >Lack of space for a maternity unit (KW) >Limited awareness on Hlth (4th ANC visits) >Poor health seeking behaviours for community members >Cultural beliefs & taboos >Distance involved to HF >Traditional birth attendants performing home deliveries

Sustainability (Group C)	Sub Question				
How likely are the project outcomes to be maintained after the end of the project?	1. Are the project outcomes likely to be maintained after the end of the project from perspective of political aspect? And Why?	2. Are the project outcomes likely to be maintained after the end of the project from perspective of financial aspect? And Why?	3. Are the project outcomes likely to be maintained after the end of the project from organizational and individual capacities? And why?	4. What are the factors that contribute the sustainability of the project outcomes	5.What are the factors that constraint the sustainability of the project outcomes? How can the project increase sustainability?
>Yes, because the project will be rolled down to the facilities and communities >Yes, project is aligned to MOPHS policies >Yes, because GOK through HSSF now support DHMT >Yes, devolved funds are being disbursed to the grassroots by GOK >There should be a plan for sustain ability >Some of the outcome can be sustained but with some external support >No, inadequate resources >80% will be sustained through consistent mindset change >Around 50% will be sustained. Most MOH project are partner driven.	>Yes, Health sector reforms are in line with the project goal. >Yes, the project can survive the insiof time, politica aspect, religious economic social ETC >Yes, Other new constitution takes over things will be put in place. >Yes because there is political will being good will >The project is supportive of VISION 2030 politics must support project to be relevant >No, the politica priorities may change abruptly.	> yes because of the devolution funes at county level) >Yes, because devolved funds are coming to the grassroots >With the new constitution there will be equiptable distribution of finances to cover all section. >Yes, Curupt person are bing delt with accordingly >Yes, finance will be delectable to county level. AOP will be funded >yes, because there is devolved funds which can be used in health sector. >Yes, because of the cultivated mindset change. >No, the districts will still depend on donor funds and the central level most supplies still missing.	>Yes, our capacities have been improved >Yes, we have knowledge and empowered. >yes, because the mindset have changed >Drive to achieve results >Yes, It's my wish that the gains are maintained within me team spirit strategic thinking >yes, team spirit being embaraced by DHMT members >Yes, mindset change is irreversible in mature people	>political food will >motivation to achieve and create impact >Consistent funding for AOP >Consistency in what has been learnt will enhance sustainity. >M&E >Capacity building to all staff involved >sustainability plan in place strategic planning	>Corruption >Political instability >cost of living too high >political turmoil or unrest >High staff turn-over >High poverty levels in project area >lack of support from the district

PDM (Version 1.0, March 2011)

プロジェクト・デザイン・マトリックス（PDM）P

プロジェクト名：ニャンザ州保健マネージメント強化プロジェクト

実施期間: 4年間（2009年7月 - 2013年6月）		バージョン	Version 1.0
対象地域およびターゲットグループ: 直接裨益者：ニャンザ州保健行政マネージメントチームおよび県保健行政マネージメントチーム、公衆衛生省プライマリー・ヘルス・サービス局 間接裨益者：ニャンザ州内の保健サービス従事者、地域住民（推定580万人）		承認日	2011年3月25日（第2回プロジェクト合同調整委員会）
プロジェクトの要約	**指標**	**指標データ入手手段**	**外部条件**
上位目標			
ニャンザ州におけるプライマリー・ヘルス・ケア・サービスの質が向上する。	1．保健施設利用者の満足度が、2015年までに90%に増加する。 2．保健マネージャーや保健従事者の職務満足度が、2015年までに90%に増加する。 3．優先的ハイ・インパクト・インターベンション（効果の証明された保健介入）のサービス提供が、2015年までに必要とされる人の80%以上に提供される。	保健リーダーシップおよびマネージメント調査報告書 保健利用者満足度調査報告書 保健リーダーシップおよびマネージメント調査報告書 年間活動予算計画（AOP）進捗レビュー報告書	地方分権に伴うネガティブな変化がプロジェクトに及ばない。 ケニアにおける治安と安全確保が保たれる。 大規模なアウトブレークや疫病の発生が人々の健康に悪影響を及ぼさない。 保健人材が十分に確保される。
プロジェクト目標			
ニャンザ州における州および県レベルの保健行政マネージメントチーム（ＰＨＭＴ，　ＤＨＭＴ）のキャパシティが強化される。	1．ＰＨＭＴ，ＤＨＭＴのキャパシティ・アセスメントの総合平均値が、2013年6月までに5段階中4に向上する。 2．ＰＨＭＴ，ＤＨＭＴの行動アセスメントの総合平均値が、2013年6月までに5段階中4に向上する。	保健リーダーシップおよびマネージメント調査報告書 保健リーダーシップおよびマネージメント調査報告書 保健セクター進捗報告書	インフラストラクチャーの保守管理が確実に行われる。 患者搬送システムが十分に機能している。 薬や機材の物品管理が十分に機能している。 保健従事者が十分に配置されている。
成果			
1 保健分野のリーダーシップおよびマネージメント研修がニャンザ州でモデル化され、普及・促進される。	1．保健戦略リーダーシップおよびマネージメント研修の実施モデルが、2011年6月までに確立される。 2．ニャンザ州内のＰＨＭＴ，ＤＨＭＴのすべてが（100%）、2013年6月までにモデル研修プログラムを受ける。	研修モデルの確立 研修完了・評価報告書	ＰＨＭＴ，ＤＨＭＴの職場環境が最低限の基準を満たしている。 保健行政官の移動手段（車両、他の仕事との両立など）が最低限確保されている。
2 保健プロモーション活動がパイロット県においてモデル化され、保健システム強化において主流化される。	1．保健プロモーション活動の実施モデルが、2012年4月までに確立される。 2．年間活動予算計画（AOP)に予算化された保健プロモーション活動が、2013年6月までにパイロット県で最低5活動以上に増加する。 3．保健プロモーションにおけるパイロット県のキャパシティアセスメント結果の総合平均が、2013年6月までには5段階中4となる。	保健プロモーション・モデルの確立 年間活動予算計画（AOP）レビュー報告書 保健プロモーション・キャパシティ・アセスメント報告書	個人的紛争解決のための職場倫理が尊重され実行されている。 保健行政官と開発パートナーとがビジョン、ミッションを共有して協調的関係にある。 すべての保健関係者が、保健システム強化を目的にマネージメント活動に参加する環境がある。
3 県保健行政マネージメントチームから各保健施設、コミュニティに対するサポーティブ・スーパービジョンおよび関連のマネージメント活動がパイロット県でモデル化され、普及・促進される。	1．サポーティブ・スーパービジョンの実施モデルが、2012年4月までに確立される。 2．統合的マネージメント・サポーティブ・スーパービジョンを受けた保健施設の数が、2013年6月までにパイロット県において80%以上となる。	サポーティブ・スーパービジョン・モデルの確立 統合的サポーティブ・スーパービジョン報告書 保健セクター進捗報告書	
4 プロジェクト介入によって証明されたエビデンスに基づく活動や教訓が、ニャンザ州内および他州に普及・促進され、国家保健政策やガイドライン、国際的ネットワークに波及される。	1．プロジェクト成果を共有するためのセミナー、ワークショップ、会議などの総数が、2013年6月まで順調に増加する。 2．プロジェクト成果を共有するための論文、報告書、出版物などの総数が、2013年6月まで順調に増加する。	議事録、抄録、会議報告書など 論文、報告書、刊行物など	

PDM (Version 1.0, March 2011)

活動	投入		外部条件
	日本側	ケニア側	
1 保健分野のリーダーシップおよびマネージメント研修がニャンザ州でモデル化され、普及・促進される。 1．1 保健マネージメント研修の実施のための研修機関ネットワーク（COPs）を構築する。 1．2 研修マネージメント作業部会（TMWG）をPHMT, DHMT, COPs、日本人専門家で組織化する。 1．3 作業部会を定期的に開催して、研修ニーズの同定、研修計画、モジュール開発などを行う。 1．4 主要マネージメント研修をパイロット県に実施し、パッケージ化のためのモデル構築を行う。 1．5 ニャンザ州の全DHMTを対象にした普及に向けて、パイロット研修の見直しを行い、パッケージ化する。 1．6 ニャンザ州の全DHMTを対象に主要マネージメント研修を対照研究デザインに基づいて実施する。 1．7 パイロット県において、DHMTが保健施設およびコミュニティレベルを対象にしたマネージメント研修を実施するための支援を行う。 1．8 パイロット県において、年間活動予算計画（AOP）作成時にマネージメント研修の成果が応用されることを支援する。 1．9 保健リーダーシップおよびマネージメント研修をエビデンスに基づく活動として評価し、文書化する。	（1）日本人派遣専門家、プロジェクト・スタッフ a.長期専門家（チーフアドバイザー、人材育成、調整員/教材開発/保健プロモーション、保健マネージメント） b.短期専門家（保健情報システムなど） c.プロジェクト・スタッフ（専門家、秘書、運転手など） （2）マネージメント研修、関連活動 （3）現地業務費 （4）事務所機材、家具、車両 （5）本邦研修	（1）カウンターパートの配置（公衆衛生省、ニャンザ州、県レベル） （2）業務支援要員の確保 （3）事務所の賃与、機材、電気水道の提供など （4）ケニア側予算の確保（コスト・シェアリング） （5）保健セクター関係者の調整など	プロジェクトで得た知見や経験を他のDHMTメンバーや関係者と適切に共有している。 開発パートナーや研究機関などとの協働体制が確保されている。 PHMT, DHMTなどのカウンターパートが十分に確保されている。
2 保健プロモーション活動がパイロット県においてモデル化され、保健システム強化において主流化される。 2．1 保健プロモーション作業部会（UCAN WG）を組織化し、定期的活動を行う。 2．2 保健プロモーションにおけるニーズ評価を、PHMT, DHMT, 保健施設、コミュニティの各レベルで行う。 2．3 保健プロモーションにおけるキャパシティ・アセスメントをパイロット県に対して行う。 2．4 保健プロモーションに関するマネージメント研修およびワークショップをPHMT, DHMTを対象に行う。 2．5 DHMTが保健施設およびコミュニティレベルを対象にした保健プロモーション活動を行う支援をする。 2．6 DHMTが保健プロモーション活動を年間活動予算計画（AOP）へ予算化する過程を促進する。 2．7 スタディ訪問などを通して、グッド・プラクティスの共有や他県とのネットワークを促進する。 2．8 DHMTがローカル・コンテクストに沿ってIEC教材作成をすることを支援する。 2．9 保健プロモーション活動をエビデンスに基づく活動として評価し、文書化する。			
3 県保健行政マネージメントチームから各保健施設、コミュニティに対するサポーティブ・スーパービジョンおよび関連のマネージメント活動がパイロット県でモデル化され、普及・促進される。 3．1 県支援作業部会を設立し、県保健システム強化のためのキャパシティ育成を行う。 3．2 マネージメントの強化とサービスの標準化を目的としてスーパービジョン制度とチェックリストの見直しを行う。 3．3 統合的マネージメント・サポーティブ・スーパービジョン（IMSS）チェックリストの開発と現場トレーニング、フィードバックのメカニズムを構築する。 3．4 IMSSチェックリストを使ったサポーティブ・スーパービジョン、現場トレーニング、フィードバックの実施を行う。 3．5 DHMTがサポーティブ・スーパービジョン活動を年間活動予算計画（AOP）へ予算化する過程を促進する。 3．6 PHMT, DHMTにおける保健管理情報システム（HMIS）、コミュニティ保健戦略（CHS）の促進を支援する。 3．7 PHMT, DHMTにおけるAOPのプロジェクト・マネージメント管理を支援する。 3．8 PHMT, DHMTにおけるステークホルダー会議、技術諮問会議などの開催を支援する。 3．9 サポーティブ・スーパービジョンや他のマネージメント活動をエビデンスに基づく活動として評価し、文書化する。			前提条件 治安や安全確保が保障されている。 主要な保健政策やガイドラインに大きな変更がない。 保健セクター改革や地方分権などが維持推進されている。
4 プロジェクト介入によって証明されたエビデンスに基づく活動や教訓が、ニャンザ州内および他州にまで普及・促進され、国家保健政策やガイドライン、国際的ネットワークに波及される。 4．1 エビデンスに基づく活動として、プロジェクトの介入効果を判定するためのオペレーショナル・リサーチをデザインし実施する。 4．2 リサーチ結果や実施モデル、教訓などを文書化・出版して、広報活動を行う。 4．3 プロジェクト成果などの普及のため、学術誌への投稿、カンファレンス、関係者フォーラムなどの継続的メカニズムを構築する。 4．4 開発パートナー、学術機関、他の実施機関との組織的ネットワークを促進する。 4．5 情報や経験の共有のためのフォーラム開催やスタディ訪問を実施し、エビデンスに基づく活動を促進する。 4．6 公衆衛生プライマリー・ヘルス・サービス局や他の部局の組織強化を支援する。 4．7 プロジェクトの成果に基づいて保健政策やガイドラインの見直しを支援する。 4．8 他の近隣諸国などとのネットワークを強化して、保健システム強化のための国際連携を促進する。			

RECORD OF DISCUSSIONS BETWEEN JAPAN INTERNATIONAL COOPERATION AGENCY AND AUTHORITIES CONCERNED OF THE GOVERNMENT OF THE REPUBLIC OF KENYA ON JAPANESE TECHNICAL COOPERATION PROJECT OF STRENGTHENING MANAGEMENT FOR HEALTH IN NYANZA PROVINCE

With respect to the Japanese technical cooperation for the Strengthening of Management for Health in Nyanza Province Project (hereinafter referred to as "the Project"), Japan International Cooperation Agency (hereinafter referred to as "JICA"), through the Chief Representative of JICA Kenya Office, held a series of discussions with the Kenyan authorities concerned.

As a result of the discussions, and in accordance with the provisions of the Agreement on the Technical Cooperation between the Government of Japan and the Government of the Republic of Kenya, signed in Nairobi on 29th April, 2004 (hereinafter refereed as "the Agreement"), both sides agreed on the matters referred to in the document attached hereto.

Nairobi, 22nd April, 2009

Mr. Yoshiyuki Takahashi

Chief Representative,
Kenya Office,
Japan International Cooperation Agency,
Japan

Mr. Mark Bor

Permanent Secretary,
Ministry of Public Health and Sanitation,
The Republic of Kenya

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

Mr. Joseph K. Kinyua

Permanent Secretary,
Ministry of Finance,
The Republic of Kenya

THE ATTACHED DOCUMENT

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

1. The Government of the Republic of Kenya will implement the Strengthening of Management for Health in Nyanza Province Project (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 Articles of the Agreement, JICA, as the executing agency for the 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, VI, and X of the Agreement will be applied to the above-mentioned experts.

2. PROVISION OF MACHINERY AND EQUIPMENT
   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
   JICA will receive the Kenyan personnel connected with the Project for technical training in Japan and will make necessary arrangements.

III. MEASURES TO BE TAKEN BY THE GOVERNMENT OF THE 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 Japanese technical cooperation will contribute to the economic and social development of Kenya.

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

4. In accordance with the provision of Article VII of the Agreement, the Government of the Republic of Kenya will take necessary measures 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. 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.

6. 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 and in third countries will be utilised effectively in the implementation of the Project.

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 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 Public Health and Sanitation (hereinafter referred to as "DoPHS"), Ministry of Public Health and Sanitation (hereinafter referred to as "MoPHS"), as the Project Director, will bear overall responsibility for the administration and implementation of the Project.

2. The head of Department of Primary Health Care Services, MoPHS, as the Project Manager, will manage technical and the administration matters of the Project at national level.

3. Provincial Director of Public Health and Sanitation – Nyanza Province, as the Field Manager, will be responsible for the technical and the administrative matters of the Project at the target province.

4. The Japanese Chief Advisor dispatched by JICA will provide necessary recommendations and advice to the Project Director, the Project Manager, and the Field Manager on any matters pertaining to the implementation of the Project.

5. The Japanese experts dispatched by JICA will give necessary technical guidance and assistance to the Kenyan counterpart personnel on technical matters pertaining to the implementation of the Project.

6. For the effective and successful implementation of technical cooperation for the Project, a Joint Coordinating Committee and Project Steering 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 VI of the Agreement, the Government of the Republic of Kenya undertakes to indemnify the Japanese experts who engage in the

Project, against claims, if any arises, which result from, occur in the course of, or otherwise are connected with the discharge of their official functions in the Republic of Kenya except for those arising from the wilful misconduct or gross negligence of the Japanese experts.

VII. MUTUAL CONSULTATION

There will be mutual consultation between JICA and the 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 for the Project under this Attached Document will be four (4) years from the date of the first dispatch of experts.

ANNEX I MASTER PLAN

1. Project Purpose

Individual capacity of health managers and institutional capacity of health management teams (Provincial and district levels) are improved in Nyanza Province

2. Outputs of the Project

1. Core management capacity [1] of health management teams (Provincial Health Management Team, PHMT and District Health Management Team DHMTs) is strengthened in Nyanza Province
2. Capacities of health management teams on operational cycle (planning, implementation, M&E) are strengthened in Nyanza Province
3. Capacities of health management teams to provide supportive supervision is improved in Nyanza Province
4. Lessons learnt and good practices from output 1-3 are shared with other provincial and national institutions and networking among health managers is strengthened through the process

3. Activities of the Project

1.1. Organise workshop[2] to identify areas that needs to be improved among PHMT and DHMTs on core management skills

1.2. Through the workshop above, develop tools for evaluation of management capacity (by self and externally) and determine the baseline of health management capacity in the province by using the developed tools

1.3. As a part of workshop, conduct exchange visit to learn from good practices in other geographic region/ country.

1.4. Through the workshop above, develop plans to improved the identified areas through 1.1

[1] This includes basic comprehensive management skills such as leadership, human resource management, financial management, improvement of work place environment, team building, facilitation, coordination, information sharing and communication etc.

[2] The workshop is composed of 3 parts; in the first part, tools for capacity assessment are developed and capacity evaluation is conducted, in the second part exchange visit is conducted, and in the third part, tools and evaluation conducted in the first part are reviewed and work plan on core management skills is developed.

1.5. Implement the plans in 1.4

2.1 Conduct needs assessment for training on operational cycle process
2.2 Develop training plan
2.3 Conduct training on operational cycle process according to the plan
2.4 Using the skills acquired through the training above, develop and appraise Annual Operational Plans (AOPs)
2.5 Review existing health information system related to AOPs and its operations
2.6 Develop training / workshop plan to address gaps identified on health information system
2.7 Conduct training / workshop on health information system and develop appropriate tools and its operation through the training /workshop
2.8 Conduct support supervision visits by DHMTs at district level monthly basis
2.9 After the visits, hold monthly meetings to review implementation of AOPs and plan for the next step at district level
2.10 Implement quarterly monitoring to DHMTs and health facilities by PHMT
2.11 After quarterly monitoring visits, hold a meeting to review the results of the activity so that they will be reflected on plan of implementation of AOP and establishing the next AOP

3.1 Review and revise supervision system and practices in light of quality of management and health services through project among project staff at national, provincial and district level managers
3.2 Conduct trainings for health managers at district and provincial level on effective system and practices of supportive supervision
3.3 Conduct regular supervision
3.4 Give feedbacks to district and health facility levels on their performance, quality, processing and utilisation of health information through supervision visits
3.5 Hold regular meetings between health facilities and DHMTs to give feedback of supervision and to discuss suggestions in terms of in-service training, skill development, and other management issues such as drug commodities, health information, and financing at district level
3.6 Hold regular meeting between DHMTs and PHMT at provincial level to discuss finding of supervision and the meeting above to improve quality of services
3.7 Conduct quarterly quality audit by PHMT and DHMT regarding facility supervision

conducted

4.1 Set up a mechanism to review and share project activities, results, and lessons learned from the project implementation of output 1-3 with other provinces and stakeholders in the health sector

4.2 Set up a mechanism of reflecting project results on policy at national level

4.3 Document all lessons learnt, best practices and challenges of the project

4.4 Conduct workshops with other provincial management teams to share the project findings

4.5 Through the workshops, existing health management system is reviewed to be standardize through incorporating the project findings

4.6 Conduct exchange visits to Nyanza from other provinces to disseminate the project models

4.7 Hold regular meetings with national level managers

ANNEX II LIST OF JAPANESE EXPERTS

1. Long-term Experts

(1) Chief Advisor

(2) System Strengthening / Training development

(3) Coordinator / documentation

2. Short-term Experts

Short-term experts will be dispatched on the following field;

a. Monitoring & Evaluation

b. Health Information System

c. Public Relations

Note: Dispatch of Experts will be considered for other fields as necessary.

ANNEX III LIST OF MACHINERY AND EQUIPMENT

Part of the equipment necessary for the effective implementation of the Project will be provided by the Japanese side within the budget allocated for technical cooperation.

The main items of the equipment to be provided are as follows.

1. Essential Materials for data management
2. Vehicles
3. Equipment for the common and general use required for the implementation of the Project

ANNEX IV LIST OF KENYAN COUNTERPART AND ADMINISTRATIVE PERSONNEL

1. Project Director: Director of Public Health and Sanitation, MoPHS
2. Project Manager: Head of the Department of Primary Health Care Services, MoPHS
3. Field Manger: Provincial Director of Public Health and Sanitation – Nyanza Province, MoPHS
4. Staff of the Department of Primary Health Care Services at the Ministry headquarter, MoPHS
5. Members of Provincial Health Management Team (PHMT) – Nyanza Province, MoPHS
6. Members of District Health Management Teams (DHMTs) within Nyanza Province, MoPHS

ANNEX V LIST OF LAND, BUILDINGS AND FACILITIES

The following items will be provided in the project field sites as well as the Central Unit of MoPHS

1. Land, buildings and facilities necessary for the implementation of the Project
2. Rooms and facilities necessary for the installation and storage of the equipment
3. Offices and necessary facilities for the Japanese experts and Kenyan personnel
4. Electricity, water supply and necessary telecommunication services

ANNEX VI ROLES OF VARIOUS COMMITTEES

I. Joint Coordinating Committee (JCC)

The Joint Coordinating Committee, which consists both of the Japanese and Kenyan sides, will be established for the smooth and effective implementation of the Project.

1. Functions

The Joint Coordinating Committee will meet at least once a year or whenever the necessity arises, in order to fulfil the following functions:

(1) To formulate and approve the Annual Plan of Operation of the Project within the framework of the R/D

(2) To review the results of the annual work plan and the overall progress of the Project and achievement of the technical cooperation

(3) To exchange views and ideas on major issues that may arise during the implementation of the Project

(4) To make decisions on major issues arising from or in connection with implementation of the Project

2. Composition

(1) Members

The committee will be composed of the chair and the members. The rules and guidelines for the business of the committee will be determined at the initial stage of the project. The composition will be as follows;

a) The Kenyan side

Permanent Secretary, MoPHS (Chair)
Project Director, Director of Public Health and Sanitation, MoPHS
Director of Medical Services, Ministry of Medical Services
Project Manager, Head of the Department of Primary Health Care Services, MoPHS
Field Manager, Provincial Director of Public Health and Sanitation – Nyanza Province
Relevant personnel accepted by Chairperson, if necessary

b) The Japanese side

JICA long term experts (i.e. Chief Advisor, Coordinator and other experts)
Chief representative, JICA Kenya Office
Other member(s) accepted by Chairperson, if necessary

II. Project Steering Committee

The Project Steering Committee will run the project on a daily basis and will meet at least quarterly basis or whenever the necessity arises

1. Functions

(1)To make quarterly and monthly work plan so as to achieve the annual work plan

(2) To monitor the progress of the project activities

(3) To take daily administrative responsibilities of the Project

2. Composition

(1) Members

The committee will be composed of the chair and the members. The composition will be as follows;

(a) The Kenyan Side

Project Manager, Head of the Department of Primary Health Care Services (Chair)

Field Manager, Provincial Director of Public Health and Sanitation – Nyanza Province

Selected members of PHMT – Nyanza Province

District Medical Officers for Health of selected DHMTs

Other member(s) accepted by Chairperson, if necessary

(b) JICA Experts:

JICA long term experts (i.e. Chief Advisor, Coordinator and other experts)

JICA short term experts

Other member(s) accepted by Chairperson, if necessary

MINUTES OF MEETINGS
BETWEEN
JAPAN INTERNATIONAL COOPERATION AGENCY
AND
THE AUTHORITIES CONCERNED OF THE GOVERNMENT OF THE REPUBLIC OF KENYA
ON THE TECHNICAL COOPERATION PROJECT FOR
"STRENGTHENING MANAGEMENT FOR HEALTH IN NYANZA PROVINCE"

The Japan International Cooperation Agency (hereinafter referred to as "JICA") ,through its Chief Representative of JICA Kenya Office, exchanged 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, the Chief Representative of JICA Kenya Office and the Kenyan authorities concerned agreed upon the matters described in the document attached hereto. This document is related to the Record of Discussions on the above-mentioned Project.

Nairobi, 22nd April 2009

Mr. Yoshiyuki Takahashi
Chief Representative
Kenya Office
Japan International Cooperation Agency
JAPAN

Mr. Mark Bor, EBS
Permanent Secretary
Ministry of Public Health & San.
REPUBLIC OF KENYA

Countersigned:

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

Mr. Joseph Kinyua
Permanent Secretary
Ministry of Finance
REPUBLIC OF KENYA

THE ATTACHED DOCUMENT

1. PROJECT DESIGN MATRIX

The Project Design Matrix (hereinafter referred to as "PDM") was elaborated through discussions by JICA and the Kenyan authorities concerned. Both sides agreed to recognize PDM as the implementation tool for project management, and the basis of monitoring and evaluation of the Project. The PDM will be utilized by both sides throughout the implementation of the Project. The PDM is shown in Annex I.

The PDM will be subject to change within the framework of the Record of Discussions when necessity arises in the course of implementation of the Project by mutual consent.

2. PLAN OF OPERATION

The Plan of Operation (hereinafter referred to as "PO") has been formulated according to the Record of Discussions, on condition that the necessary budget will be allocated for the implementation of the Project by both sides. The schedule is subject to change within the scope of the Record of Discussions when necessity arises in the course of implementation of the Project. The PO is shown in Annex II.

ANNEX I PDM
ANNEX II PO

Project Design Matrix

Project Title: Strengthening Management for Health in Nyanza Province, Kenya)

Duration: 4 years

Version: 1.0

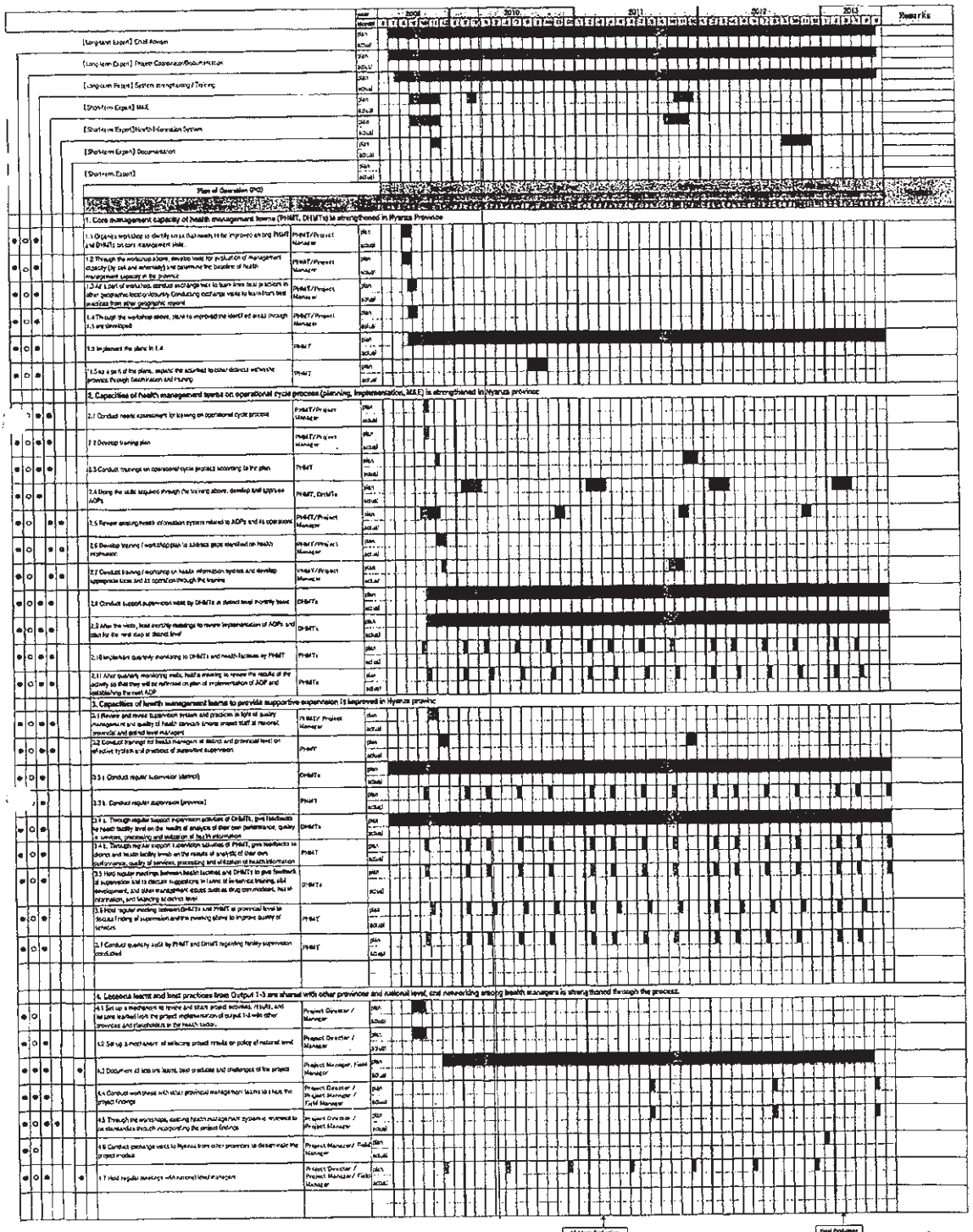
Target Group : Direct beneficiaries: Department of Primary Health Care Services (MoPHS), members of PHMT, DHMTs
Indirect beneficiaries: health staff working in health facilities, community people (estimated population of 5.2M)

Date: 22nd April 2009

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATIONS	IMPORTANT ASSUMPTIONS
OVERALL GOAL Quality of primary health care services is improved in Nyanza province	1. Customer satisfaction 2. Proportion of health workers using existing appropriate guidelines in their service delivery	Survey Report Supervision Report	1. There are no major tribal conflicts after the project 2. There are no major outbreaks of epidemic diseases in after the project 3. The supply of drugs and health commodities does not experience major interruption after the project 4. There are no major changes of the national policy and strategies in the health sector after the project
PROJECT PURPOSE			
Individual capacity of health managers and institutional capacity of health management teams (Provincial and district levels) are Improved in Nyanza Province	Following indicators evaluated by self and externally; 1. Qualitative and quantitative individual capacity of health managers evaluated by checklist 2. Qualitative and quantitative institutional capacity of health management teams evaluated by checklist1	Checklist Checklist	1. There are no major tribal conflicts that happen during the project period. 2. There are no major outbreaks of epidemic diseases in the project area 3. The supply of drugs and health commodities does not experience major interruptions 4. Changes of the national policy and strategies in health sector does not affect implementation of the project activities
OUTPUTS			
1 Core management capacity of health management teams (Provincial Health Management Team, PHMT and District Health Management Team DHMTs)is strengthened in Nyanza Province	1. Institutional capacity of health management team on core management evaluated by checklist 2. Health workers ' satisfaction	Checklist Survey Reports	Any major tribal conflicts do not happen during the project period. Any major outbreaks of epidemic diseases do not occur in the project area.
2 Capacities of health management teams on operational cycle process (planning, implementation, M&E) are strengthened in Nyanza Province	1. Annual Operational Plan (AOP) implementation rate 2. Reporting rate for routine health information and finance 3. Result of AOP evaluation reflected in the next AOP	AOP review report and AOP document Supervision report AOP document	Drugs and health commodities supply do not experience major interruptions
3 Capacities of health management teams to provide supportive supervision is improved in Nyanza Province	Proportion of facilities received standardised supervision	Supervision report	
4 Lessons learnt and good practices from output 1-3 are shared with other provinces and national level and networking among health managers is strengthened through the process	1. Number of workshop sharing project information 2. Number of documents and other ways of information materials to disseminate lessons learnt and best practices in the project 3. No of best practices / lessons influencing on decision making	Workshop reports Products of dissemination materials Policy document, Project evaluation report	
			1. The available personnel involved in the Project are retained 2. Positive collaboration with other partners and stakeholders is maintained

ACTIVITIES	INPUT		
	Japanese side	Kenyan side	
1. Core management capacity of health management teams (PHMT, DHMTs) is strengthened in Nyanza Province 1.1. Organise workshop to identify areas that needs to be improved among PHMT and DHMTs on core management skills 1.2. Through the workshop above, develop tools for evaluation of management capacity (by self and externally) and determine the baseline of health management capacity in the province by using the developed tools 1.3. As a part of workshop, conduct exchange visit to learn from good practices in other geographic region/ country. 1.4. Through the workshop above, develop plans to improved the identified areas through 1.1 1.5. Implement the plans in 1.4	JICA expert *Long term (Chief Advisor, System strengthening/ Training development, Coordinator/ Documentation) *Short term (M&E, Health Information System, Public Relations etc.) Counterpart training Equipment (vehicles, ICT equipment etc) Local activity cost (training, workshop etc.)	Counterpart staff (National, provincial and district levels) Office spaces and utilities Counterpart budget for operational cost Cost for support staff (drivers, secretary etc.)	Inputs for Project activities and secu timely delivered by both the Kenyan Japanese sides
2. Capacities of health management teams on operational cycle process (planning, implementation, M&E) is strengthened in Nyanza province 2.1 Conduct needs assessment for training on operational cycle process 2.2 Develop training plan 2.3 Conduct training on operational cycle process according to the plan 2.4 Using the skills acquired through the training above, develop and appraise Annual Operational Plans (AOPs) 2.5 Review existing health information system related to AOPs and its operations 2.6 Develop training / workshop plan to address gaps identified on health information system 2.7 Conduct training / workshop on health information system and develop appropriate tools and its operation through the training /workshop 2.8 Conduct support supervision visits by DHMTs at district level monthly basis 2.9 After the visits, hold monthly meetings to review implementation of AOPs and plan for the next step at district level 2.10 Implement quarterly monitoring to DHMTs and health facilities by PHMT 2.11 After quarterly monitoring visits, hold a meeting to review the results of the activity so that they will be reflected on plan of implementation of AOP and establishing the next AOP			
3. Capacities of health management teams to provide supportive supervision is improved in Nyanza province 3.1 Review and revise supervision system and practices in light of quality of management and health services through project among project staff at national, provincial and district level managers 3.2 Conduct trainings for health managers at district and provincial level on effective system and practices of supportive supervision 3.3 Conduct regular supervision 3.4 Give feedbacks to district and health facility levels on their performance, quality, processing and utilisation of health information through supervision visits 3.5 Hold regular meetings between health facilities and DHMTs to give feedback of supervision and to discuss suggestions in terms of in-service training, skill development, and other management issues such as drug commodities, health information, and financing at district level 3.6 Hold regular meeting between DHMTs and PHMT at provincial level to discuss finding of supervision and the meeting above to improve quality of services 3.7 Conduct quarterly quality audit by PHMT and DHMT regarding facility supervision conducted			
4. Lessons learnt and best practices from Output 1-3 are shared with other provinces and national level, and health management system networking is strengthened through the process. 4.1 Set up a mechanism to review and share project activities, results, and lessons learned from the project implementation of output 1-3 with other provinces and stakeholders in the health sector 4.2 Set up a mechanism of reflecting project results on policy at national level 4.3 Document all lessons learnt, best practices and challenges of the project 4.4 Conduct workshops with other provincial management teams to share the project findings 4.5 Through the workshops, existing health management system is reviewed to be standardize through incorporating the project findings 4.6 Conduct exchange visits to Nyanza from other provinces to disseminate the project models 4.7 Hold regular meetings with national level managers			**PRECONDITIONS** The security and safety measures in th project target areas are maintained to implementation of Project activities.

[1] Checklist will be developed through project workshop and baseline capacity will be assessed and the target will be set within the first 3 months.
[2] This includes basic comprehensive management skills such as leadership, human resource management, financial management, improvement of work place environment, team building, facilitation, coordination, information sharing and communication etc.
[3] A part of checklist for the project purpose will be used.
[4] Health care providers who are working health facilities within the province for DHMTs, and health care providers and DHMT members for PHMT
[5] The workshop is composed of 3 parts; in the first part, tools for capacity assessment are developed and capacity evaluation is conducted, in the second part exchange visit is conducted, and in the third part, tools and evaluation conducted in the first part are reviewed and work plan on core management skills is developed.


2009
2010
2011
2012
2013
Remarks
[Long-term Expert] Chief Advisor
[Long-term Expert] Project Coordinator/Documentation
[Long-term Expert] System strengthening/ Training
[Short-term Expert] M&E
[Short-term Expert]Health Information System
[Short-term Expert] Documentation
[Short-term Expert]
Plan of Operation (PO)
1. Core management capacity of health management teams (PHMT, DHMTs) is strengthened in Nyanza Province
1.1 Organize workshop to identify areas that need to be improved on the PHMT and DHMTs on core management skills.
1.2 Through the workshop above, develop tools for evaluation of management capacity (by self and externally) and determine the baseline of health management capacity in the province
1.3 a) Visit of workshop, seminar and study tour to learn from best practices in other provinces/ countries b) Conducting exchange visits to learn from best practices from other geographic regions
1.4 Through the workshop above, plans to improve the identified areas through 1.3 are developed
1.5 Implement the plans in 1.4
1.6 As a part of the plans, implement the acquired to other districts within the province through dissemination and training
2. Capacities of health management teams on operational cycle process (planning, implementation, M&E) is strengthened in Nyanza province
2.1 Conduct needs assessment for training on operational cycle process
2.2 Develop training plan
2.3 Conduct trainings on operational cycle process according to the plan
2.4 Using the skills acquired through the training above, develop and approve AOPs
2.5 Review existing health information systems related to AOPs and its operations
2.6 Develop training / workshop plan to address gaps identified on health information
2.7 Conduct training / workshop on health information systems and develop appropriate tools and its operation through the training
2.8 Conduct support supervision visits by DHMTs at district level monthly basis
2.9 After the visits, hold monthly meetings to review implementation of AOPs and plan for the next step at district level
2.10 Implement quarterly monitoring to DHMTs and health facilities by PHMT
2.11 After quarterly monitoring visits, hold a meeting to review the results of the activity so that they will be reflected on plan of implementation of AOP and establishing the next AOP
3. Capacities of health management teams to provide supportive supervision is improved in Nyanza province
3.1 Review and revise supervision system and practices in light of quality management and quality of health services (review project staff at regional, provincial and district level managers)
3.2 Conduct trainings for health managers at district and provincial level on effective system and practices of supportive supervision
3.3 a Conduct regular supervision (district)
3.3 b. Conduct regular supervision (province)
3.4 a. Through regular support supervision activities of DHMTs, give feedbacks to health facility level on the results of analysis of their own performance, quality of services, processing and utilization of health information
3.4 b. Through regular support supervision activities of PHMT, give feedbacks to district and health facility levels on the results of analysis of their own performance, quality of services, processing and utilization of health information
3.5 Hold regular meetings between health facilities and DHMTs to give feedback of supervision and to discuss suggestions in terms of in-service training, skill development, and other management issues such as drug commodities, health information, and budgeting at district level
3.6 Hold regular meeting between DHMTs and PHMT at provincial level to discuss findings of supervision and the meeting aiming to improve quality of services
3.7 Conduct quarterly audit by PHMT and DHMT regarding facility supervision conducted
4. Lessons learnt and best practices from Output 1-3 are shared with other provinces and national level, and networking among health managers is strengthened through the process.
4.1 Set up a mechanism to review and share project activities, results, and lessons learned from the project implementation of output 1-3 with other provinces and stakeholders in the health sector.
4.2 Set up a mechanism of reflecting project results on policy at national level
4.3 Document all lessons learnt, best practices and challenges of the project
4.4 Conduct workshops with other provincial management teams to share the project findings
4.5 Through the workshops, existing health management systems reviewed to be standardized through incorporating the project findings
4.6 Conduct exchange visits to Nyanza from other provinces to deepen/ scale the project models
4.7 Hold regular meetings with national level managers
Mid-term Evaluation
Final Evaluation