Partnership for Prevention and Treatment of Malaria (PPTM)

Malaria Communities Project

North Rift Valley - Kenya

Cooperative Agreement #GHN-A-00-09-00008-00

October 1, 2009 – September 30, 2012

YEAR TWO ANNUAL REPORT

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List of Acronyms:

ACT	Artemisinin Combination Therapy
ANC	Antenatal Care
APHIA*Plus*	AIDS, Population and Health Integrated Assistance Plus project
CACC	Constituency AIDS Coordinating Committee
CANA	Community Action Network of Africa
CBO	Community Based Organization
CCHANGE	Communication for Change
CHC	Community Health Committee
CHW	Community Health Worker
DHMT	District Health Management Team
DHRIO	District Health Records Information Officer
DOMC	Division of Malaria Control
HIS	Health Information System
IEC	Information/Education Communication
KeNAAM	Kenya National Alliance Against Malaria
LLITN	Long-Lasting Insecticide Treated Net
MCP	Malaria Communities Program
MOH	Ministry of Health
OCVAT	Organizational Capacity and Viability Assessment Tools
PMI	President's Malaria Initiative
PPTM	Partnership for the Prevention and Treatment of Malaria
RDT	Rapid Diagnostic Test
SBC	Social Behavior Change
SES	Socioeconomic Status
TOWA	Total War on AIDS Initiative
USAID	US Agency for International Development

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A. Main Accomplishments by Objective:

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

The Partnership for the Prevention and Treatment of Malaria (PPTM) takes a two-pronged approach to building the capacity of communities. The project partners with ten local community-based organizations who serve as behavior change agents in their communities. And the project supports the national community health strategy which includes trained units of community health workers (CHWs) coordinated by community health committees (CHCs). This project supports 21 community health strategy units in our project areas which are comprised of 1,050 CHWs and 21 CHCs.

Community Based Organizations (CBOs):
In Y2 of the PPTM project, efforts to support and build the capacity of CBOs have vamped up rapidly. Two partner CBOs were chosen in each of the five districts. In order to become a partner to HealthRight in this project, an organization must be registered with the Ministry of Social Affairs, have an active bank account, be operating in the project area and have experience implementing health activities. Organizations in the project areas tend to have very few sustainable resources and rely nearly exclusively on funding through the Constituency AIDS Coordinating Committees (CACCs) in Kenya's Total War on AIDS initiative (TOWA). Below are the partners that were selected during Year 1.

Table 1: Partner Community Based Organizations by District

District	Organization
West Pokot	Yang'at
	Sikom
North Pokot	Nalemit
	Muslim Youth Development
Central Pokot	Yes Plus
	Kamatong
Marakwet	Tumaini Support Group
	Sabon
Trans Nzoia	Community Action Network of Africa (CANA)
	Makutano Primary Health Care

In year 2, the project organized a baseline capacity assessment of each community organization. The tool chosen was derived from the Organizational Capacity and Viability Assessment Tool (OVCAT), developed for the Sustained Health Outcomes (SHOUT) Group and the Child Survival Technical Support Plus (CSTS+) Project by USAID and Macro. For our purposes of working with very small community-based organizations, the simplified OCVAT from the CORE Initiative was chosen. The tool measures organizational capacity in a number of areas including: leadership, governance, and strategy; finances; human resources; project design and management; technical capacity; networking and advocacy; and community ownership and accountability.

The OCVAT tool allows the staff of each organization to perform a self-assessment. Therefore, the scoring is subjective and can't be compared across organizations. However, it does allow each organization to identify strengths and weaknesses and to measure improvements in capacity over time.

Overall, the CBO staff felt that they had a basic level of capacity across most indicators. Seven out of ten CBOs scored an average overall score of a "3" or higher. The CBOs rated themselves highest in "Leadership, governance, and strategy" and "Networking and Advocacy" – important categories which will provide the cornerstone for their work in mobilizing communities for malaria prevention and control. However, most of the advocacy and networking experience is at a very grassroots community level. The lowest-scoring categories were "Human Resources" and "Technical Capacity" with the lowest indicator being "Budgets and cash flow planning" due to the inconsistency in funding opportunities. The indicator tying for lowest score was "Staff/Volunteer" which describes the proportion of paid staff to volunteers within the group.

Following the baseline assessment, the PPTM project staff provided two essential training sessions to the partners prior to accepting applications for sub-grants. First, Financial Management training covered the basics of developing budgets and documenting expenses. A refresher of this topic will be provided during the first month of project implementation to ensure that partners are following financial management guidelines. The PPTM staff also provided one half-day training on project development and proposal writing. This training complemented the release of the sub-grant Request for Applications (RFA). As a follow up, the HealthRight team worked closely with each partner to develop their work plans and submit their proposals for funding, a process that is new to many of the partners.

The PPTM team organized training for CBO staff on the Communication for Change (CCHANGE) methodology of social behavior change from the Academy for Educational Development (AED), a PMI partner in Kenya. The training aimed to build the technical capacity of CBO partners to affect positive behavior change in their communities. The three-day CCHANGE training offers a standardized framework in which health problems and their mitigating factors are analyzed and key messages developed. For the PPTM partners, the CCHANGE training was combined with basic malaria training and all CCHANGE activities were focused on improving knowledge and care-seeking behaviors specific to malaria.

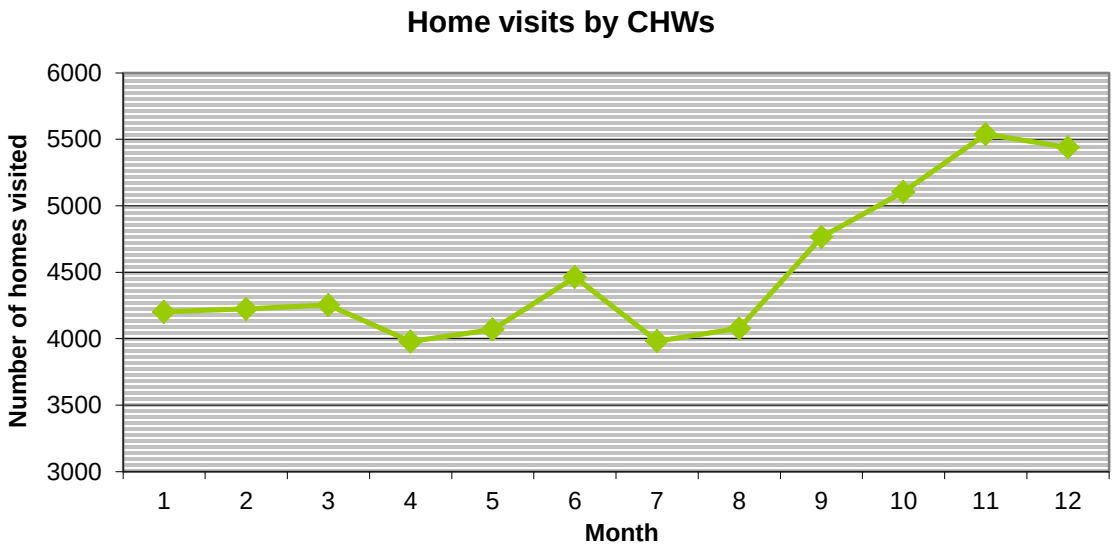
In Y2 Q4, the PPTM provided the first round of CBO sub-grants for malaria SBC projects. Most of the proposals submitted were for projects with a duration of 3-months and maximum budget of $2,000. The PPTM team followed a standardized process of review for all submissions using an approval checklist. The Community Mobilizers worked collaboratively with the CBOs to improve in their submissions and effectively address any issues raised during the review.

<u>Community Health Strategy Units</u>:
During Year 2, the PPTM continued to support the 21 units of CHWs and CHCs to provide household visits and deliver health messages while collecting community health information. The project supports the community strategy through non-financial incentives to CHWs, refreshments for monthly coordination meetings, provision of data collection tools, and ongoing capacity building through monthly refresher training sessions (on malaria as well as other key health topics). The capacity of each CHW unit varies largely depending on the involvement of other partners and projects in the districts. For example, in Year 1, CHW activities in Marakwet lagged behind other districts because there were no CHWs or CHCs existing in that district at the project outset. Therefore, the PPTM scale up of CHW

activities has been tailored to address the needs of each site and each district. However, by the end of Year 2, all units were functioning sufficiently to achieve the objectives of the PPTM.

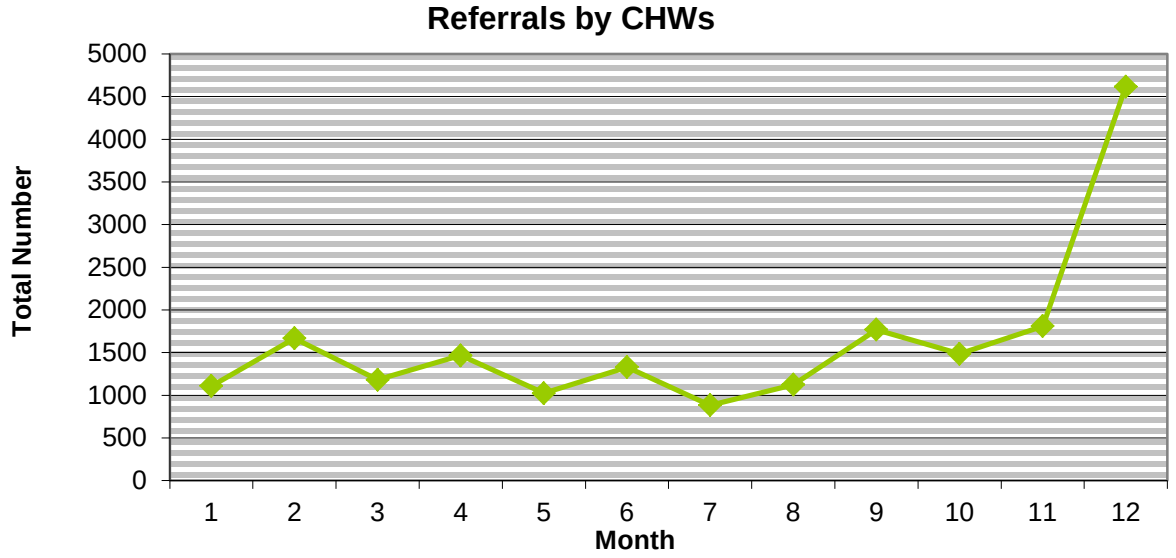
Because the Master CCHANGE Training was initially delayed last year by one quarter, the project staff was not able to deliver the 4-day training to all 21 units this year. However, all of those sessions will be completed by the end of November 2011. The highlight of this SBC training is the development of messages targeting the barriers to malaria prevention and treatment in the project areas. In the next year, messages will be further honed during the training to target each of the priority SBC groups including pregnant women, mothers of children <5, male partners and mothers-in-law.

This project's support to the community strategy has far-reaching effects. In the past year, the partner CHWs conducted 54,092 household visits, serving a total of 21,000 families. Each CHW is charged with visiting 20 households once in each quarter, or more frequently for households containing a pregnant woman, a newborn or a person with HIV/AIDS. Therefore, each month, the PPTM expects all CHWs to visit approximately 7,000 unduplicated households. The trend of household visits has been steadily increasing in the past year.



During visits, families routinely receive messages about malaria prevention and treatment, in addition to essential information about safe motherhood, HIV and hygiene. Also during visits, CHWs are encouraged to ask about LLITN ownership and use. (See **Objective 3**)

The PPTM project has been integral in the use of referral forms during CHW home visits. Throughout the year, HealthRight has provided copies of referral forms to CHWs each month and helps the CHEW to compile referral data monthly. The number of CHW referrals to the health facilities each month remains steady. However, the system of tracking referrals to the health facility has yet to be routinely implemented. HealthRight is working directly with the CHEWs and the DHRIOs to implement that referral tracking system that can be sustained beyond the life of the project.



Other Social Behavior Change Activities:
The PPTM also organizes campaigns to raise awareness about the prevention and treatment of malaria in the communities. These events were targeted this year to community meetings (called *barazas*), schools and churches. In total the HealthRight community Mobilizers organized 451 community events and reached a total of 62,485 people during year 2. In the past year, the project team have focused on honing the project messages to those most at-risk and to the most effective venues for reaching the community equitably.

In year 2, the PPTM efforts for objective one have yielded the following results:

	W Pokot	Marakwet	TZE	C Pokot	N Pokot	Total
Total number of referrals by CHWs	885	2,187	3,722	2,105	10,566	19,465
Number of Community events organized	45	44	71	20	90	270
Number of participants in events	13,681	7,207	8,806	7,120	25,671	62,485
Percentage of CHWs in monthly meeting	75.17%	62.90%	78.45%	76.58%	83.50%	75.32%
Percentage of CHC members in the monthly meeting	75.61%	81.92%	78.05%	86.93%	94.91%	83.48%
Number of home visits by CHWs	7,821	10,487	14,308	10,188	11,288	54,092

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

Training and Mentoring: Formal malaria case management training was provided to providers in all of the 21 health facilities in year 1 of the project. In Year 2, HealthRight focused efforts on regular mentoring to staff in the facilities. Based in the District Hospitals where the need is greatest, the Malaria

Managers work alongside facility staff several days each week to improve skills, answer questions and ensure that new policies are adhered to. The behavior change that the Malaria Managers promote is increased microscopy diagnosis, where possible, and appropriate treatment with ACT. Rural health centers and dispensaries are visited at least one day each month for these purposes. This year, the HealthRight Malaria Managers mentored an average of 23 providers each month.

Private Pharmacist Training: In the second quarter of this year, the PPTM began working to build the capacity of local private pharmacists or practitioners who dispense malaria medication. Many community members approach private dispensers for medication instead of seeking care or a diagnosis at a public health facility. HealthRight organized one 3-day Malaria Case Management training for these providers, many of whom were still following treatment guidelines that were many years outdated. The 17 participants learned about the appropriate diagnosis and treatment guidelines for uncomplicated and severe cases of malaria. The Malaria Managers conducted two post-training follow up visits to each participant in order to monitor for uptake of the new malaria treatment skills. Central Pokot was the only district that had no private pharmacists or providers. The training proved to be very popular and has resulted in requests for expansion and ongoing training. HealthRight will consider these requests if time and budget allow.

Support to DHMTs: In all of the project districts, the PPTM project supported the DHMT team to conduct quarterly facilitated supervision at the 21 targeted sites. HealthRight provides transport and travel expenses during the field visits. By policy in Kenya, the supervision visits are organized for the full DHMT team in order to be comprehensive; however, due to scheduling constraints with DHMT members, the trips are generally conducted by a partial team.

During the second quarter, all DHMTs worked to compile their Annual Operations Plans (AOP) for 2011. These multi-day sessions were supported through USAID's APHIA Plus project and reported to the Provincial and National levels. HealthRight's PPTM supported the compilation of activities at the local level to ensure that the activities of all local partners are accounted for and included into the plan for this fiscal year. These AOPs work to decrease duplication of efforts and improve cost efficiency of programming at the district level.

In Q1, the HealthRight Malaria Manager assisted the DHMT in North Pokot to write and submit a proposal to the Constituency AIDS Coordinating Committee (CACC), a national Kenya funding mechanism, to receive funding that will enable them to implement HIV/AIDS prevention activities in communities.

Health Systems Strengthening:

- Improved diagnostics: This year, the PPTM donated electronic microscopes to five health facilities, one in each district of operation. These microscopes are very useful in the facilities because of their ability to function with or without electricity. To date, 20/21 facilities report having functioning microscopes in the facility. However, many of these microscopes are non-electric models that are less than ideal. Therefore, in the coming year the project aims to replace some of the older microscopes with electric devices that can be used when the light is low.

  Through year 2, the PPTM continued to struggle in the establishment of a sustainable quality control system for microscopy diagnosis. In Marakwet, the District Laboratory Technologist conducts

monthly trips to the field to check a portion of the malaria diagnoses and HealthRight supports these trips with transport or meals.

- Improved data collection and use: The Malaria Managers work closely with district health information officers to monitor data collection and to provide mentoring, when necessary. All 21 of the PPTM-supported facilities are submitting their monthly data reports on time and accurately. Health data is reported and discussed during monthly district health meetings which are supported by APHIA Plus program and include representatives from all health facilities, the DHMTs and HealthRight.

- Improved inventory management and drug supply: The national supply chain system in Kenya can be slow and unreliable. However, the project supports quarterly supervision for all DHMTs and assists health facility staff to monitor supplies of ACT and LLITNs at the facility and district levels. When stock-outs are imminent, the project and the DHMT members assist health facility staff to locate surpluses elsewhere in the district and to submit orders to the national supplier. In the past three months, only facilities in Trans Nzoia districts have documented any stock-outs of ACT as they have been awaiting an order from the national level for nearly 3 months. All other districts have had ample supplies of first line medications.

- Improved quality assurance systems: The PPTM continued to support the Quality Assurance Committees in facilities where they exist. Support from the project includes attendance at and refreshments or supplies for monthly meetings, assistance with data review and documentation of areas of concern.

- Epidemic-Preparedness: The project dedicates efforts to improving the preparedness for and response to epidemics largely through the other health systems strengthening activities notably data management and use and monitoring of drug supplies. The team works collaboratively with the DHMTs to implement the national protocols for epidemic preparedness.

Below are indicators for objective two for Y2:

	W Pokot	Marakwet	TZE	C Pokot	N Pokot	Total
Total # of malaria tests	16,993	7,804	28,263	11,719	21,036	85,815
Total # of malaria cases confirmed by microscopy	2,402	1,038	12,259	3,193	6,765	25,657
Total # of malaria cases confirmed for children <5yrs	1,024	1,500	4,043	1,297	3,833	11,697
Total # of pts treated for malaria with ACT	27,709	12,824	36,144	23,295	24,749	124,721
Total # of children <5yrs treated for malaria with ACT	11,133	4,828	12,364	9,465	13,555	51,345

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

Distribution of LLITNs:
HealthRight works with PSI on the distribution of LLITNs in the project areas. To date, PSI has established an agreement with the project to oversee distribution in all districts except Trans Nzoia East, where they have little difficulty carrying out this activity independently. Therefore, the project distributes to all 91 facilities in the three Pokot districts and in Marakwet district, all of which are geographically isolated and have higher security issues than Trans Nzoia East.

In Q1, HealthRight facilitated the distribution of 12,200 LLITNs throughout the project areas. However, the distribution for Q2 had been delayed in preparation for a mass distribution. This delay resulted in stock-outs in many of the facilities while LLITNs were taken directly to the communities. HealthRight worked to minimize the effects of the stock outs by re-distributing the nets from sites of low volume to those of higher volume. In Q4, HealthRight distributed an additional 29,260 LLITNs to all facilities in North Pokot, Central Pokot, West Pokot and Marakwet.

Monitoring of LLITNs:
CHWs in the project areas routinely monitor net ownership and usage. During every household visit, the CHW inquires about the number of LLITNs present in the household and about who slept under them the night before. This data was tracked by the project in Y2 and will continue. CHWs may verify the presence of the net and assist with any issues the family has encountered in using or hanging it. Although LLITN ownership and use is not monitored monthly by the DHMTs, the HealthRight project staff use this information to document change over time.

In Y2, the CHWs conducted over 54,000 household visits. Of those families visited, 65% reported owning at least one LLITN. When asked, 27% of the families reported that on the previous night the LLITN was used by a pregnant woman and 70% reported that it was used by a child under five years. (Not every household has members within the targeted groups and some households have multiple children under 5. The project is working to provide percentages for these indicators in Year 3.)

Below are indicators for objective 3 for year 2:

	W Pokot	Marakwet	TZE	C Pokot	N Pokot	Total
Number of home visits by CHWs	7,821	10,487	14,308	10,188	11,288	54,092
Number of ITNs distributed to households from the facility	5,361	3,323	1,141	4,294	4,086	18,205
Households with at least one LLITN (of those visited)	5,525	3,381	10,074	6,894	9,085	34,959
Pregnant women sleeping under LLITNs last night (from households visited)	1,585	2,046	4,253	1,516	5,056	14,456
Children under 5 under LLITN last night (from households visited)	8,022	1,921	7,996	9,351	10,677	37,967

Table 2: Project Year 2 Accomplishments[1]

Project objectives	Indicators (current result)	Key Activities (from Y2 work plan)	Status of Activities (including outputs)	Comments
Build the capacity of community, local organizations and Community Health Workers to promote sustainable prevention and care seeking behavior.	10 partner CBOs trained in malaria basics; 189 CHC members trained on malaria	Organize malaria training to all partner CBOs and community health committees	Completed	Malaria basics combined with CCHANGE training and delivered after distribution of sub-grants
	1,050 CHWs trained on malaria prevention and treatment basics	Organize training of CHWs to make appropriate and effective referrals for malaria diagnosis and treatment; and correct usage of LLITNs	Completed	Training messages are reintroduced on a regular basis during monthly coordination meetings
	10 CBOs trained on CCHANGE SBC methodology;	Organize social behavior change training for all local partners including NGOs, CHCs and CHWs.	Partially completed. Training done for CBOs, training for CHWs and CHCs in Y3 Q1.	4 day training done by HealthRight Malaria Managers who were trained as master trainers by AED; Completion delayed by 1 qtr.
	Malaria messages developed for each context during CCHANGE training	Work with the CHCs and all community partners on the development of the key malaria messages for community campaign (during SBC training) using or adapting national MOH IEC materials as appropriate.	Partially completed. Completed with CBOs, message development with CHWs and CHCs to happen in Y3 Q1.	Messages need to be honed for each target group including pregnant women, male partners, and mothers of children <5
	54,092 household visits were conducted in Year 2 (numbers duplicative);	CHWs to monitor household net distribution and correct usage.	Ongoing	Goal to reach 7,000 households each quarter

[1] Other routine monitoring data is provided in the ME section of this report.

	21,000 total households visited			
	2 trainings organized for 30 partner CBO staff. Topics: financial management and project development/ proposal writing	Conduct organizational training for local CBO partners based on capacity gaps identified through a needs assessment.	Ongoing	Potential training topics for Y3 include M&E and Advocacy. Final assessment will be done to measure improvements in capacity.
	10 Sub-Grants distributed in September (activity not included in previous matrix but planned)		Completed for Y2, new sub grants provided in Y3.	Each partner CBO received approx. $1600 to organize malaria campaigns and projects
Build the capacity of 21 target health facilities and five DHMTs in Marakwet, Trans Nzoia East, and North, Central and West Pokot districts to deliver appropriate prevention, diagnosis, and treatment services.	An average of 23 providers (unduplicated) received mentoring each month from project staff (This indicator has changed since the last annual report.)	HealthRight malaria managers provide on-going mentorship of trained health staff and promote malaria confirmatory testing and appropriate treatment	Ongoing	
	5/21 facilities (in Marakwet) receive quality checking of malaria slides for accuracy on a regular basis	HealthRight Malaria Managers work with the DHMTs and health facility staff to provide quality checking of microscopy diagnoses.	Ongoing	Quality checks done monthly in Marakwet by District Lab Tech, SOPs routinely checked in Central Pokot by the QA Committee, system not yet established in other districts
	90 days of stock outs of ACT in 4/21 facilities in Trans Nzoia East this year	HealthRight Malaria Managers work with DHMT and health facilities to monitor malaria medications to ensure constant stocks of ACT	Ongoing	MOH pharmacists in all five districts mentored to calculate burn rates and monitor ACT stocks; PPTM assists with redistribution of ACT when necessary

	100% of epidemic-prone (4/4) districts implementing the MOH epidemic preparedness policy	HealthRight Malaria Manager assists districts in the development and implementation of an official malaria epidemic protocol	Ongoing	The Malaria managers work directly with DHMTs to facilitate the implementation of the epidemic protocols
	21/21 facilities reviewing data on a regular (monthly and weekly) basis according to MOH protocols	HealthRight Malaria Managers in epidemic-prone districts work with records information officers to implement the malaria epidemic protocol and appropriate data collecting and reporting	Ongoing	Began in Y1; Q4 Malaria Managers work with DHRIOs to collect and monitor malaria data in accordance with MOH policy. (See data collection and use in narrative.)
	HealthRight represented at all KeNAAM meetings; PPTM activities included in the annual operations plans in all districts	HealthRight Project Director will coordinate MCP activities at the local, provincial and national levels	Ongoing	
Improve the system of mosquito net distribution in the five districts to decrease malaria transmission, particularly for pregnant women and children under 5 years of age.	41,460 LLITNs received in four districts during Y2.	HealthRight works with PSI to receive an adequate supply of LLITNs for the five districts	Ongoing	PSI organized a mass distribution of LLITNs which delayed the provision of LLITNs to the facilities.
	41,460 LLITNs distributed to 90 facilities in 4 districts.	Assist in transport and logistics of distribution of nets to local health facilities	Ongoing	Good progress.
	16,935 LLITNs distributed to households from the facilities	Monitor distribution of LLITNs to community members, particularly pregnant women and children under 1 year of age, through health facilities, community health workers and other outlets.	Ongoing	

B. Constraints to Progress:

LLITN Supply Chain: Due to the mass distribution of LLITNs this year, distribution to the district health facilities was delayed resulting in stock outs. Although this was a problem for the PPTM project, it is anticipated that households received adequate LLITNs through the mass distribution despite stock outs at the facilities.

Availability of Laboratory Services: Many of the target facilities are constrained by how many malaria tests can be done by microscopy because laboratory services are not available 24 hours a day or seven days a week. Therefore, when mothers or children arrive at night or during the weekend for malaria testing, they are diagnosed clinically and treated accordingly. This is a big challenge to the PPTM and one which the team is committed to addressing with the health facilities and the DHMTs by increasing testing availability either through microscopy or RDTs.

Fuel Shortages: In the past year, the project's districts experienced fuel shortages, leading to stoppages in activities and in transport of staff. This has also led to large increases in the cost of fuel, which has affected the HealthRight budget and prompted the submission to USAID of a budget revision in October 2011.

Insecurity: For brief periods in the past year, the project areas experienced increased fighting between tribes in Turkana and in Central Pokot. The cause of the increased hostilities is likely to be a secondary effect of the drought which has been plaguing Northern Kenya and stressing communities in arid areas. Due to the insecurity, the PPTM stopped activities planned for those communities for several weeks but by the end quarter three, activities had resumed.

C. Program Changes/Adjustments:

Malaria Safe Community: HealthRight has secured cost-share funding to procure and provide RDTs to one district where they can be used to intensify the projects efforts and impact. With project partners, the PPTM staff will select one community and, using RDTs, attempt to appropriately diagnose and treat all cases of malaria over a pilot period of four months. The pilot goal is to establish a ***Malaria Safe Community*** through a coordinated effort of intensely marketing LLITN use, employing RDTs for diagnosis of all fevers, and treating confirmed malaria cases with ACT. The RDTs will be used by trained health facility staff during community outreach clinics so that patients can be diagnosed properly in the field. To maximize efficiency, CHWs will notify the community about the outreach clinic in advance and will assist in identifying fevers in all households during the clinic days. If resources are sufficient, the team will monitor trends in malaria and fever prevalence in the community through additional clinical outreach days.

HealthRight staff will collaborate with the District Malaria Coordinator on selection of the community and development of the pilot protocol. The pilot initiative will raise awareness among health facility staff about the percentage of fevers in their districts that can be attributed to malaria. Results of the pilot project will be shared with KeNAAM members, the DOMC, local DHMTs and the USAID Mission for consideration in policy making. This pilot project was not included in the initial work plan but has been discussed with the PMI Focal Person.

Revised Budget: Due to extraordinary delays from the vendor and the Kenya Customs Authority, HealthRight decided against purchasing a project vehicle, which had been included in the original

approved budget. The PPTM benefits from several vehicles procured through USAID funds from previous project budgets. Therefore, the budget has been revised to reallocate those vehicle funds to other useful expense categories. This revised budget was sent to PMI MCP office for review and approval with the 2012 work plan.

D. Monitoring and Evaluation Activities:

Regular Project Monitoring:

- At the community level: The project supports the collection of health information by CHWs through the national Community Health Information System (C-HIS). The project ensures that data collection tools are adapted, well understood, and available and that the data is collected and compiled monthly by the CHW supervisor. In addition, HealthRight added several vital LLITN monitoring indicators to the CHW reports to monitor net ownership and usage during household visits. Below are the indicators that the PPTM collects from the CHWs regularly. The indicators in **bold** are those that the project will begin to collect in Year 3.

  - # of referrals by CHWs for malaria testing and treatment
  - % of CHWs in monthly meeting.
  - % of CHCs in the monthly meeting
  - # of home visits by CHWs
  - # of ITNs distributed
  - Households visited with at least one LLITN
  - # of pregnant women sleeping under LLITNs last night
  - **% of pregnant women sleeping under LLITN last night**
  - # of children under 5 sleeping under LLITN last night
  - **% of children under 5 sleeping under LLITN last night**

- At the facility level: HealthRight works with the records officers at each partner facility and with the DHRIO to monitor malaria data in the project's target districts. When needed, the project supports data collection and reporting by providing registers and tools to the facilities and transporting monthly data reports when necessary to the district level. HealthRight also independently collects several indicators that monitor the strength of the health systems that the project supports. The list of indicators that the project tracks at the facility level includes:

  - # of malaria tests (by microscope or RDT)
  - # of malaria confirmed cases
  - # of patients treated for malaria with ACT
  - # of facilities receiving a facilitative supervision visit from DHMT this month
  - % of DHMTs that completed their annual action plan
  - # of days of stock outs of ACT drug reported at the health facility
  - # of lab technologists trained in microscope diagnosis of malaria
  - # of targeted facilities with functioning microscopes

- Project SBC Activities: HealthRight's Community Mobilizers are responsible for conducting regular awareness raising activities geared toward promoting healthy behavior change. These

activities including community events, school talks, market days, church meetings, road shows and mass media campaigns. The project collects and tracks the number of events organized and participants on a monthly basis.

- CBO monitoring: Each CBO partner submits quarterly and final reports to the PPTM team. These reports include a table of achievements that tracks the number of people reached by the CBO activities each quarter. Other indicators may also be collected that are relevant to the CBO project.

Measuring Capacity:

- Malaria competency tools: the PPTM team has chosen to use the Malaria Competency Tool from the Constellation Project to measure changes in attitudes about key malaria messages among community partners. In Year 2, the tool was adapted to include only relevant messages in the project area, eliminating messages about IPTp and presumptive treatment for children under five years. The PPTM team will start using the tool in Y3 Q1 by using it during the CHW monthly meeting and reading them aloud to compensate for low literacy. A follow up survey will be conducted at the end of the project period. Because this information was not collected at the baseline, the change in attitudes will reflect the impact of year 3 activities only.

- OCVAT baseline assessments: As mentioned in Objective 1, the PPTM project is using the OCVAT tools to measure organizational capacity. A baseline assessment was conducted in Y2. A final assessment will be conducted in Y3.

Measuring Equity by Socio-Economic Status (SES):
HealthRight International's projects focus on marginalized populations around the world. Our definition of marginalized does not merely comprise the economically marginalized but includes populations who are unable to access a variety of services for a variety of reasons. In this way, the organization begins to address global and national inequities by focusing on those most in need. In Kenya, the communities in which HealthRight works are poorer than their national counterparts because they are much less likely to own a vehicle or mobile phone, to use a protected water source or to have a home with a cement floor. However, they are much more likely to own agricultural land or livestock.

At the same time, it isn't enough for projects to target marginalized areas since every community engenders its own inequalities. The PPTM project staff is committed to ensuring an equitable impact of the project's efforts on the most vulnerable within our project area in Kenya. Therefore, in the baseline KPC survey conducted in Y1, the PPTM introduced 30 socio-economic indicators taken from the Kenya Demographic and Health Survey (DHS) tool in order to understand how families of different socio-economic status (SES) varied in fever prevalence, malaria knowledge and care-seeking practices. Survey respondents were divided into quintiles based on an index of household assets as a proxy indicator of SES. In Year 2, with assistance from a graduate student, the project analyzed the baseline malaria indicators across the five quintiles of SES within the project districts to highlight any inequities in knowledge, access to services, or care-seeking behaviors. This information will be used to guide programming in Year 3.

Equity was measured using Chi-Square analysis to measure the significance of differences between each of the wealth quintiles. The analysis showed some interesting statistically significant results. First, though knowledge of malaria symptoms is generally high in these communities with 93% of all

respondents naming at least one symptom, this knowledge is not equal across SES quintiles. The poorest families were less likely to name at least one symptom of malaria compared to their wealthy counterparts. (89% vs. 97%) Similarly, only 65% of the poorest families identified LLITNs as a means of preventing malaria compared to 81% of the richest families.

In addition, despite mass and targeted distributions of free LLITNs in Kenya, net ownership is still influenced strongly by SES. In our project areas, only 63% of the families in the poorest quintile owned at least one LLITN compared to 82% of the families in the highest SES quintile. LLITN usage for children <5 did not differ by SES quintile.

The analysis showed no inequality in the distribution of fevers in the targeted communities, with poor and wealthy families equally affected. An estimated 70% of all families experienced fever in the past two weeks.

Surprisingly, care seeking behaviors did not seem to be influenced by SES. There were no significant differences between the poorest and richest quintiles in terms of seeking care for fever within 24 hours of fever onset (65% did), or receiving ACT for malaria treatment (18%). And care seeking for fever was very high among all groups (90%) though it rarely occurred on the first day of fever (24%).

A full report of the equity analysis has been shared with MCHIP for additional review.

E. Technical Assistance:

The PMI and MCHIP teams provided some necessary technical support to HealthRight's MCP project in Kenya this year. Those activities included:

- The organization and financing of a regional technical workshop on two topics: Malaria in Pregnancy and Community Case Management. Two of the PPTM project staff attended the work shop and carried the essential messages to the team in Kenya.
- The MCP team from Washington organized a field visit to the PPTM team in Kenya. The field visit generated several useful suggestions for the team to consider in the remaining 18 months of implementation. In addition, a follow up visit from the PMI Nairobi staff served to foster closer working relationships between the field and the Mission and also led to the development of the Malaria Safe Community concept.
- The PPTM partnered with AED, supported by USAID, to provide training on the Communication for Change model of SBC to the Malaria Managers. With this new expertise, the staff rolled out the CCHANGE training to all partner community-based organizations. Training for CHW partners continues in the next quarter.

In the coming year, HealthRight will receive technical assistance from MCHIP on the development of the research protocol and data review for the Malaria Safe Community initiative using RDTs to measure malaria prevalence among fever in one community.

F. Work Plan Clarifications: (N/A)

G. PMI Team Collaboration:

In September 2011, the PMI Team at the Kenya mission visited the North Rift project this year to offer guidance on priority Y3 initiatives. In addition, the PMI team organizes and attends regular meetings between HealthRight and the DOMC. IN the next year, the Kenya PMI team will assist in the roll out of

the Malaria Safe Community Initiative. In addition, they will be needed to provide linkages between the HealthRight program and potential USAID program resources and partners at the national level, including Walter Reed for microscopy training and quality assurance.

A. Other Relevant Aspects: (N/A)

B. Publications: (N/A)

C. MCP Stories:

PPTM Case Study in Kacheliba, North Pokot

Agnes Nzuki has been the HealthRight Malaria Manager for North Pokot in the town of Kacheliba for 2 years. When the PPTM project began, Agnes reported that the Kacheliba District Hospital was providing malaria medication to anyone who had a fever. There was no adequate testing or diagnosis of malaria. She said that at times there would be up to 300 patients receiving treatment while only 50 were confirmed with malaria. Agnes identified this as not only poor medical practice, but also as a waste of resources. Agnes then set to work with the clinical team in Kacheliba, assisting them in adapting their own practices to achieve a higher level of care. Agnes' initial approach was to mentor clinicians one-on-one, though she quickly saw that this was not cultivating hospital-wide changes. Instead, she adapted her approach and began working with the team as a group, unifying them in a joint effort to reform their approach to testing and treating malaria.

Now, the hospital is becoming a shining example of success. The lab technician makes regular announcements to the waiting area that all patients with fever should come for a malaria test first, so they will have their results in hand by the time they see the doctor. In addition to improving clinical practices, HealthRight donated a new microscope with which to diagnose malaria. This comprehensive approach will one day result in a district fully enabled to provide high quality and efficient malaria care to the people who need it most.

Laboratory in PPTM supported health facility
(*Photo courtesy of Jen Olson)*

Microscope Donation from PPTM
(*Photo courtesy of Dianna Kane)*

A CBO Model Case Study: Wei Wei Yes Plus Support Group

HealthRight International is partnering with ten local community-based organizations (CBOs) to make a difference in the fight against malaria. One such partner CBO is the group "Wei Wei Yes Plus," a HIV-positive support group in Central Pokot.

Lilian is the founder and chairlady of Yes Plus. In 1996, Lilian tested positive for HIV. Lilian was a single mother of four and she knew that she must stay alive to care for her children. Lilian speaks of this as a very difficult time, and as she got stronger, she felt empathy for others who were going through the same thing. "I knew I wasn't alone," she says, "because I am from this community and I got this disease from the community, so I knew there had to be others like me suffering."

At one point, Lilian became so outraged by the negative reaction of the community against HIV that she got her pastor to let her formally address the church members one Sunday. Then, one by one, Lilian convinced her friends to go for testing. Each time a friend learned of their HIV-positive status, they joined Lilian in reaching out to others to do the same. Slowly, they organized themselves. When they became five members, they formally registered as "Wei Wei Yes Plus" self-help group. Lilian explains that "Yes" stands for acceptance and "Plus" represents the symbol "+" associated with being HIV-positive. Now, the group is 18 members strong.

HealthRight International recognizes the extraordinary potential of such groups and has committed to incorporating them into community mobilization strategies to encourage healthy behavior change. HealthRight's project has provided Yes Plus with training on malaria, social behavior change methodologies, financial management and project development. And, in September, Yes Plus received their first sub-grant through the project. Now, Yes Plus will have an opportunity to extend their reach to include malaria messaging and behavior change communication. In the year to come, HealthRight will provide ongoing capacity building support and technical assistance to the group in order to strengthen the organization and improve long-term sustainability.

Wei Wei Yes Plus Support Group – Central Pokot
(*Photo Courtesy of Dianna Kane)*

K. MCP Photos: (Attached separately)