3. PROGRAM INTERVENTIONS – BEST PRACTICES PROMISING INTERVENTIONS

3.1. Cross cutting practices and technical support

Strategic Information (Monitoring and Evaluation) - Best Practice

Effective monitoring and evaluation (M&E) practices are a critical foundation to the successful implementation of any program. The absence of a common operational M&E framework in most countries has impeded efforts to increase the capacity for quality assurance, national oversight and adequate use of M&E for policy adaptation. As a result of the lack of capacity, data is often of poor quality or simply non-existent. This constrains the effective monitoring of performance and the formulation of evidence-based policies. Kenya is no exception to this challenge. It is generally recognized that the Ministry of Health information system needs strengthening and its staff capacity improved. More specifically, Western Province has long been recognized nationally for its poor performance in M&E initiatives as a result of weak information management systems, lack of personnel and inadequate staff.

At the start of the APHIA II project, the province had a reporting rate of 56.8%. By the end of the project, a total of 149 organizations had benefited from strategic information technical assistance and 525 individuals had been trained in strategic information. The province's reporting rate had increased to over 80%, an impressive performance that has been recognized at the national level. The initiative has resulted in stronger health management information systems (HMIS) and better data quality with better structure and communication between the different parties involved. The districts are starting to make use of their data and as a result are taking interest in and responsibility for the data quality. The M&E team is now supporting the province to support an agenda for data for decision-making.

The current HMIS is headed by the Provincial Health Records and Information Officer (PHRIO) and operates on three levels, each of which faces its own challenges. Health workers manually record facility data before data clerks collate and computerize it for submission to the district health information team (DHIT). The DHIT gathers and collates information from the facilities, submits data to the national database via file transfer protocol (FTP) and prepares district summary reports. This team is also

Magnet theatre

responsible for ensuring data quality at the facility level through regular data quality assurance (DQA) activities. The provincial health information team (PHIT) is responsible for all health management information in the province. This team plays a management and supervisory role in the health information system.

Data quality in the facilities is compromised by the lack of data personnel and the general heavy workload of facility staff. The district teams struggle with untimely reporting from the facilities and lack the skills and resources to carry out sufficient DQA auditing. The provincial team is limited in its role of ensuring data quality since it only receives summarized reports from the districts. The team carries out limited monitoring of Area Operation Plans (AOPs) and lacks materials, including data tools, to distribute to facilities for recording data. The fact that facilities, district and provincial teams make limited use of the health information data gathered means that there is little incentive or motivation to ensure quality data collection and reporting.

The strategic information technical assistance by APHIA II was an initiative that aimed to support and develop a health reporting system that enables individuals, facilities, and community groups to assess their progress towards goals set out in their work plans. Through capacity building support and intensive training and mentoring the M&E team worked to streamline data collection and reporting efforts to develop a more efficient and robust monitoring and evaluation system in Western Province. They built upon existing structures and systems in accordance with the "Three Ones" principle . This helped to avoid double counting and duplication of efforts and placing additional strain on an already overstretched system.

The five-member M&E team provided support in data collection, collation, analysis and reporting to all levels

of the province's health records information system operations. They improved data collection processes by facilitating the roll-out of data collection tools and registers to the facilities and training health workers, community health workers (CHWs) and data clerks. They also carried out capacity-building activities with CBOs in record keeping and the use of COBPAR, the community-based program activity reporting that has been rolled out by the Constituency AIDS Control Committee. The DHITs were supported to carry out data quality audits and supervise facility staff. The efficiency and timeliness of facility and district reporting was improved by providing the DHIOs with computers and internet access that allowed them to submit reports electronically to the provincial team. The M&E team supported the improvement of management and supervision functions by facilitating quarterly meetings between DHIOs and facility in-charges and between the provincial team and the DHIOs. They also facilitated meetings between HMIS, District AIDS and STI Coordinating Office (DASCO), public health (PH) & RH provincial teams to review and discuss provincial information collection and management issues.

As a result of their primary focus on supporting the Ministry of Health, the M&E team has not been able to give enough support to the community reporting systems that would ensure an equal level of monitoring across all three results areas. The good working relationship and strong partnership between the provincial health records information teams and the APHIA II Western M&E team has been the foundation to the success of this activity. The underlying principle has been one of partnership and support. The team have worked hard to appreciate the challenges faced by their partners and have provided them with support where possible and necessary.

Public Private Partnerships - Best Practice

There is a growing recognition of the need to integrate private health care providers into service provision in order to meet the goals of HIV/AIDS prevention, care and treatment programs and other integrated services including RH/FP, TB and malaria. Integrating private health providers into health programs contributes to their sustainability. Developing their capacity to deliver health services strengthens the private sector's contribution to the scale-up of proven, cost-effective interventions and creates cost sharing opportunities.

There are 251 private facilities which account for 58.1% of the all health facilities in the province. It is estimated that these facilities are servicing between 25-40% of the individuals seeking health care services in the province. These facilities have been poorly integrated into the overall strategic approach and monitoring and support structures of both the Ministry of Public Health and Sanitation (MOPHS) and the Ministry of Medical Services (MOMS).

Private facility personnel weren't routinely included in continuing medical education (CME) training offered through the Ministries of Health. Nor were they accessing the free commodities available for immunization, family planning or ART services to the levels that they should. Referral practices between public and private facilities were inconsistent and there was a tendency for the public facilities to discriminate against patients referred to them from the private sector.

Inadequate monitoring and supervision practices hindered the public sector ability to monitor the quality of services provided and the numbers treated through the private sector. Broadreach Healthcare took the lead technical role in strengthening public and private partnerships in Western Province. Activities started in March 2008 across the entire province. Specific objectives were to build private facilities' capacity to provide quality health care services, to improve the working partnership between the public and private sectors and to improve referral processes between the two sectors. A total of 492 health workers were trained in a variety of technical areas, in 17 trainings. A total of 100 care providers, from the NGO, FBO and private sectors were supported through the initiative.

	HOSPITALS		NURSING HOMES	HEALTH CENTRES		DISPENSARIES		CLINICS	
DISTRICT	NGO/MISS	PRIVATE	NURSING HOMES	NGO/MISS	PRIVATE/ COMM	NGO/ MISS	PRIVATE/ COMM	CLINICS	TOTAL
Bungoma	2	1	4	4	0	3	3	5	22
Busia	1	0	3	1	0	3	0	2	10
Butere/ Mumias	2	0	5	0	0	4	7	37	55
Kakamega	1	0	10	3	0	5	3	62	84
Lugari	0	0	1	0	0	3	4	0	8
Mt. Elgon	0	0	0	2	0	1	0	0	3
Teso	0	0	1	3	0	1	0	3	8
Vihiga	4	0	3	3	0	0	0	51	61
Western	**10**	**1**	**27**	**16**	**0**	**20**	**17**	**160**	**251**

8. A set of three principles agreed upon at ICASA 2003 to improve the quality of national HIV/AIDS responses – one HIV/AIDS Action Framework; one National AIDS Coordinating Authority; and one agreed country level Monitoring and Evaluation system.

Western Province health facilities by district, type and running agency (2005)

PPP Contribution to Service Delivery

INDICATOR	TOTAL ACHIEVEMENT	PPP CONTRIBUTION		PERCENTAGE	
		PRIVATE	FBOs	TOTAL	
PMTCT service outlets	307	58 (19%)	42 (14%)	100	33%
Pregnant women provided with PMTCT services	39,334	3,569 (9%)	3,495 (9%)	7,064	18%
Pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	1,442	76 (5%)	122 (8%)	198	13%
Infants accessing DBS for EID	1,233	75 (6%)	85 (7%)	160	13%
C&T service outlets	280	61 (22%)	37 (13%)	98	34%
World Cup RRI	89,962		9,244 (10.3%)	9,244	10.3%
Clients Counseled and Tested	148,900	14,243 (9.6%)	18,085 (12%)	32,328	22%
Deliveries	12,820	547 (4.3%)	1,462 (11.4%)	547	15.7%
Maternal Deaths	36	0	4 (11%)	1,462	11%
Neonatal Deaths	171	3 (1.7%)	13 (7.6%)	16	9.3%
Service outlets providing treatment for TB to HIV-infected individuals	276	13 (5%)	27 (10%)	40	15%
HIV-infected clients attending HIV care/ treatment services that are receiving treatment for TB	1,297	64 (5%)	803 (6%)	867	11%

Activities focused on building private care provider capacity and strengthening the relationship between private care providers and the Ministry of Health. An initial assessment identified all private health care facilities and the challenges they faced. Based on these findings, trainings using Ministry of Health materials and curricula were carried out in Integrated Management of Adult and Adolescent Illnesses (IMAAI), pediatric ART, commodity management, provider initiated testing and counseling (PITC), PMTCT, integration of TB/HIV treatment, business management and infection prevention. Other capacity building activities included providing support mentorship and on the job training (OJT) for personnel in facilities that were introducing new services.

Strengthening the relationship between the private sector and the Ministry of Health centered on the involvement of the private providers in quarterly District Health Management Team (DHMT) meetings held to review all health service provision in a district. The aim was to strengthen relationships between the two sectors and recognize the private sector providers as partners in achieving health service goals in the district. The meetings gave private providers a forum through which they could work with the DHMTs to deal with challenges they faced and ensure their routine inclusion in government sponsored CME trainings.

They also enabled the DHMT to review issues affecting the quality of private sector services, with an emphasis on licensing, registration and general regulatory requirements.

Referral processes have been strengthened by ensuring that standard Ministry of Health referral procedures were followed correctly and that private facilities referred their clients on to higher levels of care when necessary. Reporting skills and systems were developed and strengthened to ensure that data on private sector care provision was included in the Ministry of Health information management systems.

By the end of the project, private care providers were operating 33% of the province's PMTCT outlets and serving 18% of pregnant women on PMTCT, treating 13% of pregnant women on ART prophylaxis in the PMTCT setting, carrying out 13% of early infant diagnosis (EID) through dry blood spot testing (DBS) and managing 15.7% of facility deliveries. They operated 35% of the province's counseling and testing sites and counseled and tested 22% of those tested. They operated 15% of sites providing treatment for TB to HIV-infected individuals and were treating 11% of those receiving these services. Regular stakeholder meetings have been a key factor in contributing to the successful integration of private service providers