MEASURE Evaluation PIMA NEWSLETTER

September 2016

From the Chief of Party

In the past four years, MEASURE Evaluation PIMA (MEval-PIMA), funded by the United States Agency for International Development (USAID), has been committed—in collaboration with other public and private partners and stakeholders—to support the Government of Kenya to build and strengthen monitoring and evaluation (M&E) systems in key programs within the Ministry of Health at national and county levels.

An important aspect of MEval-PIMA's support is promoting learning, by sharing lessons gained in the process of program implementation. In this issue, we highlight two learning opportunities, in which both MEval-PIMA staff and county staff were able to share information on the development of systems that help improve the use of data for decision making.

The first opportunity was presentation of a poster—"Missed Opportunity for Intermittent Preventive Treatment for Malaria in Pregnancy (IPTp)"—at the 3rd Monitoring & Evaluation Best Practice Conference, held in Nairobi, in June. The second was presentation of another poster—"Capturing Data on Orphans and Vulnerable Children: Kenya's Electronic System Captures, Tracks, and Reports Longitudinal Data (OLMIS)"—at the 21st International AIDS Conference, held in Durban, South Africa, in July. Another key resource we have included in this issue, on page 10, is a reprint of a poster that advocates prevention of maternal and neonatal deaths, through implementation of maternal and perinatal death surveillance and response (MPDSR) from the community to the national level.

Besides sharing knowledge and experiences, this issue highlights some practical ways to improve access to care by HIV patients, through the use of HIV referral directories developed in eight counties. This issue also describes how registration of births and deaths is improving, through training that builds the capacity of chiefs and assistant chiefs to do this work in communities. We also offer digital links to resources that stakeholders can use to implement similar activities in counties not covered by MEval-PIMA.

As we move into the final year of the project, we will continue to share information and case studies on the lessons we have learned in implementing project activities. We invite readers to stay up to date on our activities and products, by visiting http://www.measureevalution.org / pima and by engaging in discussions on the PIMA Community of Practice website: https:// knowledge-gateway.org/pima.

Abdinasir Amin
Chief of Party
MEASURE Evaluation PIMA

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All photos by Yvonne Otieno, MEval-PIMA

Improving Mortality and Morbidity Data in the Community

National mortality and morbidity statistics are critical for establishing national health program priorities, planning, and policy, and for informing allocation of health resources. These key statistics are recorded and coded at the hospital and community levels. A vital statistics system, adopted by the Kenya Statistical Commission in 1999, stresses continuous, comprehensive, and universal vital statistics registration as a crucial data source. The system provides standard concepts, definitions, coding schemes, classifications, and a tabulation plan for national adoption.

According to a study carried out in 2000, 60 percent of births and 70 percent of deaths in Kenya occur at home rather than in health facilities. The Kenya Civil Registration Services (CRS) carries out registration of home events through national government administrative officers. In this structure, assistant chiefs at the local level do the actual registration, supervised by the local chiefs. Thus, local assistant chiefs have an important role in building awareness of a need for the community's help in identifying unregistered births and deaths so the CRS can capture these events in its databases.

To increase the registration of vital statistics, the CRS system includes community-based civil registration, also under the supervision of the assistant chiefs. This system is a means for parents, relatives, or any person with information on births or deaths outside

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Improving Mortality and Morbidity Data in the Community continued

a hospital to report these events. For lay reporting of vital statistics to be reliable, chiefs and assistant chiefs need to understand the principles of "verbal autopsy," so they can help community members record causes of death.

Verbal autopsy is a method of interviewing caretakers or next of kin about illness or symptoms of illness experienced by the deceased, in order to determine the most probable cause of death. Verbal autopsy can provide a near-specific cause of death if the event occurs outside a health facility or among populations lacking health facilities and medical certification. These determinations will be in line with the international rules and guidelines set out in the International Classification of Diseases diagnostic tool (ICD-10).

MEval-PIMA strengthens the generation and use of good-quality data by key governmental and nongovernmental organizations in Kenya. In partnership with the CRS, MEval-PIMA has trained 231 assistant chiefs and 89 chiefs from Kakamega County and 155 assistant chiefs and 56 chiefs from Kisumu County on birth and death registration. The training was conducted using birth and death registration principles, and included drama and role-playing for participant practice.

During the training in Kakamega County, Kangethe Thuku, the Kakamega County Commissioner, encouraged the chiefs in attendance to apply the lessons they had learned, stating that the information was important, both for county and national planning.

"These statistics are very important in planning and allocation of resources in Kakamega, and you as chiefs have a very

Kangethe Thuku, Kakamega County Commissioner, addressing participants during the training.

Anne Mijide Kibigo, a training facilitator, watches as three assistant chiefs, Rashid Kweyu, Joseph Opiyo, and Fridah Odera, role-play a scene in which a couple have come to the subcounty chief's office to report the death of a relative.

Chiefs at the training in Kakamega

important role to play in ensuring that the data at the community level are captured accurately and submitted in good time," he said.

"This training is very useful to us, since we have one of the highest stillbirth and mortality rates in the country."

—Kangethe Thuku

The training is meant to improve data quality, increase birth and death registration coverage, and improve accuracy in ascertaining the causes of death at the community level. The assistant chiefs were also trained on the guidelines for birth reporting, which are needed to address such challenges as factors affecting children born to single mothers and other special groups.

The training's goal is to prepare the chiefs to record accurately births and deaths at the community level. Kakamega County also hopes to use short message service (SMS) technology to share information on deaths and births.

For more information on MEval-PIMA's support for CRS, please see:

http://www.measureevaluation.org/resources/publications/fs-14-112

Capturing Data on Orphans and Vulnerable Children: OLMIS Poster

During the International AIDS Conference, in July 2016, MEASURE Evaluation PIMA (MEval-PIMA) presented a poster titled "Capturing Data on Orphans and Vulnerable Children." It highlights MEval-PIMA's support of organizations funded by the U.S. Government (USG) in setting up a longitudinal management information system for orphans and vulnerable children (OLMIS). Joel Kuria, MEval-PIMA's technical advisor for OLMIS monitoring and evaluation, conducted the presentation.

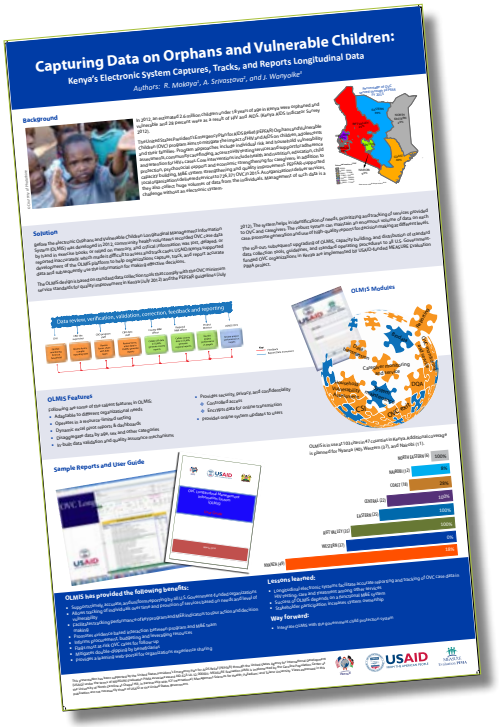
The poster highlights one of the challenges faced by many organizations that manage OVC programs in Kenya: the use of paper-based methods to track services. A paper system makes it more difficult to handle large volumes of data that show a range of services provided over time.

Programs serving orphans and vulnerable children (OVC) are meant to mitigate the impact of HIV and AIDS on children, adolescents, and their families. The programs typically involve several organizations that assess needs and provide multiple services. Data are crucial for planning and decision making and to ensure that OVC programs support the most vulnerable households. In the past, OVC case data were collected by community health volunteers, who often relied on memory and who manually recorded the data in paper notebooks. This process resulted in the loss of critical information and delayed or inaccurate reports, which made it difficult to provide targeted services and to assess the performance of programs.

To address this challenge, MEval-PIMA, funded by USAID and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), supported the rollout in Kenya of an electronic OLMIS. This system helps USG-funded OVC programs to capture, report, and track accurate data and, subsequently, to use the data for decision making.

The system also helps to identify the needs of vulnerable children and their families or caregivers and to prioritize and track services provided to them. The system maintains large databases on each child, thus promoting the generation and use of high-quality reports for decision making for OVC programming.

As part of its mandate, MEval-PIMA has supported data management practices through capacity building of staff in USG-funded OVC organizations; through upgrading digital systems; and by distributing standard data collection tools, guidelines, and operating procedures.



To date, 97 sites in 29 Kenyan counties have been supported to use the OLMIS system for decision making.

Click here for more information on the poster.

Missed Opportunity for Intermittent Preventive Treatment for Malaria in Pregnancy

What follows is the abstract for a talk given at the 3rd Monitoring & Evaluation Best Practice Conference, sponsored by the National AIDS & STI Control Programme, held June 13–15, in Nairobi.

Authors: Lilyana Dayo, Kisumu County Department of Health; Dr. George Wadegu and Dr. Agneta Mbithi, MEASURE Evaluation PIMA; Dr. Augustine Ngindu, Maternal and Child Survival Program, funded by USAID; and Dr. Dickens Onyango, Kisumu County Department of Health

To view Ms. Dayo's PowerPoint presentation, click here.

Background

Kisumu County is a malaria-endemic region, with current prevalence estimated at 27 percent. Pregnant women are among the most vulnerable population groups. In Kenya, antenatal care represents an opportunity to provide preventive malaria treatment to pregnant women. However, only about 58 percent of women attend at least four antenatal care visits and, as a result, the proportion of women with the recommended minimum two doses of intermittent preventive treatment in pregnancy (IPTp) has remained low, at 17 percent.

The World Health Organization (WHO) recommends use of IPTp with sulphadoxine/pyrimethamine (SP), to reduce the risks associated with malaria in pregnancy. Doses are recommended at four-week intervals, during skilled antenatal care in malaria-endemic zones. This preventive treatment target has not been achieved in Kisumu County, and the gap between antenatal care visits and IPTp doses represents a missed opportunity for prevention.

Methods

Data for IPTp are routinely reported in the health information system software known as DHIS 2. The county health management team (CHMT) conducted an analysis of at least four antenatal care visits and, as a result, the proportion of women with the recommended minimum two doses of intermittent preventive treatment in pregnancy (IPTp) has remained low, at 17 percent.

Results

In 2014, almost 60 percent of pregnant women received the second dose of IPTp. In 2015, there was a steady decline and, as of April 2015, only 24 percent of women received the second dose. By June 2015, uptake of the second dose was below 20 percent. During the same period, however, antenatal care visits in the county remained above 80 percent.

Following a data review meeting, the county implemented the following interventions to address the declining IPTp levels: procurement of SP that was out of stock in most facilities, mentoring health workers on the administration and documentation of IPTp, and deploying community health workers to sensitize the community on the significance of IPTp. Currently, health facilities are reporting increased IPTp uptake— above 50 percent.

Conclusion and Recommendation

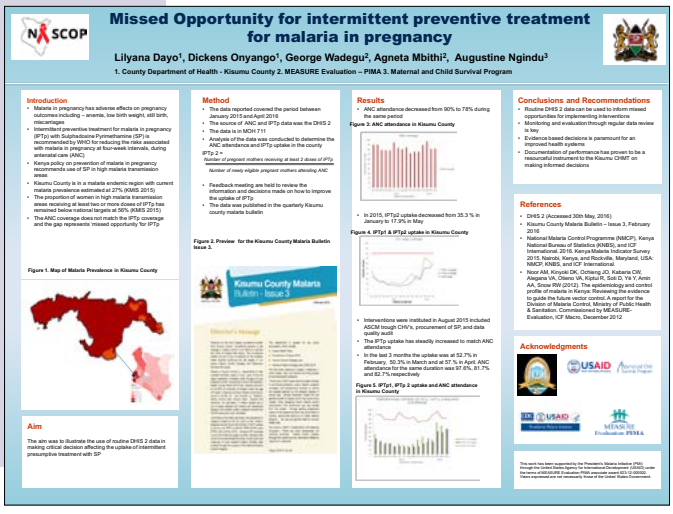
The effort by Kisumu County to examine their data and draw conclusions from it to address a health issue shows that evidence-informed decisions are paramount in designing interventions that will improve health services. Monitoring and evaluation and data use have proven to be useful instruments for the Kisumu CHMT, helping the team to make more precisely targeted decisions regarding routine program implementation.

Learning from and Sharing Kisumu County's Experiences in the Use of Routine Data for Decision Making

The 3rd Monitoring and Evaluation Best Practice Conference, held in Nairobi in June this year, was an opportunity for stakeholders to share and learn and to strengthen their use of data for evidence-informed program planning and implementation. Kisumu County's malaria coordinator, Lilyana Dayo, presented a poster at the conference titled "Missed Opportunity for Intermittent Preventive Treatment for Malaria in Pregnancy (IPTp)."

The poster illustrated the significance of using routine data from the district health information system (DHIS 2) to make critical decisions that affect the uptake of preventive treatment of malaria in pregnancy using sulphadoxine/pyrimethamine (SP). Data from DHIS 2 show that IPTp coverage is low, despite a high rate of antenatal care in the county. This gap represents a missed opportunity to increase IPTp coverage, because mothers can receive IPTp during antenatal care visits.

MEval-PIMA worked with Ms. Dayo to develop the concept and produce the poster. This activity is in line with MEval-PIMA's key capacity building and knowledge



management objectives, which are to improve the monitoring and evaluation (M&E) capacity of the programs of the Kenya Ministry of Health in order to identify and respond to information needs at national and subnational levels, and to use this information for health policy and services.

A situation analysis showed that low awareness among pregnant women and stockouts of SP at health facilities were the main causes of the coverage gap. To address these challenges, the county used community health volunteers for social mobilization and advocacy to build public awareness of the importance of taking SP during pregnancy and how to access the treatment. The county also procured supplemental stocks of SP to augment the national distribution. Post-intervention results showed an increase in the number of women receiving the second dose (IPTp2) at antenatal care clinics, from a low of 17.9 percent in May 2015, to a high of 57 percent a year later, in April 2016.

Among the lessons the county learned from this experience were the importance of using routine DHIS 2 data to inform implementation of malaria interventions; the importance of regular data reviews for M&E of implementation; the importance of using evidence to make decisions on improving health; and that the documentation of performance through the Malaria Surveillance Bulletin is a useful resource for decision making by the Kisumu County health management team.

For more information on MEval-PIMA's support of Kenya's malaria program, click here.

To view the poster, click here.

Joint Planning and Stakeholder Coordination to Improve Community Health Data Reporting: The Case of Siaya County

The 2010 *Kenya: Community Strategy Evaluation* reports that a community's health status can be substantially improved without the investment of a large amount of money, if priority-setting, planning, and action are based on the evidence of the county's disease burden. Functional community health information systems (CHIS) are the primary source for the evidence of disease burden and make an important contribution to improving the provision of basic healthcare services to communities.

These systems have the capacity to measure and evaluate critical elements of care at the community level, such as antenatal care, newborn care, nutrition, breastfeeding, delivery by trained midwives, and family planning. They should produce good-quality information for decision making by all health stakeholders.

The 2010 evaluation found that for such systems to be successful, the stakeholders must be involved in designing and implementing them. MEval-PIMA is mandated to support CHIS in five target counties: Siaya, Migori, Kisumu, Homa Bay, and Nairobi. Our work there has two objectives: enhance community reporting through improved availability and quality of community data and promote the use of data for decision making. To achieve those goals, we help target counties to fortify their CHIS, so that communities can prioritize their specific health needs and provide good-quality data to the county level and beyond.

In February, community focal persons in the five counties, with the support of MEval-PIMA, conducted a rapid assessment of the status of their CHIS, to help determine areas of need.

The findings identified gaps in the types of health data reporting tools used at subcounty levels. These findings were shared with county-level stakeholders. Some of the gaps identified were lack of knowledge among community health assistants, community focal persons, and health records and information officers at subcounty levels regarding revised reporting tools from the Ministry of Health (MOH); lack of standardization in reporting tools, which led to simultaneous use of both old and new tools; and an insufficient number of tools at the county level. These challenges affected the quality of the health data reported in the district health information system software platform (known as DHIS 2) and the quality of the data within DHIS 2.

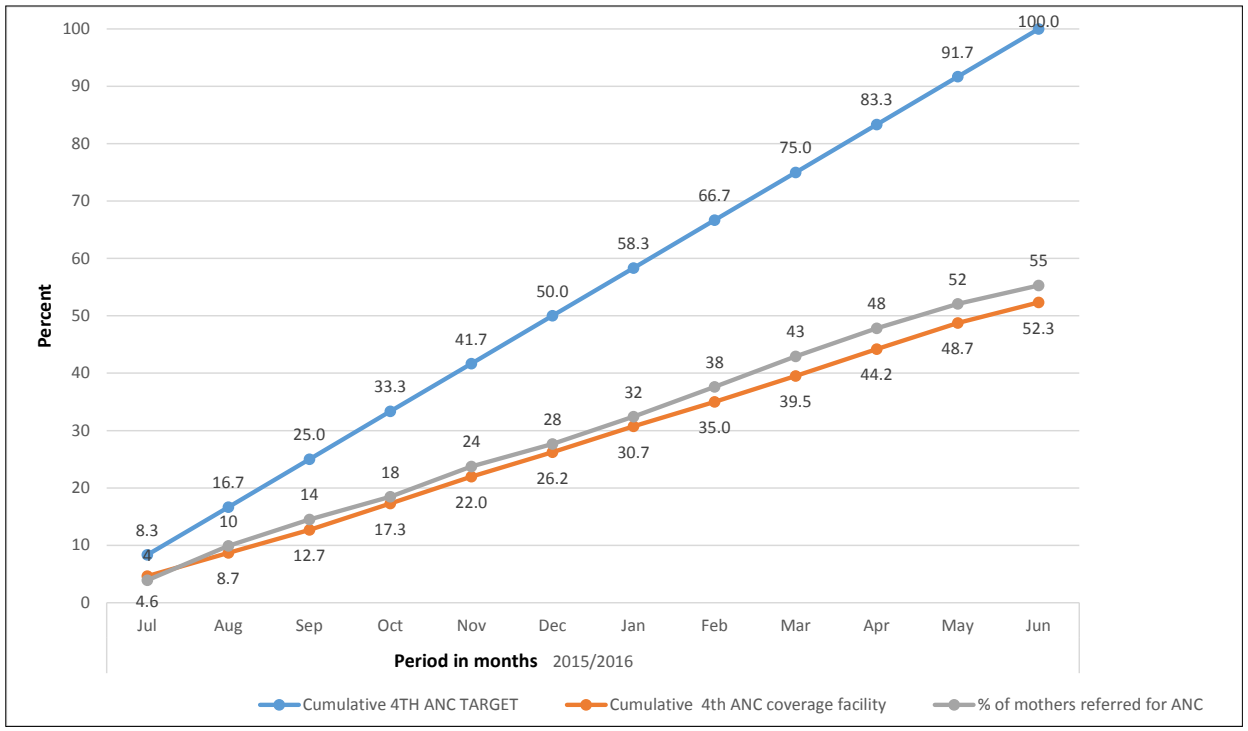
During the stakeholder forums, participants developed strategies and action plans to address the gaps. This was done jointly among implementing partners and county health officials, to ensure coordination of interventions and alignment with the needs of county departments of health. The strategies identified included ensuring timely reporting, improving data quality, and holding data review meetings.

The joint planning also resulted in commitment to implementing an action plan, including support from other implementing nongovernmental organization partners, such as APHIA*plus* (AIDS, Population and Health Integrated Assistance), which printed additional revised tools, and Plan International Kenya, which designed and revised the meeting "chalkboard"—a mobile display used to present community health indicators at meetings. (The chalkboard also is referred to as MOH 516). The MOH's Division of Health Informatics, Monitoring and Evaluation (DHIME) was also involved, to assist in coordination with the community health services unit that oversees DHIS 2.

Siaya County, with the support of MEval-PIMA, took the following steps to address some of these challenges:

- Provision of technical support for joint planning and follow-up implementation of action plans developed during the stakeholder forum

Figure 1: Comparison between 4th ANC attendance at facility and CHV referral for ANC



Percentage of women in Siaya County attending four ANC visits and percentage of referrals for ANC by community health volunteers. Source: DHIS 2

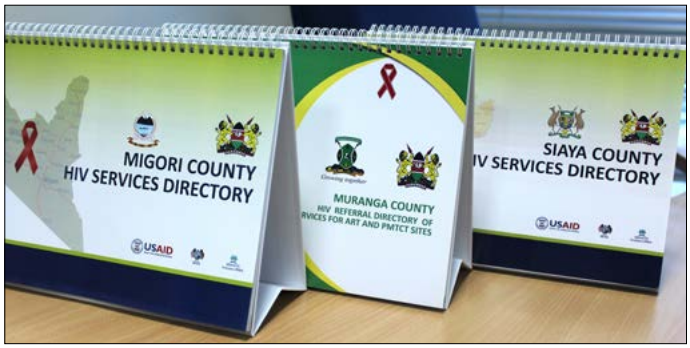
- Orientation of community health workers on revised tools
- Facilitation of a workshop to harmonize a list of facilities in the community—known as the Master Community Unit Listing— with DHIS 2 data, to ensure proper linkages between the parent facility and community units
- Facilitation of a data review meeting, to examine the performance of community indicators
- Facilitation of a follow-up regional forum for stakeholders from the national and county levels, as a way of coordinating implementation of action plans developed during the county-level stakeholder forum

Following implementation of the above interventions in Siaya County, there has been notable improvement in community health information reporting rates in DHIS 2, using both the old and revised MOH reporting tools, with almost all subcounties currently using the revised tool. There is sustained advocacy by the county to ensure transition from the old tools to the new ones.

The Siaya County community health team has also examined such community performance indicators as the number of defaulters referred for additional ANC, the percentage of mothers referred for initial ANC visits, and the total number of children referred for immunization. The county has triangulated community- and facility-level data, to demonstrate improved performance.

The graph (see above) shows the community level of effort on ANC referral (one of the performance indicators) to increase the percentage of women who received a fourth antenatal care exam. The county achieved a rate of 52 percent of pregnant women receiving fourth antenatal care visit. The community health volunteers had a cumulative referral rate of 55 percent. This analysis helped to show the volunteers how their efforts contribute to the performance of overall health indicators.

The county attributes the improved performance shown in the graph to the joint planning meeting, which helped ensure a smooth transition from old to new tools as well as encourage improved reporting rates. The successful transition in Siaya County can be replicated by other counties that aim to improve community reporting.



Migori, Muranga, and Siaya HIV service directories

Using Directories to Link HIV Clients to Care and Treatment

People's health often depends on care for multiple health issues, which usually involves multiple providers and different areas of specialty. The coordination of care among several providers is called a referral system.

A well-functioning referral system contributes to rational use of health services, improved continuity of care for patients, cost-effectiveness in healthcare provision, improved access and equity in access to care, and improved health outcomes.

The *Kenya Health Sector Referral Strategy 2014-2018 (Ministry of Health, 2014)* lists some of the challenges in the country's referral system: lack of standard tools to communicate and document referrals, poor coordination and linkages within and between facilities, noncompliance with referrals, weak referral monitoring systems, and inadequate referral infrastructure and financing.

The strategy recognizes that a strong referral system needs to communicate referrals and capture referral data using the following standard tools: referral forms, referral registers, data collection and update forms, patient tracking forms, feedback forms, and a directory of services. Development of these directories is part of MEval-PIMA's support of referral systems strengthening. A 2013 baseline assessment on the state of the health referral system in Kenya that was conducted in eight counties revealed that there were no such directories in these counties.[1]

A directory of services is an inventory of the services available within a referral network. It aims to ease communication between service providers, offer useful information for referral processes, and help ensure compliance when patients are referred to a facility.

MEval-PIMA supports Kenya's Ministry of Health in strengthening the referral system to ensure that patients receive high-quality care that is accessible, equitable, affordable, and responsive to their needs.

[1] MEASURE Evaluation PIMA. "The State of the Health Referral System in Kenya: Results from a Baseline Study on the Functionality of the Health Referral System in Eight Counties, October 2013."

As part of this effort, and in collaboration with other implementing partners, MEval-PIMA has supported the development of HIV referral directories in 10 target counties. Six of these directories have been published, three are under development, and data collection is under way for one. Kilifi, Kakamega, Siaya, Migori, Muranga, and Homa Bay counties currently have directories; in Machakos, Nakuru, and Kisumu counties, directories are pending approval by the ministry. Data collection is ongoing in Nairobi. Partners involved in the development of the directories are the Centre for Health Solutions (CHS)-Kenya and AIDS, Population and Health Integrated Assistance (APHIAplus) Kamili, among others.

Muranga County was among the first counties to develop the HIV referral directory. The process of developing the directory in Muranga County involved the following steps:

- Development of a template
- Meeting with the county health management team to ensure buy-in
- A planning meeting with the county health management team and a local stakeholder
- Collection of data
- A validation meeting
- Production and dissemination

Below are portions of interviews with some of the users of the directories.

David Kinyanjui, subcounty AIDS and STI coordinator (sub-CASCO) in Muranga and Kigumo subcounties

David Kinyanjui:

"The role of a CASCO is to coordinate HIV services at the county level. The services include HIV testing and counselling services (HTC), prevention of mother-to-child transmission (PMTCT), care and treatment, and managing commodity aspects. We oversee HIV services to ensure that the staff and the clinicians are offering quality services and managing clients with the current recommendation from the National AIDS & STI Control Programme and that clients are enrolled in comprehensive care and counselling (CCC). We have shared the directory on our WhatsApp group so all CASCOs can access it.

Portions of interviews continued

"The HIV services involve three steps: identify, link, and enroll. Our end goal is to have our HIV-positive clients achieve viral suppression. Once a client is identified as HIV-positive, the most important thing is to link the client to care. The point at which a client is tested doesn't have to be the same place where he or she is enrolled for treatment. In Muranga County, we have antiretroviral therapy (ART) sites that have 28 CCC clinics and 153 PMTCT clinics. The difference between the two is that in the CCC clinic, you can be enrolled with minimal referrals. PMTCT clinics are in Level 2 facilities and dispensaries and there are only a handful of mothers seeking treatment. There is a lot of referral from the PMTCT-only sites to care and treatment sites (ART sites). The referral can be from a care and treatment site to a PMTCT site, or to a PMTCT site that has tuberculosis services. This referral could be in the same facility or to a different facility.

"Many counties realized that we were testing many people and identifying those who were HIV-positive, but that we were unable to account for them. Clients who test positive should be entered in a linkage register for accountability. We refer to the directory to get the contacts if a client wants to be linked to care in a different facility. A linkage is considered successful only after someone goes where they were linked and makes at least one visit. The counsellor is supposed to connect with the clients in the transfer facility to confirm that the client visited the facility.

"Lack of contacts of different facilities posed a great challenge in completing the above linkage process. For follow-up on transfers, counsellors would often call the CASCO, who would then try to get the contacts of a facility. A lot of follow-up cases would get lost in the process, because it took time and was uncoordinated. The directory has eased this problem, because it has a list of all CCC clinics in Muranga with the official contact details, the services offered daily, and the basic HIV guidelines. As a CASCO, I feel that the tool helps the 28 CCC clinics to communicate directly with other referral points, and this helps in better patient management."

Mercy Maina, an HIV treatment and care provider at Makuyu Health Centre

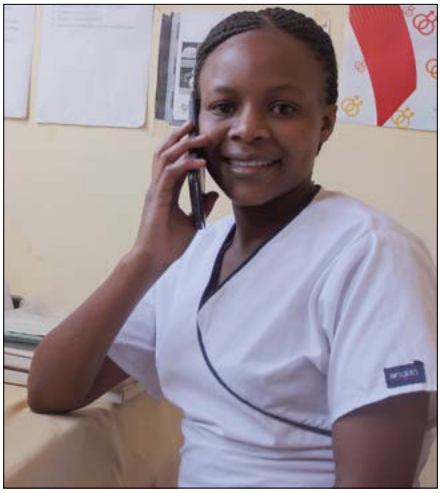
Mercy Maina:

"My work involves testing and referring clients to HIV treatment and care, based on their needs. If they prefer to go to another facility, then we use the directory to identify the facility they prefer, and then refer them there. The directory is useful, because we follow up if the client visited the facility. Before we had the directory, it was difficult, but now we can refer [to other facilities]."

Nancy Thiongo, nursing officer in-charge, Kiria-ini Missions Hospital, with Susan Kinyua, from MEASURE Evaluation PIMA, Muranga County

Nancy Thiongo:

"The directory is helpful for transfers, as it helps one know the medication and type of client management we can undertake. When you don't have the correct information when a client is referred, the client will not be well managed. Proper client management requires proper investigation. This is often done when the CCC clinics can connect and consult."



Jacinta Muya, a nurse responsible for PMTCT at Kiria-ini Missions Hospital, Muranga County

Jacinta Muya:

"There are different kinds of referrals—some from maternity to PMTCT, support groups, mentor mothers, PMTCT to CCC, and the HTC counsellor direct to CCC. Last week, there was a mother who came to us and didn't mention that she is HIV-positive. She didn't disclose her status and didn't have any drugs. For her and her baby to stay for three days without drugs means that they are not adhering. And yet, there are drugs you can give that prevent the child from being infected and the mother from getting an opportunistic infection. Newborns need drugs after three days. Since all mothers delivering in the facility are tested, we got to learn about her status and counselled her. Through this, we got information on where she receives care, and then used the directory

to get more information from the facility, which gave us detailed information. When we meet similar clients who are unwilling to provide information for fear of stigma, we follow up directly with the last facility and get some information as to why they aren't adhering. This follow-up on the drugs taken and the range of drugs given is very helpful. Without the directories, it would have been difficult to get the patient's history in time and proper care would have been delayed."

Nancy Macharia:

Nancy Macharia, HIV testing and counseling, Kiria-ini Missions Hospital, Muranga County

"The worst challenge we faced before we had the HIV directory was follow-up of clients. Sometimes we would get clients who have been referred and when we would ask what drugs they were taking, some would claim that they weren't given any drugs. In such cases, we would identify (from the patients' cards), the last facility visited, take the directory, and call the referring facility for clarity. Previously we would have to call personal contacts and sometimes the contacts were unavailable or had been transferred. Sometimes it would take an hour to get the correct person at the facility. With the directory, we have the official phone numbers of the facility and this hastens the referral process.

"It also helps in promoting appropriate use of medicine, because we can call the facility and confirm the batch number and expiry date of the drugs that the patient was given. This helps to ensure appropriate use of medicine and also reduces waste. It has also helped in saving time and costs, because you do not have to spend airtime making several calls before you get the correct contact. For now, my only wish is that the neighboring counties could also have a directory, because sometimes we get clients from the neighboring county and we experience the same challenge of trying to identify a facility we could refer them to easily.

"Before, we would use Post-it notes and printed-out A4 sheets for contacts of facilities. Now we have directories."

Christine Kararu, a clinical officer at Makuyu Health Centre comprehensive care clinic

Christine Kararu:

"My work entails care and treatment and involves client consultation, history taking, and management of patient prescriptions, and screening for any opportunistic infections or sexually-transmitted infections and managing them. It also involves follow-up on clinical presentations, lab work, and any issues with CD4 T lymphocytes [CD4 cells]; linking patients with community and peer educators; and adherence counselling and taking medications.

"The HIV directory is important, as it helps to trace, refer, and link. The tracing and follow-up are important, because, without the correct information on a client, you are never really sure whether the patient is active. Some patients are defaulters [not taking their medication]. When assessing a patient's adherence and pill counts, if the person is a defaulter, it interferes with their case management. You may give drugs, and yet they failed to take the previous ones. And sometimes you are unsure whether a patient is taking drugs from different facilities, [making it harder] for facilities to keep on hand a stock of the drugs. With the directory, you can follow up and get a snapshot of the true position of the patients, based on the last facility where they were treated.

"If a new client is tested and wants to attend clinics elsewhere, we use the directory to find out the alternative facilities they can attend. We give them the information and they choose. We call the facility to follow up on whether the client attended clinic, and if they didn't, we follow up. If they did visit the clinic, then that facility takes over the follow-up."

For more information on MEval-PIMA's support to referral systems, visit:
http://www.measureevaluation.org/pima/referral-systems

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Using data to save the lives of mothers and newborns

Pregnancy, labor, and delivery present an increased risk of death for women and their newborns.

Mothers and newborns are dying.

Each year in Kenya

7,700	40,000	33,000
mothers die during pregnancy, delivery, or shortly after	babies die during the first 28 days of their lives	stillbirths occur

Many maternal and infant deaths go unreported.

Unreliable data on maternal and newborn deaths contributes to a lack of accountability and limits the ability to make decisions for health. Better information could improve life-saving maternal health interventions and use of health resources.

The Government of Kenya has established a goal to reduce the countrywide maternal mortality rate to 200 per 100,000 live births by 2030. A national Maternal and Perinatal Death Surveillance Response (MPDSR) Committee will provide timely data that will be used to strengthen data collection for the provision of evidence-based decisions.

More than 75% of maternal and newborn deaths are preventable.

Maternal and perinatal death surveillance and response (MPDSR) is an opportunity

to ensure no mothers or babies die in the future from preventable causes.

Take Action.

Community

Notify and review deaths using a verbal autopsy approach.

Response: Provide feedback to the community, and alleviate multiple causes of first delay in accessing care.

Discuss maternal death in forums: community dialogue days, barazas.

Develop community-based transport networks.

Facility

Determine reasons leading to maternal and newborn deaths.

Review near-miss cases.

Response at the facility level focuses on addressing the causes of delay in receiving care at the facility.

Subcounty

Aggregates data and addresses community and facility factors.

Escalates action to the county level if common avoidable factors affect several subcounties.

County

Monitors MPDSR activities; ensures support for subcounties, facilities, and communities with a heavy burden of deaths.

Allocates appropriate resources for the response.

Should review and align county multi-sectoral plans to achieve MPDSR goals.

National level

The Ministry of Health is responsible for oversight of the national MPDSR program, and mobilizes resources to address avoidable factors where the need is greatest.

Count and classify every death.

For every mother and baby who dies, collect as much information as possible on:

☐ Age ☐ Antenatal history ☐ Place of delivery ☐ Mode of delivery ☐ Referrals ☐ Partography ☐ Gestational age ☐ Birth outcome

No maternal or perinatal death is complete unless it is linked with an attempt to respond to the findings with appropriate action.

Establish and mentor MPDSR committees at all levels | Timely reporting and review of deaths | Allocate finances and create policies that enable reporting of maternal and newborn deaths

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Access the Guidelines: Ministry of Health of Kenya. (2016). National Guidelines for Maternal & Perinatal Death Surveillance and Response. Nairobi: Government of Kenya, Ministry of Health. Pg. 1-44.

For additional information on maternal death surveillance and response, download these useful documents:
http://www.who.int/woman_child_accountability/countries/WCA_country_review_ken.pdf
http://www.who.int/woman_child_accountability/countries/oms-wca-kenya-countryprofilk-20140704.pdf
https://www.unfpa.org/sites/default/files/pub-pdf/Maternal_Death_Surveillance_and_Response_0.pdf

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