



**Helen Keller**  
INTERNATIONAL

**HELEN KELLER INTERNATIONAL KENYA  
ROUTINE VAS PILOT PROJECT  
(FEBRUARY 2015-DECEMBER 2015)**



**IMPLEMENTATION REPORT  
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## LIST OF ACRONYMS

CU	Community Unit
CHV	Community Health Volunteer
CHEW	Community Health Extension Worker
CHMT	Council Health Management Team
CME	Continuous Medical Education
DHIS	District Health Information System
DHRIO	District Health Record Information Officer
ECD	Early Child Development centers
HKI	Helen Keller International
KEPI	Kenya Expanded Program of Immunization
I.U	International Unit
MB	Malezi Bora
OJT	On Job Training
PMF	Project Monitoring Framework
SCHMT	Sub County Health Management Team
VAS	Vitamin A Supplementation
VASD	Vitamin A Supplementation and Deworming

## 1. BACKGROUND

There is clear evidence that shows the impact of Vitamin A supplementation (VAS) on improving health and saving lives among Vitamin A deficient (VAD) populations. When at least 80% of the vitamin A deficient children aged 6 to 59 months are supplemented twice yearly, evidence shows that a reduction of child mortality of up to 24% is expected. (Lancet, 2008, 2013)

In Kenya, Child Health Days known as 'Malezi Bora' was introduced in 2007 (before which Kenya had campaigns) to address the declining child survival indicators through increased utilization of routine child survival interventions. VAS coverage dropped drastically to 22% from 93% for 6-11 months and 15% from 52% for 12-59 months (Report on Support child health and nutrition weeks and VAS in Kenya- UNICEF 2013). Equally, there is inconsistency towards Malezi Bora implementation on the part of the Ministry of Health at the national and county levels. Even though Malezi Bora is scheduled for the first two weeks of May and November funds are not allocated for implementation by the MoH, and the events are often disrupted by polio campaigns.

Helen Keller International (HKI) Kenya main approach is to strengthen the health system by working through the existing government structures to improve the coverage of Vitamin A supplementation as well as deworming to 80% for children 6-59 months and 12-59 months respectively. Efforts have been made by the Government towards integration of VASD in the health system through routine services and Child health Days (Malezi Bora) to improve VASD (Vitamin A supplementation and Deworming) coverage. However, to attain VAS coverage of 80% especially in situations where Child Health Days would not be implemented it is important to ensure that routine VAS delivery through health facility is complemented by community outreaches with increased social mobilization and where feasible delivery should be done at Early Childhood Development (ECD) centers.

In Kenya, the use of ECD for Vitamin A Supplementation was initiated in 2010 through the ECD policy of the Ministry of Education which resulted in development of the National Guidelines for Vitamin A Supplementation through ECD by the Ministry of Public Health and Sanitation. It was evident that through systematic approach of using ECD's as an access point to young children, even the children around the ECD center were attracted to come and receive VASD.

In order to address these gaps, HKI collaborated with Bungoma North/Tongaren and Matuga sub-counties to pilot routine VAS delivery through the combination of health facility, community outreaches and ECD centers with improved social mobilization to see an improvement in VAS coverage. The choice for these project areas was based on the national MoH advice as sentinel sites for the government in 2013.

**This pilot project had 8 programmatic areas of focus for increased routine VAS coverage.**

- **Planning and Budgeting:** Ensuring early planning by the county government was important to allow timely implementation of activities. Members of the management teams both at the county and sub-county level were involved in developing the activity plans along with the budget with technical support from HKI.

- The table below shows the budget lines and amount advanced to Bungoma North and Matuga sub-counties for the project activities which were implemented between March and December in 2015.

**Table 1: Financial support to counties for the implementation of routine VAS pilot project.**

SN	Activity	Financial support to Bungoma County (\$)	Financial support to Matuga County (\$)
1.	County supportive supervision	2,345	2,253
2.	CHV social Mobilization	12,320	17,562
3.	Community dialogue days	4,703	3,408
4.	Stakeholder forums	840	840
5.	OJT & Mentorship	450	450
6.	CMEs	1,150	1,151
7.	Integrated community Outreaches	4,810	5,530
8.	ECD VAS supplementation	1,750	1,957
9.	Quarterly data audits and reviews	1,751	1,873
10.	Documentation	433	783
	<b>TOTAL</b>	<b>\$30,552</b>	<b>\$ 35,808</b>

- **Capacity Building:** Capacity building was essential since other non-nutritional staff e.g. Public health officials and nursing officers were also involved in vitamin A supplementation.
- **Social Mobilization:** Lack of awareness among caretakers was a major barrier to receipt of VAS for children 6-59 months. This component was essential to ensure that caregivers are aware of the importance of VAS and know the specific dates of VAS distributions at ECDs, community outreaches and at health facilities.
- **Logistics/Supply:** To ensure adequate stocks at health facilities and service delivery points, it was essential to support the sub-county in addressing supply issues like to repackage vitamin A capsules to smaller containers of 100 capsules for easier redistribution to areas of lower catchment population.
- **VAS distribution via Health facility, Community Outreaches and ECDs:** It was important to use multiple delivery mechanisms to be able to achieve high VAS coverage.
- **Human Resource:** Due to in adequate health facility staff, it was important to ensure the involvement of other community staff e.g. CHEWs. HKI did not hire more staff for the program, but ensured the county utilized the existing MoH staff both at the health facility and community level.
- **Supportive Supervision:** This component was important to ensure health managers were able to identify issues affecting VAS delivery and coverage and design follow up actions.
- **Reporting:** In order to monitor program progress and activity implementation, monthly reporting of activities needed to be emphasized at the sub-county level.

The attainments of these programmatic areas have contributed to the successful implementation achievement of this pilot project. During the course of implementing the project, the Performance Monitoring Framework (PMF) was monitored and updated on a real time basis.

## 2. SUMMARY OF ACHIEVEMENTS

The results and achievements presented in this section are from Tongaren (Bungoma North sub-county). Matuga sub-county has not yet reported fully hence the data could not be included in this section.

**Overall VAS coverage**, the coverage improved by 63.8% in Bungoma/Tongaren sub-county. As shown in the graph below, in 2014, only 12.4% of children 6 to 59 months received VAS twice a year through routine while in 2015 the coverage for routine VAS increased to 76.2%. It should be noted that DHIS VAS data could not be separated to different delivery mechanisms i.e. ECD, community outreaches and health facility.

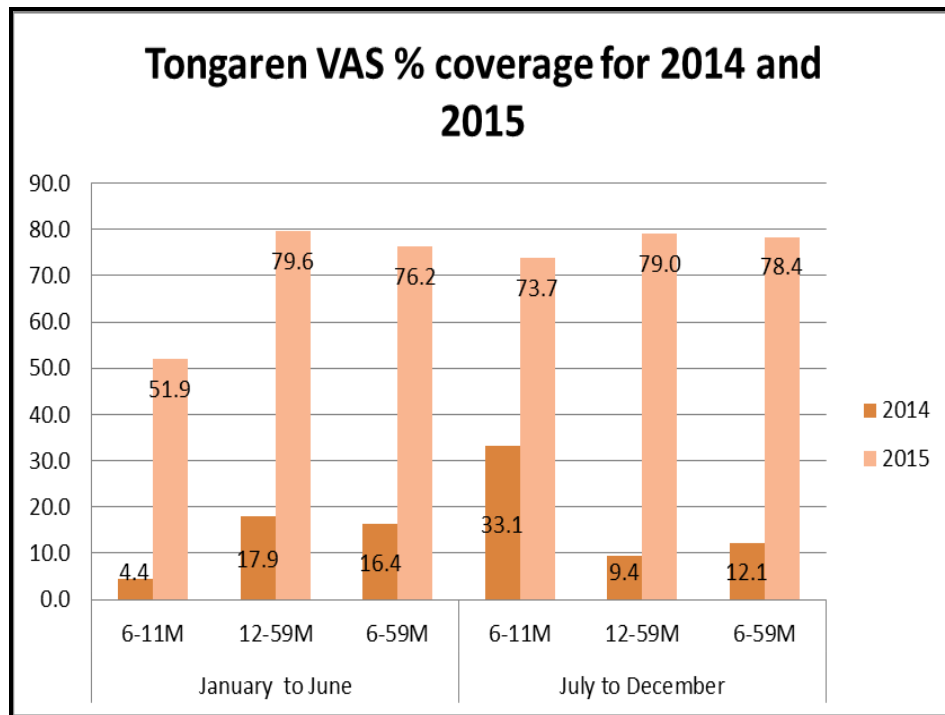


Figure 1: VAS coverage figures for Tongaren sub-county

In terms of **ECD outreaches**, during the first semester (January to June 2015) the ECD approach reached 19,165 children 12-59 months (55.5%) in Tongaren sub-county. In the second semester, 16,585 children (48%) were reached. Overall, the ECD approach contributed to a 48% increase in VAS coverage in Tongaren sub-county.

Through **community outreaches**, during the first semester (January to June 2015) the approach reached 4,635 children 6-59 months (13.4%) in Tongaren sub-county. In the second semester, 253 children (9.9%) were reached. Overall, community outreaches contributed to a (9.9%) increase in VAS coverage in Tongaren sub-county.

As for **health facility** delivery during the first semester (January to June 2015) the approach reached 4,926 children 6-59 months (14.3%) in Tongaren sub-county. In the second semester, 5831 children (25%) were reached. Overall, VAS coverage via health facility contributed to a (25%) increase in VAS coverage in Tongaren sub-county.

The graph below shows the contribution to increase in coverage by ECD, community outreaches and health facility delivery mechanisms.

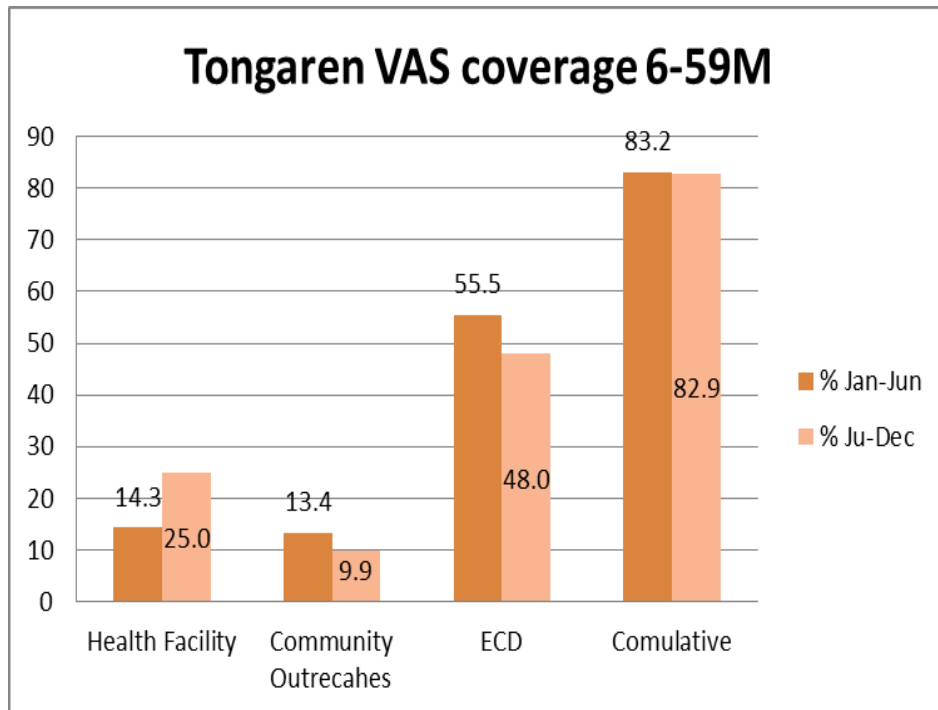


Figure 2: Tongaren VAS coverage for SEM 1 and 2 based on HKI monitoring.

### 3. CHALLENGES ENCOUNTERED DURING THE PROJECT PERIOD

Even though the project has recorded very impressive results and most targets specified in the PMF were exceeded, it faced some challenges that are highlighted below.

***Distribution of Vitamin A Capsules delays:*** There were major delays in transporting VACs (Vitamin A capsules) from the central Kenya Expanded Programme of Immunisation (KEPI) store in Nairobi to the regional KEPI stores. Due to delays in transporting VACs, Vitamin A stock outs especially the 100,000 IU were experienced in many health facilities.

***Planning exercise by the county and sub county delays:*** The county and sub-counties were supposed to use their annual work plans to guide them in developing an implementation plan for the VAS program, but due to inadequate information in the annual work plans the planning exercise took long and this led to development of several draft plans that in turn delayed the implementation process.

***Lack of financial resources for nutrition activities:*** There was a shortage of resources allocated for nutrition activities but specifically for VAS, either allocated from the Central Ministry of Health or the County Departments of Health. There was an overreliance on development partners to fund nutrition activities. More effort and resources were allocated for physical infrastructure than on service delivery and this reduced the number of activities implemented to complement and supplement HKI efforts. If this continues it will affect program continuity and sustainability in future.

***Shortage of staff:*** Inadequate staffing at the facility level created competition for activity implementation based on which activity paid better. This hampered full implementation of VAS activities in some facilities as a result of the work load. However, the inefficiencies were also contributed by inadequate reporting tools, constant stock outs of commodities.

***Lack of reporting tools:*** There was inadequate M & E tools e.g. MoH 702- immunization tally sheet, MoH 710- immunization summary sheet and MCH booklet for documentation. This was necessitated by the county government not allocating enough funds for printing new M&E tools.

***Challenges associated with competing priorities at the counties:*** Competing priorities among the management team members led to delay of activities that required their participation at the sub counties. Because of the few management team members and the many activities to be implemented daily, they are forced to prioritize which activities to participate and this cause delays in those activities that are perceived as non-priority.

***Bureaucracy at the county level:*** There were bureaucracy issues regarding release of funds from the county health account to the sub-county for program implementation which in turn led to delay in implementation of activities and reporting. Some of the activities were time bound, so they had to be postponed because of lack of funding in the sub-county.

***Delays in reporting from Matuga County:*** There were challenges in reporting from Matuga County especially for semester two. The CHMT have delayed in submitting both the technical and financial reports. Because of these delays, HKI has not been able to analyze and present any data from the sub-county. The reason for the delay has been reported by the management team as being administrative in nature.



#### 4. PROJECT COMPONENTS AND TARGETS ACHIEVED

By the end of the pilot most targets for the components of the pilot had been achieved. The project therefore achieved most of its targets set out at the outset. In this report we are presenting the work that was done in Bungoma North/Tongaren sub-county.

##### 4.1 Component1:Community Outreaches

- 62 Integrated Community Outreaches were organized in strategic venues in the community by the health workers and Community Health Volunteers (CHVs).
- The integrated package of health services offered included; VAS, deworming, immunization, ANC services, growth monitoring, treatment, FP, HIV counseling and testing and micro teaching, these are the components of a standard integrated community outreach in the sub county. All the community outreaches that were monitored by HKI staff offered these services.
- The community outreaches were carried out by the 14 high volume facilities, for each health facility two areas that were hard to reach was identified.
- Five personnel were involved in every outreach and they were comprised of 2Nurses, 1 Community Health Extension Worker (CHEW) and 2 Community Health Workers (CHWs).
- Number of children supplemented with Vitamin A per outreach ranged between 50 and 232.
- The CHEWs coordinated the social mobilization for the outreaches together with CHVs in the villages where the outreaches were held. The social mobilization started five days prior to the outreaches and was shared through announcements through social and religious leaders, CHVs messages during routine household visits and during dialogue days.



**Table 2: Final project results compared to project targets: Community outreaches**

SN	PMF Indicator	Target	Result	%	Comments
1.	Children 6-59 months old from hard to reach areas accessing VAS and deworming services as a result of community outreaches	3780-Round1	4635	123%	Coverage exceeded the sub county target for community outreaches
		3780-Round2	3407	90.1%	
2.	Community outreaches with minimum package of intervention.	62	62	100%	
3.	Community outreach sites reporting at least one health worker conducting the outreach.	62	62	100%	

## 4.2 Component 2: ECD Outreaches

- The ECDs in the sub county were clustered in 12 wards and for each ward a team comprised of one CHEW and one CHV was assigned to cover all the ECDs in that area within five days in each semester.
- The CHEW was accompanied by different CHVs depending on the location to be visited, the CHV accompanying the CHEW at a particular day came from the village where the outreach was being undertaken. This was to ensure that all ECDs were visited in all the villages.
- After the activity the CHEWs then submitted the outreach data to the link health facilities to be included in the facility summary report which was later entered to the DHIS.
- The ECD outreach aim was to reach children age cohort 12-59months who are enrolled in ECDs who do not frequently visit health facilities for routine health services.
- Services offered during ECD outreaches include; Vitamin A supplementation, case finding and treatment or referral for jiggers and malnutrition plus sharing health information on health issues occurring at the time of outreaches i.e. cholera outbreak.
- The ECD outreaches were carried out by CHEWs, CHVs and ECD teachers. The outreaches were held twice; in June 2015 and November 2015 in 280 ECDs in Bungoma North/Tongaren.
- Social mobilization was coordinated by the CHEWs in all the Community units while the CHVs visited the ECDs in their villages informing the teachers of the date for the ECD outreaches and the health package to be offered. In addition, they passed the information to religious leaders to share during church announcements and in social gatherings such as burials, chief barazas and dialogue days.
- The children below five years not enrolled in ECDs were asked to assemble in neighboring ECDs to receive the health services as well.
- The social mobilization was carried out three days prior to the outreaches by all 190 CHVs in the sub county.
- In November 2015 the ECD database was updated as new ECDs had sprung up and others had closed down this was synchronized the ECD outreach plan to ensure all ECDs were visited.



**Table 3: Final project results compared to project targets: ECD outreaches**

SN	PMF Indicator	Target	Result	%	Comments
1.	Health facilities with micro plans for their respective ECD outreach.	18	18	100%	Health facilities in the sub county prepared micro plans for all the activities they intended to carry out per financial year
2.	Number of ECDs where VAS was offered.	280	280	100%	

### 4.3 Component 3: Social mobilization

- Social mobilization was carried out by CHVs (190) and (19 CHEWS) in the 19 Community Units (CUs) prior to community and ECD outreaches.
- Social mobilization started one week prior to activity days and was carried out by CHVs. The CHVs shared information through barazas, funerals, market days, take information to churches to be read during announcements and household visits.
- Other forms of social mobilization were dialogue days which were used to sensitize the community members and their leaders of important health issues which included nutrition topics such as importance of Vitamin A and deworming, exclusive breastfeeding, WASH, reproductive health among others.
- More so, the community dialogue days acted as avenues for passing outreach messages both for community and they were conducted by CHVs, CHEWs, CHCS and community members in all the 19 CUs and were held on a quarterly basis.

**Table 4: Final project results compared to project targets: Social mobilization**

SN	PMF Indicator	Target	Result	%	Comments
1.	County plans with social mobilization plans for promotion of VAS at ECD and outreach sites.	1	1	100%	The sub county developed a plan to be used for implementation for the entire year.
3.	Health facilities with relevant mobilization materials for promotion of VAS.	18	18	100%	The health facilities had VAS, Deworming and malezi Bora posters mounted on strategic places in the health facilities.
4.	Community health committees with relevant social mobilization materials for promotion of VAS.	19	0	0%	The CHEWs sensitized the CHVs, CHCs and community members on VAS. There were no materials provided for CHCs.
5.	Social mobilization activities implemented in line with plans/micro plans. Number of activities that required Social mobilization for their implementation.	2	2	100%	Activities were community and ECD outreaches and mobilization was done through Dialogue days, CHVs household visits and religious gatherings.

### 4.4 Component 4: Capacity Building

- Capacity building was done through On Job Training/mentorship and Continues Medical Education (CME) sessions with the aim of equipping health workers with knowledge on importance of VAS and how to document VAS.
- **Continuous Medical Education (CME)** was carried out at the health facility where the staffs assembled for a short training ranging from 45 to 90 minutes at their health facility. The CMEs were facilitated by 2 SCHMT members – SCNO and SCPHN every quarter per facility.
- **On Job Training (OJT)**, were important in imparting skills from one skilled personnel to other skilled personnel on a particular issue at the place of work. OJTs were carried out quarterly for staff identified to be in need during support supervision visits.
- **Mentorship** was carried out by guiding and supporting staff on skills and knowledge previously taught or gained. The main aim for this activity was to equip health workers with Knowledge & skills to work better by motivation to enhance their ability to take on a task.

- The selection of health facilities to be visited and focus areas to be covered in OJT and mentorship was determined by the gaps identified from the supportive supervision visit which carried out in all the health facilities. These gaps included lack of skills on how to fill the VAS monitor charts.
- The trainers composed of the sub county management team and visited the health facilities to train the health workers while they are at their work station. This created room for demonstration on how to fill in the VAS monitor charts. Corrections were made and clarifications given where needed.
- CMEs covered the general topics on VAS, its importance and administrations among all staff working in health facilities. This incorporated other HINI topics such as exclusive breastfeeding and deworming.

**Table 5: Final project results compared to project targets: Capacity Building**

SN	PMF Indicator	Target	Result	%	Comments
1.	No. of health workers attending CMEs with VASD information	200	97	48.5%	The sub county did not carry out all the planned CMEs due to other conflicting priorities and delay of transfer of funds from the county.
2.	OJTs conducted with VASD information	20	10	50%	OJTs were carried out in one quarter while they had been scheduled for two due to other conflicting priorities and delay of transfer of funds from the county.

#### 4.5 Component 5: Supplies

To ensure adequate stocks at health facilities and service delivery points, HKI facilitated the sub-county to repackage vitamin A capsules to smaller containers of 100 capsules for easier redistribution to areas of lower catchment population.

**Table 6: Final project results compared to project targets: Supplies**

SN	PMF Indicator	Target	Result	%	Comments
1.	Facilities delivering routine VAS reporting no stock outs of 100 000 IU capsules in the past month.	100	0%	0%	County and sub county did not receive enough 100,000IU capsules.
2.	Facilities delivering routine VAS reporting no stock outs of 200 000 IU capsules in the past month	100	100	100%	Sub county received enough 200,000IU capsules.
3.	Community outreaches with sufficient 100 000 IU Vitamin A capsules during the previous semester. (Esther please check)	62	62	100%	50,000IU capsules were used where the 100,000IUs were not available. (this was not analyzed)
4.	Community outreaches with sufficient 200 000 IU Vitamin A capsules during the previous semester.	62	62	100%	Supply was adequate.
5.	ECD outreaches with sufficient 100 000 IU Vitamin A capsules during the previous semester.	0	0	Nil	ECDs target was 12-59months only using 200,000IU capsules.
6.	ECD outreaches in the district with insufficient 200 000 IU Vitamin A capsules during the previous semester	280	280	100%	There was enough supply of 200000IUs at the sub county stores for all ECDs.

## 4.6 Component 6: Supportive Supervision

Support supervision was carried out in two ways, routine supportive supervision and monitoring and supervision of activities.

### Routine Supportive Supervision:

- Routine supportive supervision which was carried out in all the 18 health facilities was conducted by 4 SCHMT visiting 3 facilities per day whenever a high volume facility was included and 4 facilities of low volume respectively every day.
- This exercise was aimed at identifying the gaps affecting VAS, deworming and Nutrition indicators through a discussion with the health workers and observation.
- Recommendation was drawn from the health facility staff on what would best solve their problem. Each health facility had varying issues to be addressed uniquely.
- There were several gaps identified among them are;
- **Poor documentation:** Lack of reporting tools especially MOH 710 for reporting immunizations; the facility had to photo copy older copies for reporting, tallying of VAS was not done, VAS charts not properly drafted.
- **Service delivery:** Low uptake of VAS for children between the ages of 2-5yrs, many of the children who visited the health facilities did not receive VAS, hence there was reported a high number of missed opportunities. There were delays in service delivery to clients at some facilities with large volume of clients
- **Stock:** Vitamin A 100,000IU capsules were not adequate throughout the year with periods of no capsules being experienced in the health facility. And there were no deworming tablets in most health facilities deworming tablets (Albendazole and mebendazole).
- **Training:** Health workers did not have Nutrition related training.
- **Social mobilization:** Mounting of VAS and Deworming posters was not visible in some health facilities.

### Monitoring and supervision of activities:

- The county, sub-county management teams and HKI program officers conducted routine support supervision to activity sites unannounced to ensure that services were being offered and the plans and processes were being followed by the health facilities and health workers as planned. These included community and ECD outreaches.
- The observations made were that the community outreaches were integrated as per the plans and health workers and CHVs were present at the sites. The number of people coming for the services ranged and this was attributed to the varying degree of quality of social mobilization carried out. On average the turn out for most community outreaches was good with 150 to over 200 clients coming for services.
- The ECDs outreaches had a minimal package and the mobilization of children from outside was done in varying degrees at the various sites with some having a high number of children from outside and others very low.

**Table 7: Final project results compared to project targets: Supportive Supervision**

SN	PMF Indicator	Target	Result	Comments
1.	SCHMT and CHMT have quarterly plans for supportive supervision at Health facilities.	4	4	Support supervisions were carried out with visits focusing on various departments. Nutrition support supervision was included in two quarters.
2.	Community outreaches with supportive supervision.	16	29	Outreach dates were spread across different times and the SCHMT were able to visit more outreaches.
3.	ECD outreaches with supportive supervision.	70	30	No of ECDs was large and the supplementation period was five days only; SCHMT visited six schools per day during the supplementation period.

#### 4.7 Component 7: Reporting

- During implementation of the project, VAS coverage reports were summarized by the health workers and all the totals for each health facility were forwarded to the sub-county health records and information officer. These data were then consolidated and uploaded into the DHIS.
- HKI program officer also corrected data after each activity was carried out; community and ECD outreach. The SC Nutrition coordinator and SC health records and information officer assisted in getting a copy of the reports after the outreaches. This was used to compare reporting among the health facilities in DHIS and actual data from field.
- Data quality audits and data reviews were conducted quarterly to ensure that the data from the ECDs and other outreach cites was included in the health facility summary report which was uploaded in DHIS.
- There was an improvement in documentation where HKI compared MOH data uploaded into the DHIS and data collected independently by HKI directly from the outreaches and health facilities. In the first semester there was a discrepancy of 7.8% in data collected by the two channels, while in the second semester the margin was brought down to a 5.2% difference as seen in this table.

Category		Jan -Jun 2015		Jul - Dec 2015	
		TOTAL	%	TOTAL	%
6-11M		2166	51.9	3076	73.8
	DHIS	2166	51.9	3076	73.8
12-59M		26555	87.4	25556	84.2
	DHIS	24181	79.6	24007	79.0
Variance		<b>2374</b>	<b>7.8</b>	<b>1549</b>	<b>5.2</b>

**Table 7: Final project results compared to project targets: Reporting**

SN	PMF Indicator	Target	Result	%	Comments
1.	Community outreach regularly report data back to catchment health facility	62	62	100%	Nurse in charge/CHEW at health facility submitted outreach report to SCHMT and included the data in the health facility summary report.
2.	Facilities reporting quality VASD data on a monthly basis to DHRIO	18	18	100%	All facilities reported their monthly summary report (MOH710) according to the DHIS.

## 5. LESSONS LEARNED

- In order to achieve high VAS coverage it is important to ensure that different delivery mechanisms available are used to capture different age cohorts at different places at times.
- Community outreaches requires targeted social mobilization prior to the activities to ensure a high turnout for the health services. For this to be achieved proper planning and effective communication to all stakeholders involved should be done at least one week before event.
- ECD centers provide a good avenue where around 50% of children 12-59months can be reached with health services all in one place. Sensitizing ECD teachers and empowering them to supplement the enrolled ECD children is proposed to be a more effective strategy as the teachers know children who are absent and can supplement them once they report back.
- Use of CHVs during mobilization is an effective yet expensive way to increase turn out for the outreaches as the CHVs currently are given incentives inform of Cash to carry out mobilization. A more cost effective way of rewarding the CHVs is needed to sustain the activity; this could include starting IGAs for the CHVs.
- For successful planning and implementation at the county level it is important to ensure that all the management team members are involved and understand the program. As well, the priorities of the counties should originate from the health management teams and where needed guidance should be provided to the counties.
- Continuous professional development e.g. OJT, CME and mentorship is less expensive since health workers are not taken out of their duty stations and they learn using what is actually available in their work environment.

- Lack of knowledge on how to document certain reports among health workers contributes to poor reporting. Using CMEs and OJTs to address these issues can improve reporting and documentation.
- Because of increased contact time by HKI program officers in the Counties, it was easy to follow up on the activity implementation. The presence of the program officers made it easy to have impromptu discussions with the management teams.
- Channeling of funds through the county account does not add value to the system but has only led to delays of transferring the funds to the sub county. While this was meant to strengthen the relationship between the county and sub-county it did not achieved its goal due to the numerous changes in management at the county level who need explanations to the genesis of the projects and their competing responsibilities that make them unavailable for signing out the funds from the bank. Due to this delay the sub county did not manage to carry out all the activities as had been planned and those that they managed to do did not follow the set timeline. Proposal is to sign agreements with Counties but send money directly to the sub-counties