

The European Union's Non State Actors and Local Authorities in Development Programme

Kisumu Integrated Family Health Project

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ENDTERM REVIEW
Final Report



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Implemented by CARE, KRC & FHOK

FORWARD

The End-term evaluation (ETE) of the Kisumu Integrated Family Health Project (KIFHP) was undertaken from October 2017 to November 2017. The evaluation was conducted by the Promotive Health Consultants (PHC) in collaboration with CARE Kenya and Kisumu County Ministry of Health.

PHC collected quantitative and qualitative data for the ETE through household questionnaire, focus group discussions, and key informant interviews held with relevant groups and persons in the project. Relevant government policies, project reports, and research documents were also reviewed. The draft evaluation reports were reviewed by the CARE Project team (both in Kenya and in Austria). The findings and recommendations were presented to the CARE team in the CARE Kenya Nairobi offices, and feedback acquired from the presentation was used to finalize the report.

The End-term (ETE) Report is now ready and marks a critical milestone in the lifespan of the project implementation. The report has highlighted achievements realized so far and will form a good guide for implementation of similar projects. It provides valuable findings that will inform policymakers, donors, program managers, and partners about the status KIFHP implementation, and provides explicit recommendations on how to strengthen implementation in future projects. The lessons learned during its implementation as assessed will be valuable not only to CARE team but also to any other organization that may wish to implement such projects in future.



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LIST OF ACRONYMS

ADA	Austrian Development Cooperation
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Antiretroviral Drug
BCG	Bacillus Calmette Guerin (Tuberculosis)
CCA	Continuum of Care Approach
CHA	Community Health Assistants
CHC	Community Health Committee
CHMT	County Health Management Team
CHS	Community Health Strategy
CHV	Community Health Volunteer
CIK	CARE International in Kenya
CME	Continuous Medical Education
CMOH	County Medical Officer of Health
CPR	Contraceptive prevalence rate
CSO	Civil Society Organizations
CU	Community Unit
DHS	Demographic Health Survey
DO	District Officer
DPT	Diphtheria Pertussis Tetanus
DPT-HeB-Hib- EmONC	Diphtheria Pertussis Tetanus Hepatitis B Haemophyllus Influenza B Emergency Obstetric and New-born Care
EBF	Exclusive Breastfeeding
FANC	Focused Antenatal Care
FGD	Focus group discussions
FHOK	Family Health Options Kenya
FP	Family Planning
GoK	Government of Kenya
HCP	Health Ccare Pprovider
HFMC	Health Facility Management Committee
HiNi	High Impact Nutrition Interventions
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
IDD	Iodine Deficiency Disorders
IDI	In-depth Interviews
IFAS	Iron Folic Acid Supplementation
IGA	Income Generating Activity
IMCI	Integrated Management of Childhood Illnesses

IMR	Infant Mortality Rate
IPT _p	Intermittent Preventive Treatment of Malaria in Pregnancy
ITN	Insecticide Treated Net
IUD	Intrauterine Device
IYCF	Infant and Young Child Feeding Practices
IYCN	Infant and Young Child Nutrition
JOOTRH	Jaramogi Oginga Odinga Teaching and Referral Hospital
KAIS	Kenya AIDS Indicator Survey
KCH	Kisumu County Hospital
KDHS	Kenya Demographic Health Survey
KEPH	Kenya Essential Package for Health
KII	Key Informant Interview
KNBS	Kenya National Bureau of Statistics
KRCS	Kenya Red Cross Society
LAM	Lactational Amenorrhea Method
LAPM	Long Acting and Permanent Methods
LLITN	Long Lasting Insecticide Treated Nets
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MEAL	Monitoring, evaluation, accountability and learning
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MoH	Ministry of Health
MTCT	Mother to Child Transmission of HIV
MUAC	Mid Upper Arm Circumference
MVA	Manual Vacuum Aspiration
OJT	On Job Training
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
OVC	Orphans and Vulnerable Children
PENTA	DPT-IPV/PRP-T combination vaccine
PIT	Project Implementation Team
PLWDs	Persons Living with Disabilities
PMTCT	Prevention of Mother to Child Transmission of HIV
PPP	Public–Private Partnership
PWD	Persons with disabilities
RH	Reproductive Health
SAA	Social Analysis and Action
SCHMT	Sub-County Health Management Team
SP	Sulphadoxine- Pyrimethamine

SPSS	Statistical Package for Social Sciences
SRH	Sexual and Reproductive Health
SRMNH	Sexual, Reproductive, Maternal and Newborn Health
STIs	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
VHC	Village Health Committee
WAZ	Weight for Age Z scores
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
WLHIV	Women Living with HIV
WLWDs	Women Living with Disabilities
WRA	Women of Reproductive Age

EXECUTIVE SUMMARY

Background

The Kisumu Integrated Family Health Project (KIFHP) is a three year project (November 2014 – October 2017) funded by the European Union (EU) with co-funding from the Austrian Development Cooperation (ADA) and CARE Austria. The project is implemented by CARE International in Kenya (CIK) in partnership with the Kenya Red Cross Society (KRCS) and Family Health Options Kenya (FHOK). The project is implemented in Kisumu urban slums of Manyatta and Nyalenda and works closely with Kisumu County Government under Kisumu East Sub-County. The project aims to primarily contribute to achieving sustainable development goal 3 (SDG) and former MDGs 4 and 5 a +b- “Reduce by two thirds the under-five mortality rate”, “Reduce by three quarters the maternal mortality ratio” and “Achieve universal access to reproductive health”. The overall objective of the evaluation was to establish the results that have been achieved in the three years (November 2014-October 2017) of implementation and the resultant impact this has had on the target beneficiaries.

Methodology

The evaluation took place in late October 2017 and was conducted by a core team of three lead consultants. A combination of qualitative and quantitative data collection approaches were applied in carrying out the evaluation. These included household data collection, review of relevant project documents, structured interviews with key informants and stakeholders and focus group discussions with community members. Data on anthropometric measurements of children was also collected. The Emergency Nutrition Assessment (ENA) for Standardized Monitoring and Assessment of Relief and Transitions (SMART) version 2010 was used for data entry and analysis of anthropometry data.

Key findings:

On the overall, the project has been effective in achieving the intended outcomes. Access and utilisation of MNCH services improved as demonstrated by achievement of the project’s key performance indicators across the continuum of care. For instance, the ETE reported an increase in antenatal care (ANC) attendance with 71.9% who met the Focus Antenatal Care (FANC) requirement of 4 comprehensive care visits as compared to the baseline of 65%, which indicates a 6.9 percent improvement in the percentage of women meeting the national policy requirements compared to the situation at baseline. The national figure according to KDHS 2014 is 58% of women reported having four or more ANC visits. A remarkable change was observed in the proportion of mothers who delivered in a health facility, from only 45.6% at baseline to 95.3% at endterm. The figure for the health facility delivery is higher than the National and County average of 61% and 69.6% respectively (KDHS, 2014). Similarly, the proportion of children 0-23 months whose delivery was attended to by a skilled professional (nurses, doctors, midwives) has improved and currently stands at 94% from 62% at baseline. Again, this is higher than both the county and national rates. The increase in skilled delivery can be attributed to Community Health Volunteers’ (CHV) mobilizations

and engagement with mothers directly through door to door campaign and community outreaches to sensitize them on the need for skilled care delivery. The second initiative was “open mothers days” in specific European Union (EU) supported health facilities whereby pregnant mothers visiting the health facilities are taken through a facility tour with an explanation on the need to deliver in that particular facility. The tour entails physical viewing of maternity equipment, an equipped maternity wing and maternity care environment within the facility including beddings and child care set up after delivery.

The project strategy of using multiple interventional approaches was key for delivering on the intended outcomes. Some of the implemented best practices that were unique to the project included: combining service delivery integration at user points both for outreaches and in-reaches creating a one stop service point and reducing significantly client waiting time and missed opportunities and application of social change to address some of the underlying social-cultural and gender barriers to service access. The capacity building interventions including training of health workers on both technical and soft skills further resulted in better quality of care and consequently improvement in client satisfaction. The community systems strengthening undertaken by the project through establishment of Community Units (CUs) was effective in increasing health awareness and adoption of positive MNCH behaviours and practices. The capacity building provided to CUs was key to empowering them to play a more effective role in planning and delivery of community health services. Lastly, the project was effective in enhancing the capacity of health care workers enabling them to take on their mandate much more effectively.

The table below highlights progress made under each of the key project indicators:

Summary Table of Key Indicators

Indicator		Baseline value	Midterm Value	Endterm Value
Overall Objective Indicators				
OVI1	Reduction in neonatal mortality rate	39/1000	22/1000 ¹	22/1000
OVI2	Reduction in Under-five mortality rate	149/1000	52/1000 ²	52/1000
OVI3	Reduction in maternal mortality ratio	400/100,000	362/100,000 ³	362/100,000 ⁴
Specific Objective Indicators				
SO1: Strengthened capacity of non-state and state health actors to provide quality maternal and child health, sexual reproductive health, family planning and nutrition services to communities in Manyatta and Nyalenda slums, and to integrate vulnerable groups in decision making processes				
	Increase the proportion of children 12-23 months fully immunized in Kisumu slums.	83%	88.9%	90.2%
	Decrease the proportion of under 5's who are stunted or underweight in Kisumu slums	23%	18.1%	25.4%

1 KDHS 2014

2 KDHS 2014

3 KDHS 2014

4 KDHS 2014 (No new data has been published by KDHS since 2014)

	Ensure quarterly consultation and collaboration working group meetings held between non-state and state health actors on MNCH, SRH/FP and nutrition.	0	4	5
	Ensure that interests of vulnerable population groups are voiced in at least 25% of all County Public resource allocation forums by 2017	0%	15%	25%
SO2: Targeted communities are aware and empowered to demand, access and utilize quality maternal & child health, nutrition, sexual reproductive health and family planning services				
	Increase the proportion of pregnant women attending 4 or more ante-natal care visits in Kisumu slums.	65%	66.1%	71.9%
	Increase the proportion of skilled care deliveries in Kisumu slums.	62%	77.5%	94%
	Increase the % of Women of Reproductive Age using long acting FP methods in <i>Manyatta</i> and <i>Nyalenda</i> slums, Kisumu County.	22%	66.0%	68.2%
Result 1: Capacity Building				
	No. raised of health facilities delivering essential quality MNCH, and full package of HiNi	2	8	8
	No. raised of health facilities offering comprehensive long-term FP/SRH services	4	8	8
	No. of community units offering comprehensive level 1 SRMNH and Nutrition services in <i>Manyatta</i> and <i>Nyalenda</i>	0	8	8
	% increase in the number of targeted health workers demonstrating improved attitude towards clients (women, adolescents)	40%	61%	94.9%
Result 2: Awareness & Demand of MNCH, FP/SRH, nutrition services				
	% of targeted households aware of at least 3 HiNi from baseline	16%	42%	60%
	% of women knowledgeable about at least 5 pregnancy danger signs	28%	34%	35.3%
	% of targeted population 15-49 who have knowledge on any method about Family Planning or at least one modern contraception	97%	99%	99%
	Number of target group reporting inclusion and participation in decision making processes on MNCH, FP/SRH and nutrition at county level	0	4	4 adolescent, disabled groups, pregnant women ECD teachers MCAs
	% of pregnant, lactating women, fathers and caregivers of children under 5 years demonstrate correct knowledge and practices on nutrition	31%	53%	60%
	% of targeted women confirm to practice family planning jointly with their partners, both parties demonstrate consistently sufficient knowledge on	40%	21.4%	27.4%

	SRH/FP, MNCH, and on correct use of contraception			
Result 3: Utilisation & Practices MNCH, FP/SRH, nutrition				
	% of infants of targeted women exclusively breastfed for first 6 months	37%	56%	84.2%
	% increase in Vitamin A supplementation	36%	52%	88.7%
	Increased Contraceptive Prevalence Rate in Kisumu Slums	62%	66%	68.2%
	% of persons aged 15-49 using long acting contraceptive methods	22%	66.0%	68.2%
	% increase of hospital deliveries in Kisumu slums	46%	64%	95.3%
	% reduction in children aged under 5 who are malnourished	12%	22.8%	19.5%
	% of targeted women reporting using mosquito net	94%	94.6%	94.1%

In addressing some of the gaps identified in the uptake of MNCH services, the ETE recommends the following:

Recommendations to CARE Kenya, FHOK and KRCS

- Project exit strategy: The project has yielded significant behaviour change in Kisumu urban slums (Manyatta and Nyalenda) resulting in increased access and utilization of maternal and child health services. Therefore, careful exit strategies should be put in place to ensure the gains made are not lost. Of great importance is that the County government (CHMT & SCHMT-Kisumu East) teams have been the major drivers of the project interventions supported by the project especially in year two and three - this should guarantee smooth transition of project activities.
- In future, consider initiating community based sustainable incentives as opposed to giving monthly allowances (stipend) for the CHVs as it is resource intensive and not sustainable: there is a need to explore non-financial incentives that will ensure adequate community involvement in the delivery of MNCH services. The proposed sustainable incentives include helping them initiate group savings and loan as a form of IGA, issuing of recommendation letters, exchange tours / trips to learn new ideas from successful health projects.
- Since the project did not achieve indicator 2 of the strategic objective 1 on improving nutrition, future programming on nutrition needs to have more support including provision of food supplements to the children as well as more advocacy with the county government to improve funding for nutrition related activities. The development of a County nutrition action plan as well as strengthening of the nutrition stakeholder's forum would go a long way in achieving this.
- Planning for unforeseen circumstances like the prolonged nurses' strike which affected the achievement of some targets could be addressed by having flexible designs and budgets that could allow for hiring of health workers albeit on short term contracts to deal with the persistent gaps of human resources for health in the county.

Recommendations to SCHMT and CHMTs and Kisumu County government

- The County Government should sustain investments in the implementation of the Community Health Strategy. The priority should include resources allocation within County health budget for support supervision and mentorship to the CUs, working aids, and reporting tools for the CHVs and CHAs, as well as coordinating the support offered by partners.
- The SCHMT and CHMTs should continue factoring in CHV monthly stipend in the county health budget for supporting the CUs as pledged by the previous county government after a series of engagement with County assembly members by the project advocacy strategies and ensure a strong linkage with local health facilities is maintained. Regular support supervision and mentorship to the CUs will boost their morale and increase the prospects of sustainability. The SCHMT should also ensure that future community-level projects and initiatives by both County Government and partners work with and support the already established CUs instead of starting from scratch with new ones.
- The County Government should scale up support for IGAs for active CUs, including linking them up and endorsing them for other grants including *Uwezo* Fund, constituency development fund etc. To ensure the IGAs grow into profit-making ventures, ongoing support and mentorship will be required from relevant line ministries including agriculture and livestock, water, gender and social services and trade and industry.
- In line with the project design, the CHVs should be taken over by county Government of Kisumu after close of the project to ensure that they continue to provide the services at level one. This should be through a formal monthly stipend and/or inclusion to the health care system.

Recommendations to national MOH

- The national MOH should continue providing the policy steer with regards to implementation of the community health strategy including ensuring harmonisation of the way CHS is implemented by partners. For instance, the MOH should support County government to customise the RH and Nutrition policies to suit the health challenges in Kisumu County. Secondly issue a policy position supporting the adopting of group Income Generating Activities (IGA) for incentivising CHU workforce as opposed to monthly stipends.

CHAPTER 1. INTRODUCTION

1.1 About the Kisumu Integrated Family Health Project (KIFHP)

1.1.1 Project overview

The Kisumu Integrated Family Health Project (KIFHP) is a three year project (November 2014 – October 2017) funded by the European Union (EU) with co-funding from the Austrian Development Cooperation (ADA) and CARE Austria. The project is implemented by CARE International in Kenya (CIK) in partnership with the Kenya Red Cross Society (KRCS) and Family Health Options Kenya (FHOK). The project is implemented in Kisumu urban slums of Manyatta and Nyalenda and works closely with Kisumu County Government under Kisumu East Sub-County.

1.1.2 Overall Objective

The overall objective of the KIFHP is to Improve Maternal and Child Health, Sexual Reproductive Health, Family Planning and nutritional status of communities living within Kisumu slums. The project aims to primarily contribute to achieving sustainable development goal 3 (SDG) and former MDGs 4 and 5 a +b- *“Reduce by two thirds the under-five mortality rate”*, *“Reduce by three quarters the maternal mortality ratio”* and *“Achieve universal access to reproductive health”*.

The project is anchored on two specific objectives:

- i. To strengthen the capacity of non-state and state health actors to provide quality maternal and child health, sexual reproductive health, family planning and nutrition services to communities in Manyatta and Nyalenda slums, and to integrate vulnerable groups in decision making processes.
- ii. Ensure targeted communities are aware and empowered to demand, access and utilize quality maternal & child health, nutrition, sexual reproductive health and family planning services.

1.1.3 Expected project Results

The Project’s has three expected outcomes, specifically: (a) Increasing the capacity of state and non-state actors; (b) Creating awareness and demand on the services; and (c) ensuring utilization and practices MNCH, FP/SRH, nutrition.

Result 1 - *Capacity building*: Ensure non-state and state health actors have greater capacity and improved skills to respond and meet needs on Maternal, Newborn and Child Health, Family Planning, Sexual and Reproductive Health and nutrition in Manyatta and Nyalenda slums, and adequately include affected population in health decision making;

Result 2 - *Awareness and Demand*: Ensure awareness and knowledge empowered targeted men, women and adolescents in Manyatta and Nyalenda slums take part in health decision making, and to demand accountability and quality health services on Maternal and Child Health, Family Planning, Sexual and Reproductive Health and Nutrition;

Result 3 – *Utilization & Practices MNCH, FP/SRH, Nutrition*: Ensure targeted men, women, adolescents, children and vulnerable groups in Manyatta and Nyalenda slums are empowered to increase utilization of quality Maternal, Newborn and Child Health services, Family Planning and Sexual Reproductive Health services, Nutritional health services, and take up health conducive practices in these fields.

1.2 Objectives and Criteria of the Evaluation

1.2.1 Objectives of the evaluation

The overall objective of the evaluation of the Kisumu Integrated Family Health Project was to establish the results that have been achieved in the three years (November 2014-October 2017) of implementation and the resultant impact this has had on the target beneficiaries. Recommendations emerging from the end-term evaluation will:

- Inform and guide the design of future CARE projects,
- Generate information on the level of achievement of the intervention objectives/outcomes and wherever possible any evidence of emerging impact, information which will be useful to stakeholders

Specifically, the End term evaluation sought to among others do the following:

- Provide an assessment against the project goal, objectives and expected results based on the indicators of the project log-frame.
- Assess the project objectives and proposed outcomes by measuring performance against each performance outcome indicator under each result area.
- Analyze key determinants that, positively or negatively, were critical for obtaining these results.
- Assess if the process of achieving results was efficient.
- Determine the contribution of the adopted gender equality (SAA Model) and rights based approach programming towards achieved results.
- Describe which actions have been taken from a “do no harm” perspective with regard to possible negative effects with changes in gender and power relations; how the threat of GBV was monitored, and which steps for prevention have been taken.
- Evaluate the efficiency of the organizational set-up for the project (partnership arrangement) and systems used in the delivery of the project and to what extent these contributed to or inhibited the delivery of the project outcomes.

- Assess how gender aspects have been considered and included in the implementation (with specific focus on gender mainstreaming, setting of gender equality goals...), inter alia, how women have participated or were represented meaningfully in decision-making and feedback, and will provide sex-disaggregated data.
- Assess the level of sustainability (financial, institutional and social) of the individual project components, and identify critical areas that may affect sustainability.
- Provide recommendations on future project design including how to ensure log frames are more effective.

1.2.2 Evaluation criteria

The matrix in table 1.1 summarises the evaluation criteria and key evaluation questions:

Table 1.1: Evaluation criteria and questions

Evaluation Criteria	Key evaluation questions
Assess the effectiveness of project interventions	<ul style="list-style-type: none"> ▪ To what degree have project outcomes been achieved? Were there any unexpected outcomes? ▪ What changed and who has benefited (women, men, girls, boys, health workers, CSO's, county) and in what ways? ▪ Are those changes (outcomes) relevant to people's needs? ▪ Have there been changes to policies, practice and attitudes of decision and policy makers to benefit the project's target groups? ▪ To what extent has the project contributed to the achievement of broader national and international policies, conventions, targets in the county where the project is working? ▪ To what extent has the achievement of the changes/ outcomes been influenced by external context and other factors? ▪ What have been the most effective methodologies and approaches the organisation used to bring about changes to people's lives? What has worked and what has not? What lessons have been learned? ▪ How effective is the projects partnership with MoH, Communities and other stakeholders? ▪ What is the capacity of health care workers and the health facilities in providing quality and responsive MNCH services? ▪ How effective have the project's management, monitoring, learning and financial systems been? How have they helped or hindered the delivery of lasting change? What learning has the organization drawn from the project, to improve programming and project design?
Assess the efficiency of approaches used in implementation of project activities	<ul style="list-style-type: none"> ▪ Has the project been cost effective? Did the project utilize the resources efficiently to achieve the outcomes within the implementation sites? ▪ How efficient were the management and accountability structures of the project? ▪ How have relationships between partners throughout the relationship chain helped or hindered the delivery of change /outcomes? ▪ To which extent have the intervention been harmonized between different actors, promoted synergies, avoided gaps, duplications and resource conflicts?

<p>Assess the relevance of the project within the prevailing context of devolved system of governance</p>	<ul style="list-style-type: none"> ▪ Were the achieved changes relevant to the identified priority needs and aspirations of the beneficiaries? Have changes in the environment affected its relevance? ▪ Were the project inputs and strategies realistic, appropriate and adequate to achieve the project overall results? ▪ Are there alternative approaches which have proved to be more relevant to the context in the implementation sites?
<p>Assess Project sustainability mechanism</p>	<ul style="list-style-type: none"> ▪ What advocacy efforts did the project put in place for sustainability? ▪ Is the MOH committed to the project initiatives and likely to support continuation of the initiatives, what initiatives have the MOH taken over? ▪ How did the project work with existing Government, community and other stakeholders' structures in building their capacity to be able to sustain the project? ▪ Are there existing challenges that may hinder sustainability of the project initiatives?

CHAPTER 2. EVALUATION APPROACH AND METHODOLOGY

2.1 Evaluation Logic Model

While there are various approaches to assessing service provision at community and health facility level, we utilized the continuum of care approach (CCA) for this evaluation. As a paradigm, the Continuum of Care approach (figure 1), is formulated to address issues relating to maternal, newborn and child health by focusing on the access to care provided among families and communities, by outpatient and outreach services, and by clinical services throughout the lifecycle, including adolescence, pregnancy, childbirth, the postnatal period, and childhood.

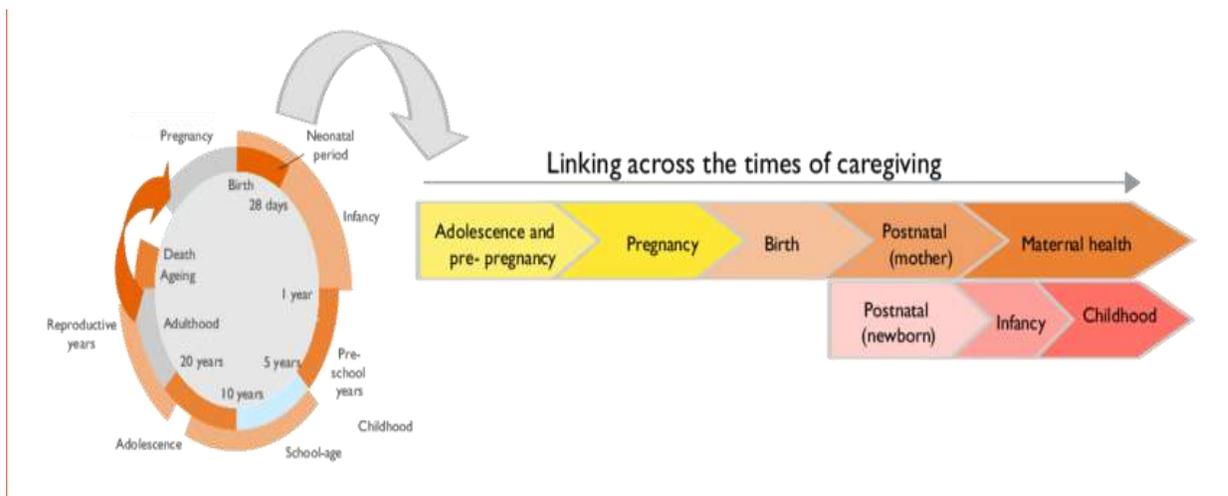


Figure 2.1: Connecting Care Giving Across the Continuum for Maternal, Newborn and Child Health

The use of the CCA approach allowed the assessment of how well MNCH-RH services are integrated at various level of the continuum of care ranging from the household, the community and the facility levels. The CCA approach fits well with both the KEPH and the Community strategies, which are together aimed at addressing the health care needs from the community to tertiary levels. The CCA approach examined issues relating to MNCH-RH across a continuum starting from pre-pregnancy, through pregnancy, childbirth, and the early days and years of life as illustrated in figure 2.1. The Continuum of Care approach also provides a useful framework for identifying various places of care giving whose capacity to provide care should be strengthened and linked in order to adequately address health care needs relating to MNCH as illustrated in figure 2.2.



Figure 2.2: Places of Care Giving for Maternal, Newborn, and Child Health

Based on this approach, the evaluation too examined the capacities that exist at both community and health facility level to address the above components of MNCH-RH at two levels; the community and the facility level. At community level, the assessment focused on documenting knowledge, attitudes, practices and behaviour (KAPB) of the community in relation to care-seeking patterns, and demand for MNCH-RH. In addition, community based structures that support MNCH-RH including HFMCs and SCHMTs were documented, as well as the perspectives of different community leaders (including, opinion leaders, religious leaders, government health workers etc.) on their current attitudes to MNCH-RH. In particular, community attitudes relating to MNCH-RH services such as childhood immunization demand for and use of ANC, delivery by skilled personnel, PMTCT service utilization, family planning service utilization, utilization of insecticide treated nets (ITNs) by pregnant women, and, male involvement in MNCH-RH services were explored.

2.2 Evaluation Design

This was descriptive cross sectional design that employed both qualitative and quantitative methods. Multifaceted qualitative approaches were used based on social norms theory (Berkowitz, 2004), theory of planned behavior (Ajzen, (1991) and health belief model (Rosenstock, 1966).

2.3 Population of Interest

The evaluation targeted the women and men of reproductive ages and other stakeholders within Kisumu County:

Specifically the evaluation targeted the following project beneficiaries:

- Women of child bearing age category 15-49
- Children under 5 years
- Opinion leaders drawn from women groups, chiefs and teachers, etc.
- Community members including men and vulnerable groups
- Public and Private health care providers in the supported hospitals
- County and Sub County Health Management Teams

2.4 Data Collection Methods

A combination of qualitative and quantitative data collection methods was applied in carrying out the end term evaluation.

2.4.1 Qualitative Methods

A number of qualitative data collection methods were employed. These included document reviews, focus group discussions (FGDs), and Key informant interviews (KIIs).

Documents and Literature Review

The consultants reviewed various national guidelines, programs and relevant documents on maternal and child health in Kenya with a bias on the targeted population, project documents. Specifically documents reviewed included but not limited to: the project proposal, project log frame, baseline survey report, Midterm evaluation report, Annual and Semiannual reports produced by the project team during the course of the project.

Key Informant Interviews (KIIs)

To help cross-check and authenticate the information provided by respondents, key informants with valuable insight and knowledge on project interventions were interviewed. The information obtained through key informants included soliciting their views on relevance, effectiveness, efficiency, sustainability, lessons learnt, best practices, facilitating factors, challenges in implementation and their recommendations for future programming.

To this end, the consultants held discussions with key Project Management Team at the Care (K) offices in Nairobi and the MNCH Project Manager based in Kisumu as well as FHOK

and KRCS team to get information on project activities and strategies being used to reach the communities (linkages and partnerships) in place. Further interviews were held with County Health management Teams (CHMT), Sub-County Health Management Teams in Kisumu and Health Facility in charges in supported health facilities.

Focus Group Discussions (FGDs)

The consultants used Focus Group Discussion (FGDs) to gather information on a set of relevant questions in a group environment. FGD is a good method for getting people to express a range of different opinions about topical issues such as maternal and child health, family planning, nutrition and ASRH. The FGDs were conducted with WRA, CHVs, CHCs, men, adolescent boys and adolescent girls. They were facilitated by experienced moderators assisted by the note takers. All the FGDs were tape recorded and later transcribed using persons with in-depth understanding and knowledge on transcriptions

Table 2.1: Sampling for qualitative methods

Respondent category	Sample size	Rationale
Women	<ul style="list-style-type: none"> • 2 FGDs 	<ul style="list-style-type: none"> • Participants were drawn from all villages and mixed ethnically so as to generate diverse views.
Men	<ul style="list-style-type: none"> • 2 FGDs 	<ul style="list-style-type: none"> • Participants were drawn from all villages and mixed ethnically so as to generate diverse views. It included project beneficiaries sensitized on Male involvement.
Adolescents boys and girls	<ul style="list-style-type: none"> • 1 FGD for boys • FGD for girls 	<ul style="list-style-type: none"> • Participants were drawn from all villages and ethnically mixed. The FGDs were separated for boys and girls to enhance participation and capture gender dynamics.
Community Health Volunteers (CHVs)	<ul style="list-style-type: none"> • 2 FGDs 	<ul style="list-style-type: none"> • CHVs were drawn from the existing Community Units (CUs) supported by the project.
Community Health Committees (CHC)	<ul style="list-style-type: none"> • 2 FGD 	<ul style="list-style-type: none"> • CHCs from the existing CUs supported by the project ensuring good mix of gender
Key informants	<ul style="list-style-type: none"> • Project Team from CARE, FHOK and KRCS • CHMT • SCHMT 	<ul style="list-style-type: none"> • The Key informants were those thematically determined based on the contribution to the project

	<ul style="list-style-type: none"> • Health Facility In-charges • Health providers • CHEWs 	
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2.4.2 Quantitative Methods

Household Interview

This was the main technique used to collect data from the respondents in the targeted communities. The purpose of this method was to record the endterm situation, problems, and demographic profiles of the specific target categories of respondents (mothers and children). A cross sectional household survey covering a representative sample of households drawn from the target populations was included in the study using questionnaires similar to that used in the demographic and health surveys (DHS). The English household questionnaires were translated into Luo language to standardize the way questions were asked in particular among the illiterate mothers. The use of locals was encouraged and as far as possible, the research team avoided on-the-spot interpretations since this tends to produce more errors in data collection.

Quantitative technique was used to collect data from the target women respondents (15-49). A two stage cluster sampling was applied using villages as cluster strata and households as the sampling unit. Only households with children under five were included in the sample. The maternal and child health tool captured data on: antenatal care coverage, number and timing of antenatal visits, components of the antenatal care: including tetanus toxoid vaccination, child immunization coverage including measles, DPT, polio etc; vaccination in the 1st year of life including up to age 5; delivery care including place of delivery, assistance during delivery, post-natal care; prevalence of diarrhoea and its management, treatment / health seeking behaviour and feeding practices during diarrhoea. Also to be included was the usage of long lasting insecticide treated nets (LLITNs) among the pregnant women and children aged less than 5 years.

To evaluate the nutritional status for children within the project area, the evaluation captured anthropometric data by measuring the height and weight of all children aged 6-59 months in the households. The data was obtained with the aim of calculating three indices namely, weight-for-age, height for age and weight-for-height all of which take age and sex into consideration. The following information was gathered from all eligible children aged 6-59 months:

- **Age:** The child's immunization card, birth certificate or birth notification was the primary source for this information. In the absence of these documents, a local calendar of events developed with community members, enumerators and child's caretakers were used to estimate these.
- **Sex:** This was recorded as either 'f' for female or 'm' for male.

- **Weight:** A bathroom secca “digital” scale was used to measure the children’s weight. These were calibrated using a standard weight to ensure accuracy
- **Height:** A height board was used to measure height while length was taken for children less than 2 years of age with heights measurements taken for those aged two years and above.
- **MUAC:** measured on the left arm, at the middle point between the elbow and the shoulder, while the arm was relaxed and hanging by the body’s side. MUAC was measured to the nearest mm. In the event of a disability the right arm was used or for those who are left-handed, MUAC was taken on the right arm.
- **Bilateral Oedema:** This was assessed by the application of moderate thumb pressure for at least 3 seconds to both feet. Only children with bilateral oedema were recorded as having nutritional oedema.
- **Maternal nutrition:** Mothers or caretakers of reproductive age (15-49 years) in the sampled household were taken a MUAC measuring to determine their nutritional status.

Client Exit interviews

Client exit interviews were conducted among clients visiting the facility for FP, MNCH and ANC services to understand the range of services available and their perception on the quality of services. A particular emphasis was made on the attitude of healthcare workers from the perspective of clients. A total of 200 exit interviews were targeted from two facilities that were supported by the project namely, Migosi health Centre and Nightingale hospital.

The client exit interview examined the following areas:

- Family Planning
- Antenatal care
- Post natal care.
- Child Welfare clinic

2.5 Sampling and Sample Size

Sample design

A two-stage sampling design was used. In the first stage, a random sample of clusters was selected for each sub county based on probability proportional to their population (PPP). The number of clusters selected from each sub county was determined based on population data from the 2009 Kenya Population and Housing Census which detailed the number of women and men per household in each locality. In the second stage, a minimum of 20 households was selected in each cluster in order to create a representative sample. The target population of women respondents aged 15-49 years residents of the household on the dates of the survey in Kisumu were sampled and interviewed individually.

Sample Size Determination

The target sample size for the target areas was calculated using the formula below:

For the calculation of the sample size, the key indicator used is the immunization coverage among children age 12-23 months. The following formula was used to estimate the required sample size for these indicators:

$$n \equiv \frac{4 (r) (1-r) (f) (1.1)}{[(0.12r)^2 (p) (nh)]}$$

where

- n is the required sample size, expressed as number of households
- 4 is a factor to achieve the 95 per cent level of confidence
- r is the predicted or anticipated prevalence (coverage rate) of the indicator
- 1.1 is the factor necessary to raise the sample size by 10 per cent for non-response
- f is the shortened symbol for *deff*(design effect)
- $0.12r$ is the margin of error to be tolerated at the 95 per cent level of confidence,
- defined as 12 per cent of r (relative sampling error of r)
- p is the proportion of the total population upon which the indicator, r , is based
- nh is the average household size.

For the calculation, r (the immunization coverage) was assumed to be 71 percent. The value of *deff* (design effect) was taken as 1.3 based on estimates from previous surveys, p (percentage of children aged 12-23 months in the total population) was taken as 3.2 percent, and nh (average household size) was taken as 4.4 households.

The resulting number of households from this exercise was $n = 400$ households which was the sample size be distributed across the intervention areas based on individual population weights. The average cluster size was determined as 20 households.

Household characteristics were obtained from the household head or someone available and knowledgeable about the household. All children under five had their weight, height and immunization history taken and recorded by competent health workers who served as the supervisors in this project.

2.6 Data collection process

The data collection took place using the following steps:-

Step one: Recruitment and Training of Research Assistants and Pre-testing of tools

The research team in collaboration with Care (K) recruited qualified RAs to assist in data collection. The criteria for recruitment included; possession of language and cultural skill appropriate for the study site as well as prior experience doing both quantitative and

qualitative research on health-related behaviours. The consultant strived to recruit an equal number of men and women as RAs to ensure gender-sensitive data collection.

Data collection was preceded by a two day intensive training session to orient RAs on the purpose and objectives of the study; to instill a shared perspective of the study. During this training, pre-testing of tools was undertaken as part of the research assistants' training. Any grey areas in the tools were clarified and suggestions incorporated into the final tools. All research tools were approved by Care (K) before the commencement of data collection.

Step two: Pre-testing of data collection tools

Once the tools of data collection had been developed, they were pre-tested in one of the sites in order to ascertain the tools' appropriateness and suitability in line with the study objectives. The pre-tested tools were revised in readiness for the actual data collection.

Step three: Actual data collection

The RAs conducted household interviews. However, it was the responsibility of the consultants to verify the completeness and thoroughness of the questionnaires before handing them over to data entry clerks. The consultants facilitated the FGDs. Each FGD was done by two researchers to ensure smooth running of sessions. The RAs assisted in recording in writing the FGD proceedings.

All interviews and FGDs were conducted in a language in which participants are conversant. Audio recordings were made using a digital voice recorder with the consent of the participant(s). In addition to audio recordings, extensive notes were also taken to supplement audio recorded information. In both cases, interviews or FGDs were carried out at an agreed upon venue that offers much privacy.

Step four: Supervision and quality control

During the fieldwork, the consultant's met with the RAs and field coordinators daily for debriefing. The Consultants, besides coordinating the fieldwork conducted the IDIs and facilitated focus group discussions.

2.7 Data analysis

All the quantitative data from the household surveys was entered and analyzed using the Statistical Package for Social Scientists (SPSS version 20). Data was checked for inaccuracies and inconsistencies daily before entry and verification. Proportions for key outcomes have been presented with 95% confidence intervals. Anthropometric data was analysed in ENA for SMART software November 2012 version. Daily data entry was undertaken for all data sets so as to ensure close supervision and quality of data as the survey progressed. Extreme

values flagged by the software were excluded from the final analysis. On the other hand, Qualitative data was taped, translated into English, transcribed and typed into Microsoft word software. It was then stored and managed using Nvivo8 (QSR international). Preliminary analysis entailed open coding and progressive categorization of issues based on inductive (where analytical categories were derived gradually from the data) and deductive approaches (where ideas from the interview schedule shaped the coding scheme). Final analysis was organized around a description of the main issues identified. Validity and rigor was enhanced during the interpretative analysis through a series of feedback sessions with members of the research team.

2.8 Quality Assurance Measures

Throughout, the research team endeavoured to mitigate or minimize the impact of any constraints by employing a methodology carefully designed to be pragmatic and by deploying resources efficiently. Risks associated with misinterpretation are inherent in consecutive translation, but a number of strategies were used to improve on accuracy. Tools were refined through pretesting. During interviews, the research team validated sections of narrative that are transcribed ad verbatim and certain responses reiterated for clarification and confirmation. Transcripts were further cross-referenced with field notes and areas of digression highlighted and discussed. Comparison between initial field analysis and use of NVIVO was used as a benchmark for reliability. Thus triangulating results using separate techniques ensured the rigor of the analytical process.

2.9 Ethical considerations

Informed consent is universally recognized as a central component of ethical conduct in research involving people. Informed consent is given when a competent person who has received and understood sufficient information voluntarily decides whether or not to take part in research. Informed consent can be obtained in verbal or written form depending on the nature of the study and the setting. In this study verbal consent was sought from all respondents. As far as possible, data collection was planned around local community timetables and took considerations of events and routine activities. The research aim and processes were explained to all participants as appropriate, and their informed consent was obtained both for participation and for recording of interviews where applicable. Protecting the identity of participants at the point of data collection and reporting is an important ethical procedure. During all FGDs, use of number tags in place of names was used to ease note taking and to anonymous data at the point of collection and reporting when using quotes. Interviewees were also given an option of not using tape recorders during interviews or if they did not want their quotes used during reporting.

2.10 Limitations

There is a limitation that between midline and end line no routine measurement was done such as that done in the Kenya Demographic and Health Survey (KDHS) hence the measurement of some indicators such as Maternal Mortality rate is based on the last KDHS of 2014/15.

CHAPTER 3. EVALUATION FINDINGS AND DISCUSSIONS

This chapter provides the key evaluation findings which are organised to align with the objectives and criteria of the evaluation. Socio-demographic profile of the household survey respondents is provided as a start to provide a preview of the context.

3.1 Socio-demographic Characteristics

The characteristics of the respondents are summarized in Table 3.1. The table depicts the key parameters such as marital status, level of education, religion, as well as the main economic activity of the household as these are some of the individual factors known to influence uptake of programmatic interventions. From the results, it emerged that majority (84.5 percent) of the respondents are currently married or living with a partner with the proportion of respondents who have never married being 13.7 percent, while 1.6 percent are either divorced or separated and 0.2 percent are widowed. In terms of the education level most respondents were literate with 41.6 percent having a secondary level education, 48.2 percent had primary education whereas 7.3 percent have a tertiary level education as depicted in Table 3.1.

Table 3.1: Socio-demographic Characteristics

Characteristic	Description	Frequency	Percent
Cluster (n=505)	Manyatta	282	55.8
	Nyalenda	223	44.2
Religion (n=501)	Protestant	301	60.1
	Muslim	8	1.6
	Roman Catholic	92	18.4
	Adventist	55	11.0
	Traditional religion	15	3.0
	Others	26	5.2
	None	4	0.8
Marital Status (n=503)	Single/never married	69	13.7
	Married	425	84.5
	Divorced/separated	8	1.6
	Widowed	1	0.2
Highest level of education of respondent (n=452)	Preschool	3	0.7
	Primary	218	48.2
	Secondary	188	41.6
	Tertiary/University	33	7.3
	Post graduate	5	1.1
	Others	5	1.1

3.2 Effectiveness of the Project Interventions

This section presents findings of the evaluation with regards to the extent to which the project outcomes were achieved, comparing the end-term status with the situation at baseline and midterm for key performance indicators. Where data is available, comparison is also drawn between the current status in the project areas with that of the county and national averages for key MNCH indicators.

Promote Interests of the vulnerable groups

<i>SO1-Indicator 4:</i>	<i>Ensure that interests of vulnerable population groups are voiced in at least 25% of all County Public resource allocation forums by 2017</i>
<i>Achievement:</i>	<i>The project through advocacy with the county and sub county groups has promoted the interests of the vulnerable groups</i>

The vulnerable groups in the context of the project included adolescents, HIV positive pregnant women, people living with disability and the youth.

During the ETE, through interviews with the project team, the CHMT and FGDs with adolescents, it emerged that the project facilitated and supported twelve (12) forums of which six (6) forums discussed interest of vulnerable groups and sensitized the county officials on the needs and challenges of the vulnerable groups. This led to the organization of a youth convention attended by over 800 youths within the county where they used theatre art and participatory edutainment to pass on reproductive health messages and educate the youths on dangers of early pregnancy, early sex and need to seek care in recognized health facilities when affected.

To augment these gains, the project engaged the adolescents through interactive radio talk shows sponsored by the project and the key guiding topics of discussion were on Family Planning, gender mainstreaming, dangers of early pregnancy and seeking early care utilizing youth friendly services at the health facilities.

Finally, the project engaged mentor mothers to offer services to HIV exposed mothers and their infants. These mentor mothers encouraged the women to screen for HIV and also participated in referring HIV exposed pregnant mothers to receive quality care during their pregnancy period at the health facilities.

Capacity Building

<i>R1-Indicator 1:</i>	<i>Increase the number of health facilities providing both essential MNCH services and full High Impact Nutrition Interventions (HiNi) package from 2 to 5 in Kisumu slums</i>
<i>Achievement:</i>	<i>The capacity of the health facilities has been improved from 2 to 8. All the 8 facilities are now offering essential MNCH services except conducting deliveries on a 24 hour basis</i>

The end term evaluation results established that this has been achieved with all the 8 EU, ADA and CARE supported health facilities currently offering the integrated packages of

high quality MNCH, FP/SRH and nutritional services as targeted by the project within Manyatta and Nyalenda by the time of end term evaluation.

<i>R1 –Indicator 2:</i>	<i>Increase the number of health facilities offering comprehensive long-term FP/SRH services from 4 to 8 in Kisumu slums</i>
<i>Achievement:</i>	<i>All the 8 health facilities supported by the project are now offering comprehensive long-term FP/SRH methods.</i>

With regard to increasing the number of health facilities offering comprehensive long-term FP/SRH services from 4 to 8 in Kisumu slums, the evaluation established that all the 8 health facilities have been equipped and staffs trained to offer the comprehensive package of MNCH, FP/ SRH and Nutrition by the project. Through the project resources all staffs from the 8 EU supported facilities were trained on the thematic areas and given the basic equipment to offer the comprehensive packages.

Interviews with health care workers revealed that, as a result of the On Job Trainings (OJTs) and Continuous Medical Education (CMES) provided by the project, they are now proficient enough to offer Long Acting and Permanent Methods (LAPMs) both during in-facility and outreaches. Additionally, through FGDs with CHVs, it emerged that the community strategy approach promoted by the project ensured communities and clients are sensitized on the availability of the services at the supported facilities and mobilization leading to an increase in utilization of the in reach and outreach services.

<i>R1 –Indicator 3:</i>	<i>Increase the number of community health units offering comprehensive level 1 Sexual, Reproductive, Maternal and Newborn Health (SRMNH) and nutrition services in Kisumu slums from 0 to 4 units by 2017</i>
<i>Achievement:</i>	<i>The project supported the establishment of 8 functional Community Units (CUs) offering comprehensive level 1 SRMNH and nutrition services in Kisumu slums</i>

The Community Health Strategy (CHS) was adopted in 2006 as a national approach aimed at taking the Kenya Essential Package for Health (KEPH) to the community level and enhancing involvement and engagement of communities in taking charge of their own health care. The KIFH project supported the establishment of 8 Community Units (CUs) offering comprehensive level 1 SRMNH and nutrition services in Kisumu slums. By the end term evaluation, using a community unit score card and after interviews with the Sub County Community strategies focal point it was reported that all the 8 community units established by the project as initially targeted are now fully functional and are offering all the essential services within the community health strategy package.

The improvement in CU functionality was attributed to the support provided by the project including training and ongoing mentorship; strengthening CU-health facility linkage; provision of IEC materials, basic medical kits, reporting tools, t-shirts and bags; and supporting CHVs to initiate Income Generating Activities (IGAs). Three key training areas were the focus of this project, namely: (1) training of CHVs, CHCs and CHAs on the basic

modules of the CHS that provided them with understanding of their roles and essential skills of working with communities, (2) technical modules focusing on MNCH, Community-based Integrated Management of Childhood Illnesses (C-IMCI) and Water, Sanitation and Hygiene (WASH), and (3) Community-based Health Management Information System (CBHMIS). In addition, the CHVs received regular support supervision from CHAs and SCHMTs.

The evaluation found that the project support enabled the CHS structures to adequately undertake their envisaged roles. Community members and key informants affirmed that CHVs were key sources of health information and were influential in changing behaviours and creating demand for services. The evaluation found that CHVs created awareness through interpersonal communication conducted during home visits (each CHV was allocated 20 households), through public meetings, village forums and community dialogue and action days. The CHVs are also offering MNCH, FP/SRH and Nutrition services as per MOH minimum package requirement.

In the focus group discussions with mothers and interviews with key informants, CHVs were said to have contributed significantly in the increased uptake of RMNCH services. For instance, CHVs conducted home follow-up of pregnant and lactating mothers to ensure they made the recommended four ANC visits, had birth plans and their children received immunisation on schedule.

“...I attribute the increase in service uptake to the awareness creation done by the CUs....where we have active CUs it is very rare to find a mother who does not complete more than 4 ANC visits... during their home visits the CHVs identify eligible mothers and refer them to the health facility or sometimes escort the reluctant ones. After training of the CHVs on community IMCI we noted improvements in mothers’ knowledge of danger signs and importance of birth planning. The messages from the (CHVs) are reinforced by the health care workers during facility-based counselling sessions.” Key Informant, Migosi SCH.

<i>R1 –Indicator 4:</i>	<i>At least 75% of clients report that targeted health actors demonstrate improved attitude towards clients (women, adolescents)</i>
<i>Achievement:</i>	<i>Improved attitude towards clients (women, adolescents) from the 40% reported at baseline to 94.9% at endterm</i>

The evaluation established an improved attitude towards clients (women, adolescents) from the 25% reported at baseline to 94.9% at endterm. The remarkable improvement could be attributed to the support the health facilities got from the project. This has in effect led to increased number of clients accessing the targeted services. This increase in the number of final beneficiaries accessing services suggests an increased level of confidence towards health providers and an improved attitude of health workers towards clients. Exit interviews also show that people have confidence in the facilities supported by the project and their staff. Most health facility staff is willing to efficiently work with the project team, even during prolonged hours of outreaches (Figure 3.1).

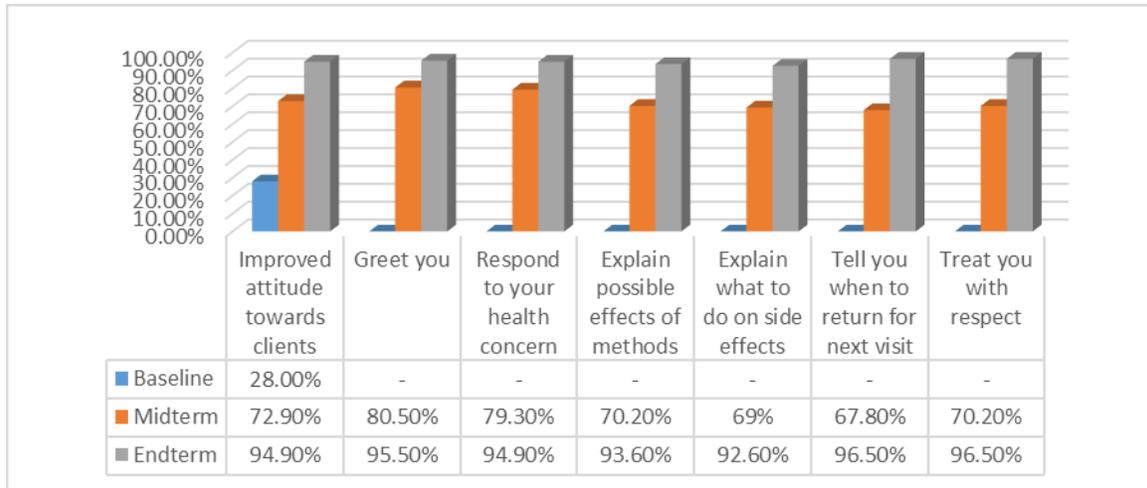


Figure 3.1: Attitude towards clients (women, adolescents)

As highlighted in the earlier sections of this report, capacity of health facilities to provide quality MNCH services has improved as a result of enhanced technical and soft skills among health care workers as well as availability of essential equipment and commodities. The prospect that this change will be sustainable seems positive for a number of reasons. First, improved technical skills gained from the project will remain and can be propagated through peer-to-peer knowledge and skills transfer (including through CMEs, OJTs and mentorship) that have been institutionalised by the SCHMTs. Monthly CMEs and mentorship through quarterly supportive supervisions have become routine agenda items in the plans of all the four SCHMTs. The quality and responsiveness of care offered at health facilities is likely to be sustained under the leadership of quality improvement teams and through support supervision by SCHMTs.

In regard to capacity building of health care worker, the lesson learnt was that soft skills such as customer care, effective communication and positive work attitude are as critical as technical skills. Training of health care provider on soft skills results in tremendous improvement in utilisation of services and client satisfaction. For the SCHMTs, building their leadership and managerial capacity results in better health governance including more effective planning, motivated workforce and ultimately better quality of services.

Maternal Health Services

The health status of mothers and children is an important indicator of the overall economic health and well-being of a country (United Nations, 2010). Maternal health is inextricably linked with the survival of newborns. For every woman who dies, another 30 suffer long-lasting injuries and illnesses such as obstetric fistula (UNDP, WHO, UNFPA, and World Bank, 2006). The International Conference on Population and Development, held in Cairo, Egypt, in 1994, called for the development of comprehensive reproductive health policies,

programmes, and implementation plans (UNFPA, 1994). This call defined the focus of the Kenya National Reproductive Health Programme, through which efforts towards improvements in maternal health have been made by ensuring the continuum of care during pregnancy, labour and delivery, and the postnatal period resulting in reduced maternal and neonatal morbidity and mortality.

To improve the quality of the maternal health services, the project did the following:

Enhancing infrastructure and provision of basic equipment: At the beginning of the project, Care Kenya observed some critical gaps in availability of requisite infrastructure and equipment that was critically hampering delivery of MNCH services in some health facilities. A priority list of health facilities to be renovated/ improved and equipment gaps to be filled by the project was agreed on with the SCHMT and health facility in-charges. The priority infrastructure and equipment support provided included the following: (1) renovation of health facilities to provide conducive room for MNCH services; (2) provision of basic equipment to enhance capacity of health facilities to provide quality MNCH services. Some of the equipment provided included weighing scales, fetoscopes, delivery couches, blood pressure machines among others.

In addition to the above direct project support that was aimed at improving capacity at level 2 and 3 health facilities, the project worked closely with SCHMT, CHMT and other actors to address other health systems challenges that hampered delivery of quality services. Particularly, the project targeted the SCHMT and CHMTs with policy advocacy and lobbying for allocation of additional resources. The primary focus of the project's advocacy was on increasing the human resources for health (HRH) especially the number of health workers available at level 2 and 3. Lobbying for additional resources was conducted during county and sub county forums and through face-to-face meetings with key decision makers.

Key informants affirmed that over the last three years the capacity of health facilities to provide quality services had improved as a result of County Government investments and the support of partners including Care Kenya. In regard to essential commodities, consistent availability had improved and less stockout were experienced since County government signed a memorandum of understanding with Kenya Medical Supplies Authority (KEMSA). Additional support such as distribution logistics and training on quantification of needs were complemented by the project and other partners. The impact of these investments in the level 2 and 3 health facilities has resulted in clearly discernible outcomes as aptly summed up in the quote below:

"... Most dispensaries were not conducting deliveries. maternity services were thought to be beyond the capacity of a dispensary. Most dispensary health workers lacked skills or the confidence to conduct a delivery...even the very basic skills like use of partograph to monitor labour were lacking. Dispensaries were like a forwarding station, any mother who came in labour they would simply call an ambulance or ask the mother to organise own transport. But over the last 3 years, things have changed. With more staff, availability

of equipment and commodities and improvement in skills, dispensaries are now able to handle normal deliveries and do primary management of complications if they occur.” Project Staff

Support Supervision: During the ETE, SCHMTs reported having adequate resources for support supervision as a result of an increase in allocation within the county government budget and additional support from partners including Care Kenya. The SCHMTs demonstrated better planning and inspired local solutions to challenges. Moreover, prioritisation of limited resources has improved and there has been notable improvement in the SCHMT’s support supervision skills.

Antenatal Care

<i>Outcome indicator:</i>	<i>% of women with antenatal care from a skilled provider</i>
<i>Achievement:</i>	<i>Access to ANC has remained high, nearly universal in the entire project site, 99% at endterm compared to the 97% reported during baseline.</i>

Antenatal care is one of the high impact interventions in the area of Maternal and Child Health. WHO recommends a minimum of four ANC visits, ideally at 16 weeks, 24-28 weeks, 32 and 36 weeks (USAID/Population council, 2006). Each visit should include care that is appropriate to the overall condition and stage of pregnancy and should include four main categories of care (with specific examples provided for each category):

- Identification of pre-existing health conditions (e.g., check for weight and nutrition status, anaemia, hypertension, syphilis, HIV status)
- Early detection of complications arising during pregnancy (e.g., check for pre-eclampsia, gestational diabetes)
- Health promotion and disease prevention (e.g., tetanus vaccine, prevention and treatment of malaria, nutrition counselling, micronutrient supplements, family planning counselling)
- Birth preparedness and complication planning (e.g., birth and emergency plan, breastfeeding counselling, antiretroviral for HIV positive women and reducing mother-to- child transmission [MTCT] of HIV)

The results of the evaluations showed that there was a slight increase on the proportion of women reporting ANC utilization which was 99% at endterm compared to 97% reported during baseline. This figure compares with the National average, which has ANC utilization at 95.5%(KDHS 2014). Figure 3.2 depicts the ANC coverage, an indicator for access to antenatal care services.

When asked who provided them with the ANC services, a majority mentioned doctors, nurses and midwives indicating that ANC was from a skilled provider. As aptly captured in the quotes below, the improvement in utilisation of ANC services is attributable to increased

awareness and mobilisation conducted by CHVs through home visits and community dialogue “...the CHVs have really helped us, they go round educating and urging every woman who is expectant on the importance of attending clinics” Woman participant in an FGD.

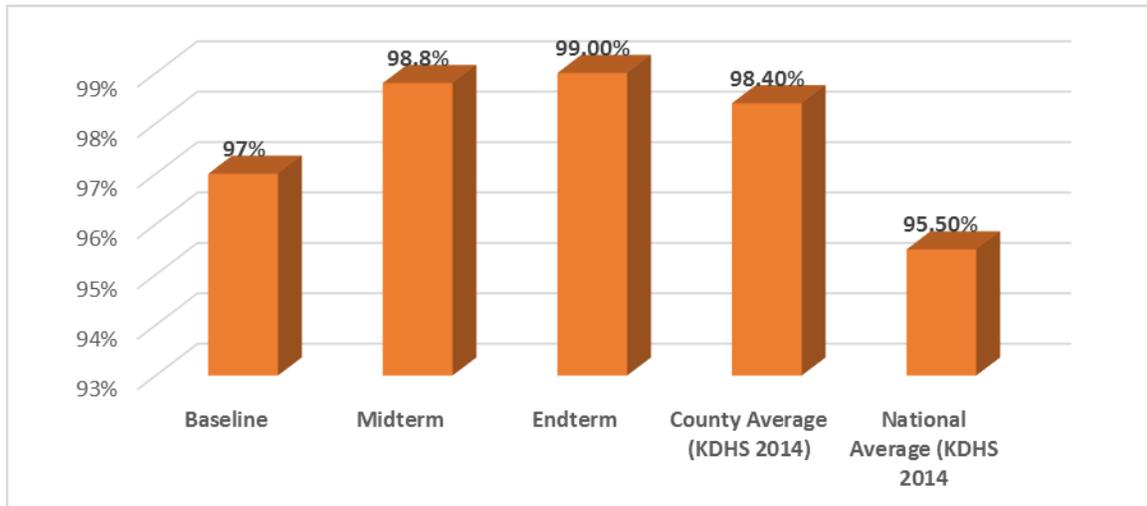


Figure 3.2: Proportion receiving antenatal care from a skilled provider

Number of Antenatal Visits- Focused Ante-Natal Care (FANC)

<i>SO2 - Indicator 1:</i>	<i>Increase the proportion of pregnant women attending 4 or more ante-natal care visits from 65% to 70% in Kisumu slums.</i>
<i>Achievement:</i>	<i>There has been a 6.9 percentage point improvement (from 65% at baseline to 71.9% at endterm) in the proportion of mothers of children 0-23 months who attended ANC at least four times during most recent pregnancy</i>

Regular antenatal care is helpful in identifying and preventing adverse pregnancy outcomes when it is sought early in the pregnancy and is continued until delivery. It is possible during these visits to detect health problems associated with a pregnancy and to plan interventions. In the event of any complications, more frequent visits are advised, and admission to a health facility may be necessary (MOH, 2012). The ETE established that 71.9% met the FANC requirement of 4 comprehensive care visits as compared to the baseline of 65% which indicates a 6.9 percent improvement in the percentage of women meeting the national policy requirements compared to the situation at baseline. The national figure according to KDHS 2014 is 58% of women reported having four or more ANC visits. The positive results achieved on this indicator can be attributed to the community partnerships / linkages and referral systems put in place by the project. All the facilities in the project area have committed CHWs linked to the health facilities to support community health outreaches and referrals.

In the focus group discussions with mothers and interviews with key informants CHVs were said to have contributed significantly in the increased uptake of RMNCH services. For instance, CHVs conducted home follow-up of pregnant and lactating mothers to ensure they made the recommended four ANC visits, had birth plans and their children received immunisation on schedule.

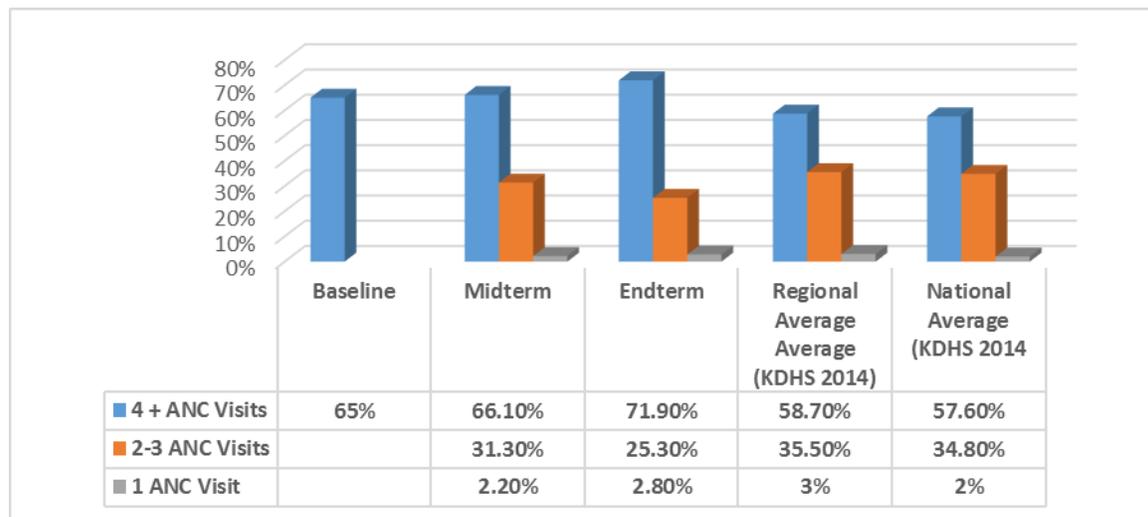


Figure 3.3: Proportion of mothers of children 0-23 months who attended ANC at least four times during most recent pregnancy

From the FGDs with CHVs, it was noted that women have been taught about ANC through household visits by the CHVs. Hence most mothers are aware of the number of times they should attend ANC clinics and the importance of ANC visits which include finding out if they have any disease and, if necessary, how they can benefit from drugs like IFAS, and detect complications or danger signs. This aspect was brought out by a CHV who had this to say: *“We do home visits, and follow up ANC mothers. We go round village asking if mothers have gone for second ANC visit, if she did not go, we tell her to go. If a mother delivers, we come check on her at night, take her to hospital and if everything is okay we leave her with the husband to go back home.”*

As aptly captured in the quotes below, the improvement in utilisation of ANC services is attributable to increased awareness and mobilisation conducted by CHVs through home visits and community dialogue as well as traditional birth attendants who acted as referral agents.

“...the CHVs are everywhere and they go round urging every woman who is expectant to come for the clinics” Woman participant in an FGD at Nyalenda

Relationship between Focused ANC and Socio-demographic Characteristics

To ascertain the determinants of uptake of services, a further analysis was done to using chi square test to establish the relationship between FANC and various demographic characteristics. The results indicated that only education status was significantly associated with FANC. Participants with post primary education (secondary, university, post graduate

education level) tended to practice more FANC than those with primary education level only.

Table 3.2: Relationship between Focused ANC and Socio-demographic Characteristics

Variable		Focused ANC				X^2	<i>df</i>	<i>P-value</i>
		3 or less ANC attendance		4+ ANC attendance				
		no.	%	no.	%			
Marital Status	Single/living alone	23	30.7%	52	69.3%	0.342	1	0.559
	Married	115	27.4%	305	72.6%			
Education Status	Primary	68	32.1%	144	67.9%	3.845	1	0.05
	Post Primary	53	23.7%	171	76.3%			
Religion	Protestants	85	28.6%	212	71.4%	4.136	4	0.388
	Muslim	3	37.5%	5	62.5%			
	Roman Catholic	26	28.6%	65	71.4%			
	Adventists	10	18.9%	43	81.1%			
	Traditional Religion	2	13.3%	13	86.7%			

Quality of antenatal care

Measuring the content of antenatal care is essential for assessing the quality of antenatal care services. Pregnancy complications are a primary source of maternal and child morbidity and mortality. To help assess the quality of antenatal services, respondents were asked whether they had been advised of complications or received certain screening tests during at least one of their antenatal care visits. Respondents were asked whether they had received each of the following services at least once during the antenatal care visits: weight and height measurement; blood pressure measurement; urine and blood sample taken; were tested for HIV; counselling for infant feeding options in case of HIV and counselling on or receipt of IPT for malaria.

The answers given were dependent on their recall of events during their last antenatal visits, which may have taken several months before endterm. Nonetheless, this information is important in providing insights into the content and quality of ANC services that pregnant women received within the intervention areas.

WHO guidelines are specific on the content on antenatal care visits which include:

- Blood pressure measurement
- Urine testing for bacteriuria and proteinuria
- Blood testing to detect syphilis and severe anaemia
- Weight/height measurement (optional)

As depicted in Figure 3.4, the findings of the evaluation indicate that more mothers were receiving more services as stipulated in the FANC guidelines indicating an improvement in the comprehensiveness of ANC.

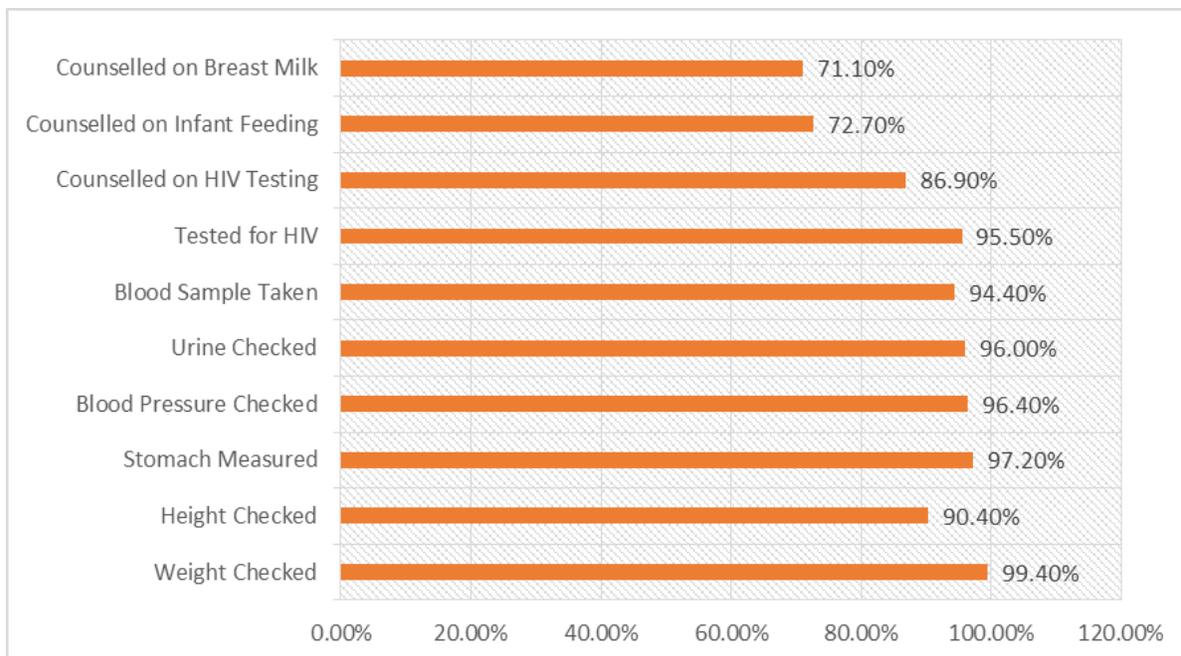


Figure 3.4: Proportion of mothers who received specific services during their ANC visits

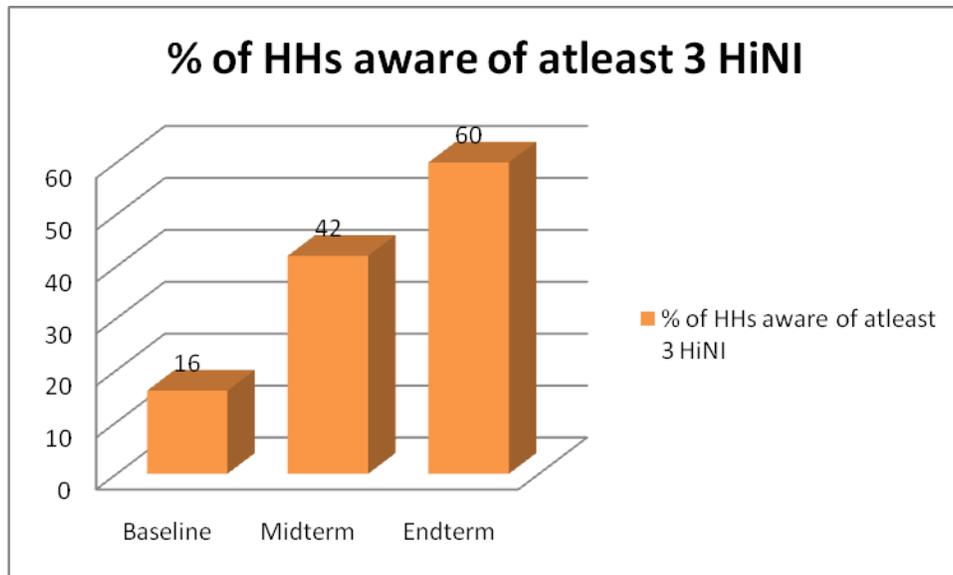
Interviews conducted with service providers confirmed that both the technical and soft skills trainings had positively impacted on their capacity and quality of care they provided. For instance, the use of partograph to monitor labour was initially poorly practiced. The project staff working with SCHMTs identified this as a priority gap and put a lot of emphasis on use and correct interpretation of partograph, as a quality of care marker. The BEmONC training, CMEs, OJTs and supportive supervision emphasised on the use of partograph. As a result, the evaluation found that currently the use of partograph is now a routine practice in the maternity and delivery rooms across all health facilities and consequently “*more births are handled correctly and there are fewer unnecessary referrals*” according to a key informant in Migosi Sub County Hospital.

Awareness of at least 3 High Impact Nutrition Interventions

R2 –Indicator 1:	% of targeted Households aware of at least 3 HiNi from Baseline
Achievement:	There has been a 44 percentage point improvement (from 16% at baseline to 60% at

Numerous programmes have been scaled up to improve nutrition in Kenya, including the Infant and Young Child Feeding Nutrition (IYCN) intervention; micronutrient supplementation and fortification; supplementary food distribution in food insecure areas; as well as the High Impact Nutrition Interventions (HINI) countrywide approach. High Impact Nutrition Interventions (HINI) have the potential of covering underlying causes of malnutrition such as poor pre-natal and maternal nutrition, weak infant feeding practices, and insufficient coverage of childhood disease prevention. The HiNi interventions include: exclusive breastfeeding, timely complementary feeding, iron folate, vitamin A and zinc supplementation, hand washing, deworming, food fortification and management of moderate and severe acute malnutrition.

The evaluation revealed that the project intervention used the OJT training guidelines which supported the mentoring of the Health workers for HINI including Management of Acute Malnutrition (MAM). This was also augmented by the health promotion provided to the households by the Community health volunteers during the household visits which in turn improved the knowledge and practices around HINI.



Pregnancy Related Complications (Obstetric care)

<i>R2 –Indicator 2:</i>	<i>% increase of WRA knowledgeable about at least 5 pregnancy danger signs from 28% to 40%.</i>
<i>Achievement:</i>	<i>There has been a 7.3 percentage point improvement (from 28% at baseline to 35.3% at endterm) in the % of women knowledgeable about at least 5 pregnancy danger signs</i>

Globally, 80% of maternal deaths are due to direct causes, arising from obstetric complications of the pregnancy state (pregnancy, labour and the puerperium). These arise from omissions, incorrect treatment or a chain of events resulting from any and/or a combination of these. The single most direct cause of maternal deaths is obstetric haemorrhage, generally occurring during postpartum. Other causes are obstructed labour; puerperal infection (sepsis) often a consequence of poor hygiene during delivery; unsafe induced abortion and hypertensive disorders of pregnancy, particularly pre-eclampsia (pregnancy-induced convulsion). Indirect causes like malaria, HIV and anaemia also contribute to maternal deaths (WHO/UNFPA/UNICEF/World Bank, 2009). For every woman who dies, it is estimated that 15 to 30 women suffer from chronic illnesses or injuries as a result of pregnancy related causes. A mother's knowledge on danger signs in pregnancy is an important factor in uptake of Emergency Obstetric and New-born Care EmONC services. As shown in Figure 4 below, the evaluation found that knowledge of danger signs in pregnancy has improved generally, though a wide variation is notable. Overall, 35.3% of mothers spontaneously mentioned more than 5 dangers signs in pregnancy. This is slightly higher than the 34.4% and 28% reported at midterm and baseline respectively. It is important to note the target for this indicator of 40% was not achieved and this could be attributed to the fact that the last year of the project was marred by nurse's strike running for over 6 months.

The improved awareness among mothers of the danger signs in pregnancy was attributed to a number of project interventions including health education and counselling provided at health facilities and outreaches by health workers and at the community level by CHVs and mentor mothers. Indeed, when mothers were asked whether they had been counselled on danger signs during their last pregnancy, 85.4% of the sampled women in the intervention areas confirmed having been told of a number of pregnancy related complications. This is slightly higher than the 82.7% reported at midterm.

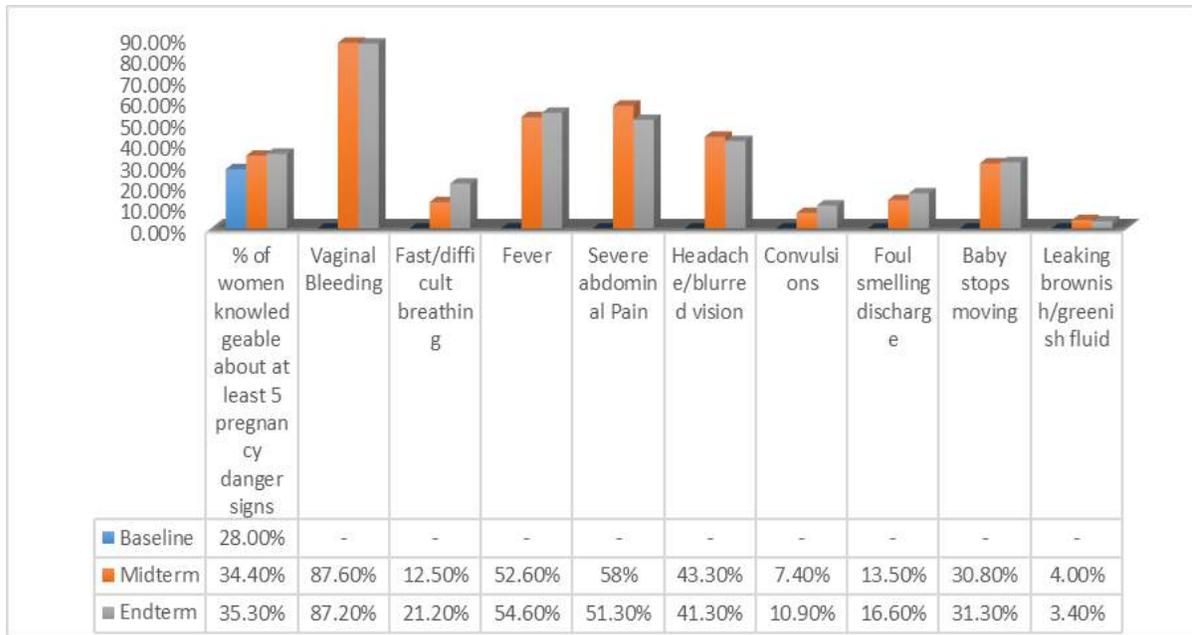


Figure 3.5: Mothers' knowledge of danger signs in pregnancy

Skilled attendance at birth

SO2 –Indicator 2: Proportion of skilled care deliveries (nurses with midwifery training, doctors, midwives) increase from 62% to 65% in Kisumu slums.

Achievement: The proportion of children 0-23 months whose delivery was attended to by a skilled professional (nurses, doctors, midwives) improved from 62% at baseline to 94% at endterm.

SO2 –Indicator 2: % of women whose most recent live birth was delivered in a health facility
Achievement: A remarkable change was observed in the proportion of mothers who delivered in a health facility, from only 45.6% at baseline to 95.3% at endterm.

Increasing the percentage of births delivered in health facilities is important for reducing deaths arising from complications of pregnancy. The expectation is that if complications arise during delivery in a health facility, a skilled birth attendant can manage them or refer the mother to the next level of care. Kenya is promoting skilled care during pregnancy and childbirth for both mothers and newborns (MOH, 2009).

The Kisumu Integrated Family Health Project aimed at increasing the proportion of mothers delivering at health facility under the care of skilled professionals in Kisumu County. This was to address gaps identified during project conception. The key challenge was that a majority of mothers were not delivering at health facilities. The baseline survey revealed that majority (54.4%) of mothers in the intervention areas delivered at home with only 45.6% giving birth at health facilities. The factors that contributed to the low demand for facility-

based birth services included: inadequate capacity and negative attitudes among health workers, poorly-equipped health facilities, negative perception of health facility births, and generally low awareness of the benefits of delivering at health facilities and the risks of home delivery.

The project addressed these constraints by providing technical and soft skills training to health workers, and training CHVs on essential package of MNCH and holding them accountable especially on tracking pregnant mothers to the household level and holding them accountable in addressing the first delay to skilled, basic essential equipment, and awareness raising and demand creation through CU activities, open mother days to enable mothers tour the facility and see for themselves how clean the facility is ,how equipped the facility is and confirm the hospitality provided at the facility and meet the staff at the maternity as a way of encouraging hospital delivery especially for sub-county hospitals and health centres as a way of decongesting KCH and JOOTRH. Mapping of all pregnant mothers and tracking them up to the point of delivery was also instrumental in increasing skilled care deliveries. The mapping exercise was conducted after every three (3) months with the help of CHVs. This led to a reduced dropout rates and increased health facility deliveries. The mapping of mothers was one of the best practices that have contributed to remarkable improvement in the skilled birth attendance as outlined below:

Increase in births delivered in health facilities under skilled care: A remarkable change was observed in the proportion of mothers who delivered in a health facility, from only 45.6% at baseline to 95.3% at endterm. The figure for the health facility delivery is higher than the National and County average of 61% and 69.6% respectively (KDHS, 2014).

Among the few mothers who had delivered their last born child at home, the predominant reasons included: that birth came abruptly, long distances to the health facility, or that the health facility was closed at the time labour started (often at night). Another notable finding was that whether a mother would deliver at a health facility or not was positively correlated with her level of education. Among mothers whose highest educational attainment was primary school and below, 79% of them delivered at health facility in comparison with 99% of those with secondary level education and above ($p < 0.01$).

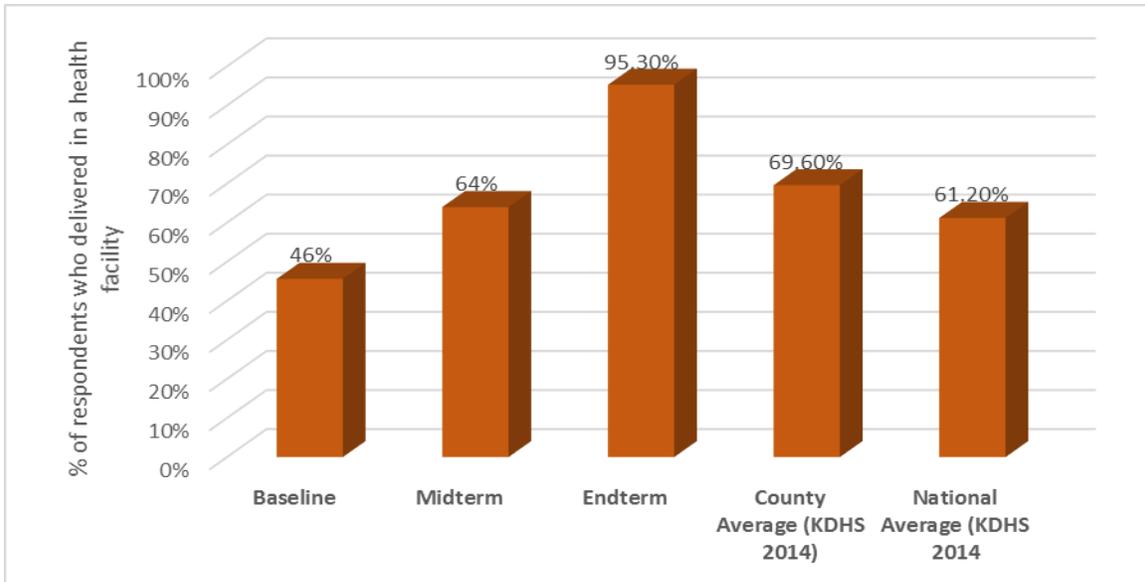


Figure 3.6: Percentage of mothers whose last birth was at a health facility

Similarly, the proportion of children 0-23 months whose delivery was attended to by a skilled professional (nurses, doctors, midwives) has improved and currently stands at 94% from 62.0% at baseline. Again, this is higher than both the county and national rates as shown in Figure 3.7.

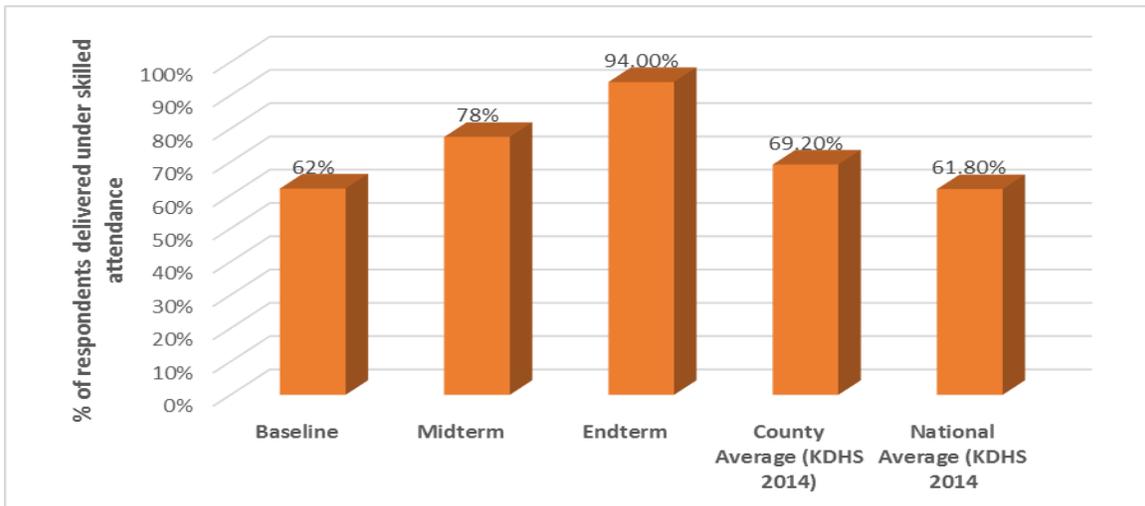


Figure 3.7: Proportion of mothers whose last birth was assisted by a skilled birth attendant

The increase in skilled delivery can be attributed to CHV mobilizations and engaging with mothers directly through door to door campaign and community outreaches to sensitize them on need for skilled care delivery. The second initiative was open mothers days in specific EU supported health facilities whereby pregnant mothers visiting the health facilities are taken through a facility tour with an explanation on the need to deliver in that particular

facility. The tour entails physical viewing of maternity equipment, an equipped maternity wing and maternity care environment within the facility including beddings and child care set up after delivery.

The increase in skilled delivery was collaborated by CHVs during an FGD who had this to say: *“Knowledge of SBA has increased amongst Kisumu residents, most mothers now deliver at the health facilities. Mothers do not deliver at homes anymore only in emergency cases like when going to the health facility and when labour pains occur at night. In these cases, mothers are encouraged by the CHVs to go to health facilities the following day. The number of TBAs has drastically reduced and the remaining few have been trained on the risk factors of unskilled delivery and encouraged mothers to deliver in health facilities. Currently CHVs follow up all pregnant mothers to term.”*

Another discussant had this to say: *“Before the Care (K) project, delivery at health facilities was a challenge and the attitude of health care workers towards mothers was poor especially in public health facilities. These contributed to high maternal and neonatal deaths, mothers delivering at TBAs, mothers not attending clinics etc. Most women deliver at the health facilities now because health care workers have developed positive and friendly attitude thus mothers have gained confidence in their services especially in public health facilities.”* (Health Facility Incharge, Migosi Health center)

Relationship between the skilled birth attendance and Socio Demographics

Further chi-square statistics were done to establish if there was a relationship between the skilled birth attendance and the household characteristics and the results as shown in the table below indicated that none of the background characteristics was significantly associated with uptake of skilled birth attendance.

Table 3.3: Relationship between the skilled birth attendance and Socio Demographics

Variable		Skilled birth attendance				X ²	df	P-value
		No		Yes				
		no.	%	no.	%			
Marital Status	Single/living alone	5	6.4%	73	93.6%	1.802	1	0.179
	Married	49	11.5%	376	88.5%			
Education Status	Primary	21	9.6%	197	90.4%	1.807	1	0.179
	Post Primary	14	6.2%	212	93.8%			
Religion	Protestants	29	9.6%	272	90.4%	3.5i2	4	0.476
	Muslim	1	12.5%	7	87.5%			
	Roman Catholic	15	16.3%	77	83.7%			
	Adventists	6	10.9%	49	89.1%			
	Traditional Religion	1	6.7%	14	93.3%			

Postnatal Care (PNC)

Outcome indicator: % of mothers of infants of 0-5 months who attended postnatal care (PNC) within two days of delivery.

Achievement: The proportion of mothers who attended postnatal care within two days of delivery steeply increased from 26% at baseline to 85.5% at endterm

The postpartum period is a critical moment for mother and baby pair as this is the time they are most vulnerable. Evidence has shown that a large proportion of maternal and neonatal deaths occur during the postpartum period, more so within 24 hours of birth (WHO, 2013). Postnatal care contacts provides opportunities to assess and monitor the mother and babies health, early management of maternal and neonatal conditions, counsel the mother on newborn care including cord care and thermal care, promote exclusive breastfeeding and begin the child on immunisation. The project aimed to promote access to, availability and utilisation of quality PNC services in the intervention areas. The project interventions were meant to address the identified barriers that included low awareness.

This evaluation assessed the extent to which the project had contributed to increase in PNC uptake. Women aged 15-49 who had a birth in the two years preceeding the survey were asked whether they had received postnatal care for themselves and their newborn, when they had received it (timing) and from whom (provider).

The proportion of mothers who attended postnatal care within two days of delivery increased from 26% at baseline to 85.5% at end-term as shown in Figure 3.8.

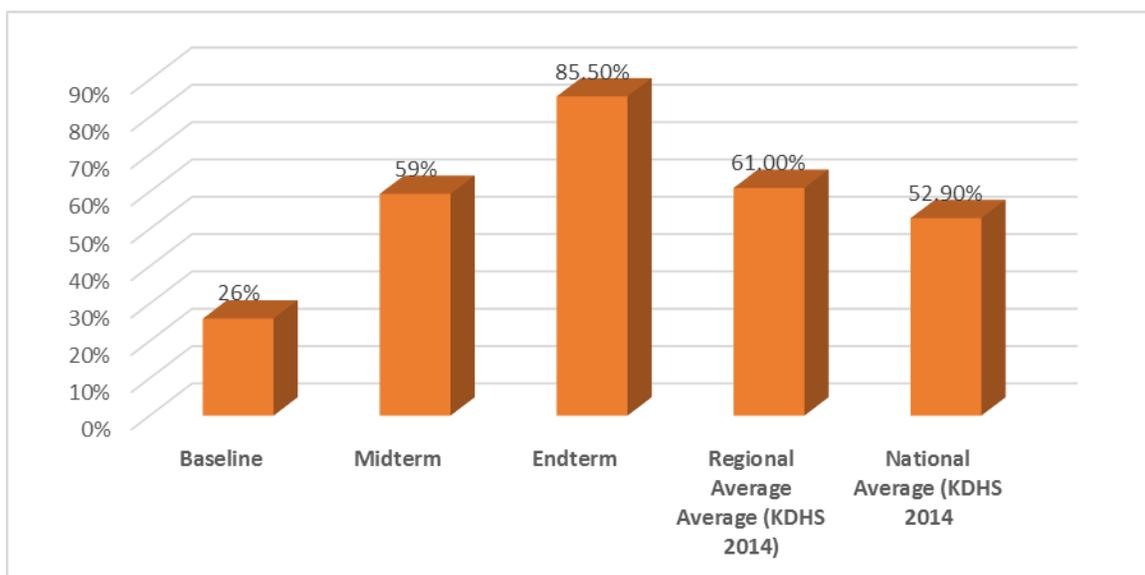


Figure 3.8: Proportion of mothers who attended PNC within 2 days of giving birth

Child Health Services

Of special importance to child health and survival are birth weight and size, childhood vaccination status, and treatment practices for respiratory infection, fever, and diarrhoea. Information on birth weight and size influences the design and implementation of programs aimed at reducing neonatal and infant mortality. Many deaths in early childhood are preventable if children are immunized against preventable diseases and receive prompt and appropriate treatment when they become ill. Additionally, the source of the vaccination information, whether based on a written vaccination card or on the mother's recall, is documented. Differences in vaccination coverage among subgroups of the population will assist in program planning.

Information on treatment practices and contact with health services by children with the three most important childhood illnesses (acute respiratory infection, fever, and diarrhoea) help in the assessment of national programs aimed at reducing the mortality from these illnesses.

Childhood Immunization

<i>SO1 –Indicator 1:</i>	<i>Increase the proportion of children under 1 fully immunized in Kisumu slums from 83% to 87% by 2017.</i>
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<i>Achievement:</i>	<i>The evaluation established that 90.2% of children aged 12-23 months were fully immunised by end term. This indicator has surpassed the project target of 87%</i>
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Immunization plays a key part in this goal. Information on child immunization coverage within the five districts was obtained in two ways – from the health cards and from the sampled mothers' verbal reporting. Eligible mothers were asked to show the interviewer the child immunization health card on which the child's immunization status is recorded. If the card was available, the interviewer copied the dates for which each vaccination was received. If a vaccination was not recorded on the card, the mother was asked to recall whether that particular vaccine had been given to her child. If the mother was unable to present a card for a child, she was asked whether the child had received BCG, PENTA 1, 2, and 3, polio and measles vaccines. If she indicated that the child had received the polio or PENTA vaccines, she was asked the number of doses that the child had received. The information received covered all the children in the household aged 12-23 months at the time of the survey. Analysis was done for specific vaccines and for the full immunisation coverage. The findings are outlined below.

A majority of children aged 12-23 months had received all the basic vaccines. Specifically, 91.4 % had received 3 doses of pentavalent, 90.2% had received measles vaccines, 88.7% Vitamin A supplementation and 80% had been dewormed in the last 6 months.

In Kenya, a child is considered to be fully immunised if it has received BCG at birth, three doses each of polio, pentavalent and pneumococcal vaccines, rotavirus vaccine and a vaccination against measles. Using measles vaccination as a proxy for full immunization, the evaluation found that 90.2 % of children aged 12-23 months were fully immunised. This is an improvement from 83% at baseline. The coverage of fully immunised children is higher than the 2014 county average of 78.9% as well as the national average of 75%.

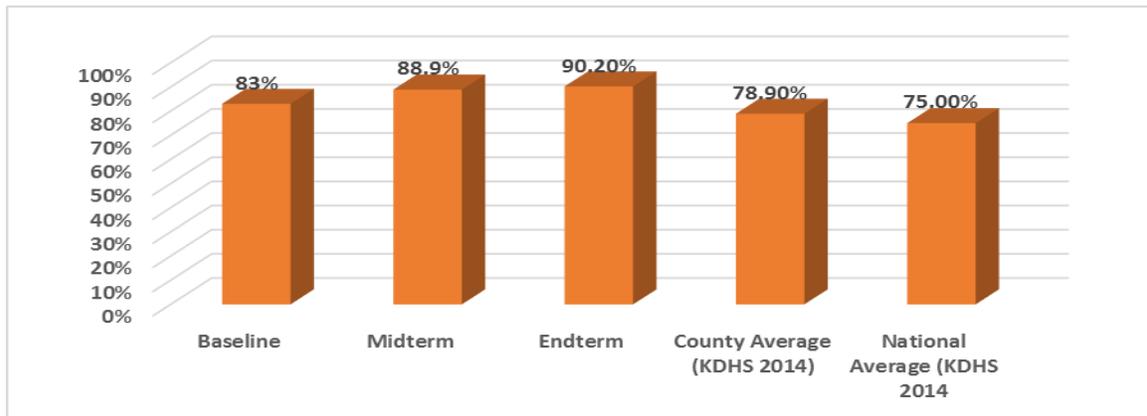


Figure 3.9: Percentage of children age 12-23 months who are fully immunised

The results indicate that the project achieved 90% full immunization coverage rate which surpassed the target of having 87%/. During the ETE, We established that one of the mechanisms that the project used to scale up the immunization status was to increase the number of outlets for reaching children who were due for immunization. This was mainly done through the project supported outreaches that ensured the delivery of the integrated MNCH services at community levels at the door step. It also emerged during Focus group discussions with CHVs that as a result of the training and facilitation provided by the project, they were able to intensify case tracking of all children within the project sites. This in turn ensures there were no immunization defaulters.

The improvement in immunisation uptake was attributed to project-supported awareness and community mobilisation interventions as illustrated in the quotes below:

“During the early days when we started home visits, we used to find many women who had not taken their children for immunization because they would say they are tired of walking. They would have missed one appointment for vaccination and then they would be scared to go to the hospitals because they would get reprimanded by the nurses. They would therefore just decide that the vaccines the baby had received were enough and miss the rest. We spent a lot of time educating them and as a result nowadays very few mothers miss clinic appointments.” CHV, Manyatta CU

One of the FGD discussants had this to say

We have been trained by the Care (K) project and when we go to the households we pass health messages to the community. We have particularly trained mothers on how to handle common illnesses at the household level like diarrhoea among children. During outreaches, we are able to provide services like family planning, child immunizations to those who find the health facilities to be far. Through the mapping of pregnant

mothers, we are able to follow them up through to delivery and also ensure that their children are immunized without any defaulters. (A-CHV FGD discussant in Manyatta)

Relationship between Immunization uptake and socio-demographics

A chi square statistical test was employed to assess the relationship between the socio-demographic characteristics of the respondents and the uptake of child immunizations at the households. The results indicated that none of the socio-demographic characteristics of participants was significantly associated with uptake of immunization

Table 3.4: Relationship between Immunization uptake and socio-demographics

Variable		FIC				X ²	df	P-value
		Yes		No				
		no.	%	no.	%			
Skilled Birth Attendance	No	20	90.9%	2	9.1%	0.002	1	0.963
	Yes	259	91.2%	25	8.8%			
Marital Status	Single/living alone	44	88.0%	6	12.0%	0.719	1	0.396
	Married	233	91.7%	21	8.3%			
Education Status	Primary	119	88.1%	16	11.9%	2.104	1	0.47
	Post Primary	125	93.3%	9	6.7%			
Religion	Protestants	170	90.9%	17	9.1%	3.52	4	0.475
	Muslim	3	100.0%	0	.0%			
	Roman Catholic	47	85.5%	8	14.5%			
	Adventists	31	93.9%	2	6.1%			
	Traditional Religion	10	100.0%	0	.0%			

Management of Childhood Diseases

Fever Management

Integrated Management of Childhood Illness (IMCI) is an important strategy which aims at reducing child morbidity and mortality associated with six major preventable diseases in children (less than five years of age) namely malaria, acute respiratory infections (ARI) and diarrhoea. The approach seeks to promote and integrate care at the community and at all levels of the health care system.

Household practices especially prompt symptom recognition and appropriate health seeking behaviour is the cornerstone of managing childhood illness. Asked if their child has had fever in the last two weeks preceding the survey, 35.5% confirmed malaria/fever in their child compared to 45% reported at baseline. It is evident that there has been a significant decline in fever cases among children in the project areas compared to the situation at baseline.

The ETE established that 83.4% of the mothers sought advice or treatment for fever with only 25% seeking advice within the same day.

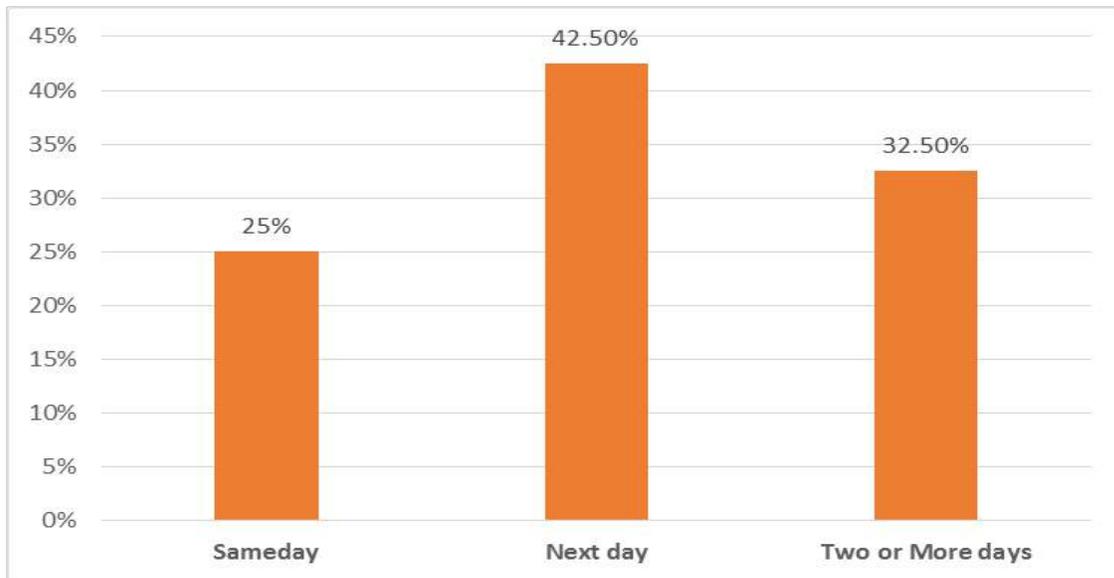


Figure 3.10: Duration after which sought treatment, percentage who sought treatment

With regards to the question “do you take any drugs in order to prevent malaria” in pregnant women, the evaluation established that 75.4% of the women took them. The evaluation further established that 94.1% of the mothers while pregnant and 75.8% of the children under five slept under a long lasting insecticide treated net.

Diarrheal Disease and Case Management

Dehydration caused by severe diarrhoea is a major cause of morbidity and mortality among children under 5 years in Kenya. Mothers were asked if any of their children aged 0-59 months has had diarrhoea in the two weeks preceding the survey. The evaluation established that 20.5% of the children in the project area had experienced diarrhoea (most likely due to use of contaminated water, unhygienic practices in food preparation and disposal of excreta). The prevalence of diarrhoea in the project area was found to be higher when compared the baseline figure of 11% as well as the national average of about 15% of diarrhoea cases (KDHS 2014).

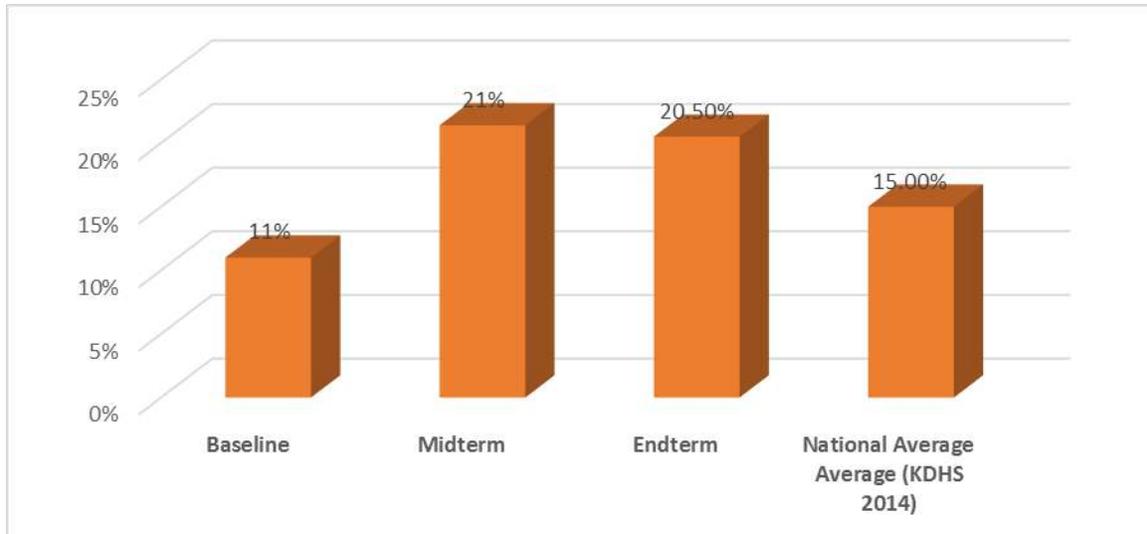


Figure 3.11: Percentage of Mothers Reporting Child Had Diarrhoea in the Past 2 weeks

A child needs more nutritional requirements during diarrhoeal episode to replenish lost fluids. A simple and effective response to a child’s dehydration is to promptly increase intake of appropriate fluids, possibly in the form of solutions prepared from oral rehydration salt (ORS) and zinc supplements. Mothers were therefore asked about their feeding habits during children’s diarrhoeal episodes and actions that you would take to treat and manage. Majority (30.6%) of the children who presented with diarrhoea were given ORS to help arrest followed by 23.7% of the mothers reporting that they gave zinc supplements. The best practice for childhood diarrhoeal management is to continue breastfeeding and to provide ORT or zinc supplements to decrease severity of the episodes; decrease future recurrence and reduce the risk of contracting pneumonia which is a major killer for the under 5 children.

Breastfeeding practices

<i>R 3 –Indicator 1:</i>	<i>Increase the proportion of infants exclusively breastfed for first 6 months of life from 37% to 45%</i>
<i>Achievement:</i>	<i>The proportion of children aged 6-23 months who were exclusively breastfed for 6 months increase from 37% at baseline, to 84.2% at endterm</i>

UNICEF and WHO recommend that children be exclusively breastfed during the first six months of life and that children be given solid and semisolid complementary foods in addition to continued breastfeeding from six months until 24 months or more when the child is fully weaned. Exclusive breastfeeding is recommended because breast milk is uncontaminated and contains all of the nutrients necessary for children in the first several months of life. In addition, the mother’s antibodies in breast milk provide immunity to

disease. Early supplementation is discouraged for several reasons. First, it exposes infants to pathogens and increases their risk of infection, especially disease. Second, it decreases infants' intake of breast milk, and therefore suckling, which reduces breast milk production. Third, in low-resource settings, supplementary food is often nutritionally inferior. The 2014 KDHS showed that the proportion of children younger than age 6 months who were exclusively breastfed had markedly increased from 32 % in the 2008-09 KDHS to 61%. This evaluation sought to find the situation in the project intervention areas.

The evaluation findings indicate a remarkable improvement in breastfeeding. The proportion of children aged 6-23 months who were exclusively breastfed for 6 months increased from 37% at baseline to 84.2% at end-term. Exclusive breastfeeding in the intervention areas was way above the National average of 61% (KDHS 2014).

The remarkable improvement in breastfeeding can be attributed to the establishment of Mother to Mother support groups that have sensitized the mothers on the importance of exclusive breastfeeding, and the technical training of CHVs regarding good nutritional practices and training of health care workers on IYCF. The project also worked with mother to mother support group members which was comprised of pregnant and lactating mothers. These were trained on MIYCN, including breastfeeding and MNCH, and were tasked to reach out to other mothers in the community. This effect was illustrated by a CHV who said:

“Children under 6 months are now exclusively breastfed and given colostrum immediately after birth. Before this project, mothers used to give 3 day old infants porridge and light foods, because they had no information on EBF and its importance.”(CHV FGD discussant in Nyalenda)

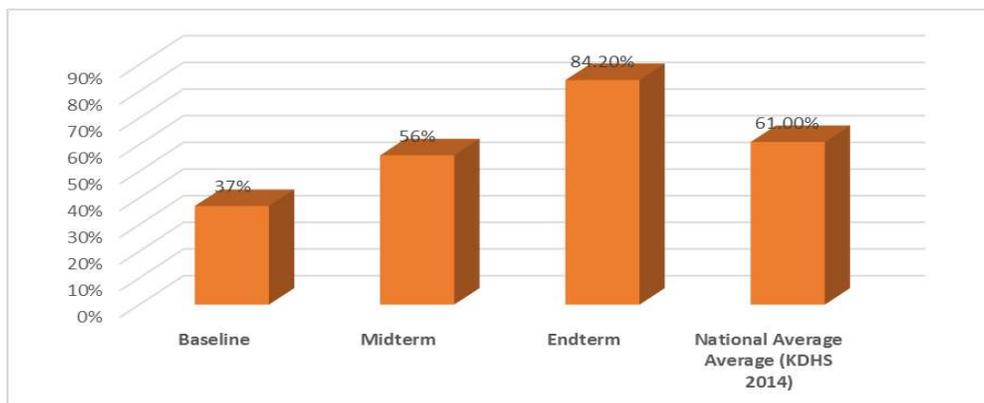


Figure 3.12: Proportion of children aged 6-23 months who were exclusively breastfed for 6 months after birth

Nutritional Status of Children

Children's nutritional status is a reflection of their overall health. When children have access to adequate food supply, they are not exposed to repeated illness, and are well cared for; they reach their growth potential and are considered well nourished.

Malnutrition is associated with more than half of all child deaths worldwide. Undernourished children are more likely to die from common childhood ailments, and those who survive have recurring sicknesses and faltering growth. In a well-nourished population, there is a reference distribution of height and weight for children under age five. Under-nourishment in a population can be gauged by comparing children to a reference population. The reference population used in this report is based on new WHO growth standards. Each of the three nutritional status indicators can be expressed in standard deviation units (z-scores) from the median of the reference population.

The data on the nutrition component for children were captured and analyzed using the WHO recommended software, Emergency Nutritional Assessment (ENA).

Anthropometric indicators interpretations: children (based on WHO standards 2005)

The anthropometric results were defined based on the global acute malnutrition which is defined as <-2 z scores weight-for-height and/or oedema, severe acute malnutrition is defined as $<-3z$ scores weight-for-height and/or oedema. The indices height-for-age, weight-for-height and weight-for-age provide different information about growth and body compositions, which is used to assess nutritional status. The height-for-age index is an indicator of linear growth retardation and cumulative growth deficits. Children whose height-for-age z score is below minus two standard deviation (-2 SD) are considered short for their age (stunted) and are chronically malnourished. Children whose height for age are below minus three standard deviations (-3 SD) are considered severely stunted. The weight-for-height index measures body mass in relation to body height or length and describes current nutritional status. Children whose z score are below minus two standard deviations (-2 SD) are considered thin and wasted and are acutely malnourished. Weight-for-age is a composite index of height for age and weight-for-height. It takes into account both acute and chronic malnutrition. Children whose weight-for-age is below minus two standard deviations are classified as underweight.

Prevalence of Acute malnutrition Weight-for-Height

Low weight-for-height: Wasting or thinness indicates in most cases a recent and severe process of weight loss, which is often associated with acute starvation and/or severe disease. However, wasting may also be the result of a chronic unfavorable condition. Provided there is no severe food shortage, the prevalence of wasting is usually below 5%, even in poor

countries. The Indian subcontinent, where higher prevalence are found, is an important exception. A prevalence exceeding 5% is alarming given a parallel increase in mortality that soon becomes apparent. On the severity index, prevalence between 10-14% are regarded as serious, and above or equal 15% as critical. Typically, the prevalence of low weight-for-height shows a peak in the second year of life.

The malnutrition levels unveiled by these findings indicate that the overall prevalence rate of global acute malnutrition (<-2 z-score and/or oedema) is at 19.5% for all the children in the study aged between 6-59 months. The prevalence of global acute malnutrition is slightly higher among girls (21.2%) compared to the boys (17.9%). The ETE figure 19.5% is slightly lower than what was reported at MTE (22.8%) but comparably higher compared to the baseline findings of 9%. This poor nutritional status may be attributed to poor feeding as a result of the long famine that affected Kenya in the year 2017 coupled with political unrest which greatly affected the project sites of Manyatta and Nyalenda informal settlements. The evaluation also shows that the prevalence rate of **moderate** acute malnutrition is at 5% for the combined sexes and is higher among the boys at 6.2% compared to girls at 3.6%. The findings further shows that the prevalence for **severe** acute malnutrition stands at 14.5% for combined boys and girls and is more pronounced in girls where 17.5% are severely malnourished while 11.7% of the boys age between 6-59 months are severely malnourished (Table 3.5).

Table 3.5: Prevalence of Wasting (weight-for-height z-scores) (WHO, Standards 2006)

Nutritional Status Indicator	Baseline			Mid-term Evaluation			End-term Evaluation		
	All	Boys	Girls	All n = 162	Boys n = 79	Girls n = 83	All n = 282	Boys n = 145	Girls n = 137
Prevalence of Global malnutrition (<-2 z-score and/or oedema)	9%	-	-	(37)22.8%	(18)22.8%	(19)22.9%	(55)19.5%	(26)17.9%	(29)21.2%
Prevalence of Moderate malnutrition (<-2 z-score and >=-3 z-score)	-	-	-	(20)12.3%	(7)8.9%	(13)15.7%	(14)5%	(9)6.2%	(5)3.6%
Prevalence of severe malnutrition (<-3 z-score and/or oedema)	-	-	-	(17)10.5%	(11)13.9%	(6)7.2%	(14)14.5%	(17)11.7%	(24)17.5%

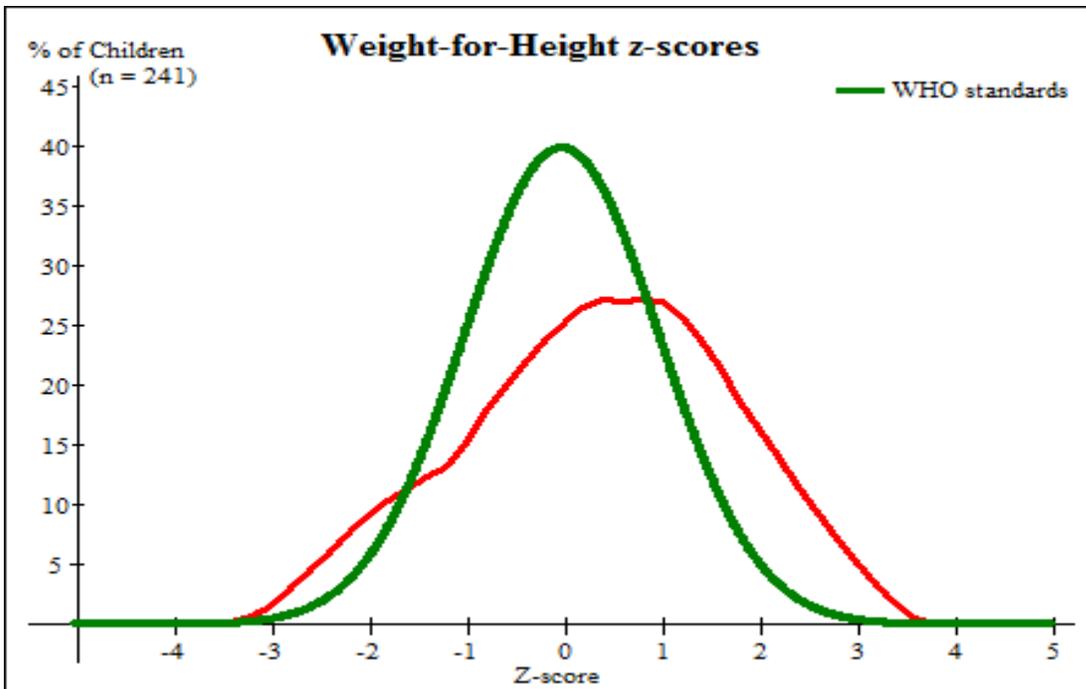


Figure 3.13: Weight for Height z-scores showing malnutrition

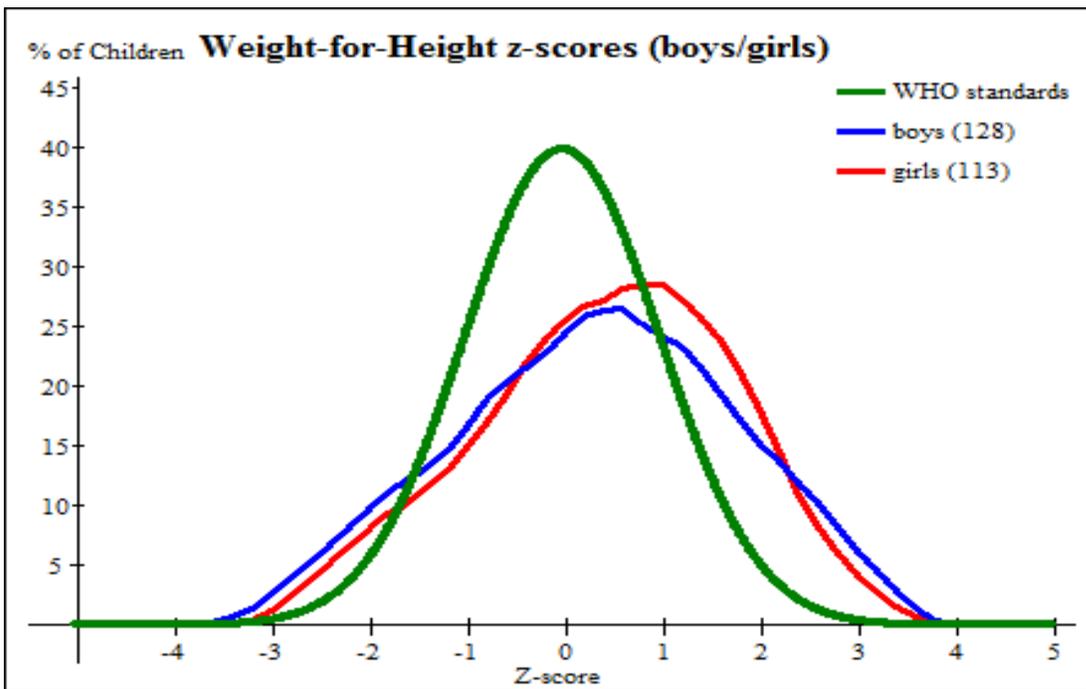


Figure 3.14: Weight for Height z-scores (boys/Girls)

Prevalence of Stunting (Height-for-Age Scores)

Low height-for-age: Stunted growth reflects a process of failure to reach linear growth potential as a result of suboptimal health and/or nutritional conditions. On a population basis, high levels of stunting are associated with poor socioeconomic conditions and increased risk of frequent and early exposure to adverse conditions such as illness and/or inappropriate feeding practices. The worldwide variation of the prevalence of low height-for-age is considerable, ranging from 5% to 65% among the less developed countries. In many such settings, prevalence starts to rise at the age of about three months; the process of stunting slows down at around three years of age, after which mean heights run parallel to the reference. Therefore, the age of the child modifies the interpretation of the findings: for children in the age group below 2-3 years, low height-for-age probably reflects a continuing process of “failing to grow” or “stunting”; for older children, it reflects a state of “having failed to grow” or “being stunted”. Thus, to develop the extent of chronic malnutrition 347 children after factoring age errors or outlier figures in a randomly selected survey sample of 508 households were measured for height and age. The results were calculated through height for age z-score. Children whose height-for-age z score is below minus two standard deviation (-2 SD) are considered short for their age (stunted) and are chronically malnourished. Children who are below minus three standard deviations (-3 SD) are considered severely stunted.

This enderm evaluation revealed that prevalence of stunting rates is 25.4% for all children with girls being more affected at 26.7% and boys 24.1%. The ETE figure is comparably higher compared to the MTE and baseline finding of 18.1% and 23% respectively for global stunting. Again, the poor nutritional status may be attributed to poor feeding as a result of the long famine that affected Kenya in the year 2017 coupled with political unrest which greatly affected the project sites of Manyatta and Nyalenda informal settlements. The moderate stunting for all children in the age-group was at 18.2% with girls being more affected at 22.2% and boys 14.5%. The findings further shows that the prevalence for **severe** stunting stands at 7.1% for all and is more pronounced in boys where 9.7% are severely stunted while 4.4% of the girls age between 6-59 months are severely stunted (Table 3.6).

Table 3.6: Prevalence of stunting

Nutritional Status Indicator	Baseline			Mid-term Evaluation			End-term Evaluation		
	All	Boys	Girls	All n = 282	Boys n = 141	Girls n = 141	All n = 280	Boys n = 145	Girls n = 135
Prevalence of stunting (<-2 z-score)	23%	-	-	(51) 18.1% (C.I. 13.6-22.6)	(26) 18.4% (C.I.12.0-24.8)	(25) 17.7% (C.I. 11.4-24.0.)	(71) 25.4% (C.I. 20.3-30.5.)	(35) 24.1% (C.I. 17.2-31.1.)	(36) 26.7% (C.I. 19.2-34.1.)
Prevalence of moderate stunting (<-2 z-score and >=-3 z-score)	-	-	-	(39) 13.8% (C.I.9.8-17.9)	(18) 12.8% (C.I.7.3-18.3)	(21) 14.9% (C.I.9.0-20.8.)	(51) 18.2% (C.I.13.7-22.7.)	(21) 14.5% (C.I. 8.8-20.2.)	(30) 22.2% (C.I.15.2-29.2.)
Prevalence of severe stunting (<-3 z-score)	-	-	-	(12) 4.3% (C.I.1.9- 6.6)	(8) 5.7% (C.I. 1.9-9.5.)	(4) 2.8% (C.I.0.1-5.6)	(20) 7.1% (C.I. 4.1-10.2.	(14) 9.7% (C.I. 4.8-14.5.)	(6) 4.4% (C.I.1.0-7.9.)

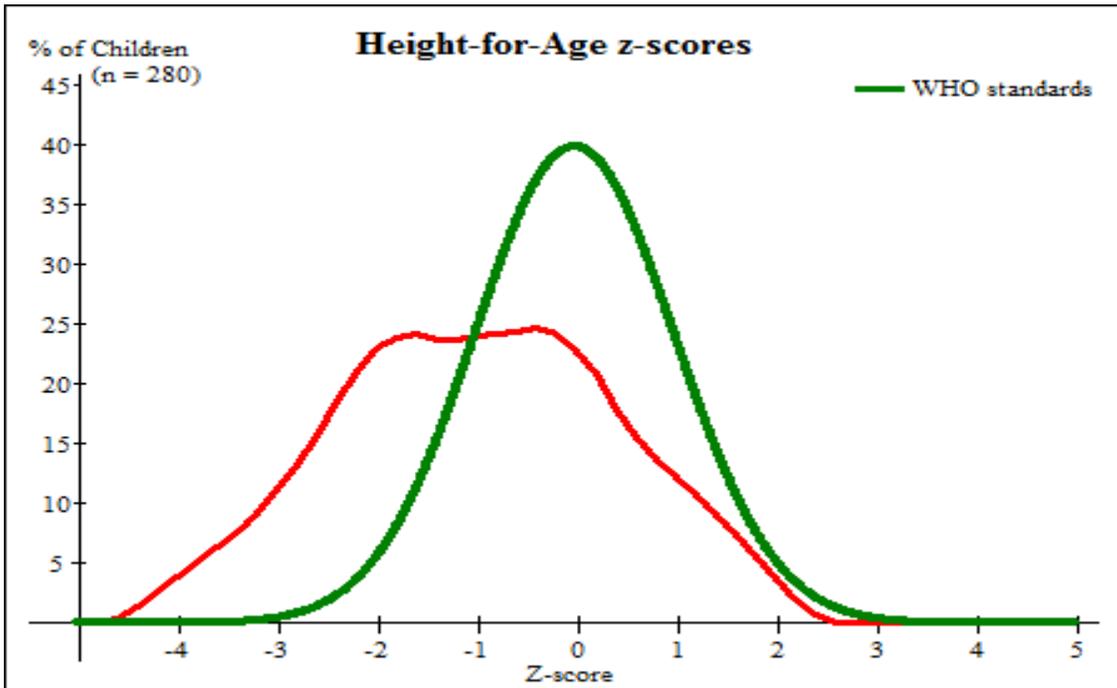


Figure 3.15: Height for Age z-scores All children showing stunting

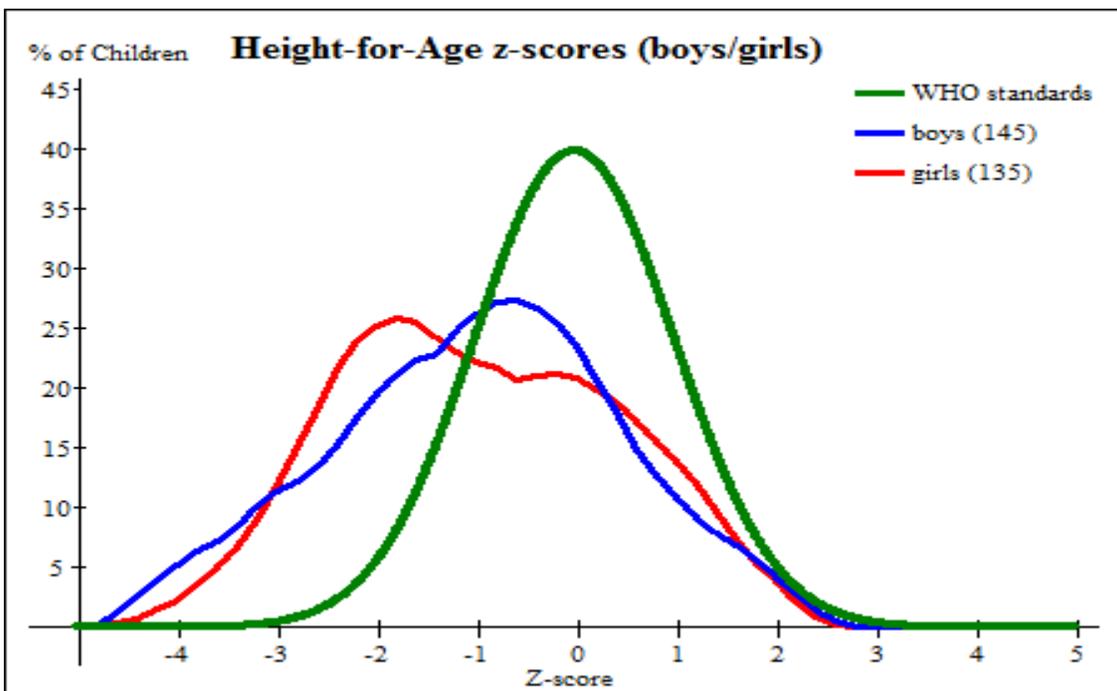


Figure 3.16: Height for Age z-scores for girls and boys showing stunting

Prevalence of Underweight among children (Weight for Age)

The weight-for-age (WAZ) index provides a composite measure of wasting and stunting and is commonly used to monitor the growth of individual children in Mother-child booklet since it enables mothers to easily visualise the trend of their children's increase in weight against age. A low WAZ is referred to as underweight. Because of its simplicity, it has been used nationally as the indicator to assess nutritional status in children under five on a routine basis through health facilities.

The table below shows an **overall** underweight prevalence of 6.6% among all children aged between 6-59 months in Kisumu. The underweight prevalence was higher among the boys at 7% compared to 6.1% among the girls. These figures are comparably significantly lower compared to the MTE and baseline findings of 28.3% and 11% respectively for underweight children. Hence it is a significant decline in prevalence of underweight indicator.

For **moderately** underweight, 5.9% of the children were moderately underweight and was higher among boys than the girls at 6.3% and 5.3% respectively. There were 0.8% of all the children who were **severely** underweight. Among the boys, 0.7% were classified as severely underweight while 0.9% of the girls were classified as severely underweight.

Table 3.7: Prevalence of Underweight children

Nutritional Status Indicator	Baseline			Mid-term Evaluation			End-term Evaluation		
	All	Boys	Girls	All n = 282	Boys n = 141	Girls n = 141	All n = 256	Boys n = 142	Girls n = 114
Prevalence of underweight (<-2 z-score)	11%	-	-	(64) 28.3% (C.I 22.4-34.2.)	(39) 35.1% (C.I 26.3-44.0.)	(25) 21.7% (C.I 14.2-29.3.)	(17) 6.6% (C.I 3.6-9.7.)	(10) 7.0% (C.I.2.8-11.3)	(7) 6.1% (C.I 1.7-10.5.)
Prevalence of moderate underweight (<-2 z-score and >=-3 z-score)	-	-	-	(44) 19.5% (C.I.14.3-24.6.)	(26) 23.4% (C.I 15.5-31.3.)	(18) 15.7% (C.I 9.0-22.3.)	(15) 5.9% (C.I 3.0-8.7.)	(9) 6.3% (C.I 2.3-10.3.)	(6) 5.3% (C.I 1.2-9.4.)
Prevalence of severe underweight (<-3 z-score)	-	-	-	(20) 8.8% (C.I.5.1-12.6.)	(13) 11.7% (C.I. 5.7-17.7.)	(7) 6.1% (C.I 1.7-10.5.)	(2) 0.8% (C.I - 2.1.)	(1) 0.7% (C.I -0.7-2.1.)	0.9% (C.I-0.8- 2.6.)

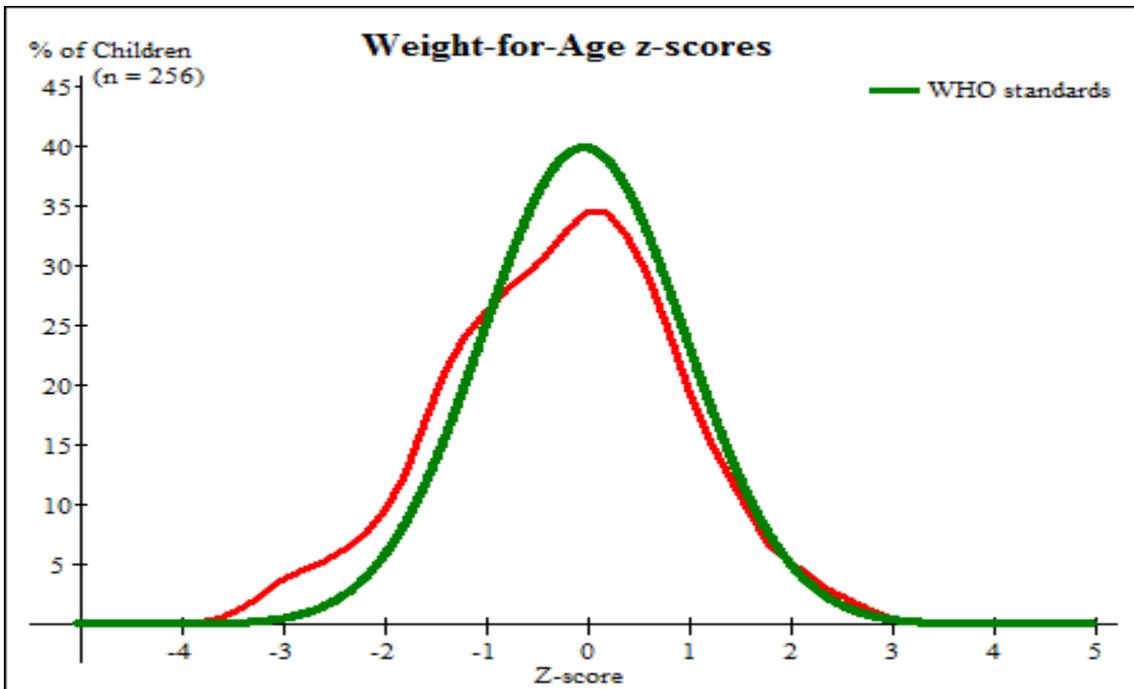


Figure 3.17: Weight for Age z-scores showing underweight status

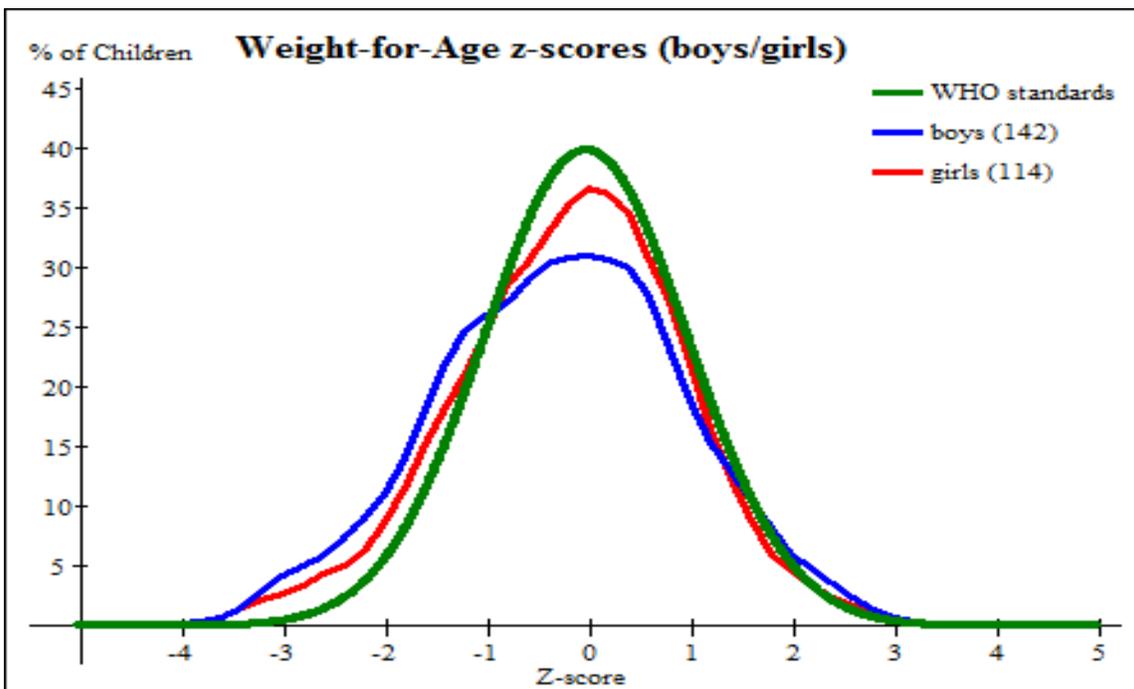


Figure 3.18: Weight for Age z-scores for boys and girls showing underweight

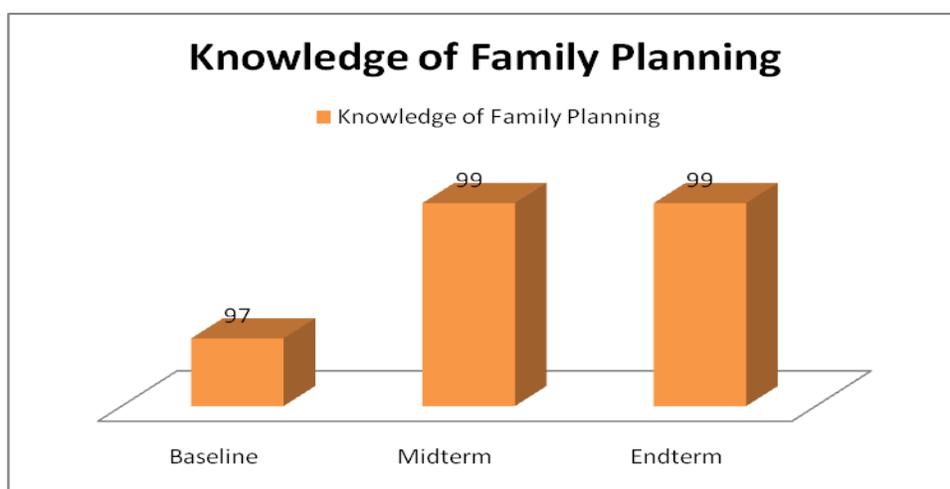
Sexual, Reproductive Health and Family Planning

Knowledge of Family planning methods

R 2 –Indicator 3:	<i>% of the targeted population 15-49 who have knowledge on any method of family planning or atleast one method of contraception</i>
Achievement:	<i>The % of the target population with knowledge of atleast one method of modern contraception increased from 97% at baseline to 99% at end term</i>

Development of a profile regarding knowledge of family planning methods was one of the objectives of the ETE, because knowledge of methods is a prerequisite for making a decision to initiate contraceptive use. The ETE collected information on knowledge of contraception by asking respondents whether or not they had heard of 10 modern methods (female sterilisation, male sterilisation, the pill, intra-uterine devices [IUDs], injectables, implants, male condoms, female condoms, lactational amenorrhoea, and emergency contraception) and two traditional methods (rhythm or calendar method and withdrawal).

The results indicated that the knowledge on the methods of family planning improved from baseline to endterm with nearly all (99%) of the women of reproductive age having knowledge of at least one method of modern contraception.



Contraceptive prevalence

SO 2 –Indicator 3:	<i>Increase the % of WRA using long acting FP methods from 22% to 26% in Manyatta and Nyalenda slums, Kisumu County.</i>
Achievement:	<i>The % of WRA using long acting FP methods in Manyatta and Nyalenda slums, Kisumu County increased from 22% at baseline to 68.2% at endterm.</i>

This section presents information on the prevalence of current contraceptive use among all women, currently married women, and sexually active unmarried women age 15-49. Current

use of contraceptives is the most widely employed and valuable measure of the success of family planning programmes. The contraceptive prevalence rate (CPR) is usually defined as the percentage of currently married women who are currently using a method of contraception.

The women were asked if they were currently practicing FP, figure 3.19 shows that 68.2% were using family planning method at the time of the evaluation. Compared to the baseline figures, this indicator had tripled as only 22% of women were on FP. The figure for contraceptive use is higher than the National average as well as County average of 58% and 62.4% respectively according to KDHS 2014. For a context where there were a myriad of access and utilisation barriers at the start of the project, a 46.2 percentage point increase is remarkable.

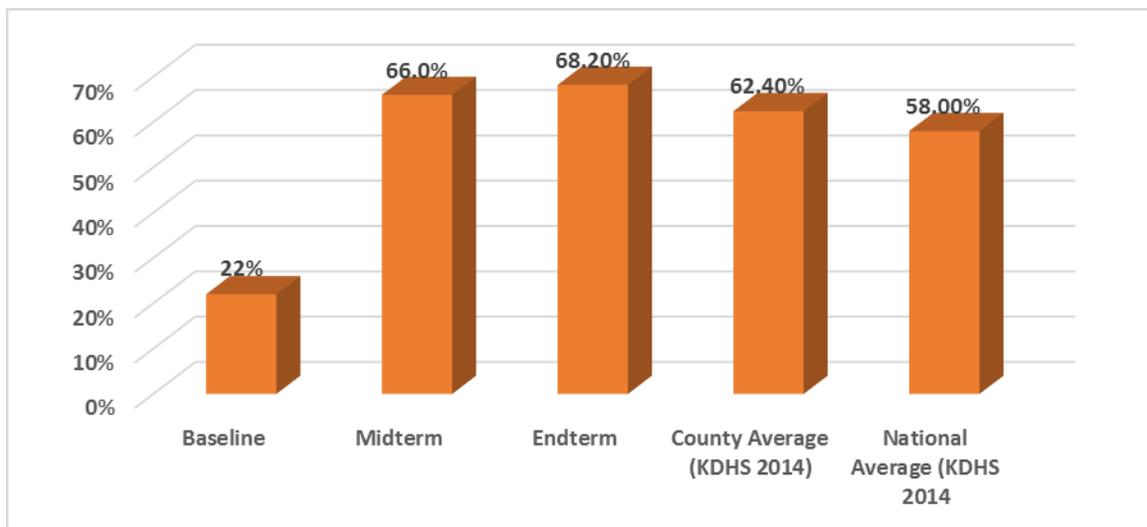


Figure 3.19: Percentage of currently married women who are currently using a method of contraception

The increase in contraceptive prevalence rate was attributed to increased availability of a mix of FP methods, improved skills and attitudes among service providers and increased awareness among community members.

“Many people are now appreciating FP unlike before when there was so many myths and misconceptions about family planning...Before people associated FP with infidelity unlike now when it is understood and used by many mothers of reproductive age. Men are also encouraging us spouses to practice family planning unlike in the past.” Woman participant in an FGD.

A Community Health Volunteer had this to say:

“Level of utilization of family planning methods is currently high. Women follow the CHV’s even to their houses to get the family planning services. Back then the level of awareness was low and it was a challenge since most women used the calendar method. Currently the number of pregnant mothers is countable.”

Generally, there has been a positive change in use of family planning. Men are now encouraging their women to go for family planning. *“Before there was no men involvement and nobody encouraged women to practice family planning. With the men involvement, the men even remind their wives to take the tablet in case they’re using the pills method.”* said one CHV FGD participant

Health facility staff interviewed confirmed that availability of a mix of FP methods had improved in the last 3 years and this had offered a wider choice for clients. Health worker skills in provision of long term methods specifically implants and IUCD was reported to have improved due to trainings provided in recent past. In addition, due to improvement in health worker attitudes, more were willing to provide long term methods as opposed to the situation before when they used to push clients to the “quick and easy” methods – pills and injectables. This finding is reflected in the quote below:

“...one of the areas that has really improved is the health worker skills particularly on the long term methods. Before you could find in a hospital only one person had the skills and at lower level health facilities none of the providers. Also the health worker attitudes have improved. They used to push clients to the simple and quick methods such as injections and pills... I think it was also an issue of workload. You know depo and pills are quick to give, so if you have a queue of people waiting to be served you don’t want a client asking for long term methods that will take longer to serve, so the tendency was to dissuade them from it”. Key informant from SCHMT

There used to be many misconceptions and myths regarding family planning. For instance, there were myths that IUCD would get stuck in the womb or injure the man during sexual intercourse. Pills were associated with cancer and injections were said to stop menstrual period which then could lead to cancer. FGD discussants and key informants noted that these myths and misconceptions were on the decline. This is illustrated by the comment below from a CHV:

“Men used to think that family planning is a woman’s responsibility while others couldn’t allow their wives to use. In fact some women used family planning in secret. But nowadays men accompany their wives...there were many misconception and myths, for instance that the coil would get lodged in a mother’s womb or in a baby’s body. These kinds of myths have diminished due to better awareness” CHV, Manyatta CU

3.3 Efficiency of Project Approaches

This section provides the findings in regards to the efficiency of approaches used in implementation of project activities. The focus of analysis was on efficiency in the utilisation of project resources, efficiency of project management and assessment of collaboration and coordination with other players.

3.3.1 Efficiency in resource utilization

The evaluation did not quantify the financial cost and management procedures and its effect on project implementation / the implementing of project activities vis a vis the outcome.

However, an outstanding positive attribute of this project was the fact that it was investing in areas that were considered low priority in government budgetary allocations but by design and practice the project was able to gradually influence the increased allocation and takeover by the Kisumu county government. Leveraging additional resources from the government and other actors was a notable strength that enabled the project to achieve, and in some cases exceed, its target. In addition, the use of peer-to-peer learning methods such as CMEs, mentorship and on-the-job training saved on the costs. Notably, the project also avoided “re-inventing the wheel” through use of pre-existing resources such as training manuals, tools and reference materials.

Efficiency was also noted in the use of resources for community systems strengthening. By mobilising communities to take lead in interventions, nurturing the spirit of voluntary community service and harnessing community-owned resources, CARE ensured that the project activities were implemented at lower costs and within budget. Overall the evaluation noted that the project remained on track throughout its lifespan with the donor grading it as “green” all along. The grant burn rate was also found to have been efficient, including justifiable budget amendments to accommodate some costs that were underestimated and reallocate budget lines that had been overestimated.

3.3.2 Partnership, collaboration and coordination

Key informants were asked for their views on how well the project worked with the MoH, SCHMT, communities and other stakeholders. There was general consensus that the project performed exemplarily in regards to partnership, collaboration and coordination with other stakeholders. Right from the needs assessment and design stage of the project, the MoH and SCHMTs were consulted and involved in prioritising interventions. The selection of the project locations was done jointly with the SCHMTs and was done in a way that promoted synergies, avoided gaps, duplications and resource conflicts. The project proposal and work plans were shared with the SCHMTs and incorporated into the sub county annual work plans (AWPs) thus ensuring the project inputs were harmonised with those of the government and other players.

Capacity building of SCHMT, service providers and community units was at the core of the project’s design. Capacity gaps were jointly identified with SCHMT and trainings delivered together primarily utilising training of trainers (TOTs) from among the SCHMTs and national MOH. Lastly, the relationship chain between the donor, EU and CARE was noted to have been positive and devoid of conflicts. Each partner understood and played their roles harmoniously and with a passionate desire for overall success. The project team appreciated the donor’s flexibility to allow changes to the project during implementation in line with the ongoing learning.

Interviews with the project team also revealed that there was a very good collaboration among the implementing partners CARE, FHOK and KRCS. The synergy and the

cooperative advantage brought on board by the partners in their areas of strength played a key role in the success of the project.

3.3.3 Efficiency of project management

Good project management practices were noted right from the early days of the project start-up including intensive consultation with beneficiary communities, MOH and SCHMTs. At the onset, CARE recruited the right calibre of project staff that has been instrumental in successful delivery of the project. The key elements of success in this regard were cited as: staff with the right skills mix, job description that were clear, a staffing organogram that had a staff in-charge of each of the key project components as well as geographical focus, and generally a cohesive well motivated team in terms of project management processes, a number of success factors were highlighted. These included elaborate work planning and regular project reviews, involvement of the key partners- MOH and SCHMT- in the running of the project as members of the project implementation team (PII), and strict adherence to organisational policies and procedures.

With regards to monitoring, evaluation and learning, the evaluation found a similarly positive picture. A monitoring and evaluation framework developed at the start of the project was evidently used throughout the course of implementation and tracking of key performance indicators was done consistently. A baseline survey conducted at the start of the project provided the benchmark for measuring project achievements. Monthly and quarterly planning and review meetings provided opportunity to discuss the progress, identify challenges and come up with solutions. The participation of MOH, SCHMTs, and CHMTs in the planning and review meetings was noted as a good practice.

3.4 Project Relevance and Strategic Fit

The evaluation assessed the project's relevance with regards to the priority needs and aspirations of the target beneficiaries. In regards to strategic fit, the evaluation assessed the extent to which the project remained aligned to the relevant MNCH policies and strategic plans at the county and national levels. The findings are outlined below.

3.4.1 Relevance to needs of the target beneficiaries

The priority needs of the target beneficiaries were identified through intensive consultations that happened at the design stage of this project. Community members, health care workers, SCHMTs and other stakeholders involved in the consultation identified poor maternal and child health outcomes as a priority problem in Manyatta and Nyalenda slums. Access, demand, utilisation and quality of MNCH services were noted as poor due to a myriad of underlying challenges. The health system in the intervention areas was under significant strain due to constraints such as, shortage of staff and inadequate capacity among the few

available, stock out of essential commodities, dysfunctional referral system, and lack of quality data for use in planning among others. Pregnant mothers were not completing the recommended 4 ANC visits. The evaluation found that the project interventions have remained relevant to the needs of mother, children and households in the intervention areas as demonstrated by increased uptake of key MNCH services including ANC, skilled care at birth, emergency obstetric care, postnatal care, immunisation, and management of childhood illnesses. The project was also relevant in regards to building the capacity of local health systems to effectively lead and coordinate provision of quality, comprehensive and community-responsive MNCH services. The project's community system's strengthening was a remarkable success. Communities that had hitherto felt disconnected from the formal health system and had little engagement in planning and delivery of health services were mobilised, sensitised and as found in this evaluation were now advocates for change in health resource allocation. This transformation is in line with Kenya's constitution that stipulates public participation in development.

As evidenced from the baseline survey, there were major challenges relating to mainstreaming and participation of the vulnerable groups. In fact, the baseline revealed that the health workers lacked adequate capacity to provide youth friendly services.

The attitude towards women with disability was negative with limited knowledge of their needs. Besides, FGD with PWDs indicated that young girls with disability experienced sexual abuse and abandonment by men who pose as husbands. They said that there are no support groups amongst Women with Disability but cited Coalition on Violence against Women – Kenya COVAW (K) as the only organization that has attempted to educate them on their rights.

The end term evaluation revealed that the project design was appropriate in improving the soft skills of the health workers through the CMEs and OJTs to improve on their capacity for service delivery and a change of the perception of the clients. The use of social action and analysis (SAA) assisted to address the negative cultural practices and barriers hence improving uptake of the services. The project also provided disability friendly delivery coaches for mother with disability. This has enhanced service delivered towards people with disability.

3.4.2 Strategic fit with county and national policies and priorities

Kisumu County Integrated Development Plan, 2013- 2017 identified poor health standard as one of the main problems affecting the County development. The underlying causes include: inaccessibility to health facilities, inadequate medical personnel, and inadequate supply of essential drugs, low health awareness, poor nutrition, and high HIV/AIDS prevalence rates among other factors. To address these issues, the plan prioritises investment in health infrastructure, health workforce, service delivery with an emphasis on reproductive,

maternal, newborn and child health services and demand creation through awareness raising and positive behaviour change. The Kisumu Integrated Family Health Project therefore aligns perfectly with the health priorities identified in this county development blueprint. Moreover, interviews with county health officials confirmed the strategic fit between the project interventions and county strategic plans.

Over the last decade, the government of Kenya has laid emphasis in the implementation of the Community Health Strategy (CHS). The strategy is considered a flagship investment that could give the required thrust towards improved health status envisaged in the country's vision 2030. Nevertheless, implementation of the strategy has been hampered by inadequate resource allocation. As such, the project's support in rolling out the CHS by using CHVs was not only a strategic fit but also the right investment.

Improving maternal and child health outcomes is a key priority of the government of Kenya. At the time of designing the project, there was significant global and national attention towards achieving MDG 4 and 5. Kenya missed the targets for both MDG 4 and 5, and as the attention shift to the new SDGs a redoubling of effort is needed. In January 2013, the Ministry of Health inaugurated The Kenya Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) Investment Framework that presents a prioritized set of smart interventions to be scaled up in order to rapidly improve the health outcomes of Kenyan women, children and adolescents. Noteworthy, all the activities implemented by the project are included among the interventions prioritised in the framework. Recent policy changes such as the policy on free maternity services in all public facilities and initiatives such as the First Lady's beyond Zero campaign are geared towards increased reduction in maternal and child mortality. Hence, the project is in line with both the immediate and longer term priorities of the government.

3.5 Project Sustainability

The evaluation assessed the project's sustainability strategies in regards to extent of their implementation and the prospects that the project's initiatives and results would be sustained after its completion. The findings are presented below.

3.5.1 Sustainability of the strengthened leadership and governance:

Right from the design of the project, CARE and consortium partners recognised that the SCHMTs' full involvement was fundamental to the achievement of sustainable change, both financial and systemic. It was clear that the SCHMTs would ultimately be responsible for continuing the activities after the project phases out. The consortium partners' model therefore focused on partnering with the SCHMT from the earliest stage, building their capacity to work effectively and be accountable to their roles and responsibilities. Among the strategies that the project applied to put the SCHMTs on "the steering wheel" included involving them in the planning, implementation and monitoring of project activities,

ensuring project plans were aligned with the sub county plans and providing training especially on leadership and governance. The project also tapped into already available local expertise such as certified trainers to undertake planned activities.

The Kisumu County Government has prioritised health sector in their annual and five year plans and budgets. This has had significant impact on the functioning of the health system. The advocacy efforts by CARE and other players have influenced the increasing allocation of resources to address priority gaps such as shortage of human resources for health.

3.5.2 Sustainability of the improved capacity at health facilities

As highlighted in the earlier sections of this report, capacity of health facilities to provide quality MNCH services has improved as a result of enhanced technical and soft skills among health care workers. The prospect that this change will be sustainable seems positive for a number of reasons. First improved technical skills gained from the project will remain and be propagated through peer-to-peer knowledge and skills transfer (including through CMEs, OJTs and mentorship) that have been institutionalised by the SCHMTs. Monthly CMEs and mentorship through quarterly supportive supervisions have become routine agenda items in the plans of all the SCHMT.

Supportive supervision: The project provided both logistical and technical support to SCHMTs to enable them to undertake regular and quality supportive supervision to health facilities, community units and CSOs. Key informants affirmed that the quality of the supervision had improved especially after the training of the SCHMTs on leadership and governance. As noted in the quote below, not only did the supervision become more comprehensive but also friendly and supportive to the service providers.

“..Supportive supervision has really improved. We now undertake the supervision as a team not like before when we used to work in silos... now the team members check on all issues and not only the aspects for their departments; also the way we handle the staff during the supervision is friendly... we used to be very tough on them and many used to dread our visits” SCHMT member.

3.6 Lessons Learnt and Best Practices

Several lessons were learnt from this project in regard to design and implementation of MNCH interventions. Moreover, the project approaches that produced the desired results in an efficient manner were considered best practices and are presented below.

Project design: The project was designed through a consultative process that was informed by a thorough analysis of operating context and priority needs. This was noted as a best practice. A lesson learnt was that allowing adequate time for stakeholder consultations and inputs during project design is a critical starting point in securing the support of the government and acceptance by the target community.

Social Analysis and Action (SAA) facilitators were instrumental in creating safe spaces for communities to engage in recurring dialogue about topics considered taboo. CARE was responsible for providing training to SAA facilitators on the methodology and purpose of SAA and to provide refresher courses for those already trained as well as those who joined the effort at various points throughout the life of the project. CARE was also responsible to hold monthly or quarterly at minimal, reviews with SAA facilitators throughout the life of the project. The SAA enabled the project beneficiaries to challenge negative social norms which led to a change in attitude and as a result to better health seeking behaviour.

Participatory Education Theatre (PET) groups: CARE worked through existing drama groups to create dramatized messaging and learning opportunities for communities about family planning, gender roles, and inequitable power relations. On occasion, small group discussions or large community-wide public dialogues may have followed these dramas. PET groups and SAA facilitators worked closely and collaboratively at times, and independently at other times throughout the life of the project. This contributed a great deal to the project achieving the desired results since the PET groups were able to pass health messages in a way that could be understood by the general population.

Capacity building: In regard to capacity building of health care worker, the lesson learnt was that soft skills such as customer care, effective communication and positive work attitude are as critical as technical skills. Training of health care provider on soft skills results in tremendous improvement in utilisation of services and client satisfaction. For the SCHMTs, building their leadership and managerial capacity results in better health governance including more effective planning, motivated workforce and ultimately better quality of services.

Behaviour Change Communication (BCC) and demand creation strategies that apply multiple approaches work better in addressing diverse barriers. Male partners and in-laws hold a lot of influence on a woman's knowledge of MNCH and practice of healthy behaviours including utilisation of services. For this reason, programme design must incorporate specific strategies of reaching and working with men and in-laws. Behaviour change communication through peer-to-peer approaches such as mother-to-mother and father-to-father support groups are effective strategies in a context like Nyalenda and Manyatta where communities are close knit.

The project addressed structural barriers, such as harmful socio-cultural beliefs and norms and gender prejudices, through partnering with community gate keepers, men, in-laws and TBAs. The evaluation findings indicated that misinformation and misconceptions especially around family planning and birth had waned as a result of increased health awareness. Some harmful home remedies for childhood illnesses had also waned including the traditional practice of extracting a child's milk teeth in the false believe that they cause illness in children. Male involvement on issues of MNCH, and especially on matters of family planning, was reported to have improved as depicted in the quote below:

“... Another factor that has helped improve our MNCH service uptake is male involvement. On family planning we encourage the female clients to come along with their partners so we can educate them and deal with misconceptions. Partnering with father to father support groups has helped to get the male support on matters that were previously seen as feminine like clinic attendance. During community dialogue days and other community forums, we highlight the need for men to support their pregnant and lactating wives. Generally, male involvement is a strategy we are very keen on expanding.” Key Informant, SCHMT

Evidence-based advocacy: Integrating a learning agenda in projects is a good practice as the evidence and lessons generated are useful in refining project strategies and informing advocacy. Collaborative project implementation based on open dialogue and mutual accountability for results was noted as a best practice that offers valuable opportunities to influence policy and practice.

Peer to peer methodologies: The use of peer-to-peer learning methods such as CMEs, mentorship and on-the-job training saved on the costs. As noted earlier, the project also avoided “re-inventing the wheel” through use of pre-existing resources such as training manuals, tools and reference materials.

The mother to mother support groups were credited for improvement in breastfeeding practices; in addition, the male support groups were also instrumental in mobilising for male involvement in MNCH and especially allowing their wives to take up family planning.

Community strategy as a model - Interviews with key informants at facilities and from the SCHMTs affirmed that the formation and support to the CUs had resulted in a closer linkage between the formal health system and the community and provided a platform for public participation in decision making. CHVs, CHAs and health facility staff regularly held meetings to plan and review progress. The Community Health Committee (CHC) played a governance role including overseeing the activities of the CUs and leading in community dialogue and action days. The CHCs were also key in lobbying for additional support from the County Government and Constituency Development Fund (CDF).

CHAPTER FOUR: CONCLUSION AND RECOMMENDATIONS

4.0 Introduction

This chapter presents the overall conclusion and recommendations drawn from the findings of the evaluation. The conclusions are organised in line with the evaluation criteria, i.e. effectiveness, efficiency, relevance and sustainability. Recommendations are organised to reflect the party they are directed to.

4.1 Conclusions

- ***Effectiveness:*** On the overall, the project has been effective in achieving the intended outcomes. Access and utilisation of MNCH services improved as demonstrated by achievement of the project's key performance indicators across the continuum of care. The training of health workers on both technical and soft skills resulted in better quality of care and consequently improvement in client satisfaction. The community systems strengthening undertaken by the project through establishment of CUs was effective in increasing health awareness and adoption of positive MNCH behaviours and practices. The capacity building provided to CUs was key in empowering them to play a more effective role in planning and delivery of community health services. Lastly, the project was effective in enhancing the capacity of health care workers enabling them to take on their mandate much more effectively.
- ***Efficiency:*** The approaches and strategies applied by the project were largely efficient as evident from the fact that most expected results were achieved within budget and on time. The project design and implementation promoted synergies, avoided duplications and resource conflicts. The project partnered with the MoH, SCHMT, communities and other stakeholders and leveraged additional resources from the government and other actors. By adopting and improving existing resources such as training materials and TOTs, tool kits and models, the project avoided "re-inventing the wheel" thus enhancing efficiency. Mobilising communities to take lead in interventions, nurturing the spirit of community service and harnessing community-owned resources, not only fostered local ownership but also efficiency. Efficiency was also achieved through good project management practices including the right staff mix, robust financial control and strong monitoring and evaluation. In addition, the use of peer-to-peer learning methods such as CMEs, mentorship and on-the-job training saved on the costs. The choice of local partners- small grassroots CSOs- with full time presence in the project villages not only reduced the operations costs but also ensured that nearly the entire sub-grant amounts were directly spent in community health interventions.

Relevance: The evaluation found that the project interventions have remained relevant to the needs of mother, children and households in the Kisumu as demonstrated by increased uptake of key MNCH services including Family Planning, ANC, skilled care at birth, emergency obstetric care, postnatal care, immunisation, and management of childhood illnesses. Improving access, demand, utilisation and quality of MNCH services is a priority need in Kisumu County. The project was aimed to support the local health system to address the main constraints that hampered achievement of MNCH targets. Kisumu County Integrated Development Plan, 2013- 2017 identified poor health standard as one of the main problems affecting the County. The plan prioritises investment in health infrastructure, health workforce, service delivery with an emphasis on reproductive, maternal, newborn and child health services and demand creation through awareness raising and positive behaviour change. The evaluation found that the *KIFH project* was perfectly aligned with the health priorities identified in this county development blueprint.

The project was also relevant in regard to building the capacity of local health systems to effectively lead and coordinate provision of quality, comprehensive and community-responsive MNCH services. This relevance became even more pronounced during the transition into devolved form of government as CHMT and SCHMT were expected to take on more roles in planning and management of health services. For some this was an entirely new arena requiring skills they did not have. Capacity building in leadership and governance was not only relevant but highly appreciated by the sub county and county teams.

Sustainability: The project's sustainability strategies were appropriate and sufficiently implemented. The evaluation findings indicate substantial prospect that the local stakeholders, including SCHMTs, health workers, CUs and CSOs, will continue with the project initiatives and sustain the outcomes achieved.

The project partnered with the SCHMT from the earliest stage, building their capacity to work effectively and be accountable to their roles and responsibilities. By the project's third year, Care Kenya's involvement reduced, with the SCHMTs increasing their leadership and coordination, in line with their mandate. This gradual handover model was noted to have enhanced ownership and prospects for sustainability.

The strategy of cascading the training for health workers through a peer-to-peer approach proved to be valuable particularly in creating spill over effect, which is good for sustainability, and also in filling gaps occasioned by routine staff transfer and attrition.

4.2 Recommendations

Recommendations to CARE Kenya, FHOK and KRCS

- Project exit strategy: The project has yielded significant behaviour change in Kisumu urban slums (Manyatta and Nyalenda) resulting in increased access and utilization of maternal and child health services. Therefore, careful exit strategies should be put in place by to ensure the gains made are not lost. Of great importance is that the County government (CHMT & SCHMT-Kisumu East) teams have been the major drivers of the project interventions supported by the project especially in year two and three. The best practices including mapping of pregnant mothers, mentor mothers, as well as integrated community service delivery should be a common package for all MNCH related programming. This should guarantee smooth transition of project activities.
- In future, consider initiating community based non-financial incentives as opposed to giving monthly allowances (stipend) for the CHVs as it is resource intensive and not sustainable: there is need to explore non-financial incentives that will ensure adequate community involvement in the delivery of MNCH services.
- Since the project did not achieve indicator 2 of the strategic objective 1 on improving nutrition, future programming on nutrition needs to have more support including provision of food supplements to the children as well as more advocacy with the county government to improve funding for nutrition related activities. The development of a County nutrition action plan as well as strengthening of the nutrition stakeholders' forum would go a long way in achieving this.
- Planning for unforeseen circumstances like the prolonged nurses' strike which affected the achievement of some targets could be addressed by having flexible designs and budgets that could allow for hiring of health workers albeit on short term contracts to deal with the persistent gaps of human resources for health in the county.

Recommendations to SCHMT and CHMTs and Kisumu County government

- The County Government should sustain investments in the implementation of the Community Health Strategy. The priority should include resources allocation within County health budget for support supervision and mentorship to the CUs, working aids, and reporting tools for the CHVs and CHAs, as well as coordinating the support offered by partners.
- The SCHMT and CHMTs should continue factoring in CHV monthly stipend in the county health budget for supporting the CUs as pledged by the previous county government after a series of engagement with County assembly members by the project advocacy strategies and ensure a strong linkage with local health facilities is maintained. Regular support supervision and mentorship to the CUs will boost their morale and increase the prospects of sustainability.

- The SCHMT should also ensure that future community-level projects and initiatives by both County Government and partners work with and support the already established CUs instead of starting from scratch with new ones.
- The County Government should scale up support for IGAs for active CUs, including linking them up and endorsing them for other grants including *Uwezo* Fund, constituency development fund etc. To ensure the IGAs grow into profit-making ventures, ongoing support and mentorship will be required from relevant line ministries including agriculture and livestock, water, gender and social services and trade and industry.

Recommendations to national MOH

- The national MOH should continue providing the policy steer in regards to implementation of the community health strategy including ensuring harmonisation of the way CHS is implemented by partners. For instance, the MOH should support County government to customise the RH and Nutrition policies to suit the health challenges in Kisumu County. Secondly, issue a policy position supporting the adopting of group Income Generating Activities (IGA) for incentivising CHU workforce as opposed to monthly stipends.

ANNEXES

Annex 1: Household survey Tool



HOUSEHOLD SURVEY TOOL

HOUSEHOLD SURVEY TOOL ENDTERM EVALUATION FOR THE KISUMU INTEGRATED FAMILY HEALTH PROJECT

Identification	
Cluster Number	Manyatta [1] Nyalenda [2]
Household Number	
Village Name	
Name of Mother	
Name of Supervisor	

Interview date	___/___/___ day/month/year	<i>For Supervisor</i>		
Name of Interviewer		Day		
		Month		
		Year		

Consent Page

INFORMED CONSENT

Hello. My name is _____, and I am working with (MoH and CARE KENYA). We are conducting an endterm Evaluation of KIFH Project and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help (MoH and CARE KENYA) to plan health services and assess whether it is meeting its goals to improve children's health in this community. The interview will take 40 minutes to complete. Whatever information you provide will be kept strictly confidential.

Participation in this interview is voluntary and you can choose not to answer any individual question or all of the questions. You can stop the survey at any time. However, we hope that you will participate in this survey since your views are important.

Will you participate in this survey?

At this time, do you want to ask me anything about the survey?

Signature of interviewer: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED RESPONDENT DOES NOT AGREE TO BE INTERVIEWED

INSTRUCTIONS:

- (1) ALL QUESTIONS ARE TO BE ADDRESSED TO MOTHERS WITH A CHILD LESS THAN 24 MONTHS OF AGE.
- (2) ASK FOR OFFICIAL DOCUMENTATION REGARDING CHILD (ANTENATAL CARDS, IMMUNIZATIONS RECORDS, BIRTH CERTIFICATES, ETC.)

No.	Questions and Filters	Coding Categories	Skip
Section 1 Introduction			
101.	What is your age?	<input type="checkbox"/> Years <input type="checkbox"/> don't know .....88	
102.	What is your religion?	Christian Orthodox .....1 Other Christian .....2 Muslim .....3 Roman Catholic .....4 Adventist .....5 Traditional religion .....6 Other .....7 None .....8	
103.	What is your current marital status?	Single/ never married .....1 Married .....2 Divorced/ separated .....3 Widowed .....4	
104.	How old were you when you married?	<input type="checkbox"/> Years <input type="checkbox"/> don't know .....88	
105.	What is your spouse's age?	<input type="checkbox"/> Years <input type="checkbox"/> don't know .....88	
106.	Who usually lives in this house with you? (tick all that apply: probe for all residents)	Father .....1 Mother .....2 Husband .....3 Children .....4 Brother/s .....5 Sister/s .....6 Mother-in-law .....7 Father-in-law .....8 Other relatives .....9 Other non-relatives .....10	
107.	Have you ever attended school?	Yes .....1 No .....2	→ 109
108.	What is the highest level of education completed by you?	Pre-School .....0 Primary .....1 Secondary .....2 University .....3 Postgraduate .....4 DK .....5 Other .....6	
109.	What is the highest level of education completed by your spouses?	Pre-School .....0 Primary .....1 Secondary .....2 University .....3 Postgraduate .....4 DK .....5 Other .....6	
110.	Could you decide to go to a health clinic or hospital if you wanted to?	Yes .....1 No .....2	

No.	Questions and Filters	Coding Categories	Skip																				
111.	How old were you when you gave birth to your first child?	AGE..... <input type="text"/> <input type="text"/> DON'T KNOW.....998																					
112	What is the name, sex, date of birth of your youngest child that you gave birth to and that is still alive?	YOUNGEST CHILD NAME _____ <u>SEX</u> MALE1 FEMALE.....2 <u>DATE OF BIRTH</u> DAY MONTH YEAR <input type="text"/> <input type="text"/>																					
Section 2 Maternal and Newborn Care																							
201	During your pregnancy with (Name), did you see anyone for antenatal care? IF YES: Whom did you see? Anyone else? PROBE FOR THE TYPE OF PERSON AND RECORD ALL PERSONS SEEN.	DOCTOR/MEDICAL ASSISTANT.....A NURSE.....B MIDWIFE.....C TRADITIONAL BIRTH ATTENDANTD OTHER _____X (SPECIFY) NO ONE.....Y	→ 203																				
202	How many months pregnant were you when you first received ANC in your last pregnancy? (Refer to Mother and Child Booklet)	MONTHS <input type="text"/> <input type="text"/>																					
203	During your pregnancy with (Name), how many times did you receive antenatal care?	TIMES <input type="text"/> <input type="text"/> DON'T KNOW98																					
204	Were any of the ANC visits made above fall within the most critical times mainly: at 16 weeks, 24 weeks, 32 weeks or at 36 weeks (Refer to Mother and child Booklet)	<table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>NO</th> <th>DK/Can't Recall</th> </tr> </thead> <tbody> <tr> <td>16 weeks (4 months)</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>24 weeks (6 months)</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>32 weeks (8 months)</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>36 weeks (9 months)</td> <td>1</td> <td>2</td> <td>3</td> </tr> </tbody> </table>		Yes	NO	DK/Can't Recall	16 weeks (4 months)	1	2	3	24 weeks (6 months)	1	2	3	32 weeks (8 months)	1	2	3	36 weeks (9 months)	1	2	3	
	Yes	NO	DK/Can't Recall																				
16 weeks (4 months)	1	2	3																				
24 weeks (6 months)	1	2	3																				
32 weeks (8 months)	1	2	3																				
36 weeks (9 months)	1	2	3																				
205	During this /last pregnancy, were any of the following done at least once? Circle All that Apply	Weighed1 Height measured.....2 Stomach measured.....3 Blood pressure.....4 Urine sample.....5 Blood sample.....6 Tested for HIV/AIDS.....7 Counseled on HIV testing (VCT).....8 Counseled on Infant feeding.....9 Counseled on Breast milk.....10 Counseled on how long to wait before bathing the child..11																					
206	I don't want to know the results, but were you tested for the AIDS virus as part of your antenatal care?	YES.....1 NO.....2																					

No.	Questions and Filters	Coding Categories	Skip
207	Were you and your spouse offered a test for the AIDS virus as part of your antenatal care?	YES.....1 NO.....2	
208	I don't want to know the results, but did you get the results of the test?	YES.....1 NO.....2	
209	During your pregnancy with (Name) did you receive an injection in the arm to prevent the baby from getting tetanus; that is convulsions after birth?	YES.....1 NO.....2 DON'T KNOW .....9	→ 211 → 211
210	While pregnant with (name), how many times did you receive such an injection?	ONE.....1 TWO .....2 THREE OR MORE .....3 DON'T KNOW .....9	
211	Did you receive any tetanus toxoid injection at any time before that pregnancy, including during a previous pregnancy or between pregnancies?	YES.....1 NO.....2 DON'T KNOW .....9	→ 213 → 213
212	Before the pregnancy with (Name), how many times did you receive a tetanus injection?	ONE.....1 TWO .....2 THREE OR MORE .....3 DON'T KNOW .....9	
213	During (any of) your <u>antenatal care</u> visits, were you told about the signs of pregnancy <u>complications</u> ?	YES.....1 NO.....2 DON'T KNOW .....9	→ 215 → 2215
214	Were you told where to go if you had any of these <u>complications</u> ?	YES.....1 NO.....2 DON'T KNOW .....8	
215	During pregnancy, woman may encounter severe problems or illnesses and should go or be taken <u>immediately to a health facility</u> . What types of <u>symptoms</u> would cause you to seek <u>immediate care at a health facility (right away)</u> ? ASK: Anything else? DO NOT READ RESPONSES. RECORD ALL THAT ARE MENTIONED.	VAGINAL BLEEDING .....A FAST/DIFFICULT BREATHING .....B FEVER .....C SEVERE ABDOMINAL PAIN .....D HEADACHE/BLURRED VISION.....E CONVULSIONS .....F FOUL SMELLING DISCHARGE/FLUID FROM VAGINA.....G BABY STOPS MOVING .....H LEAKING BROWNISH/GREENISH FLUID FROM THE VAGINA.....I OTHER X (SPECIFY) DON'T KNOW .....Z	
216	During your pregnancy with (Name), were you given or did you buy any <u>iron folate/ IFAS tablets</u> ?	YES.....1 NO.....2 DON'T KNOW .....8	→ 218 → 218

No.	Questions and Filters	Coding Categories	Skip
217	<p>During the whole pregnancy, for how many days did you take the tablets?</p> <p>IF THE ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER OF DAYS.</p>	<p>DAYS <input type="text"/> <input type="text"/> <input type="text"/></p> <p>DON'T KNOW .....998</p>	
218	<p>Where did you give birth?</p>	<p>HEALTH FACILITY .....1</p> <p>OTHER (SPECIFY) 2</p>	→ 220
219	<p>Why did you choose not to deliver at a health facility?</p> <p>PROBE AND RECORD ALL MENTIONED REASONS</p>	<p>DISTANCE .....A</p> <p>COST .....B</p> <p>DISSATISFACTION WITH QUALITY OF CARE.....C</p> <p>OTHER (SPECIFY) D</p>	
220	<p>Who assisted with the delivery of (Name)?</p> <p>Anyone else?</p> <p>PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD ALL MENTIONED.</p> <p>IF RESPONDENT SAYS NO ONE ASSISTED, PROBE TO DETERMINE WHETHER ANY ADULTS WERE PRESENT AT THE DELIVERY.</p>	<p>DOCTOR.....A</p> <p>NURSE.....B</p> <p>MIDWIFE.....C</p> <p>AUXILIARY MIDWIFE.....D</p> <p>OTHER HEALTH STAFF WITH MIDWIFERY</p> <p>SKILLS.....E</p> <p>TRADITIONAL BIRTH ATTENDANT .....F</p> <p>COMMUNITY HEALTH WORKER.....G</p> <p>RELATIVE/FRIEND.....H</p> <p>NO ONE.....I</p>	
221	<p>After (Name) was born, did any health care provider check on (Name's) health?</p>	<p>YES.....1</p> <p>NO.....2</p>	→ 224
222	<p>How many hours, days or weeks after the birth of (Name) did the first check take place?</p> <p>IF LESS THAN ONE DAY, CIRCLE 0 AND RECORD HOURS; IF ONE TO SIX DAYS CIRCLE 1 AND RECORD DAYS; IF MORE THAN 6 DAYS CIRCLE 2 AND RECORD WEEKS.</p>	<p>HOURS.....0 <input type="text"/> <input type="text"/></p> <p>DAYS.....1 <input type="text"/> <input type="text"/></p> <p>WEEKS .....2 <input type="text"/> <input type="text"/></p> <p>DON'T KNOW .....998</p>	→ 226
223	<p>Who checked ON (NAME'S) HEALTH at that time?</p> <p>Anyone else?</p> <p>PROBE FOR THE MOST QUALIFIED PERSON AND RECORD ALL MENTIONED.</p>	<p>DOCTOR.....A</p> <p>NURSE.....B</p> <p>MIDWIFE.....C</p> <p>AUXILIARY MIDWIFE.....D</p> <p>OTHER HEALTH STAFF WITH MIDWIFERY</p> <p>SKILLS.....E</p> <p>TRADITIONAL BIRTH ATTENDANT .....F</p> <p>COMMUNITY HEALTH VOLUNTEER.....G</p> <p>RELATIVE/FRIEND.....I</p> <p>NO ONE.....J</p>	
224	<p>Did a health care provider or a traditional birth attendant check ON YOUR HEALTH after the delivery of (Name), either at a health facility, at home, or other location?</p>	<p>YES .....1</p> <p>NO .....2</p>	→ 226

No.	Questions and Filters	Coding Categories	Skip
225	<p>How long after the delivery did the first check take place?</p> <p>IF LESS THAN ONE DAY, CIRCLE 0 AND RECORD HOURS; IF LESS THAN ONE WEEK CIRCLE 1 AND RECORD DAYS; IF MORE THAN 6 DAYS CIRCLE 2 AND RECORD WEEKS</p>	<p>HOURS.....0 <input type="text"/><input type="text"/></p> <p>DAYS.....1</p> <p>WEEKS.....2 <input type="text"/><input type="text"/></p> <p>DON'T KNOW.....998</p>	
226	<p>Sometimes children get sick and need to receive care or treatment for illnesses. What are the <u>signs</u> of illness that would indicate your child needs treatment?</p> <p>RECORD ALL MENTIONED.</p>	<p>LOOKS UNWELL OR NOT PLAYING NORMALLY.....A</p> <p>NOT EATING OR DRINKING.....B</p> <p>LETHARGIC OR DIFFICULT TO WAKE.....C</p> <p>HIGH FEVER.....D</p> <p>FAST OR DIFFICULT BREATHING.....E</p> <p>VOMITS EVERYTHING.....F</p> <p>CONVULSIONS.....G</p> <p>DIARRHEA.....H</p> <p>OTHER.....X</p> <p>(SPECIFY)</p> <p>DON'T KNOW.....Z</p>	
227	<p>Did you ever breastfeed (Name)?</p>	<p>YES.....1</p> <p>NO.....2</p>	→ 229
228	<p>How long after birth did you first put (Name) to the breast?</p> <p>IF LESS THAN ONE HOUR, RECORD 00 HOURS. IF LESS THAN 24 HOURS RECORD THE HOURS, OTHERWISE RECORD DAYS</p>	<p>HOURS.....0 <input type="text"/><input type="text"/></p> <p>DAYS.....1</p> <p>WEEKS.....2 <input type="text"/><input type="text"/></p> <p>DON'T KNOW.....88</p>	
229	<p>Did you give (Name) the first liquid (Colostrum) that came from your breasts?</p>	<p>YES.....1</p> <p>NO.....2</p> <p>DON'T KNOW.....9</p>	
230	<p>Now I would like to ask you about family planning - that is the various ways or methods that a couple can use to avoid or delay a pregnancy. Which ways or methods have you heard about? (DO NOT READ THE CHOICES: tick all mentioned and probe for more)</p>	<p>FEMALE STERILIZATION.....1</p> <p>MALE STERILIZATION.....2</p> <p>PILL.....3</p> <p>IUD.....4</p> <p>INJECTABLES.....5</p> <p>IMPLANTS.....6</p> <p>CONDOM.....7</p> <p>FEMALE CONDOM.....8</p> <p>DIAPHRAGM.....9</p> <p>FOAM/JELLY.....10</p> <p>LACTATIONAL AMEN METHOD.....11</p> <p>STANDARD DAYS METHOD/ CYCLEBEADS.....12</p> <p>RHYTHM METHOD (OTHER THAN STANDARD DAYS).....13</p> <p>WITHDRAWAL.....14</p> <p>OTHER.....15</p> <p>(SPECIFY)</p>	

No.	Questions and Filters	Coding Categories	Skip
231	Are you currently doing something or using any method to delay or avoid getting pregnant?	YES.....1 NO.....2	→ 301
232	Which method are you (or your husband/ partner) using? DO NOT READ RESPONSES. CODE ONLY ONE RESPONSE. IF MORE THAN ONE METHOD IS MENTIONED, ASK, What is your MAIN method that you (or your husband/ partner) use to delay or avoid getting pregnant? IF RESPONDENT MENTIONS BOTH CONDOMS AND STANDARD DAYS METHOD, CODE “12” FOR STANDARD DAYS METHOD. IF RESPONDENT MENTIONS BREASTFEEDING, CODE “15” FOR OTHER AND RECORD BREASTFEEDING. IF RESPONDENT MENTIONS ABSTINENCE OR ISOLATION, CODE “15” FOR OTHER AND RECORD RESPONSE IN SPACE PROVIDED.	FEMALE STERILIZATION .....1 MALE STERILIZATION.....2 PILL .....3 IUD .....4 INJECTABLES .....5 IMPLANTS.....6 CONDOM.....7 FEMALE CONDOM .....8 DIAPHRAGM .....9 FOAM/JELLY .....10 LACTATIONAL AMEN METHOD.....11 STANDARD DAYS METHOD/ CYCLEBEADS .....12 RHYTHM METHOD (OTHER THAN STANDARD DAYS).....13 WITHDRAWAL.....14 OTHER _____ 15 (SPECIFY)	
233	Who made the decision to use this particular method that you are now using?	Own idea..... 1 Spouses/ partner..... 2 Joint decision.....3 Mother-in-law.....4 Health provider 5 Other person (specify)..... 6	
234	When you last accessed family planning services what was the MAIN reason you chose the method and not another method? TICK ONE ONLY	Easy to access .....1 Affordable.....2 Provider attitude .....3 Providers are competent .....4 Good quality.....5 Recommended by others .....6 Lack of alternative .....7 Confidentiality 8 Couple friendly.....9 Youth friendly .....10 Male friendly.....11 Counseling services.....12 Other reason.....13	

No.	Questions and Filters	Coding Categories	Skip																																																												
235	On Your Last Visit To The Health Care Provider for FP advice/ Services, did he/she...	Greet you? 1. Yes 2. No 3. DK Respond to your health concerns? 1. Yes 2. No 3. DK Explain possible effects of method? 1. Yes 2. No 3. DK Explain what to do on side effects? 1. Yes 2. No 3. DK Tell you when return for next visit? 1. Yes 2. No 3. DK Treat you with respect? 1. Yes 2. No 3. DK																																																													
Section 3 Breastfeeding/ Infant and Young Child Feeding																																																															
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302	PLEASE FILL OUT THE FOLLOWING TABLE WITH THE ANSWERS TO THE QUESTIONS BELOW: Now I would like to ask you about (other) liquids or foods that (NAME) may have had yesterday during the day or at night I am interested in whether your child had the item even if it was combined with other foods Did (NAME) drink/eat:	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td colspan="4">GROUP 1: DAIRY</td> </tr> <tr> <td>A. CHECK Q301D – IF YES, CIRCLE YES HERE Commercially produced infant formula?</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td>B. CHECK Q301C – IF YES, CIRCLE YES HERE Milk such as tinned, powdered, or fresh animal milk?</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td>C. Cheese, yogurt, or other milk products?</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td colspan="4">GROUP 2: GRAIN</td> </tr> <tr> <td>D. CHECK Q301E – IF YES, CIRCLE YES HERE Any fortified, commercially available infant and young Child food (egCerelac)?</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td>E. CHECK Q301F – IF YES, CIRCLE YES HERE Any (other) porridge or gruel?</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td>F. Bread, rice, noodles, or other foods made from grains?</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td>G. White potatoes, white yams, manioc, cassava, or any other foods made from roots?</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td colspan="4">GROUP 3: VITAMIN A RICH VEGETABLES</td> </tr> <tr> <td>H. Pumpkin, carrots, squash, or sweet potatoes that are yellow or orange inside?</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td>I. Any dark green leafy vegetables?</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td>J. Ripe mangoes, papayas or (INSERT ANY OTHER LOCALLY AVAILABLE VITAMIN A-RICH FRUITS)?</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td>K. Foods made with red palm oil, palm nut, palm nut pulp sauce?</td> <td>1</td> <td>2</td> <td>9</td> </tr> </tbody> </table>		YES	NO	DK	GROUP 1: DAIRY				A. CHECK Q301D – IF YES, CIRCLE YES HERE Commercially produced infant formula?	1	2	9	B. CHECK Q301C – IF YES, CIRCLE YES HERE Milk such as tinned, powdered, or fresh animal milk?	1	2	9	C. Cheese, yogurt, or other milk products?	1	2	9	GROUP 2: GRAIN				D. CHECK Q301E – IF YES, CIRCLE YES HERE Any fortified, commercially available infant and young Child food (egCerelac)?	1	2	9	E. CHECK Q301F – IF YES, CIRCLE YES HERE Any (other) porridge or gruel?	1	2	9	F. Bread, rice, noodles, or other foods made from grains?	1	2	9	G. White potatoes, white yams, manioc, cassava, or any other foods made from roots?	1	2	9	GROUP 3: VITAMIN A RICH VEGETABLES				H. Pumpkin, carrots, squash, or sweet potatoes that are yellow or orange inside?	1	2	9	I. Any dark green leafy vegetables?	1	2	9	J. Ripe mangoes, papayas or (INSERT ANY OTHER LOCALLY AVAILABLE VITAMIN A-RICH FRUITS)?	1	2	9	K. Foods made with red palm oil, palm nut, palm nut pulp sauce?	1	2	9	
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No.	Questions and Filters	Coding Categories	Skip
	GROUP 4: OTHER FRUITS/VEGETABLES	YES NO DK	
	L. Any other fruits or vegetables like oranges, grapefruit or pineapple?	.....1 2 9	
	GROUP 5: EGGS	YES NO DK	
	M. Eggs?	.....1 2 9	
	GROUP 6: MEAT, POULTRY, FISH	YES NO DK	
	N. Liver, kidney, heart or other organ meats?	.....1 2 9	
	O. Any meat, such as beef, pork, lamb, goat, chicken, or duck?	.....1 2 9	
	P. Fresh or dried fish or shellfish?	.....1 2 9	
	Q. Grubs, snails, insects, other small protein food?	.....1 2 9	
	GROUP 7: LEGUMES/NUTS	YES NO DK	
	R. Any foods made from beans, peas, lentils, or nuts?	.....1 2 9	
	GROUP 8: OILS/FATS	YES NO DK	
	S. Any oils, fats, or butter, or foods made with any of these?	.....1 2 9	
	T. CHECK 302A – 302S: HOW MANY FOOD GROUP (GROUPS 1-8 IN ABOVE TABLE) HAVE AT LEAST ‘YES’ CIRCLED?	Number of Groups..... <input type="text"/> <input type="text"/>	
	GROUP 9: OTHER FOODS	YES NO DK	
	U. Tea or coffee?	.....1 2 9	
	V. Any other liquids?	.....1 2 9	
	W. Any sugary foods, such as chocolates, candy, sweets, pastries, cakes, or biscuits?	.....1 2 9	
	X. Any other solid or soft food?	.....1 2 9	
303	<p>How many times did (NAME) eat solid, semi-solid, or soft foods other than liquids yesterday during the day or at night?</p> <p>WE WANT TO FIND OUT HOW MANY TIMES THE CHILD ATE ENOUGH TO BE FULL. SMALL SNACKS AND SMALL FEEDS SUCH AS ONE OR TWO BITES OF MOTHER’S OR SISTER’S FOOD SHOULD NOT BE COUNTED</p> <p>LIQUIDS DO NOT COUNT FOR THIS QUESTION. DO NOT INCLUDE THIN SOUPS OR BROTH, WATERY GRUELS, OR ANY OTHER LIQUID</p> <p>USE PROBING QUESTIONS TO HELP THE RESPONDENT REMEMBER ALL THE TIMES THE CHILD ATE YESTERDAY</p> <p>IF CAREGIVER ANSWERS SEVEN OR MORE TIMES, RECORD “7”</p>	<p>NUMBER OF TIMES..... <input type="text"/> <input type="text"/></p> <p>DON’T KNOW <input type="text"/></p>	

No	Questions and Filters	Coding Categories	Skip
Section 4 Vitamin A Supplementation- (For children 6-23 months only)			
401	Has (Name) ever received a Vitamin A dose (like this/any of these)? SHOW COMMON TYPES OF AMPULES/CAPSULES/SYRUPS	YES 1 NO 2 DON'T KNOW 9	→ 501 → 501
402	Did (Name) receive a Vitamin A dose within the last 6 months?	YES 1 NO 2 DON'T KNOW 9	
Section 5 : Child Immunizations			
501	Do you have a card or child health booklet where (Name's) vaccinations and Vitamin A (capsules) are written down? IF YES: May I see it please?	YES 1 NO 2 DON'T KNOW 9	→ 504 → 504
502	COPY VACCINATION DATE FOR VITAMIN A, Pentavalent (PV) 1, Pentavalent (PV) 3, ROTAVIRUS VACCINE AND MEASLES FROM THE CARD OR BOOKLET IF VACCINES ARE NOT RECORDED IN CHILD HEALTH CARD OR BOOKLET, FILL IN 99/99/9999	DAY MONTH YEAR VITAMIN A |__| |__| / |__| |__| / |__| |__| |__| PV1..... |__| |__| / |__| |__| / |__| |__| |__| PV3..... |__| |__| / |__| |__| / |__| |__| |__| Rotavirus.. |__| |__| / |__| |__| / |__| |__| |__| MEASLES |__| |__| / |__| |__| / |__| |__| |__|	
503	Has (NAME) received any vaccinations that are not recorded on this card, including vaccinations given during immunization campaigns?	YES 1 NO 2 DON'T KNOW 8	→ 601 → 601
504	Has (NAME) received a Pentavalent (PV) vaccination, that is, an injection given in the thigh, sometimes at the same time as polio drops?	YES 1 NO 2 DON'T KNOW 9	→ 506 → 506
505	How many times?	NUMBER OF TIMES <input type="text"/> <input type="text"/>	

No	Questions and Filters	Coding Categories	Skip
506	Did (Name) ever receive an injection in the arm to prevent Measles?	YES 1 NO 2 DON'T KNOW 9	
507	Did (Name) receive a de-worming tablet in the last 6 months (show common de-worming tablet)	YES 1 NO 2 DON'T KNOW 9	
Section 6 : Malaria - Treatment and Prevention			
601	Has (Name) been ill with fever at any time in the last 2 weeks?	YES 1 NO 2 DON'T KNOW 9	→ 606 → 606
602	Did you seek advice or treatment for the fever?	YES 1 NO 2	→ 604
603	How many days after the fever began did you first seek treatment for (Name)?	SAME DAY 0 NEXT DAY 1 TWO OR MORE DAYS 2	
604	At any time during the illness did (Name) take any drugs for the fever?	YES 1 NO 2 DON'T KNOW 9	→ 606 → 606
605	What drugs did (Name) take? Any other drugs? RECORD ALL MENTIONED ASK TO SEE DRUG(S) IF TYPE OF DRUG IS NOT KNOWN IF TYPE OF DRUG IS STILL NOT DETERMINED, SHOW TYPICAL ANTIMALARIAL DRUGS TO RESPONDENT **COUNTRY SPECIFIC BASED ON NATIONAL MALARIAL PROTOCOL FOR EACH ANTIMALARIAL MEDICINE ASK:How long after the fever started did (NAME) start taking the medicine? CIRCLE THE APPROPRIATE CODES: SAME DAY = 0 NEXT DAY AFTER THE FEVER = 1 TWO OR MORE DAYS AFTER THE FEVER = 2 DON'T KNOW = 9	ANTI-MALARIAL A. SP/Fansidar.....0 1 2 9 B. Chloroquine.....0 1 2 9 C. Amodiaquine.....0 1 2 9 D. Quinine.....0 1 2 9 E. ACT(Coartem*) .....0 1 2 9 OTHER DRUGS A. ASPRIN.....0 1 2 9 B. PARACETAMOL.....0 1 2 9 X Other .....0 1 2 9	
606	When you were pregnant with (NAME), did you take any drugs in order to prevent you from getting malaria?	YES.....1 NO.....2 DON'T KNOW..... 9	
607	Which drugs did you take to prevent malaria? RECORD ALL METNIONED. IF TYPE OF DRUG IS NOT DETERMINED, SHOW TYPICAL ANTIMALARIAL DRUGS TO RESPONDENT.	SP/FANSIDAR.....A CHLOROQUINE.....B OTHER.....X DON'T KNOW..... Z	
608	Does your household have any long lasting insecticide treated nets?	YES.....1	

No	Questions and Filters	Coding Categories	Skip
		NO .....2	
609	Who slept under the long acting ITN last night? MULTIPLE RESPONSES ALLOWED	YOUNGEST CHILD .....1 MOTHER .....2 ALL CHILDREN UNDER FIVE .....3 HUSBAND/PARTNER.....4 OTHER HOUSEHOLD MEMBERS .....5 NONE.....6	
610	Has the net (nets) ever been soaked / dipped in insecticide?	YES .....1 NO .....2	→ 612
611	When was the last time the net(s) was (were) soaked/dipped in insecticide?	WHEN I GOT THE NET.....1 WITHIN THE LAST 6 MONTHS.....2 6-12 MONTHS AGO.....3 MORE THAN 12 MONTHS AGO.....4 NEVER.....5 DON'T KNOW.....88	
612	During your last pregnancy, did you sleep under an long acting ITN?	YES.....1 NO .....2	
SECTION 7: Control of Diarrhea			
701	Has (Name) had diarrhea in the last two weeks?	YES..... 1 NO 2 DON'T KNOW..... 9	→ 703 → 703
702	What was given to treat the diarrhea? Anything else? If answer pill or syrup, show local packaging for zinc and task if the child received this medicine RECORD ALL MENTIONED	NOTHING..... A FLUID FROM ORS PACKET B HOME-MADE FLUID C PILL OR SYRUP, ZINC D PILL OR SYRUP, NOT ZINC E INJECTION F IV (INTRAVENOUS) G HOME REMEDIES/HERBAL MEDICINES H OTHER (SPECIFY) I	
703	Have you heard of ORS? IF YES, ASK MOTHER TO DESCRIBE ORS PREPARATION FOR YOU IF NO, CIRCLE 3 (NEVER HEARD OF ORS) ONCE MOTHER HAS PROVIDED A DESCRIPTION, RECORD WHETHER SHE DESCRIBED ORS PREPARATION CORRECTLY OR INCORRECTLY CIRCLE 1 [CORRECTLY] IF THE MOTHER MENTIONED THE FOLLOWING: • USE 1 LITER OF CLEAN DRINKING WATER (1 LITER=3 SODA BOTTLES) • USE THE ENTIRE PACKET • DISSOLVE THE POWDER FULLY	DESCRIBED CORRECTLY 1 DESCRIBED INCORRECTLY 2 NEVER HEARD OF ORS..... 3	
SECTION 8: ARI/Pneumonia			

No	Questions and Filters	Coding Categories	Skip
801	Has (Name) had an illness with a cough that comes from the chest at any time in the last two weeks?	YES 1 NO 2 DON'T KNOW 9	→ 901 → 901
802	When (Name) had an illness with a cough, did he/she have trouble breathing or breathe faster than usual with short, fast breaths?	YES 1 NO 2 DON'T KNOW 9	→ 901 → 901
803	Did you seek advice or treatment for the cough/fast breathing?	YES 1 NO 2	→ 901
804	Who gave you advice or treatment? Anyone else? RECORD ALL MENTIONED	DOCTOR A NURSE B AUXILIARY NURSE C COMMUNITY HEALTH WORKER D OTHER X	
805	How long after you noticed (NAME's) cough and fast breathing did you seek treatment?	SAME DAY 0 NEXT DAY 1 TWO DAYS 2 THREE OR MORE DAYS 3	

Section 9. Water and Sanitation

901	What is the main source of drinking water for members of this household? (CHECK ONE)	PIPED WATER INTO DWELLING 1 PIPED WATER INTO YARD/PLOT/BUILDING 2 PUBLIC TAP/STANDPIPE 3 TUBEWELL/BOREHOLE 4 PROTECTED DUG WELL 5 UNPROTECTED DUG WELL 6 PROTECTED SPRING 7 UNPROTECTED SPRING 8 RAIN WATER COLLECTION 9 CART WITH SMALL TANK/DRUM 10 TANKER TRUCK 11 BOTTLED / SACHET WATER 12 SURFACE WATER (RIVER/STREAM/ETC.) 13 OTHER 96 (SPECIFY)	
902	Do you treat your water in any way to make it <u>safe</u> for drinking?	YES 1 NO 2	→ 904

903	<p>If yes, what do you usually do to the water to make it safer to drink?</p> <p>Anything else?</p> <p>ONLY CHECK MORE THAN ONE RESPONSE IF SEVERAL METHODS ARE USUALLY USED TOGETHER, FOR EXAMPLE, CLOTH FILTRATION AND CHLORINE.</p>	<p>LET IT STAND AND SETTLE/ SEDIMENTATION..... A</p> <p>STRAIN IT THROUGH CLOTH B</p> <p>BOIL..... C</p> <p>ADD BLEACH/ CHLORINE D</p> <p>WATER FILTER (CERAMIC, SAND, COMPOSITE) E</p> <p>SOLAR DISINFECTION F</p> <p>OTHER..... X (SPECIFY)</p> <p>DON'T KNOW..... Z</p>	
904	<p>Do you know the times when it is <u>important</u> to wash hands?</p> <p>IF FOR WASHING MY OR MY CHILDREN'S HANDS IS MENTIONED, PROBE WHAT WAS THE OCCASION, BUT DO NOT READ THE ANSWERS.</p> <p>(DO NOT READ THE ANSWERS, ASK RESPONDENT TO BE SPECIFIC. ENCOURAGE "WHAT ELSE" UNTIL NOTHING FURTHER IS MENTIONED AND CIRCLE ALL THAT APPLY)</p>	<p>BEFORE PREPARING FOOD..... A</p> <p>BEFORE EATING B</p> <p>BEFORE FEEDING CHILD..... C</p> <p>AFTER CLEANING CHILD'S BOTTOMS D</p> <p>AFTER USING THE TOILET E</p> <p>AFTER EATING..... F</p> <p>AFTER CLEANING..... G</p> <p>AFTER TOUCHING SOMETHING STICKY, OILY, SMELLY..... H</p> <p>OTHER X (SPECIFY)</p>	
905	<p>Can you show me where you usually wash your hands and what you use to wash hands?</p> <p>ASK TO SEE AND OBSERVE</p>	<p>INSIDE/NEAR TOILET FACILITY..... 1</p> <p>INSIDE/NEAR KITCHEN/COOKING PLACE..... 2</p> <p>ELSEWHERE IN YARD 3</p> <p>OUTSIDE YARD 4</p> <p>NO SPECIFIC PLACE 5</p> <p>NO PERMISSION TO SEE 7</p>	<p>→ 1001</p> <p>→ 1001</p>
906	<p>OBSERVATION ONLY: IS THERE SOAP OR DETERGENT OR LOCALLY USED CLEANSING AGENT?</p> <p>THIS ITEM SHOULD BE EITHER IN PLACE OR BROUGHT BY THE INTERVIEWEE WITHIN ONE MINUTE. IF THE ITEM IS NOT PRESENT WITHIN ONE MINUTE CHECK NONE, EVEN IF BROUGHT OUT LATER</p>	<p>SOAP..... 1</p> <p>DETERGENT..... 2</p> <p>ASH 3</p> <p>MUD/SAND..... 4</p> <p>NONE..... 5</p> <p>OTHER..... 6 (SPECIFY)</p>	

Section 10 HEALTH CONTACTS AND SOURCES OF HEALTH INFORMATION

NO	QUESTIONS AND FILTERS	CODING CATEGORIES			SKIP
		FREQUENTLY (4 or more times)	SOMETIMES (1-3 times)	NEVER (0 times)	
1001	During the last month, how often have you come in contact with each of the following:				
	Doctor	1	2	3	
	Nurse/Midwife	1	2	3	
	Community Health Worker	1	2	3	
	Health Educator	1	2	3	
	Growth Monitoring Person	1	2	3	
	Trained Birth Attendant	1	2	3	
	Traditional Healer	1	2	3	

1002	Where do you get general information or advice on health or nutrition?	Formal Network		
		Doctor	A	
	RECORD ALL MENTIONED	Nurse/Midwife	B	
		Auxiliary Midwife	C	
		Trained Birth Attendant	D	
		Community Health Worker	E	
		Health Educator	F	
		Growth Monitoring Person	G	
		Informal Network		
		Husband/Partner	H	
		Mother/Mother-In-Law	I	
		Sister	J	
		Grandparent	K	
		Aunt	L	
		Friend/Neighbor	M	
		Traditional Healer	N	
		Village Elder	O	
		OTHER _____ (Specify)	X	

Section 11 HOUSEHOLD DECISION-MAKING

NO	QUESTIONS AND FILTERS	CODING CATEGORIES				SKIP
		Myself	Husband	Jointly with My husband	Others (specify)	
1101	Who in your household usually makes the final decision on the following					
	a. Your own health	1	2	3		
	b. When to visit a health facility	1	2	3		
	c. How to use the money that you bring to the household (your money)	1	2	3		
	d. What you should wear	1	2	3		
	e. Whether you should work to earn money	1	2	3		
	f. What food should be cooked each day	1	2	3		
1102	Do you agree with the following statement about a man or a woman?	Agree	Unsure	Disagree		
	a. A husband is justified in hitting the woman if she goes out without telling him?	1	2	3		
	b. A husband is justified in hitting his wife if she argues with him?	1	2	3		
	c. A woman is justified in refusing her husband sex if she knows her husband is unfaithful	1	2	3		
	d. A woman is justified in refusing her husband sex if she has a sexually transmitted infection	1	2	3		
	e. A woman is justified in refusing her husband sex if she has recently given birth	1	2	3		
	f. A woman is justified in refusing her husband sex if she is tired	1	2	3		
	g. A man is the one who decides when to have sex with the wife	1	2	3		
	h. You don't talk about sex you just do it	1	2	3		
	i. Only when a woman has a child she is a woman	1	2	3		

	j. Only when a woman has a boy child she is a woman	1	2	3		
--	---	---	---	---	--	--

Section 12: Rating of quality of health services

Can you rate your most recent MNCH visit to the health facility on a list of criteria?					
1201	Cleanliness	1.Excellent	2.Good	3.Fair	4.Poor
1202	Waiting time	1.Excellent	2.Good	3.Fair	4.Poor
1203	Stock availability	1.Excellent	2.Good	3.Fair	4.Poor
1204	Friendliness of staff	1.Excellent	2.Good	3.Fair	4.Poor
1205	Received explanation of treatment etc	1.Excellent	2.Good	3.Fair	4.Poor

SECTION 13: NUTRITIONAL MEASUREMENTS FOR CHILDREN UNDER 5 IN THE HOUSEHOLD

	Measurements	Last Child	2 nd Last Child	3 rd Last Child	4 th Child
1301	Weight in kilograms. <i>Record weight to the nearest 1 decimal place.</i>	|_|_|_|_|.|_|_| Kgs	|_|_|_|_|.|_|_| Kgs	|_|_|_|_|.|_|_| Kgs	|_|_|_|_|.|_|_| Kgs
1302	Height in centimeters. <i>Record height in centimeters.</i>	|_|_|_|_|_|_| cms	|_|_|_|_|_|_| cms	|_|_|_|_|_|_| cms	|_|_|_|_|_|_| cms
1303	Was the child's stature measured with the child standing up?	Yes 1 No 2	Yes 1 No 2	Yes 1 No 2	Yes 1 No 2
1304	OEDEMA? Check child's feet for oedema	Yes 1 No 2	Yes 1 No 2	Yes 1 No 2	Yes 1 No 2
1305	Mid Upper Arm Circumference (MUAC) of child in Centimeters. <i>To the nearest 1 decimal place</i>	|_|_|_|_|.|_|_| cms	|_|_|_|_|.|_|_| cms	|_|_|_|_|.|_|_| cms	|_|_|_|_|.|_|_| cms
1306	Age in Months	|_|_|_|_| Months	|_|_|_|_| Months	|_|_|_|_| Months	|_|_|_|_| Months

Thank you for your time

.....END.....



Annex 2: Client Exit

The Kisumu Integrated Family Health Project
End-term Survey

CLIENT EXIT INTERVIEW

Informed consent

Hello. My name is _____. We are here on behalf of CARE Kenya and the Ministry of Health, Kisumu County to learn more about you and your children’s health status. I will be asking you questions about various aspects of your health and that of your children. All of the answers you give will be completely confidential and will not be shared with anyone other than members of our survey team.

The questions will take about 20 to 30 minutes. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important to help improve the health of women and children in your area. If I ask you any question you don't want to answer, just tell me and I will go on to the next question. You can stop the interview at any time if you change your mind about it.

If there is any question that is not clear, or that you do not understand, please tell me, and I will explain.

If at any time later, after this interview, you have any questions about this study, you can contact Dr. George Ochieng Otieno: mobile - 0719506770 email otienogo@gmail.com or Dr. John Paul Oyore mobile - 0722335878.

Do you have any questions? *(Reply to any questions he/she has)*

Do you agree to participate in this interview? *(Circle his/her answer below, and sign your name below).*

Yes

No (→end interview)

Signed by interviewer: _____ *Date:* _____

I have written your answer on this form, and signed my name next to it. (Show her questionnaire).

Section A. Background information

Date of visit: _____ interviewer names: _____
 Project Area: 1. Nyalenda : _____ 2. Manyatta _____
 Facility name: _____

(Sample: interview 100 clients per facility; pick on every 3RD woman exiting ANC Clinic)

Background information				
<i>First I will ask some general questions</i>				
101	Highest level of education <u>attained</u> ?	None..... Non-formal..... Primary..... Secondary..... College..... University.....	1 2 3 4 5 6	
102	Main Occupation (enter code from list)	Livestock herding..... Own farm labour..... Employed (salaried).. Waged labour (Casual)..... Petty trade..... Merchant/trader..... Housewife..... Domestic help..... Hunting, gathering.... Firewood/charcoal.... Handicraft..... Others (Specify)	1 2 3 4 5 6 7 8 9 10 11 88	
103	Religion	Protestant..... Muslim..... Roman Catholic..... Adventist..... Traditional religion..... Other (Specify)..... None.....	1 2 3 4 5 6 7	
104	Marital status	Single/never married..... Married..... Divorced/separated..... Widowed..... Others (specify).....	1 2 3 4	
105	Monthly Income	_____		
106	If married Age at initial cohabitation	_____		
107	How old were you at your last birthday?	_____		
108	How many children under the age of five do you have (start with the index child)	Name age sex Alive Dead		
		1		
		2		
		3		
109	Were you accompanied by your spouse?	Yes .....1 No .....2		

Section 2 Services Sought					
<i>Ask these questions to clients who have come for family Planning services</i>					
201	What services did you come for today?	Family Planning..... Antenatal care..... Post natal care..... Child Welfare clinic Others specify.....	1 2 3 4 5	→ → → →	Sec 3 Sec. 4 Sec. 5 Sect.6
202	Did you receive the service you wanted?	Yes..... .. No.....	1 2		Sec.7
203	Was the service of your choice?	Yes..... No.....	1 2		
Section 3: Family Planning					
<i>If the client came for Family Planning, she should be asked the following questions</i>					
301	What was the service or method you received?	Female sterilization..... Male sterilization Pill..... IUD..... Injectables..... Implants..... Male condom..... Female condom..... Diaphragm..... Foam/jelly..... Lactational amen. method..... Periodic abstinence..... Withdrawal..... Cycle beads..... Standard Days Method..... Others (Specify).....	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16		
302	Which method are you currently using to delay pregnancy	Female sterilization..... Male sterilization Pill..... IUD..... Injectables..... Implants..... Male condom..... Female condom..... Diaphragm..... Foam/jelly..... Lactational amen. method..... Periodic abstinence..... Withdrawal..... Cycle beads..... Standard Days Method..... Others (Specify).....	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16		
303	Did you discuss with your husband/partner about your coming for family planning services?	Yes No	1 2		
304	Did he provide any support to come for these services?	Yes No	1 2		
305	What was the type of support your partner provided?	Moral support Money for transport Accompanied me Others specify	1 2 3		
306	When you arrived at this facility, how long in (hrs) did you wait before you were attended to	_____			
307	How long does it take you to travel to the facility?	_____			

4. ANC				
<i>If the client came for ANC, she should be asked the following questions</i>				
401	What was the birth order of the child whose pregnancy you are carrying	_____		
402	Did you intend to have your current pregnancy?	Yes..... No.....	1 2	→404
403	What may have caused the unintended pregnancy?	Lack of knowledge on return of fertility Lack of knowledge on appropriate contraceptives use..... Lack of knowledge on long acting methods Poor service provision and counseling myths..... misconception about birth spacing methods.... Erosion of cultural practices.....	1 2 3 4 5 6	
404	What is your preferred birth interval	_____		
405	Give reasons for your answer	Want to regain health ... Want to go back to work Want to have a small family size	1 2 3	
406	If client came for ANC, please indicate which visit	Initial Follow-up (indicate 1 st , 2 nd , 3 rd , TT2, etc.):	1 2	
407	<i>(If the woman was in the last trimester only)</i> Did the healthcare worker talk to you about immediate breast feeding within one hour of giving birth?	Yes..... No.....	1 2	
408	Did the healthcare worker encourage you to breast feed for 6 months?	Yes..... No.....	1 2	
409	Did the healthcare worker tell you about the benefits for you and your baby of breast feeding for 6 months?	Yes..... No.....	1 2	
410	Do you plan to breast feed for 6months?	Yes..... No.....	1 2	
411	Can you tell me two benefits of breast feeding?	1 _____ 2 _____		
412	Has your husband accompanied you on the ANC visit to help make decisions about:			
	a. Safe birthing practices?	Yes No	1 2	
	b. Breast feeding?	Yes No	1 2	
	c. Contraception?	Yes No	1 2	
5. Postnatal <i>(If the client came for Postnatal Care, she should be asked the following questions)</i>				

501	At Your Last Delivery, Who assisted you? (Probe for correct response)	Nurses or midwives..... Doctors..... Clinical officers..... Ward or patient attendant Traditional birth attendant (TBA) Mother or other family members Other. Specify...	1 2 3 4 5 6 7	
502	After your last delivery, did you have post natal check up?	Yes..... No	1 2	
503	How many weeks after delivery did you have the post natal check up?	2 weeks 2-4 weeks..... 5-6 weeks >6 weeks	1 2 3 4	
504	Did anyone talk with you about the health benefits of waiting until your baby is at least 2 year before trying for another pregnancy	Yes..... No.....	1 2	
505	Did anyone tell you about all the FP options you have?	Yes..... No.....	1 2	
506	Did anyone show you all the FP options you have?	Yes..... No.....	1 2	
507	Have you made a decision?	Yes..... No.....	1 2	
508	Do you plan to wait at least 2 years before another pregnancy?	Yes..... No.....	1 2	
6. Child welfare clinic (If the client came for Child welfare clinic, she should be asked the following questions)				
601	How old are your 2 youngest children? (indicate the Date of birth)	1. _____ 2. _____		
602	What service in the child welfare clinic did you come for?	Normal clinic..... The child is unwell.....	1 2	
603	Did you receive the service?	Yes..... No.....	1 2	

7. Attitude of Health Care Workers (HCWs) (How would you rate the attitude of health care workers in this health facility)

	Items						Remark
		Poor	Unsatisfactory	Satisfactory	Good	Excellent	
701	Courtesy, respect by HCW						
702	The way staff treated you						
703	The way staff treated family or companion						
704	Acceptance of your opinion by staff						

8. Quality of services

801. How would you rate the service(s) you received from this health care facility? (*Ask the client about each item individually*)

	Items						
		Poor	Unsatisfactory	Satisfactory	Good	Excellent	Remark
801	Waiting time						
802	Privacy/space for consultation						
803	Information/education materials						
804	Interaction with HCW						

805. What do you think can be done to improve the services at this health care facility?

1. Train health service providers
2. Increase supply of contraceptives
3. Increase outreach services
4. Others specify

Thank the respondent for her time.

Thank you for taking the time to do the interview.



Annex 3: FGD for Women of Reproductive Age

FGD –WOMEN OF REPRODUCTIVE AGE

END TERM EVALUATION FOR THE KISUMU INTEGRATED FAMILY HEALTH PROJECT

Introduction (Objective of the ETE)

Group interviewed:	District :	Location:
Date	Division:	Sub-location:
Site:	Time started:	Time ended:
Number participants:	District	Interview site
Female		
Name(s) of facilitator(s):		
Moderator		
NAME	AGE	

GENERAL

I would like us to talk about Maternal, Newborn and Child, Family Planning and Nutrition

What are the main maternal and child health, Family Planning and Nutrition concerns in your community? Probe for specific concerns in MNCH, Fp and Nutrition and problems (**How has this changed over time**)

Maternal Health and Delivery Services

1. What information is given to women during ante-natal visits?
2. What are the danger signs during pregnancy/ delivery and post delivery?
3. Where do women go for treatment of complications associated with pregnancy / childbirth? Probe for health facilities: Government, Missionary, Private and NGOs (**How has this changed over time**)
4. Where do women in this community mostly deliver? Probe for social and economic reasons (cost and cultural reasons behind the home deliveries) (**How has this changed over time**)
5. What do you think about the services offered by traditional birth attendants when compared to skilled professional: such as nurses and doctors with midwifery training? Are they useful in this community? (**How has this changed over time**)
6. Do women / men in the community use family planning? (**How has this changed over time**)
7. Are family planning services available at all the time? Probe for providers availability and supplies within the community / facilities (**How has this changed over time**)
8. What are men's perception on the use of family planning methods by their spouses and partners in the community? (Probe for approval/ disapproval, indifference etc) (**How has this changed over time**)
9. What are the key barriers on FP uptake / utilization among women in the community? Probe for men, cultural and religious reasons (**How has this changed over time**)
10. Who should make decisions regarding child spacing and use of contraceptives? Probe for spouse, mother-in-law, woman, friend etc. (**How has this changed over time**)
11. Who is responsible for taking a child to a health facility in your community/household? Does a mother make a decision herself? (Probe: does she need her husband's/ family's approval for health facility, THA? How has this changed over time since CARE(K) intervention?)
12. Are there active committees/associations which act on community behalf? Are there community-based volunteers and outreach workers? In which areas are they active? How has this changed over time since CARE(K) intervention?
13. When was the last time that you saw a volunteer measuring children with MUAC or conducting sensitization in your community? Do you know how a child is referred to CMAM site?
14. Have you involved in and support a community engagement (case finding, referral, sensitization, transporting, support to volunteers' works ...)? If yes, how often? What you get in return
15. Do infants under six months of age feed exclusively breast milk? (**Probe:** colostrum given)? At what age do mothers start to give additional liquids to infants? How many times per day does a mother feed a 12 month-old infant? What is the child fed? (**Probe:** food taboo, any change in dietary intake during pregnancy, when a child is sick) How has this changed over time since CARE(K) intervention?
16. What are the recommendations to improve Maternal child, Family Planning and Nutrition in this community



Annex 4: FGD - YOUTH

END TERM EVALUATION FOR THE KISUMU INTEGRATED FAMILY HEALTH PROJECT

Discussion questions

1. Let us open the discussion with some questions about the sexual behaviours and sexually transmitted infections (STIs) among adolescents in Kisumu.
 - a. At what age do most adolescents start having sex in Kisumu? Is it different for boys and girls?
 - b. What would you say about the sexual partners for most adolescents? Same age-group, older, younger? Is it different for boys and girls?
 - c. Is it common for adolescents to have multiple sexual partners? How would you compare that among adolescent boys and girls?
 - d. In Kisumu, what is the situation like in regards to sexually transmitted infections among adolescents? Is the situation different for boys and girls?
 - e. What STIs are common among adolescents in Kisumu?
 - f. What do adolescents do when they contract STIs in Kisumu? What influences the course of action?
 - g. What in your views is the situation of adolescent use of protective measures to avoid sexually transmitted infections?
 - h. Are condoms available for adolescents who are having sex? If so, from where? Are adolescents using them? Do girls use them? Do boys use them? If not, why not?
 - i. What in your views need to be done to protect more adolescents in Kisumu from STIs?
2. Let us talk about family planning
 - a. What family planning methods do you know of? (probe)
 - b. Where can one access these FP methods?
 - c. Are these methods available and accessible to adolescents in Kisumu? (probe for each method mentioned)
 - d. If the methods are not accessible to adolescents, what are the reasons for your answer?
 - e. Do adolescents commonly use family planning in Kisumu? What are the reasons that constrain use of family planning by adolescents in Kisumu?
 - f. What is the attitude towards family planning among adolescents?
 - g. What about the general community attitude about adolescents using family planning?
3. Let us now discuss about abortion and Post-Abortion Care (PAC) among adolescents
 - a. Is abortion common among adolescent girls in Kisumu?
 - b. For what reasons do adolescent girls procure abortion in Kisumu?
 - c. From where are abortions procured?
 - d. What are the risks of unsafe abortion?
 - e. Are there post-abortion care services available in Kisumu? Where would one find such services?
4. Adolescent awareness of RH and access to RH information
 - a. How would you describe the knowledge/ awareness on Family Planning among adolescents in Kisumu? What are the reasons for your answer? How would you compare the knowledge/awareness among boy and girls

- b. How would you describe the knowledge/ awareness among adolescents in Kisumu on sexually transmitted infections? What are the reasons for your answer? How would you compare the knowledge/awareness among boy and girls?
 - c. When adolescents become pregnant in Kisumu what would you say about their utilization of antenatal care services? What about giving birth- do they prefer birth at health facility or at home? Why is that so?
 - d. What are the sources of information on reproductive health among adolescents? Are there some sources of information that are more popular with adolescents-Which ones and why?
 - e. In your view, what information sources and dissemination methods would be most effective in reaching Kisumu adolescent with RH information?
5. Access and availability of adolescent friendly services
- a. Generally, would you consider health services in Kisumu accessible to adolescents?
 - b. Would you consider the reproductive services offered in health facilities in Kisumu to be adolescent friendly? Explain the reasons for your answer.
 - c. What changes would you like to see to make RH health services better in addressing the needs of adolescents in Kisumu?
 - d. Are you aware of any community-based health services targeting adolescents? If, yes tell me your opinions about them.



Annex 5: FGD -CHC

END TERM EVALUATION FOR THE KISUMU INTEGRATED FAMILY HEALTH PROJECT

Introduction (Objective of the ETE)

Group interviewed:	District :	Location:
Date	Division:	Sub-location:
Site:	Time started:	Time ended:
Number participants:	District	Interview site
Female		
Name(s) of facilitator(s):		
Moderator		
NAME	AGE	

Section A: CHC's views in regards to KAP on RMNCH in Kisumu

	Knowledge	Attitude	Practices
Family Planning	How would you describe the level of awareness on family planning in	Generally speaking what is the attitude on family	How would you describe the level of utilization of family

	<p>Kisumu?</p> <p>Probe awareness of:</p> <ul style="list-style-type: none"> - FP methods - Where to access FP methods - Benefits of using FP <p><i>(Probe -How has this changed over time as a result of CARE(K)s MNCH, FP and Nutrition project in Kisumu)</i></p>	<p>planning among Kisumu residents?</p> <p><i>(Probe -How has this changed over time as a result of CARE(K)s MNCH, FP and Nutrition project in Kisumu)</i></p> <p>-</p>	<p>planning among residents of Kisumu?</p> <p>Has the level of uptake of FP changed over the last, say 2-5 years? Explain your answer with what you attribute that to?</p> <p><i>(Probe -How has this changed over time as a result of CARE(K)s MNCH, FP and Nutrition project in Kisumu)</i></p>
Antenatal Care	<p>In your view, how knowledgeable is the community in Kisumu on antenatal care? <i>(Probe -How has this changed over time as a result of CARE(K)s MNCH, FP and Nutrition project in Kisumu)</i></p> <p>Probe for key messages</p>	<p>Generally speaking what is the attitude on antenatal care among Kisumu residents?</p> <p><i>(Probe -How has this changed over time as a result of CARE(K)s MNCH, FP and Nutrition project in Kisumu)</i></p>	<p>How would you describe the use of antenatal care among pregnant women in Kisumu?</p> <p><i>(Probe -How has this changed over time as a result of CARE(K)s MNCH, FP and Nutrition project in Kisumu)</i></p>
Skilled Birth Attendance	<p>Let us now talk about giving birth.</p> <p>What would you say is the level of awareness in Kisumu community on the benefits of delivering under skilled care?</p> <p><i>(Probe -How has this changed over time as a result of CARE(K)s MNCH, FP and Nutrition project in Kisumu)</i></p>	<p>What is the general perception of delivery/birth services in health facilities in Kisumu?</p> <p><i>(Probe -How has this changed over time as a result of CARE(K)s MNCH, FP and Nutrition project in Kisumu)</i></p>	<p>Where do women commonly give birth at in Kisumu?</p> <p><i>(Probe -How has this changed over time as a result of CARE(K)s MNCH, FP and Nutrition project in Kisumu)</i></p>
Post-natal Care	<p>In your view, how knowledgeable is the community in Kisumu on postnatal care?</p> <p><i>(Probe -How has this changed</i></p>	<p>Generally speaking what is the attitude on PNC among Kisumu residents?</p> <p><i>(Probe -How has this</i></p>	<p>How would you describe the use of postnatal care among pregnant women in Kisumu?</p> <p><i>(Probe -How has this</i></p>

	<i>over time as a result of CARE(K)s MNCH, FP and Nutrition project in Kisumu)</i>	<i>changed over time as a result of CARE(K)s MNCH, FP and Nutrition project in Kisumu)</i>	<i>changed over time as a result of CARE(K)s MNCH, FP and Nutrition project in Kisumu)</i>
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Section B: Roles of CHCs in addressing RMNCH gaps in Kisumu

1. What is the role of CHCs in improving RMNCH services in Kisumu? Probe for support by **CARE(K)s MNCH, FP and Nutrition project**
 - a. Roles in enhancing family planning
 - b. Roles in promoting maternal, newborn and child health
2. Were you trained by **CARE(K)s MNCH, FP and Nutrition project** to be able to provide these services? Provide details on
 - a. What did the training cover?
 - b. Who conducted the training?
 - c. How long was the training?
 - d. When was the last training provided to you?
 - e. What do you think about the training received so far- has it been sufficient to enable you effectively undertake your role as a CHC?
3. How did the **CARE(K)s MNCH, FP and Nutrition project** support CHCs function?
 - a. How regularly do they meet?
 - b. What the common agenda items during CHC meetings?
 - c. Do the CHCs maintain records of their meetings and activities?
 - d. What would you say have been the key successes of your CHC since its formation?

Section C: Support required by CHCs

1. What challenges do you face in your role as CHCs under the **CARE(K)s MNCH, FP and Nutrition project**?
2. What support would help to address those challenges and enable you to deliver services to your village/community more effectively?



Annex 6: KII- GOK STAFF

END TERM EVALUATION FOR THE KISUMU INTEGRATED FAMILY HEALTH PROJECT INDEPTH INTERVIEWS GUIDE FOR STAKEHOLDERS (LINE MINISTRIES)

- *MoH- Division of Reproductive Health*
- *County Health Management Team(CHMT)*
- *SubCounty Health Management team(SCHMT)*
- *Health Facility Incharge(HFI/c)*
- *Community health extension workers(CHEWs)*

Consent

Hello. My name is _____. I am here to conduct Endterm evaluation for the KIFHP project behalf of Care(k). We would like to ask you a few questions regarding the process of implementation, experiences, challenges faced and overall outcomes of the project. We would also like to know the existing gaps and why it is so and your suggested way forward. There is no right or wrong answer and whatever information you give will be handled confidentially without any risk of implication or victimization. In addition, only project staff may have access to the transcript of your interview. We are taking into consideration the limited time you have and we greatly appreciate your being able to spare us a few minutes. Do have any question for us?

Part A: General Information

Name of Respondent	
Current Role	
Number of years working in the project	
Gender	Date
Time Interview started	Time Interview Ended
Name of interviewer	
Name of Note taker	

Discussion questions

1. How do you partner with CARE(K) Kenya in the provision of *MNCH/FP/NUTRITION* related services to this community? How was the partnership with in this initiated?

2. To what extent have CHMT/SCHMTs been supported and empowered by the project to promote MNCH-RH in the community. I would like the discussion to on the following areas
 - i) Training of Health Care Workers on Harmonized BEmONC*
 - ii) Supporting Health Facilities to put up service charters on MNH*
 - iii) Sensitization and re-orientation of TBAs in their new role of referral and champions for (ANC, facility based delivery, IFA, Child care and post- delivery care).*
 - iv) Training and mentoring CHWs on Community based Maternal and Newborn health care including harmful cultural practices for effective mobilization in established CHUs using the national guidelines.*
 - v) Procurement of basic essential obstetric care equipment*
3. What is your opinion on the **relevance** of the SRHR project within the prevailing context of **devolved system of governance** as well as national health policies.(Probe for devolved functions at county level and the ability of the county to handle. Give specific examples)
4. Do you think the project is fulfilling the equity principle - reaching the vulnerable and hard to reach beneficiaries in its catchment population(Are beneficiaries selected based on need? Were you involved in the selection of sites; explain?)
5. What would you describe as the **key achievements/ what you have been able to do differently as a result of** this partnership with CARE(K) KIFHP project?
6. What would you consider as **facilitating factors** that made the project achieve the results indicated above
7. What is your opinion on the soundness of **mechanisms, plans and strategies** put in place for project **sustainability** (please describe the mechanisms put in place and state how they can assist in ensuring sustainability)
8. What are the **challenges** that you face in service provision to the community in relation to *KIFHP project implementation* and other health-related activities?
9. Any **recommendations for Future projects**



Annex 7: KII Project Team

END TERM EVALUATION FOR THE KISUMU INTEGRATED FAMILY HEALTH PROJECT

Programme Manager

Project Coordinator

Project Officers/Assistants

Project M and E officer

Name:	Date:	Position
County:	Time started:	Time ended:
Profession:	Female/Male:	Name of interviewer:

Guiding questions

Section A: Background & General issues

1. What are your areas of interventions in this MNCH, FP and Nutrition Project in Kisumu
2. Describe your target groups and beneficiaries for your interventions?

Section B: Relevance

3. To what extent the programme interventions were relevant and appropriate in achieving the overall and specific objectives given existing national and County governments', SCIs objectives?
4. Were the inputs and strategies identified, realistic, appropriate and adequate to achieve the results?
5. To what extent did the project reflect the needs and priority of the target groups (children under 5, pregnant mothers, adolescents WRAs, men)
6. Were the achieved changes relevant to the identified priority needs of the beneficiaries?

Section C: Program Effectiveness:

7. How would you describe the extent to which you have achieved your funded programmatic objectives, expected results and their expected targets as outlined in your in your design and annual plans? Probe for
 - a. To what extent have the **objectives of the project** been achieved
 - b. How did the project support community structures (2 Community Health Units and Safe motherhood promoters) in improvement of utilisation and accessibility of MNCH, FP and Nutrition services
 - c. How did the project support the improvement of capacity of selected health facilities in the project area to meet MNCH, FP and Nutrition needs of the community? Explain and give relevant examples
 - d. Describe the extent **of utilization** of MNCH, FP and nutrition services (which include family planning, antenatal care, deliveries attended by skilled personnel, post-natal care, and child immunization) among Kisumu Community that you can associate with the project interventions.
 - e. In your opinion, what were some of the socio- **cultural barriers to access and utilization** of maternal, child and newborn health services nutrition and family planning interventions in Kisumu.

SECTION D: PROJECT EFFICIENCY -Efficiency refers to proper use of available funds, time, human resources and materials

Giving relevant examples, what would you say about the efficiency of the project under the following headings

- i. Was the process of achieving results efficient? Specifically did the actual or expected results (outputs and outcomes) justify the costs incurred? Were the resources effectively utilized?
- ii. Did project activities overlap and duplicate other similar interventions (funded nationally and/or by other donors?) Are there more efficient ways and means of delivering more and better results (outputs and outcomes) with the available inputs?
- iii. Could a different approach have produced better results?

- iv. How was the project's collaboration within and without?
- v. How efficient were the management and accountability structures of the project?
- vi. How did the project financial management processes and procedures affect project implementation? How have they ensured a lasting change?
- vii. How efficient was the projects partnership with MoH, Communities and other stakeholders?

SECTION E: SUSTAINABILITY

What is your opinion on the soundness of mechanisms, plans and strategies put in place for project **sustainability** (please describe the mechanisms put in place and state how they can assist in ensuring sustainability) Probe for

- i. To what extent are the benefits of the projects likely to be sustained after the completion of this project?
- ii. To what extent were the recommendations given during baseline implemented?
- iii. What is the likelihood of continuation of the project initiatives after completion of the project, looking at the laid down structures, systems or processes to ensure viability of project post-funding?
- iv. How effective are the exit strategies and approaches put in place during project phase out?
- v. Did the partners (Ministry of Health) understand the nature of the project and are they likely to sustain their commitment?
- vi. How has the project been able to work with existing National Government, County and Sub County Government , community and other stakeholders' structures in building their capacity to be able to sustain the project?
- vii. Are there existing challenges, or challenges that may hinder sustainability of the project initiatives?

SECTION F: CHALLENGES

- I. What have been some of the internal and external obstacles to project implementation?
- II. In your opinion, what would you say are some of the possible areas of improvement?

SECTION G: FACILITATING FACTORS

- I. What would you consider as **facilitating factors** that made the project achieve the results indicated above?

SECTION H: LESSONS LEARNT AND BEST PRACTICES

- I. What are some of the key lessons learnt thus far during the project implementation?
- II. What would you consider as some of the best practices that may need to be scaled up in the remaining project period?

SECTION I: RECOMMENDATIONS

- I. Any recommendations for future projects

Annex 8: List of key Informant Interviewees

A. Government Partners

Sno.	Name	Designation	Representation
1.	Dr Dickens Onyango	County Director of Health	CHMT
2.	Rael Mwando	County Nutritionist	CHMT
3.	Mr Oyola	County Community Strategy Focal	CHMT
4.	Dr Kennedy Otieno	Sub County MoH	SCHMT
5.	Monica Oyanga	Sub County Nutritionist	SCHMT
6.	Elizabeth Onyango	Sub County RH Coordinator	SCHMT
7.	Everline oruko	Health Facility In charge	Migosi SC Hospital
8.	Ken Onduto	Registered Clinical officer	Migosi SC Hospital
9.	Agnes Dawa	Health Facility In charge	Nyalenda HC
10.	Michael Omudho	Health Facility In charge	Nightingale HC
11.	Janet Ogutu	Director	Gods Will

B. Project Implementation Team

Sno.	Name	Designation	Representation
1.	Ferdinand Mose	Program manager	Care Kenya
2.	Fred Adongo	Project officer	FHOK
3.	Cynthia Muhambe	Project officer	Care kenya
4.	Sharon Ayodi	Project officer	Kenya Red cross
5.	Linet Achieng	Regional Nutrition Coordinator	Kenya Red Cross