



The European Union's Civil Society and Local Authorities Thematic Programme

Siaya Maternal and Child Nutrition *Nawiri* Project

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MID TERM EVALUATION REPORT



WITH FUNDING FROM
 AUSTRIAN
DEVELOPMENT
COOPERATION



FORWARD

The midterm evaluation (MTE) of the Nawiri Project was undertaken from November 2017 to December 2017. The evaluation was conducted by the Promotive Health Consultants (PHC) in collaboration with CARE Kenya and Siaya County Ministry of Health.

PHC collected quantitative and qualitative data for the MTE 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 an audience of stakeholders in Siaya County, and feedback acquired from the stakeholders was used to finalize the report.

The Mid-term Evaluation (MTE) 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 further implementation of the project. It provides valuable findings that will inform policymakers, donors, program managers, and partners about the status of Nawiri Project implementation, and provides explicit recommendations on how to strengthen implementation. The lessons learned during its implementation as assessed will also be used to revise the project implementation plan accordingly.



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ABBREVIATIONS AND ACRONYMS

ADA	Austrian Development Agency
ANC	Antenatal Clinic
ARI	Acute Respiratory Infection
BMI	Body Mass Index
CARE	Cooperation for Assistance and Relief Everywhere
CASCO	Constituency Aids and STIs Coordinator
CHIS	Community Health Information Systems
CHMT	County Health Management Team
CHV	Community Health Volunteers
CSOs	Civil Society Organization
CME	Continuous medical education
DHIS2	District Health Information Software
EC	European Community
ENA	Emergency Nutrition Assessment
FBOs	Faith Based Organizations
FGD	Focus Group Discussion
FHOK	Family Health Options
GAM	Global Acute Malnutrition
GS	Growth Standards
HW	Health Workers
IEC	Information, Education and Communication
IMAM	Integrated management of acute malnutrition
IMC	International Medical Corps
KEMRI	Kenya Medical research Institute
KII	Key Informant Interview
KMET	Kisumu Medical and Education Trust
MAM	Moderate Acute Malnutrition
MCA	Member of County Assembly
MIYCN	Maternal Infant and Young Child Nutrition
MMCG	Mother to Mother Care Groups
MTMSGs	Mother to Mother Support Groups
MUAC	Middle Upper Arm Circumference
NCHS	National Centre for Health Statistics
NGO	Non-Governmental Organizations
ODK	Open Data Kit
OPV	Oral Polio Vaccine
OJT	On Job Training
SAM	Severe Acute Malnutrition
SD	Standard Deviation
SOP	Standard Operating Procedures
SPSS	Statistical Package for Social Sciences
SWOT	Strengths, Weaknesses, Opportunities and Threats
TBA	Traditional Birth Attendant
TWG	Technical Working group
UNICEF	United Nations International Children Emergency Fund
WASH	Water, Sanitation and Health
WFA	Weight For Age

WFH
WHO

Weight for Height
World Health Organization

EXECUTIVE SUMMARY

Introduction

The Siaya Maternal and Child Nutrition *Nawiri* Project is a 36-months intervention on maternal and child nutrition. The project is executed in partnership between CARE (the coordinator), Family Health Options Kenya (FHOK) and the Kisumu Medical and Education Trust (KMET) in Siaya County with funding support from the European Commission (EC), the Austrian Development Agency (ADA) and CARE. The overall objective of the project is to contribute to improving maternal, infant and young child nutrition (MIYCN), including nutrition of women of reproductive age, in Siaya County.

Objectives of the Midterm evaluation

The *specific objectives* of the mid-term evaluation of the Nawiri Project were to (1) assess the process and progress in project implementation and achievement of expected results, (2) provide an opportunity for an in-depth analysis and understanding on any unintended or intended outcomes, (3) as well as provide an opportunity for learning by project teams, partners and other stakeholders.

Evaluation Design -This was a cross-sectional study with a pre-post approach whereby data was collected using a mix of qualitative and quantitative methods and comparison undertaken with similar data from the project's baseline survey. The pre-post approach enabled the midterm evaluation to draw the changes due to the project, both directly (those attributable to project through a direct cause-effect relationship) and indirectly (changes for which project contributed). Triangulation of data from the mixed sources was undertaken to enhance the credibility and reliability of the findings and subsequent conclusions and recommendations.

Summary table of indicators

	Intervention logic	Objectively verifiable indicators of achievement	Baseline	MTE	Target (Overall Project Targets)
Overall objectives	O1 – To contribute to improving maternal, infant and young child nutrition, including nutrition of women of reproductive age, in the Siaya County, Kenya.	<u>Indicator 1:</u> Percent reduction of micronutrient deficiencies (Vitamin A, Iron, Iodine and Zinc) among children under 5 years and women of reproductive age (15-49 years)	Vit A 63.55% IFAS 44.5% Exclusive breastfeeding <6months: 62.5% Zinc: 86.94%	Vit A 54.0% (Uptake is at 46.0%) IFAS 6.3% (Uptake is at 93.7%) Exclusive breastfeeding <6months: 42.2% (uptake is at 57.8%) Zinc: 88.1% (Uptake is at 11.9%)	Vit A 20% IFAS 20% Exclusive breastfeeding <6months: 60% Zinc: 100%
		<u>Indicator 2:</u> Percent reduction in stunting, wasting and underweight among children under 5 years.	Under 6 months (MAM) Wasting- 11.9% Underweight- 10.4% Stunting- 12.7%	Under 6 months (MAM) Wasting: 10.0% Underweight: 5.3% Stunting: 8.9%	Under 6 months (MAM) Wasting- 5.95% Underweight- 5.2% Stunting- 6.35%
		<u>Indicator 3:</u> Percent reduction in acute malnutrition (SAM and MAM) among women of reproductive age (15-49 years).	6-59months (MAM) Wasting- 10.5% Underweight- 20.3% Stunting- 29.7%	6-59months (MAM) Wasting: 5.0% Underweight: 6.8% Stunting: 9.0%	6-59months (MAM) Wasting- 7.35% Underweight- 14.2% Stunting- 20.79%
			Wasting 1.7%	Wasting 1.7%	Wasting 1%

Specific Objective	SO 1 – To increase the capacity and commitment of CSOs and state health actors to provide and facilitate access to coordinated, complementary, quality maternal, infant and young child nutrition services in Siaya County.	<u>Indicator 1:</u> Number of Sub Counties with functional nutrition coordination in place, executing their mandates at all levels	0 ¹	All the 3 supported sub counties have functional nutrition coordination in place, executing their mandate at all levels	3
		<u>Indicators 2:</u> Number of nutrition implementing agencies in Siaya County integrating their nutrition priorities into county plans	4	4 nutrition implementing implementing agencies in Siaya County integrating their nutrition priorities into county plans (Kenya Red Cross, Aphia Plus, MAP Int. and AMREF)	10
Expected results	ER1 – “Advocacy for political commitment” – Political commitment and good nutrition governance in the Siaya County are strengthened and vulnerable groups are integrated in decision-making processes.	<u>Indicator 1:</u> Number of county assembly members and executive leaders reached with advocacy for nutrition-specific and nutrition sensitive messaging.	0 County Assembly Members ²	4 Executive leaders engaged (Governor, CEC Health, Chief Officer and Health Director) 0 MCAs (<i>MCAs could not be met at the period because of the political activity-The MTE happened at the heart of dispute over repeat election and Civil Disobedience</i>)	37 County Assembly Member 68 executive political leaders 7 Members of the National Assembly 1 Senator ³
		<u>Indicator 2:</u> Proportion increase in county budgetary allocation for MIYCN services.	0.08% ⁴	0.24% (for only nutrition activities, excluding the funds targeting HRH)	0.5%

¹ The baseline does not provide adequate data to measure this indicator. CARE therefore decided to start with a baseline of 0 and foresees that all 3 sub-counties will execute their mandate with regards to nutrition coordination by the end of the project.

² The baseline study consulted County Assembly Members only.

³ The targets given here are representative for the entire Siaya County and will be achieved in cooperation with Amref.

⁴ This value was extracted from the County Integrated Development Plan 2013-2017 (CIDP) of Siaya county.

		Indicator 3: Costed County Nutrition Strategic Plan developed and Nutrition Action Plan implemented.	0	1 CNAP developed	1
ER2 – “Capacity-building” – CSOs and state actors have a greater capacity (including human capacity) and improved skills and systems to respond to maternal and child nutrition needs in the Siaya County		Indicator 1: Number of health workers ⁵ trained on relevant nutrition guidelines and SOPs	5 health workers trained on SOPs and MIYCN ⁶	36 health workers trained (23 males and 13 females)	35 health workers trained on SOPs
		Indicator 2: Number of health workers and CHVs workers trained on MIYCN.	5 health workers trained on SOPs and MIYCN ⁷	38 health workers trained on SOPs and MIYCN (21 females and 17 males)	35 health workers trained on MIYCN 1054 CHVs trained on MIYCN
		Indicator 3: Proportion of health facilities experiencing no stock outs of essential nutrition commodities in past 3 months.	50%	80% of facilities reporting no stock outs of essential nutrition commodities	80%

⁵ CHVs are generally not trained on nutrition guidelines and SOPs, therefore CARE decided to remove the CHVs for this indicator.

⁶ The data collected in the baseline derives from interviews with only 12 health workers and no CHVs. Therefore, CARE considers that the numbers given in the baseline are not representative of the number of health workers and CHVs trained in the 3 sub counties Gem, Bondo and Rarienda, and should be treated with caution.

⁷ See footnote 6.

ER3 – “Sensitisation and mobilisation” – Targeted communities are informed and empowered to demand, access and utilize quality maternal and child nutrition services.	<u>Indicator 1:</u> Percentage increase of pregnant women who take iron-folic acid supplements during pregnancy.	55.5%	93.7% pregnant women taking iron-folic acid supplements	80%
	<u>Indicator 2:</u> Percentage increase of children under 6 months who are breastfed exclusively.	37.5%	57.8% of children under six months of age were on exclusive breastfeeding	50%
	<u>Indicator 3:</u> Percentage increase of children aged 6-59 months receiving Vitamin A supplementation twice a year.	36.45%	46.0% children aged 6-59 months received Vitamin A supplementation twice a year in 2017	80%
	<u>Indicator 4:</u> Percentage increase of children under 5 years with diarrhoea who are treated with zinc supplements.	13.06%	11.9% children less than 5 years with diarrhea who are treated with Zinc supplements	100%
	<u>Indicator 5:</u> Percentage increase of male and female final beneficiaries being able to name at least three benefits of healthy nutrition practices.	46.92%	58% male-female beneficiaries able to name at least three benefits of MIYCN	80%

		<u>Indicator 6:</u> Proportion of final beneficiaries expressing the positive change in gender attitudes for MIYCN.	55.6%	60.6% beneficiaries expressing positive attitudes to MIYCN	80%
	ER4 – “Evidence-building” – Evidence on effective nutrition sensitive and nutrition-specific actions is built, discussed and disseminated.	<u>Indicator 1:</u> Proportion of county health facilities with source documents data matching health facility summary sheet data.	66.7%	80.0%	100%
		<u>Indicator 2:</u> Proportion of county health facilities with source documents data matching DHIS2 data.	66.7%	95.0%	100%
		<u>Indicator 3:</u> Proportion of county health facilities timely reporting nutrition data.	74.1%	75.0%	90%
		<u>Indicator 4:</u> Proportion of Community Units timely reporting nutrition data.	74.1%	75.0%	90%

		Indicator 5: Number and type of good practices and research results documented moreover, disseminated for evidence-based advocacy	Information brochure Evaluation reports Nutritional survey ⁸	- Male involvement module developed - Research committee reactivated	1 MSC booklet 1 best practice publication 3 studies 3 research abstracts
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⁸ The data collected in the baseline study only looked at the types of materials, and not the numbers.

Efficiency

Efficiency refers to how well resources were utilised to ensure maximum achievement of the project's goals. All the planned activities were implemented as per the work plan despite few competing activities such as the national polio campaign which partly affected planned project activities. There was also a 4 months Nurses' strike and disruptions following the political situation. Synergy between the consortium partners (CARE, FHOK, and KMET) ensured cost cutting measures in implementation, saving on logistics and human resources. This is because of the joint planning which ensured the same vehicles moving in one particular direction would carry staff of different projects. The project team also mobilized resources from the county government especially in-kind such as through trainings thus reducing the costs.

Through group interviews with County and Sub county health management team as well as with project staff, there was a general consensus that overall, the support team has been efficient in delivery of the intervention within the limitations it faced. Activity and implementation planning was done collaboratively with the MoH county and sub-county teams and reviewed regularly in case of changes. It was highlighted that although the activity planning went smoothly, one of the biggest challenges that hampered implementation was the constantly changing work-plan due to competing priorities of the MoH staff including county wide health campaigns, activities with other partners among others.

Effectiveness

Effectiveness refers to the extent to which the project has achieved target against the milestone indicators as set in the project log frame. Interviews with the stakeholders at the county and sub county levels revealed that the project interventions have been effective. The following are some of the key issues that emerged.

- i) *Formation of a county research technical working group:* Interviews with the government officers revealed that the project supported the county to establish a county research technical working group which brought together CARE and the **Kenya Medical Research Institute** (KEMRI). The Technical Working Group (TWG) reviews all potential researches in the county and provides approvals for anyone to conduct studies in the county. The TWG has improved the coordination of research in the county leading to better outcomes. It also helps to avoid duplication of research topics. It also emerged that following this TWG, KEMRI is in the process of establishing a research center in the county. The TWG is in the process of organizing a scientific conference due for April 2018 to provide an opportunity for the researchers to showcase the results.
- ii) *Advocacy for increased budgeting for nutrition related activities by the county-* The project through the results area on advocacy has worked with the health committee in the county assembly to advocate for more funding for nutrition related functions in the county. There is a functional Nutrition advocacy committee in charge of this that is supported by Nawiri and Stawisha, both EU Funded nutrition projects which is promoting advocacy for nutrition in the county. Interviews with CHMT members and health committee members revealed that the budgeting for nutrition has increased from 1 million in the year 2016 to Ksh3,000,000 by the year 2017 .
- iii) *Commodity and equipment supply* – Interviews with the health facility in-charges indicated

that most of the health facilities did not have basic commodities like the height boards, weighing scales, and MUAC tapes for measuring the nutritional status before the Nawiri project. The provision of these commodities through the *Nawiri* project has improved diagnosis of nutritional conditions leading to better management of malnutrition.

- iv) *Capacity building for Health workers*- Interviews with health workers revealed that the *Nawiri* project targeted the health workers with CME highlighting key areas on nutrition. As a result of this training the Health Workers (HWs) can now conduct spot diagnosis and refer clients for nutrition related services. This has also helped enhance the knowledge gaps around nutrition. The trainings of trainers targeting the CHVs in the supported CUs enabled them to acquire skills on nutrition including exclusive breastfeeding, MIYCN and breast care. The messages are then cascaded to the households during the household visits. To ensure high quality of delivery and management of nutrition project activities, the project conducted trainings for Nutrition officers from the health facilities supported by the project. Human Resource for Health (HRH) especially Nutritionists is far below the recommended WHO numbers: The county is severely under staffed with only nine (9) nutritionists employed by county government while implementing partners have hired 6 nutritionists. The present nutritionist population ratio of 1:104,000 is extremely below compared to the WHO recommended ratio of 1:50,000. The distribution of these staff is as follows: county level management-2, sub county level management-6, hospitals-9. The health centres and dispensaries have no nutritionists. The nutrition services are thus offered by other cadres in suboptimal levels. For instance in Bondo sub county, there are only four (4) nutritionists; two (2) employed by county government and two (2) by implementing partners. The four nutritionists are diploma level.
- v) *Support national days* – The project supported the county and sub counties to commemorate national days such as *Malezi Bora* which has assisted to create awareness to the general public on nutrition matters. Towards increasing uptake of key nutrition behaviors, the project leveraged on campaigns held during the *Malezi Bora* events to provide key messages regarding breastfeeding practices and complementary feeding practices. The County Nutrition Coordinator reiterated that there is World Nutrition day, *Malezi Bora* weeks in May and November each year and World Iodine day, where *Nawiri* fully takes part in and supports the county with logistics to achieve this.
- vi) *Development of County Nutrition action plan*- The project supported the development of the county nutrition action plan CNAP which was planned to be launched in January 2018. This document once completed will provide a roadmap for implementing nutrition interventions in line with the CIDP and annual plans for the county. It will also help to provide synergy and coordinate approach to the interventions.
- vii) *Health education and promotion* – The evaluation revealed that the project has supported the development of key nutrition messages on nutrition which help in addressing the knowledge gap. This is augmented by the supply of IEC materials with health information. It was also reported by CHMT that the radio programs on “NAM

LOLWE” supported by the project has increased the reach to the target beneficiaries. The question and answers sessions during the radio shows assist in clarifying myths on nutrition.

viii) There has been increased capacity of HWs and CHVs in terms of skills and understanding of processes and tools used for capturing nutrition data. Training of health workers has shown an improvement in documentation and reporting since 2016, improved nutrition services coverage through outreach and mobile services, more regular visits, feedback and follow-up as well as improved commitment to health and nutrition activities. There has been a noted improvement in coverage of IMAM, MIYCN, and health services, particularly, an increased number of households have been reached with MIYCN through the M2MSGs. The M2MSGs have been an avenue of intervention that promise the highest level of sustainable impact thus far particularly because the interviewed groups seem to show a commitment and ability to continue propagating knowledge and practices on MIYCN amongst themselves and the wider communities as well as continuously seeking to sustain nutrition and dietary benefits through strengthening livelihoods based activities.

Facilitating Factors that Made the Project Achieve Results

- Collaboration with MoH and other stakeholders including community engagement and participation provided smooth implementation of project activities and enhanced partnership. It is noted that there were continuous discussions to draw out challenges and come up with solutions.
- The outreach activities promoted by the project played an important role in enhancing the coverage and accessibility of health care services by the community especially in the hard to reach areas. This led to the services being brought closer to the people.
- Adequate support in terms of resources provided by the project. It was reported that the project consults widely with the CHMTs in prioritization of the support needed and this is very much appreciated by the county.
- Transparency and integrity in engagement with stakeholders cemented close partnership and collaboration towards realization of the project goal. CARE maintained neutrality and professionalism throughout project life.
- Joint work planning between the County and the NGOs ensures a harmonized plan leading to a good working relationship

Sustainability

- The project has enhanced health system strengthening which ensures that MoH is able to carry out interventions with or without CARE, as well as advocacy initiatives which ensure there is adequate resources for nutrition interventions
- MoH have the capacity to implement nutrition interventions owing to several capacity building initiatives undertaken by CARE under the Nawiri project. In regards to capacity development on nutrition, MoH have capacities to prevent and treat malnutrition. Several advocacy initiatives have seen the county government allocate more resources for health

and nutrition. HCW have been trained on community score card (CSC) which is a participatory approach that enhances problem identification and seeking ways of addressing the problems. With skills on CSC, HCW will continue with strategies of community involvement in service delivery at whatever level.

- CARE worked with mother to mother support groups (MTMSGs) and ensured vulnerable women are targeted by the project. The Nawiri project links MtMSGs to livelihood programs such as kitchen gardening, savings and loan activities among others in effort to ensure women are empowered.
- The social and political environment have been supportive, however, the political entity requires a lot of targeted advocacy to reinforce the need for ownership and taking the lead in key sector activities by advocating for prioritization and proper management of county funding. It is critical to note that achieving definite sustainability of project benefits within the institutional, environmental and community context of the project would require a consistent and well-coordinated effort amongst all stakeholders within the County.

Challenges in Project Implementation

- Despite joint planning between MoH and CARE, a key challenge was the difficulty to adhere to the work-plan due to competing priorities of the MoH staff including county wide health campaigns, activities with other partners among others.
- Nurses' strike and disruption by political activities in the run up to 8th August elections and repeat elections.
- Deep rooted cultural practices and beliefs and lack of committed opinionated leadership to champion optimal nutrition practices. The cultural practice included the kind of meals/or food a woman is allowed to eat; sharing latrine with father-in-law amongst others. This contributed to the slow pace of behaviour change which led to development of social behaviour change strategy that addresses barriers to change process.
- The vastness of the area (three sub-counties) with only one project vehicle sometimes delays implementation of some activities. This challenge has been mitigated by allowing the project officers to use rental cars (taxies) to execute project activities. Also, the project officers must plan jointly and adhere to the plan so that no one is inconvenienced.
- The high expectations of community members to the extent that most of them ask for payment or food supplements whenever they participate in Nawiri related activities

Constraining Factors to the Implementation of the Project

- Inadequate resources for nutrition attributed to low budgetary allocation for nutrition by the county government affected the scale of activities and led to over-reliance on donor funding.
- Inadequate access to health and nutrition services attributed to inadequate staffing of nutritionists and poor distribution of health facilities affected project coverage.

Lessons Learnt

The implementation of the CARE Nawiri project has identified a number of lessons:

- 1) The synergy between project consortium members enhanced impact and quality programming as they would support each other. The joint planning of the activities

ensured efficiency in the use of resources such as vehicles.

- 2) Health system strengthening is crucial in building sustainability. Involvement of county coordination structures ensured harmonized implementation and health system strengthening by different actors.
- 3) The use of CHVs in the CUs and the CBOs to pass messages are cost effective strategies.
- 4) Adopting different advocacy strategies constituting social mobilization, communication and political advocacy works.

Conclusions

- The relevance of the project is relatively high with the programme goal and objectives responding to the serious nutritional conditions of under-five children and pregnant and lactating mothers. There is a clear linkage between the project's general objective of contributing towards reduction in morbidity and mortality associated with acute malnutrition in children under- five and in pregnant and lactating women with the identified needs regarding food and nutrition security of under five children and pregnant and lactating women.
- The project has been effective and has been able to reach some of the identified impact and outcome level changes. In particular the improvements in dietary intake of small children, improved feeding practices among the community members and enhanced use of Iron Folate supplementation and initiation of breastfeeding and exclusive breastfeeding. The changes in knowledge, attitudes and practices on nutrition and hygiene related issues showed mixed results with the communities' knowledge on management of childhood illnesses and feeding practices much more enhanced.
- In terms of efficiency, the project management structure mechanisms set up proved to work well. So did the coordination systems at the Country and County offices. The trainings that were undertaken by the project, the utilisation of knowledge and skills obtained from the project's training effort speak to efficient use of resources. All the planned activities were implemented as per the work plan despite few competing activities such as national polio campaign which partly affected planned project activities.
- For sustainability and impact, a high level of coordination with the implementing partners was noted, in particular, with the MoH. The County MoH officials that were interviewed noted that because of the constant coordination and collaboration amongst partners, there has been a reduction in duplication of activities and an increase in complimentary service provision which has contributed to enhanced effectiveness and efficiency of delivery of nutritional interventions. In addressing sustainability more directly, the CARE/County MoH partnership has been (and continues to be) very relevant as both partners are supporting and strengthening existing MoH systems as opposed to creating parallel systems, and this is more sustainable in MoH's short and long term capacity to deliver services.
- The focus on health system strengthening through capacity development of health workers ensured sustainability and ownership by the county government. The strategy of promoting positive social behavior change is still valid and aimed at addressing poor child care and

maternal health due to retrogressive cultural practices.

Recommendations:

Short Term

- MoH - Community strategy and implementing partners to conduct inter MtMSGs exchange visits for learning purposes with focus on learning good practices between MtMSGs aimed at improving maternal, infant and young child nutrition and promoting linkages to livelihood or income generation activities. The projects can also carry out a process evaluation to review implementation of the MtMSGs approach/model.

Medium Term

- To alleviate the human resources for health issues relating to nutrition, the project can lobby to the county to employ staff even on short term contracts to help bridge the gaps of few nutritionists in the county.
- MoH and Implementing partners to map out and coordinate implementation of social behaviour change and communication strategy towards promoting positive health and nutrition behaviour change.

Long term

- Continued advocacy targeting county government to support implementation and formation of community strategy that will see improvement in coverage of health and nutrition services. This includes supporting CHIS reporting and CHVs' incentives
- Nutrition actors to intensify advocacy geared towards ensuring there's recruitment of more human resource for health to bridge the current staffing gaps.
- The county government to spearhead a multi-sectoral and multi-stakeholder approach to holistically address under nutrition. This entails use of surveys and surveillance information e.g. annual integrated SMART surveys to develop, implement and monitor a multi-sectoral early warning and response plans.
- Linking MtMSGs to IGAs and VSLA supported by other partners and different government line ministries implementing nutrition sensitive interventions for sustainability. This ensures increased purchasing power of members towards improving optimal complementary feeding for children 6-23 months.
- County government to mobilize resources for establishment of health facilities and outreach services in hard to reach areas following mapping of outreaches by MoH and CARE which highlighted uneven distribution of health and nutrition services. This will contribute to improved access to health and nutrition services

1. Introduction

1.1 The Nawiri Project

1.1.1 Project overview

The Siaya Maternal and Child Nutrition *Nawiri* Project is a 36-month intervention on maternal and child nutrition. The project is executed in partnership between CARE (the coordinator), Family Health Options Kenya (FHOK) and the Kisumu Medical and Education Trust (KMET) in Siaya County with funding support from the European Commission (EC), the Austrian Development Agency (ADA) and CARE. The overall objective of the project is to contribute to improving maternal, infant and young child nutrition (MIYCN), including nutrition of women of reproductive age, in Siaya County. In order to increase the nutritional status of children under the age of five and of women of reproductive age, the project aims to alleviate the most severe obstacles of poor MIYCN in Siaya County. It will increase the capacity and commitment of Civil Society Organizations (CSOs) and state health actors to provide and facilitate access to coordinated, complementary, quality MIYCN services in Siaya County (specific objective). This project will be implemented in Siaya County, Kenya.

1.1.2 Expected Results

The *Nawiri* project has the following expected results (ER):

- ER1: “**Advocacy for political commitment**” - Political commitment and good nutrition governance in the Siaya County are strengthened and vulnerable groups are integrated in decision-making processes;
- ER 2: “**Capacity-building**” - CSOs and state actors have greater capacity (including human capacity) and improved skills and systems to respond to maternal and child nutrition needs in Siaya County;
- ER 3: “**Sensitization and mobilization**” - Targeted communities are informed and empowered to demand, access and utilize quality maternal and child nutrition services;
- ER 4: “**Evidence-building**” - Evidence on effective nutrition-sensitive and nutrition-specific actions is built, discussed and disseminated

1.2 Objectives of the Midterm evaluation

The *specific objectives* of the mid-term evaluation of the Nawiri Project were to (1) assess the process and progress in project implementation and achievement of expected results, (2) provide an opportunity for an in-depth analysis and understanding on any unintended or intended outcomes, (3) as well as provide an opportunity for learning by project teams, partners and other stakeholders.

The midterm evaluation covered the first one and half years of implementation – 1st May 2016 to 30th November 2017 - and builds upon the baseline survey conducted in 2016.

2. Methodology

2.1 Overview of methodology

The Mid-term evaluation used a mixed-method approach which harnessed the participation of various stakeholders including the beneficiary community, CARE (K), *KMET*, *FHOK*, Siaya-CHMT, Ministry of Health (MOH), non-governmental organizations (NGOs) partners working in the area.

2.2 Evaluation Design

This was a cross-sectional study with a pre-post approach whereby data was collected using a mix of qualitative and quantitative methods and comparison made with similar data from the project's baseline survey. The pre-post approach enabled the midterm to draw the changes due to the project, both directly (those attributable to project through a direct cause-effect relationship) and indirectly (changes for which project contributed). Triangulation of data from the mixed sources was undertaken to enhance the credibility and reliability of the findings and subsequent conclusions and recommendations.

2.3 Study Population and Respondents

The study population was mainly Women of reproductive Age (WRA) and children (aged 0-23 and 24-59 months), Adolescents/Teens, Men within Bondo, Rarieda and Gem sub-counties where the *Nawiri* project is being implemented. The study respondents were mother/caregivers of children (aged 0-23 months and 24-59 Months) WRA, health services providers at supported health facilities, CHMT, the SCHMT in the three sub-counties, Community Health Volunteers (CHVs), Mother to Mother support groups, Outreach mothers, Health Committee at the County assembly, Civil Society organisations (CSOs), Research TWG members, Interagency collaboration Committee member among others.

Two inclusion criteria for mothers/caregivers were used, namely: (i) residents in the project area over the last one year and (ii) mothers/caregivers of children aged 0-59 months. For the other respondents (for the focus group discussions and in-depth interviews), inclusion was based on an informant's role in regards to delivery of the *Nawiri* project.

2.4 Sampling technique

A combination of probability and purposive sampling techniques was applied to arrive at individual study participants as described below:

Sampling for the quantitative household survey

A two-stage cluster sampling technique was utilized to select mothers/ care-givers of children aged less than 59 months. The technique involved the following steps:

- (1) A sub-location was considered as the cluster and was the primary sampling unit (PSU). A listing of all sub-locations in Bondo, Rarieda and Gem Sub counties was drawn. The sub-locations / clusters selected were those considered to be directly targeted/reached by the project either via the supported CBOs, CUs or linked to the supported health facilities and hence purposively sampled and included in the study.

- (2) The population of each of the sub locations was determined and the sample size allocated to each based on probability proportionate to size.
- (3) From the clusters, households (secondary sampling unit) were selected through a simple random sampling procedure whereby a team of 4 data collectors identified the centre of each sub-location. From the centre, the 4 data collectors walked in four different directions and picked the first household and every other third household until the allocated sample size is attained. Two of the data collectors picked households on their left-hand, while the other two picked households to their right. A household was considered as a group of people who usually eat together from the same pot.
- (4) Once in the household, mothers/ caregivers of children aged 0-59 months were interviewed. Households that did not have a mother/caregiver meeting the inclusion criteria were replaced by selecting the immediate next household (that has a mother/caregiver meeting the criteria). In a situation where more than one mother in a household met the criteria, one was randomly selected and interviewed.

Sampling for in-depth interviews:

Purposive sampling procedure was used whereby, in consultation with the project team, implementing partners and the SCHMTs, all the stakeholders for in-depth interviews were identified. All the key informants had to be those working directly with the project.

Sampling for FGDs:

Purposive sampling procedure was used to identify participants who had participated in or benefited from the project interventions. The included Women of reproductive age (WRA) in the project sites, Community Health Volunteers (CHVs) from the supported Community Units (CUs), and members of the Community Based organizations (CBOs) as well as MtMSGs.

Sampling of health facilities: 30% of the health facilities directly supported by the project were included in the assessment with priority given to the high volume facilities.

Table 2.1: Summary of various data collection methods for various results areas

Result area	Sampled respondents
ER1: “ Advocacy for political commitment ” - Political commitment and good nutrition governance in the Siaya County are strengthened and vulnerable groups are integrated in decision-making processes;	<ol style="list-style-type: none"> 1. KII-Members of the Health committee at the county assembly 2. KII=Members of the Advocacy Technical working Group 3. KII-CHMT
ER 2: “ Capacity-building ” - CSOs and state actors have greater capacity (including human capacity) and improved skills and systems to respond to maternal and child nutrition needs in Siaya County;	<ol style="list-style-type: none"> 1. KII-Trained Health care workers especially nurses and Nutritionists 2. Sample CME Sites 3. Group Interview with -Members of the CSOs trained on Social Analysis and Action
ER 3: ” Sensitization and mobilization ” - Targeted communities are informed and empowered to demand, access and utilize quality maternal and child nutrition services;	<ol style="list-style-type: none"> 1. Household survey with mothers of children under 0-59 months 2. FGD with Teen mothers support groups 3. FGD with Mothers to Mothers groups 4. FGD with Outreach mothers/Men 5. FGD with SAA beneficiaries 6. FGD with Food demonstrations beneficiaries 7. FGD with Men participating in project activities 8. FGD with beneficiaries of Community scorecard initiative 9. Human Interest story per sub county
ER 4: ” Evidence-building ” – Evidence on effective nutrition-sensitive and nutrition-specific actions is built, discussed and disseminated	<ol style="list-style-type: none"> 1. KII with CHMT members looking at the capacity building and Nutrition Action Plan, SOPs 2. KII with Research TWG members 3. KII with Interagency Collaborative Committee members 4. KII with County Nutritionist on nutrition documentations, archiving and data use forum 5. KII with all the sub county Nutritionist on reporting processes and evidence gathering

2.5 Sample Size Determination and Sampling Procedure

2.5.1 Sample Size Determination

The target sample size for the MTE was calculated using the Fishers et al. (2003) formula below:

$$n = \frac{Z^2 pq}{d^2}$$

where

n = the required sample size, expressed as number of households

Z = the standard normal deviate usually set at 1.96 at 95% level of confidence

p = the proportion of the target population with the desired outcome (set at 50%)

q = the proportion of the study population without the desired outcome usually expressed as 1-p

d = the degree of accuracy set at 0.05 at 95% confidence interval

D= Design effect of 1.5

$$n = \left[\frac{(1.96)^2 * (0.5 * 0.5) \times 1.5}{(0.05)^2} \right]$$

n = **576** adjusted for 9% non-response rate for a total sample size of **628** households

The sample size was allocated proportionately (using population size) to three project sites (Bondo, Rarieda and Gem) as shown below:

Table 2.2: Sampling frame

Sr. no	Project site	Total population (Siaya CIDP, 2013)	Proportion	Targeted sample size (HH)	Actual HHs reached from the analysis
1	Bondo	183,565	35.0%	220	232
2	Gem	184,100	35.1%	220	213
3	Rarieda	156,804	29.8%	188	192
	Total	524,469	100.0%	628	637

2.6 Data collection procedures

Data was collected from multiple sources using both quantitative and qualitative methods. While the quantitative methods enabled quantification of changes due to project interventions,

qualitative methods allowed the MTE team to explore the factors that influence the status of the measures of project outcomes. Below are the data collection methods that were employed.

2.6.1 Literature review

- a. **Review of project documents**, among them project proposal documents, baseline survey report, project implementation plan, project M&E plan, progress reports, activity reports such as training and meeting reports and reports by other organizations.
- b. **Review of relevant national and county documents** including the Kenya Health Sector Strategic and Investment Plan (2014-18), Nutrition Action Plan, Siaya County Integrated Development Plan (CIDP), the 2014 Kenya Demographic and Health Survey (KDHS).

2.6.2 Household survey

A quantitative household survey was conducted targeting mothers/caregivers of children aged less than 59 months. The purpose of the survey was to generate quantitative measures of the status of the project's key performance indicators on the uptake of maternal and child nutrition services. An interviewer-administered survey questionnaire was used to collect the information.

2.6.3 In-depth interviews

In-depth key informant interviews were conducted for the following categories of respondents:

Table 2.3: Selected staff for Key Informant Interviews

Respondent Categories	Selected staff for KIIs
Care Kenya	The Project Manager, Project Officer
KMET	Project officer and Project assistant
FHOK	Project officer and Project assistant
CHMT	County Nutritionist County Director of Health
Sub-county Health Management Team (SCHMT)	Sub County Nutritionists
Health services providers	The in-charges of the 8 of the 21 project-supported health facilities were interviewed
For Advocacy and Political Commitment Result area	1. Members of the Health committee at the national assembly 2. Members of the Nutrition Advocacy Technical working Group
Capacity Building Result area	1. Trained Health care workers especially nurses and Nutritionists 2. FGD Sample CME beneficiaries at the selected health facilities 3. FGD with Community score card TOTs 4. Members of the CSOs trained on Social Analysis and Action

Evidence Building Result area	<ol style="list-style-type: none"> 1. CHMT members looking at the capacity building and Nutrition Action Plan 2. Research TWG members 3. Interagency Collaborative Committee members 4. County Nutritionist 5. All the sub county Nutritionist 6. KII with County Nutritionist on nutrition documentations, archiving and data use forum 7. KII with all the sub county Nutritionist on reporting processes and evidence gathering
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2.6.4 Focus Group Discussions (FGDs)

FGDs with the following categories of respondents were conducted. The focus groups had between 8 to 12 participants, selected purposely in a manner that reflects gender balance. Sessions were facilitated in the local language (Dholuo) by a skilled moderator and both written and audio records taken.

Table 2.4: FGD Categories

FGD category	No. of FGDs
Teen mothers support groups	3
Community Health Volunteers	3
Mothers to Mothers groups	3
Outreach mothers	3
SAA beneficiaries	1
Food demonstrations beneficiaries	1
Male beneficiaries In the project	1
Total	12

2.6.5 In-depth Interviews

In-depth Interviews was done with the members of the following groups supported by the project

Community Based Organizations supported by the project assessment

Table 2.5: List of sampled CBOs

Sub County	CBO	Ward
Rarieda	Rachar youth group	West Uyoma
	Mahaya Libamba Youth Group	West asembo
Bondo	Jerusalem Ogam women group	East Yimbo
	Matangwe youth development group	North Sakwa
Gem	Afya Elimu	North Gem
	Siela Kaduol	South gem

In-depth Interviews with Health facility in-charges: Further interviews were conducted with the health facility in charges to ascertain the support received through the Nawiri project in terms of trainings, support supervisions, equipments among others in line with the various project expected results areas. The following facilities were visited during the MTE.

Table 2.6: List of selected health centers'

Sub-county	Facility	Ward
Bondo	Bondo Sub County Hospital	West Sakwa
	Gobei Health Centre	North Sakwa
	Usigu Health Centre	East Yimbo
	Nyenye Misori Dispensary	West Yimbo
	Othach Dispensary	East Yimbo
	Uyawi Sub County Hospital	Central Sakwa
	Nyaguda Health Centre	South Sakwa
Rarieda	Madiany Sub County Hospital	South Uyoma
	Pap Kodero Health Centre	Central Uyoma
	Manyuanda Health Centre	West Uyoma
	Naya Health Centre	South Uyoma
	Masala Dispensary	North Uyoma
	Ndori Health Centre	East Asembo
Gem	Yala Sub County Hospital	Yala Township
	Sirembe Dispensary	North Gem
	Ndere Health Centre	North Gem
	Gongo Health Center	Central Gem
	Lihanda Health Center	East Gem
	Rera Health Center	South Gem
	Wagai Health Center	West Gem

2.7 Data management

2.7.1 Data analysis

For the qualitative data, the verbatim transcripts were individually reviewed for content by the lead consultant and information manually grouped into categories and emerging themes. The themes and supporting verbatim transcripts were corroborated with information from the other data sources and conclusions drawn. Nudist Nvivo software was used to manage qualitative data.

Quantitative data was entered and analyzed using SPSS ver.20. Both descriptive and inferential statistical analyses have been performed. Categorical indicators were summarized into frequencies and percentages while interval indicators were summarized using mean and standard deviations. Where appropriate, tests of significance using either chi-square or independent t-test have been used to determine strength of relationships between variables and any differences.

2.8 Quality Assurance

A number of measures were taken to ensure data is of utmost quality, including: pretesting and refinement of the data collection tools, training the research assistants, close supervision, data cleaning and filtering any erroneous data and questionable outliers and triangulation of the data from the various sources so as to minimize bias.

2.9 Ethical Considerations

Risks and benefits: The risks associated with participation in the MTE were considered as minimal. There were no direct benefits to participants for participating in the MTE.

Informed consent: All project participants were required to provide a written consent to participate in the MTE. A consent form was signed by all those who consented while those who did not were thanked and replaced.

Protection of participants and confidentiality: Protection and confidentiality of project participants was ensured through: conducting individual interviews in a private setting; maintaining confidentiality of all materials and information provided during the MTE; limiting access to study information to only authorized personnel and ensuring no identifying information on individual participants was included in the analysis and report.

2.10 Implementation of the MTE

2.10.1 Survey Team

The MTE was coordinated and supervised by external consultants from Promotive Health Consultants, working closely with the team from Care (K) and the SCHMT mainly nutritionists from Gem, Rarieda and Bondo Sub counties. The team leader was in charge of the data quality control in the team. Each team was assisted by a CHV (recruited at the community Unit) to guide the survey team in locating the boundaries of the village and also to assist with the population statistics for the HH and FGDs.

2.10.2 Training of team members

Two-day training was conducted at Bondo Pride Hotel before the commencement of the survey by the consultants, collaboration with Care (K) Siaya team. The training focused on the objectives of the MTE, cluster and household selection, interviewing techniques, accurate recording of responses, and data entry and analysis. Role-plays on how to administer the questionnaire and record responses were conducted. One day of the training was allocated to pre-testing of the questionnaire (in areas that had been selected for inclusion in the survey) and reviewing of the data collection tools based on the feedback from the pre-test.

2.10.3 Pre-testing

A one-day pre-testing of the questionnaires for accuracy, clarity and validity was conducted on the last day of training and questionnaires modified accordingly. Each team conducted interviews

and recorded responses. The consultants accompanied and observed the teams during the pre-testing in order to identify the weaknesses and strengths of the teams. The survey teams also tested the survey procedures; sampling, interviewing techniques, and the duration taken to sample and interview one household. All the filled-in questionnaires were checked by the consultants. The survey team met to give feedback on the pre-testing exercise and the necessary adjustments made to the questionnaire.

2.11 Data Quality Control

The quality of data was controlled as follows:

- a) Thorough training of the team members to ensure thorough understanding of the MTE methodology to include selection of households to be visited, understanding the essence of each question and how to ask and record the responses. Thorough training was conducted to standardize the interviews and other data collection procedures;
- b) Field level cross checking of the questionnaires by the team leaders before leaving the households to ensure that they are filled correctly and completely;
- c) Consultants observed 20% of the interviews and made corrections where necessary; and
- d) The consultants checked filled questionnaires daily and if information is incomplete, inconsistent or not clear, then the team returned to the households the next day to verify the information.

3. Mid-Term Evaluation Findings

This chapter provides the key mid-term evaluation findings which are organized to align with the objectives and criteria of the evaluation. The Socio-demographic profiles of the household survey respondents is presented first to understand participants of the household survey.

3.1 Characteristics of Survey Respondents

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, majority (80.8%) of the respondents are currently married or living with a partner; slightly more than half (52.0%) of the respondents were protestants; most (39.2%) of the respondents had completed primary education, while 29.0% of the respondents indicated their main economic activity is business. The mean age of the respondents was 26.2 years old with the youngest being of age 15 years old and the oldest being 47 years old. Almost three quarter (71.9%) of the respondents were aged below 30 years old.

Table 3.1: Socio-demographic Characteristics

<i>Characteristic</i>	<i>Description</i>	<i>Frequency</i>	<i>Percent</i>
Sub county (n=637)	Bondo	232	36.8
	Rarieda	188	29.8
	Gem	211	33.4
Age of the respondent (n=635) (Mean=26.2; SD =5.8)	15-19	61	9.6
	20-24	205	32.2
	25-29	192	30.1
	30-34	112	17.6
	35-39	52	8.2
	40-44	10	1.6
	45-49	3	.5
Religion (n=606)	Protestant	315	52.0
	Muslim	3	0.5
	Roman Catholic	114	18.8
	Adventist	34	5.6
	Traditional religion	130	21.5
	Other	7	1.2
	None	3	0.5
Marital Status (n=636)	Single/never married	89	14
	Married	514	80.8
	Divorced/separated	14	2.2
	Widowed	18	2.8
Highest level of education (n=635)	Primary not completed	179	28.2
	Primary completed	249	39.2

	Secondary not completed	95	15
	Secondary completed	62	9.8
	Tertiary/University	45	7.1
Main Economic Activity (n=634)	No reliable source of HH income	67	10.6
	Salaried employment	53	8.4
	Casual labor/wage earner	147	23.2
	Assistance/handouts	7	1.1
	Business	184	29
	Crop farming	134	21.7
	Animal Husbandry	2	0.3
	Fishing	40	6.3

3.2 Project implementation and achievement of expected results

3.2.1 Advocacy for political commitment

–Political commitment and good nutrition governance in Siaya County are strengthened and vulnerable groups are integrated in decision making processes

The evaluation findings in regards to advocacy for political commitment are presented below, organised and discussed under the following three key indicators: (1) County assembly members and executive leaders reached with advocacy for nutrition-specific and nutrition sensitive messaging (2) County budgetary allocation for MIYCN services and (3) Costed County Nutrition Strategic Plan developed and Nutrition Action Plan implemented.

3.2.2 County assembly members and executive leaders reached with advocacy for nutrition-specific and nutrition sensitive messaging

<i>R1-Indicator 1:</i>	<i>Number of county assembly members and executive leaders reached with advocacy for nutrition-specific and nutrition sensitive messaging.</i>
<i>Achievement:</i>	<i>4 executive leaders (Governor, CEC- Health, Chief Officer –health and Health Director) have been engaged No MCA have been engaged</i>

The evaluation established that Nawiri project have engaged executive leaders many times since the project started. The CARE health team has met the Governor of Siaya County and engaged him more than once on nutrition related issues. The project team has held discussions with CEC Health, Chief Officer and Health Director at least twice on Nutrition investment at the county. Due to prevailing political situation during the MTE, the consultants were not able to meet the MCAs to find out to what extent they have been engaged on the Nutrition investment for the County. The MTE data collection was conducted during at the heart of dispute over repeat presidential election and general civil strife with Siaya County having been the hotbed of such strife.

The evaluation established that *Nawiri* project has finalized formative work necessary to engage County Assembly Members. The Advocacy TWG has developed the advocacy briefs in

preparation for engagement with the county executive and county assembly. There was some political disruption of this process due to the August national elections – something that has modified both availability and interest of political leaders within the County. Plans are now underway to reach out to the new elected leaders.

A KII with the County nutrition coordinator revealed:

“The Naviri project has engaged with the political class in the county. The members of the County assembly are now aware of the relationship between nutrition and education and/or development. This has made them to prioritize nutrition activities. As a result of this the governor has started a school feeding program and also bought 12 tractors to improve agriculture and thus food security in the county”

A KII with project team member showed that the leadership having realized the political temperature in the country asked project team members to desist from engaging the politicians:

“We received communication from the headquarter [Nairobi Office] around March April to stop direct engagement with politicians”

3.2.3 County budgetary allocation for MIYCN services

<i>R1-Indicator 2:</i>	<i>Proportion increase in county budgetary allocation for MIYCN services.</i>
<i>Achievement:</i>	<i>The proportion increase at baseline was 0.08%. The proposed budgetary allocations towards nutrition were given to be 3million, up from 1million Kenya shillings in 2017 being 0.24% of the budget.</i>

In an effort to advocate for county budgetary allocation for MIYCN service, the evaluation established that the project identified and sensitized 60 Community Health Volunteers (CHVs) from the 3 Sub Counties on how to voice MIYCN needs for budget allocation. The sensitized CHVs advocated for nutrition budgetary allocation in 2017/2018 Siaya County budget during public budget hearing sessions held from 20th-24th March 2017 in close collaboration with the Department of Public Service and Governance of Siaya County.

A member of the health committee reported that *“Having seen the light, we have now approved that the budgetary allocations towards nutrition from 1million to 3million in the 2016/17 budget”*.

3.2.4 Costed County Nutrition Strategic Plan developed and Nutrition Action Plan implemented

<i>R1-Indicator 3:</i>	<i>Costed County Nutrition Strategic Plan developed and Nutrition Action Plan implemented</i>
<i>Achievement:</i>	<i>CNAP has been developed and launched</i>

Compared to the baseline where there was no County Nutrition Strategic Plan and Nutrition Action Plan, the MTE established that a draft CNAP has been developed. Development of the draft County Nutrition Strategic Plan was coordinated by County Nutrition Coordinator who lead a 17 member TWG with representation from MoH nutritionists, Kenya Medical Training College (KMTc) nutritionist, Ministry of Agriculture, Ministry of Social Services, Ministry of Education, Amref’s Stawisha project and CARE’s Nawiri project.

This draft is currently under review by the national nutrition unit, after which it will be finally edited and printed. In line with CNAP, the project plans to develop and print the MIYCN Charter. The delay was caused by the uncertainties as a result of the general elections.



Plate 3.1: County Nutrition Strategic Plan and Nutrition Action Plan Development Workshops

3.3 Expected Result 2- “Capacity-building”

– CSOs and state actors have a greater capacity (including human capacity) and improved skills and systems to respond to maternal and child nutrition needs in Siaya County

This result area is tailored to focus on improving the technical and management capacity of CSOs and state health actors to provide quality MIYCN services. The evaluation examined health workers and CSOs who had been trained on relevant nutrition guidelines as well as on MIYCN. Further, the proportion of health facilities experiencing stock outs was examined.

3.3.1 Health workers trained on relevant nutrition guidelines and SOPs

R2-Indicator 1:	Number of health workers trained on relevant nutrition guidelines.
Achievement:	A total of 36 health workers have been trained on relevant nutrition guidelines among them are 23 males and 13 females.

The evaluation established that nutrition reporting guidelines training has been carried out for facility in charges and sub county health records and information officers, (23 male and 13 female {total 36}). The County CNAP TWG has been supported by the project to develop nutrition Standard Operating Procedures (SOPs) that have been reviewed nationally awaiting dissemination concurrently with CNAP. This is an improvement compared to the situation at baseline where only 5 health care workers had been trained.

HCW were enthusiastic on the capacity building training that they had received and many of them became more aware of the importance of reporting accurate data for improved decision making. This led to timely reporting and sustained effort to ensure there are no stock outs in facilities.

3.3.2 Health workers and CHVs workers trained on MIYCN

<i>R2-Indicator 2:</i>	<i>Number of health workers and CHVs workers trained on MIYCN.</i>
<i>Achievement:</i>	<i>The number of health workers and CHVs trained (TOTs) on MIYCN are 38 participants (21 females and 17 males) against a baseline value of 5 people trained on MIYCN</i>

The evaluation established that MIYCN Training of Trainers (ToTs) training was done reaching 38 participants (21 female and 17 male) drawn from Nawiri supported facilities and nutritionists. Orientation of CHVs and Community Health Assistants (CHAs) on use of guidelines on community based maternal, infant and young child nutrition interventions was carried out in October 2016.

A health facility in charge at Othach Dispensary reported

“Under the Nawiri project we received some training on MIYCN. The training covered areas that were new to me, for instance previously we were not able to diagnose malnutrition. During the training, we covered areas such as the importance of breastfeeding, how to express and store breast milk to promote exclusive breastfeeding and how to care for the breast. Currently I am able to pass the information to the mothers during counselling sessions”

3.3.3 Health facilities reporting no stock out

<i>R2-Indicator 3:</i>	<i>Proportion of health facilities experiencing no stock outs of essential nutrition commodities in past 3 months</i>
<i>Achievement:</i>	<i>The proportion of health facilities reporting no stock outs increased from 50% at baseline to 80% at MTE</i>

The Nawiri project supported the health faculties by procuring the essential nutrition commodities for the supported health facilities. This has gone a long way in reducing stock outs of the commodities.

A health facility in-charge of Usigu Dispensary reported that

“The Nawiri project implemented by CARE has supported us by procuring for us essential nutrition commodities and equipments such as weighing scales, MUAC tapes, Height boards which has enabled us to do proper monitoring of the nutritional status of the children under fives at the facility”.



a) Siaya County Chief Officer, Health, Mrs Dorothy Owino b) Nawiri Project Manager, Lilian Kong'ani

Plate 3.2 : Launch of Anthropometric equipments

3.4 Expected Result 3- “Sensitization and mobilisation”

- Targeted communities are informed and empowered to demand, access and utilise quality maternal and child nutrition services

This result area focuses on empowering men and women, boys and girls to demand access to and utilization of quality MIYCN services bearing in mind that political commitment and capacity to provide quality MIYCN services alone are not sufficient to reduce malnutrition. Men and women, boys and girls will be supported to hold authorities accountable and actively claim their rights to these services. The result indicators include percentage increase of women taking supplements during pregnancy, percentage increase of children under six months who are breastfed exclusively, percentage increase of children age 6-59 months receiving vitamin A supplementation twice a year, percentage increase of children under five years with diarrhoea who are treated with zinc supplements, increase of male and female beneficiaries being able to name at least three benefits of healthy nutrition practices, and the proportion of final beneficiaries expressing positive change in gender attitudes towards maternal child health.

A SCHMT member reported during a KII that

“As a result of the Community Score Card (CSC) the community members approached a nurse at Nyamonye dispensary who was fond of harassing mothers at the facility. She was talked to and she has since changed her attitude, the mothers are happy and the health facility utilization has gone up. The health seeking behavior has improved and the women are taking sick children to the hospital”

The benefits were also seen among the health workers, as a KII with a nursing officer in-charge of a health facility revealed:

“As a result of the project, the nutritionist has become more active, she supervises more frequently and confirms if commodities are available at facility”.

3.4.1 IFAS during Pregnancy

The MTE results reveal that 93.7% of pregnant women compared to the 55.5% at baseline were taking iron-folic supplements. This demonstrates 6.3% of unmet demand at the time of MTE.

Table 3.2 present the result of analysis between demographic characteristics and IFAS in pregnancy. Of the factors included in the analysis, only area of intervention (Sub-County) was significantly influencing uptake of IFAS ($\chi^2(2)=7.46$, $p\text{-value} =0.02$). Uptake of Iron/Folate supplementation was lower in Rarieda (28.2%), compared to Bondo (38.2%) and Gem (33.6%). It was not, however, clear what could be attributed to this difference, since none of the facilities in Rarieda reported stock outs of IFAS. Indeed, the interview with HCW indicated that the supplementations are given even during outreaches. Table 3.3 shows the relationship between age and IFAS uptake. There was no significant relationship between age and IFAS uptake.

Table 3.2: Demographic characteristics influencing Iron/folate supplementation in pregnancy

Variables		Uptake of IFAS tablets during pregnancy				χ^2	df	P-value
		Yes		No				
		n	%	n	%			
Sub County	Bondo	213	38.2%	9	23.7%	7.46	2	0.02
	Rarieda	157	28.2%	8	21.1%			
	Gem	187	33.6%	21	55.3%			
Marital Status	Single/living alone	111	19.7%	5	13.5%	0.85	1	0.36
	Married	452	80.3%	32	86.5%			
Level of Education	Primary	378	67.9%	28	75.7%	0.98	1	0.32
	Post Primary	179	32.1%	9	24.3%			
Main source of income	No reliable source of income	71	12.7%	1	2.6%	3.40	3	0.33
	Salaried employment	174	31.1%	13	34.2%			
	Business	159	28.4%	12	31.6%			
	Farming	156	27.9%	12	31.6%			
Religion	Protestants	309	58.2%	22	59.5%	0.84	2	0.66
	Roman Catholic	101	19.0%	5	13.5%			
	Other religions	121	22.8%	10	27.0%			

Table 3.3: The influence of Age on IFAS uptake

Age category	IFAS during Pregnancy				χ^2	df	p-value
	Yes		No				
	n	%	n	%			
15-19	48	90.6%	5	9.4%	3.94	3	0.27
20-24	183	93.8%	12	6.2%			
25-29	176	96.2%	7	3.8%			
30 years and above	154	91.7%	14	8.3%			
Total	561	93.7%	38	6.3%			

A KII with a facility in-charge in Rarieda attributed this increase to constant supply of commodities.

The KII reported:

“Nowadays, the facility does not lack iron-folic supplements and women are now aware about the importance of the iron-folic acid supplement during pregnancy”.

A facility in-charge at Pap Kodero Health Centre, reported that:

“Since the Nawiri [Project] started we are well stocked with supplementations which we use even during the outreaches that we conduct under the project”.

This happened even against the long national nurse’s labour dispute (strike) that lasted several months.

3.4.2 Breastfeeding and Complementary Feeding

Feeding practices play a critical role in child development. Poor feeding practices can adversely impact the health and nutritional status of children, in turn resulting in direct consequences for their mental and physical development. The duration and intensity of breastfeeding also affect a mother’s period of postpartum infertility and, hence, the length of the birth interval and fertility levels.

3.4.2.1 Initiation of breastfeeding

Early initiation of breastfeeding is important for both the mother and the child. Early suckling stimulates the release of prolactin, which helps in the production of milk, and oxytocin, which is responsible for the ejection of milk. It also stimulates contraction of the uterus after childbirth and reduces postpartum blood loss. The first liquid to come from the breast, known as colostrum, is produced in the first few days after delivery. Colostrum is highly nutritious and contains antibodies that provide natural immunity to the infant. WHO recommends that children be fed colostrum immediately after birth (within one hour) and that they continue to be exclusively breastfed even if the regular breast milk has not yet started to flow. Prelacteal feeding, giving food or fluids to newborns before the initiation of breastfeeding, is not recommended.

The sampled mothers were asked about breastfeeding practices following child birth. Of interest to the study was the percentage of new-borns starting breast feeding within an hour of delivery. The survey established that 82 of the mothers initiated breastfeeding within an hour after delivery.

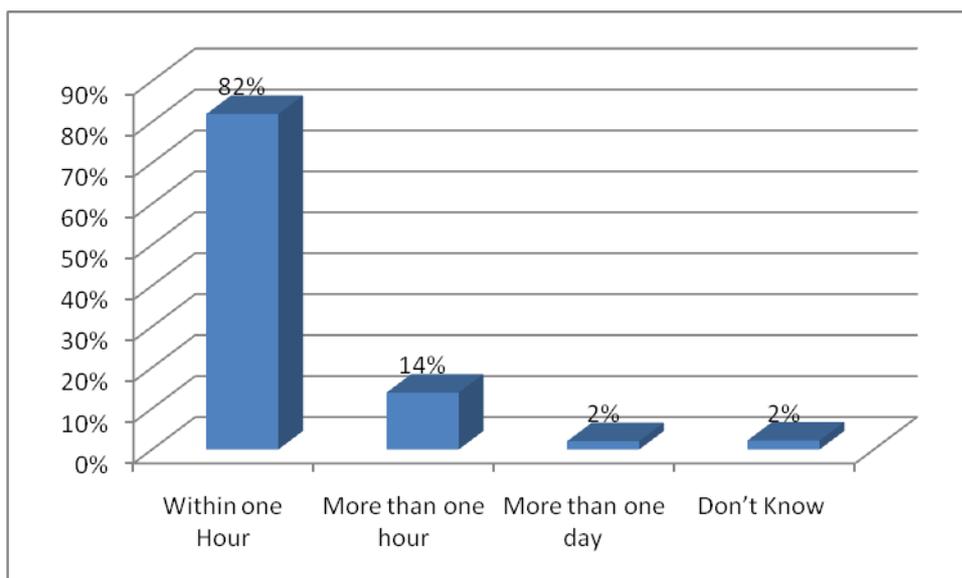


Figure 3.1: Initiation of breastfeeding

3.4.2.2 Exclusive breastfeeding for 6 months

<i>R3-Indicator 2:</i>	<i>Percentage increase of children under 6 months who are breastfed exclusively.</i>
<i>Achievement:</i>	<i>Children under 6 months who were exclusively breastfed increased from baseline value of 37.5% to 57.8% at mid-term evaluation</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 of breastmilk with other foods 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 results of this survey indicated that the proportion of mothers practising exclusive breastfeeding since birth is at 57.8%. This is higher than the 37.5% reported at baseline but slightly lower than the National average of 61% according to KDHS 2014.

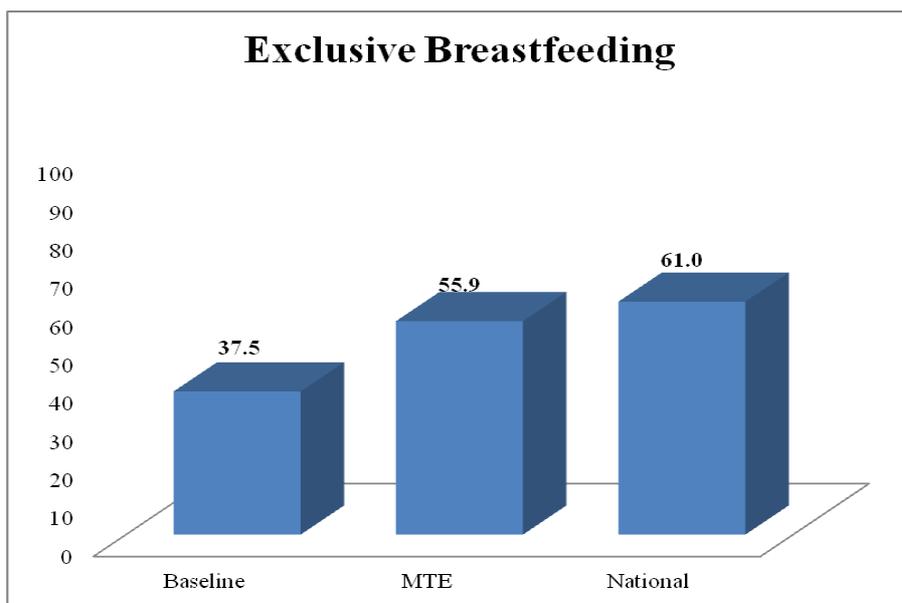


Figure 3.2: Proportion of children 6 months who were exclusively breastfed

The achievement realized so far is as a result of intensive campaign using CSO, mother to mother support groups as well as CHVs as revealed by the following interviews:

“Naviri has enabled us to do seven outreaches with clear message to pregnant mothers, lactating and mothers as well as those with under-five children. We have been able to train mothers how to breastfeed”

[A discussant in a FGD with CHVs at Naya Health Centre]

“In our communities there has been several myths about breastfeeding, but now, through our drama and outreaches, the myths have been demystified...., moreover many mothers now deliver at health facilities where they are encouraged and taught how to breastfeed”

[A member of Rachar Youth Group reported in an FGD]



Plate 3.3: An FGD with CSO

A Mentor Mother reiterated that:

“As a result of the trainings received from the project, we are now cascading the trainings to other women in the community during chiefs barazas, community dialogues days.”



Plate 3.4: M2M Graduation presided over by Dr Bob Awino, Deputy director of health

Analysis of association between exclusive breastfeeding and some selected demographic characteristics did not show any significant association (Table 3.4). Also, when age was cross-tabulated with exclusive breastfeeding, the relationship was found to be insignificant (Table 3.5)

Table 3.4: Demographic factors associated with Exclusive breastfeeding

Variables		Exclusive breastfeeding				χ^2	df	P-value
		No		Yes				
		n	%	n	%			
Sub County	Bondo	19	44.2%	24	55.8%	0.20	2	0.90
	Rarieda	16	42.1%	22	57.9%			
	Gem	17	47.2%	19	52.8%			
Marital status	Single/living alone	10	34.5%	19	65.5%	1.55	1	0.21
	Married	42	47.7%	46	52.3%			
Level of Education	Primary	32	44.4%	40	55.6%	0.02	1	0.89
	Post Primary	19	43.2%	25	56.8%			
Main source of income	No reliable source of income	8	44.4%	10	55.6%	5.86	3	0.12
	Salaried employment	17	47.2%	19	52.8%			
	Business	9	27.3%	24	72.7%			
	Farming	17	56.7%	13	43.3%			
Religion	Protestants	29	43.3%	38	56.7%	1.32	2	0.52
	Roman Catholic	13	52.0%	12	48.0%			
	Other religions	7	35.0%	13	65.0%			

Table 3.5: Influence of Age on exclusive breast feeding

Age category	Exclusive Breastfeeding				χ^2	df	p-value
	No		Yes				
	n	%	n	%			
15-19	7	35.0%	13	65.0%	1.98	3	0.58
20-24	18	43.9%	23	56.1%			
25-29	18	52.9%	16	47.1%			
30 years and above	9	39.1%	14	60.9%			
Total	52	44.1%	66	55.9%			

3.4.3 Vitamin A supplementation Coverage for Children of ages 6-59 months

<i>R3-Indicator 3:</i>	<i>Percentage increase of children aged 6-59 months receiving Vitamin A supplementation twice a year.</i>
<i>Achievement:</i>	<i>Percent of children aged 6-29 months who received Vitamin A supplementation twice in 2017 was 46.0% , which was above to 44.8% in 2015 and 36.5% in 2016</i>

A serious contributor to childhood morbidity and mortality is micronutrient deficiency. Children can receive micronutrients from foods, food fortification, and direct supplementation. Vitamin A is an essential micronutrient for the immune system and plays an important role in maintaining the epithelial tissue in the body. Severe vitamin A deficiency (VAD) can cause eye damage.

The WHO guidelines, stipulate that children 6-59 months of age living in areas where the vitamin intake is inadequate must receive vitamin A supplement every 6 months. Kenya has adopted these guidelines and aims to provide the supplementation once every 6 months for children 6-59 months old. According to these guidelines, in a period of 12 months; children 6-11months of age should receive the supplement once, while those of ages 12 months or more should receive twice. The number of times a child receives the supplement may be higher than twice in a 12-month period because of the integration of vitamin A supplementation with immunization during national/campaign days, which are meant to improve coverage especially in areas where there is limited accessibility to health facilities

The results of this evaluation showed that 86.4% of children aged 6-59 months have been given vitamin A supplements. About a third (29.4%) had received vitamin A supplements twice a year, while another 15.6% had received vitamin A supplements thrice in 2017. Overall, the number of children aged 6-59 months who received vitamin A supplements twice was 46.0% in the period under review. The result was above the baseline value of 36.5% of children aged 6-59 months in 2016. A member of the Mother to mother support group reported that

“Kitchen gardens have been developed as a result of the trainings and mentorship we received. This is making the vegetables such as spinach which are rich in Vitamin A readily available at the household levels providing alternatives source“

Analysis of association between Vitamin A supplementation uptake and selected demographic characteristics showed a significant relationship in the following factors:- Sub-County ($\chi^2[2]=5.22$, $p\text{-value}=0.07$); marital status ($\chi^2[1]=3.22$; $p\text{-value}=0.07$); main source of income ($\chi^2[3]=10.84$; $p\text{-value}=0.01$). Rarieda (54.9%) reported higher uptake than compared to Bondo (41.9%) and Gem (44.0%). On the other hand, married women (48.0%) and salaried women (54.3%) reported relatively higher uptake of Vitamin A supplementation. The result of this analysis is presented in table 3.6.

Table 3.6: Demographic factors associated with Vitamin A supplementation uptake

Variables		Vitamin A supplementation				χ^2	df	P-value
		Once		Twice				
		n	%	n	%			
Sub County	Bondo	93	58.1%	67	41.9%	5.22	2	0.07
	Rarieda	55	45.1%	67	54.9%			
	Gem	84	56.0%	66	44.0%			
Marital	Single/living alone	50	63.3%	29	36.7%	3.35	1	0.07

status	Married	186	52.0%	172	48.0%			
Level of Education	Primary	163	54.9%	134	45.1%	0.06	1	0.81
	Post Primary	73	53.7%	63	46.3%			
Main source of income	No reliable source of income	30	66.7%	15	33.3%	10.84	3	0.01
	Salaried employment	63	45.7%	75	54.3%			
	Business	66	50.4%	65	49.6%			
	Farming	76	62.3%	46	37.7%			
Religion	Protestants	133	56.1%	104	43.9%	3.60	2	0.17
	Roman Catholic	36	46.2%	42	53.8%			
	Other religions	60	60.0%	40	40.0%			
Age	Mean[sd]	26.1[6]		26.8[5.4]		t=-1.30	434	0.196

3.4.4 Children under 5 Years with Diarrhea Treated With Zinc Supplements

R3-Indicator 4: Percentage increase of children under 5 years with diarrhoea who are treated with zinc supplements.

Achievement: 25.7% of the mothers of children under 5 years with diarrhoea reported that they gave their children zinc supplements compared to baseline value of 13.1%

Dehydration caused by severe diarrhoea is a major cause of morbidity and mortality among the 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 found that 25.6% 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) compared to 74.4% who had not. The prevalence of diarrhoea in the project area was found to be higher when compared to the national average of about 15% of diarrhoea cases (KDHS 2014).

A child has 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 they had taken to treat and manage diarrhoea. The results showed that 25.7% of the mothers reported that they gave their children zinc supplements with another 20.8% of the mothers reporting that they gave ORS packets. The uptake of treating diarrhoea with Zinc was higher compared to the baseline value of 13.1%, despite the nurses strike that affected most service delivery.

The best practice for childhood diarrhoeal management is to continue breastfeeding and to provide ORS and 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. None of the mothers reported breastfeeding more during such episodes. This is a pointer to the lack of knowledge among mothers in the project area on diarrhoea management in young children which the project can address as it interfaces with communities.

Table 3.5 presents the result of the analysis of the association between uptake of treatment of diarrhea with Zinc among the under-fives and selected demographic characteristics. The results show significant association between uptake of treatment of diarrhea with Zinc and Sub-County

($\chi^2[2]=8.00$; p -value 0.02), and level of education($\chi^2[1]=7.91$, p -value 0.01). Uptake of treatment of diarrhea using Zinc was lower in Rarieda (19.0), but higher in Gem (47.1%). On the level of education, mothers with post primary education had higher uptake (55.0%) than those with primary education (30.3%). This can be explained by the fact that more educated women understand better the need for managing a child diarrhea to prevent dehydration.

Table 3.7: Demographic characteristics influencing Under-five with diarrhea treated with Zinc Supplement

Variables		With Diarrhea treated with Zinc Supplement				χ^2	df	P-value
		No		Yes				
		n	%	n	%			
Sub County	Bondo	41	63.1%	24	36.9%	8.00	2	0.02
	Rarieda	34	81.0%	8	19.0%			
	Gem	27	52.9%	24	47.1%			
Marital status	Single/living alone	16	69.6%	7	30.4%	0.39	1	0.53
	Married	86	62.8%	51	37.2%			
Level of Education	Primary	83	69.7%	36	30.3%	7.91	1	0.01
	Post Primary	18	45.0%	22	55.0%			
Main source of income	No reliable source of income	10	58.8%	7	41.2%	0.40	3	0.94
	Salaried employment	28	63.6%	16	36.4%			
	Business	27	62.8%	16	37.2%			
	Farming	38	66.7%	19	33.3%			
Religion	Protestants	54	62.8%	32	37.2%	0.59	2	0.75
	Roman Catholic	18	69.2%	8	30.8%			
	Other religions	24	60.0%	16	40.0%			
Age	Mean[sd]	26.1[5.3]		25.5[5.5]		t=0.65	159	0.57

3.4.5 Beneficiaries Awareness on Benefits of Healthy Nutrition Practices

R3-Indicator 5: Percentage increase of male and female final beneficiaries being able to name at least three benefits of healthy nutrition practices.

Achievement: 58% of male-female beneficiaries were able to name at least three benefits of MIYCN

Most of the beneficiaries were aware of the benefits of healthy nutrition practices, 58% of the beneficiaries were able to name at least three benefits of MIYCN. The findings show that health benefits such as reduced occurrence of diseases, strong bones, and teeth for children as well as having the recommended weight were perceived to have the highest benefits as shown by 84.1% for reduced occurrence of diseases, 47% for strong bones and teeth and 41.6% for recommended weight. At baseline, less than half (46.9%) of the beneficiaries were able to name at least three benefits of MIYCN.

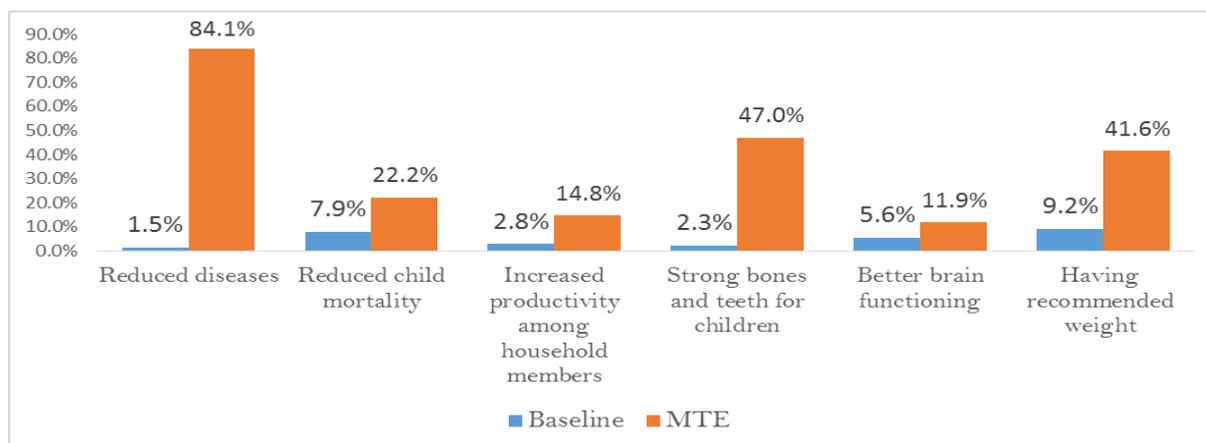


Figure 3.3: Benefits of healthy nutrition practices

Table 3.8 presents selected factors that were analyzed against awareness of at least three (3) benefits of health nutrition practices. Only Sub-County variable was significantly associated with awareness of at least three benefits of healthy nutrition practices ($\chi^2 [2]=12.90$; p -value 0.00). Bondo had the highest level of awareness with 38.8% of respondents able to name at least 3 benefits of healthy nutrition practices.

Table 3.8: Demographic factors related with being aware of at least three (3) benefits of health nutrition practices

Variables		Aware of at least 3 benefits of healthy nutrition practices				χ^2	df	P-value
		No		Yes				
		n	%	n	%			
Sub-County	Bondo	142	61.2%	90	38.8%	12.90	2	0.00
	Rarieda	144	76.6%	44	23.4%			
	Gem	153	72.5%	58	27.5%			
Marital status	Single/living alone	80	66.1%	41	33.9%	0.81	1	0.37
	Married	362	70.3%	153	29.7%			
Level of Education	Primary	306	71.5%	122	28.5%	2.45	1	0.12
	Post Primary	132	65.3%	70	34.7%			
Main source of income	No reliable source of income	51	68.9%	23	31.1%	0.08	3	0.99
	Salaried employment	140	70.0%	60	30.0%			
	Business	128	69.6%	56	30.4%			
	Farming	121	68.8%	55	31.3%			
Religion	Protestants	237	67.9%	112	32.1%	0.84	2	0.66
	Roman Catholic	79	69.3%	35	30.7%			
	Other religions	101	72.1%	39	27.9%			
Age	Mean[sd]	26.0[5.7]		26.8[5.7]		t=-1.63	633	0.102

3.4.6 Beneficiaries Gender Attitudes towards MIYCN

R3-Indicator 6:	Proportion of final beneficiaries expressing the positive change in gender attitudes for MIYCN.
Achievement:	61.0% of beneficiaries expressed positive attitudes to MIYCN

Sixty percent (60.6%) of beneficiaries expressed a positive gender attitude towards maternal and child health. Fifteen percent (15%) of the respondents believed that health and nutritional services are women and children issues only, 50.8% agree that MIYCN is a very important service to the community and 46.1% agree that MIYCN should be a concern for all household members. At baseline, slightly over half (55.6%) of beneficiaries expressed a positive gender attitudes towards maternal and child health and sixty-one (61%) of the respondents believed that health and nutritional services are women and children issues only.

A CSO coordinator reported: “ We have seen improvement in nutrition practices, and a reduction in myths and beliefs related to nutrition. There is less conflict in houses between spouses as a result of the education we provide because men now understand the importance of nutrition”.

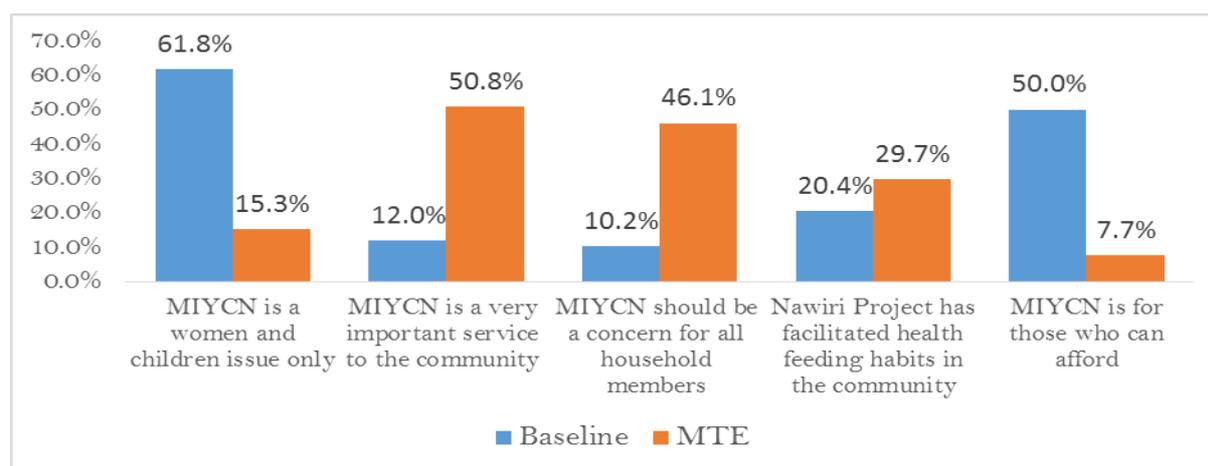


Figure 3.4: Beneficiaries Gender Attitudes towards MIYCN

3.5 Nutritional status among children

3.5.1 Maternal and Child Nutrition Status

Good nutrition is a prerequisite for the national development of countries and for the well-being of individuals. The 2010 Constitution of Kenya recognizes adequate food and nutrition as a human right. It states that every person has the right to be free from hunger and the right to adequate food of acceptable quality (Article 43) and that every child has the right to basic nutrition (Article 53). Furthermore, the Government of Kenya’s 2011 Food and Nutrition Security Policy states that nutrition is central to human development in the country (Government of Kenya, 2011).

Adequate nutrition is critical to children’s growth and development. The period from birth to age 2 years is especially important for optimal physical, mental, and cognitive growth, health, and development. Unfortunately, this period is often marked with nutrient deficiencies that interfere

with optimal growth and may cause common childhood illnesses such as diarrhoea and acute respiratory infections.

A woman's nutritional status has important implications for her health as well as for the health of her children. Malnutrition in women results in reduced productivity, increased susceptibility to infections, slowed recovery from illness, and a heightened risk of adverse pregnancy outcomes. For example, a woman with poor nutritional status, as indicated by a low body mass index (BMI), short stature, or micronutrient deficiencies, has a greater risk of obstructed labour, of having a baby with a low birth weight, of death from postpartum haemorrhage, and of morbidity for both herself and her baby.

This section covers the nutritional concerns for children and women. Specifically, it presents information on the nutritional status of children and women based on anthropometric measurements, infant and young child feeding practices including breastfeeding and complementary feeding, micronutrient intake among children and women, and salt iodisation.

Children's nutritional status is a reflection of their overall health. When children have access to adequate food supply, are not exposed to repeated illness, and are well cared for; they are more likely to 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 illnesses, 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 of 2006. Each of the three nutritional status indicators can be expressed in standard deviation units (z-scores) from the median of the reference population.

To evaluate the nutritional status for children within the project area, the baseline survey captured anthropometric data by measuring the height and weight of all children aged 6-59 months in the households. The baseline 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

- a. **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 the age.
- b. **Sex:** This was recorded as either 'f' for female or 'm' for male.
- c. **Weight:** A bathroom secca "digital" scale was used to measure the children's weight to the nearest 0.1kg. These were calibrated using a standard weight to ensure accuracy

- d. **Height:** A height/length board was used to measure length for children less than 2 years of age, while heights measurements were taken for those aged two years and above. Both were measured to the nearest 0.1 cm.
- e. **MUAC:** this was measured to the nearest mm 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. In the event of left-handedness or a disability on the left arm, the MUAC was taken on the right arm.
- f. **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.
- g. **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.

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.

3.5.2 Anthropometric indicators and interpretations

The anthropometric results were defined based on the global standard (WHO, 2006) which defines acute malnutrition 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.

3.5.2.1 Mid Upper Arm Circumference (MUAC)

MUAC analysis was also undertaken to determine the nutrition status of targeted children. During the evaluation, all severe and moderately malnourished children as per MUAC cut offs referred to nearby facilities. The MUAC criteria used are listed in table 3.9.

Table 3.9: MUAC Guidelines

MUAC Guideline	Interpretation
MUAC < 115mm and/or bilateral oedema	Severe acute malnutrition with high risk of malnutrition
MUAC ≥ 115mm and < 125mm	Moderate acute malnutrition with risk of mortality
MUAC ≥ 125mm and < 135mm	Risk of malnutrition
MUAC > 135mm	Adequate nutritional status
Maternal MUAC Cut-Offs	
MUAC < 21cm	Malnourished
MUAC ≥ 21cm ≤ 21.5cm	At risk
MUAC > 21.5cm	Normal

3.5.2.2: Weight-for-height Scores (Wasted) for children aged 6-59 months

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.

Based on the above WHO standards, the MTE reveals that 6% of all the children (boys: 6.2% and girls: 5.8%) within the target sub counties are considered as thin (wasted) and are acutely malnourished. A lower proportion 0.5% of all the children within the county are severely malnourished (boys: 0% and girls: 1.2%) as captured in the table below. The prevalence of global acute malnutrition in the intervention areas for children aged 6-59 months has dropped compared to the 17.8% reported at baseline but slightly higher when compared to the National average which stands at 4 percent of children according to KDHS, 2014. The Prevalence of oedema associated with malnutrition was 0.5% (n=2).

Table 3.10: Prevalence of Acute Malnutrition Based On Weight-For-Height Z-Scores

	All n=365	Boys n=194	Girls n=171
Prevalence of global acute malnutrition (<-2 z-score and/or oedema)	(22) 6%	(12) 6.2%	(10) 5.8%
Prevalence of moderate acute malnutrition (<-2 z-score and >=-3 z-score, no oedema)	(20) 5.5%	(12) 6.2%	(8) 4.7%
Prevalence of severe acute malnutrition (<-3 z-score and/or oedema)	(2) 0.5%	(0) 0%	(2) 1.2%

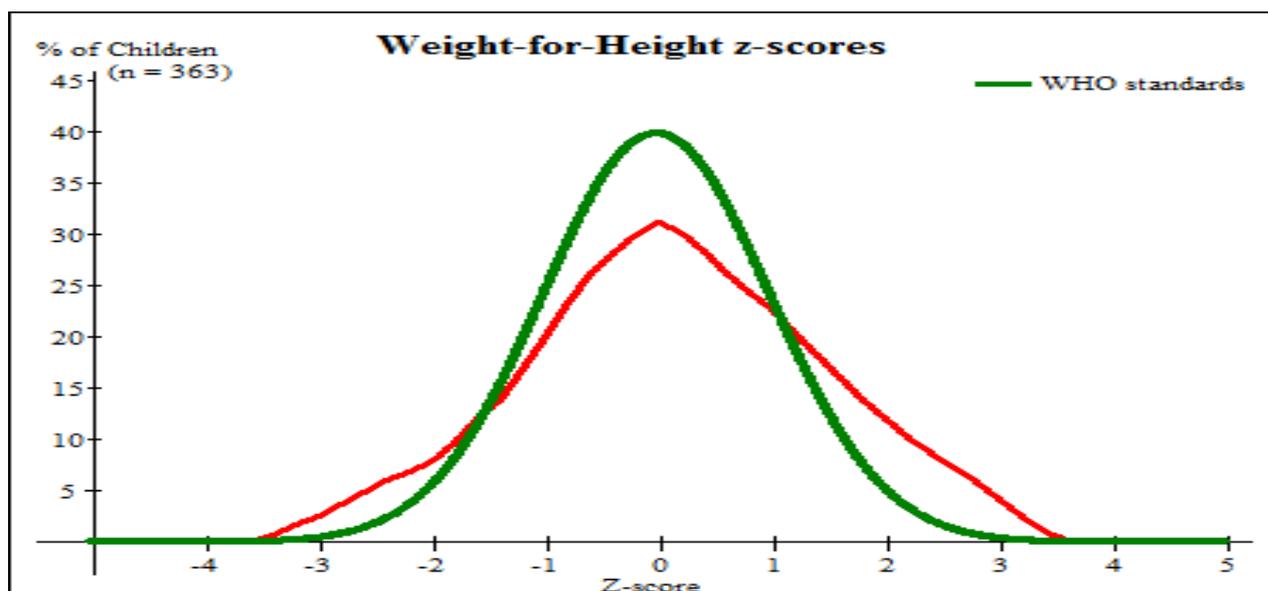


Figure 3.5: Weight-for-Height Z scores for children aged 6-59 months

3.5.2.3: Weight-for-Age Scores (Underweight) for children aged 6-59 months

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 MTE results for WAZ: Prevalence of underweight based on the (<-2 z-score) reveals that for all children 12.6% are considered underweight with 15.3% being boys and 9.4% girls. The prevalence of moderate underweight and severe underweight were 11.3% and 1.3% respectively. Compared to the baseline figures of 20.3% and 7.1% the prevalence of moderate underweight and severe underweight has dropped but it is slightly higher than the National average of 11 percent of according to KDHS, 2014.

Table 3.11: Prevalence of (Underweight) for children aged 6-59 months

	All n=390	Boys n=209	Girls n=181
Prevalence of underweight (<-2 z-score)	(49) 12.6%	(32) 15.3%	(17) 9.4%
Prevalence of moderate underweight (<-2 z-score and >=-3 z-score)	(44) 11.3%	(30) 14.4%	(14) 7.7%
Prevalence of severe underweight (<-3 z-score)	(5) 1.3%	(2) 1%	(3) 1.7%

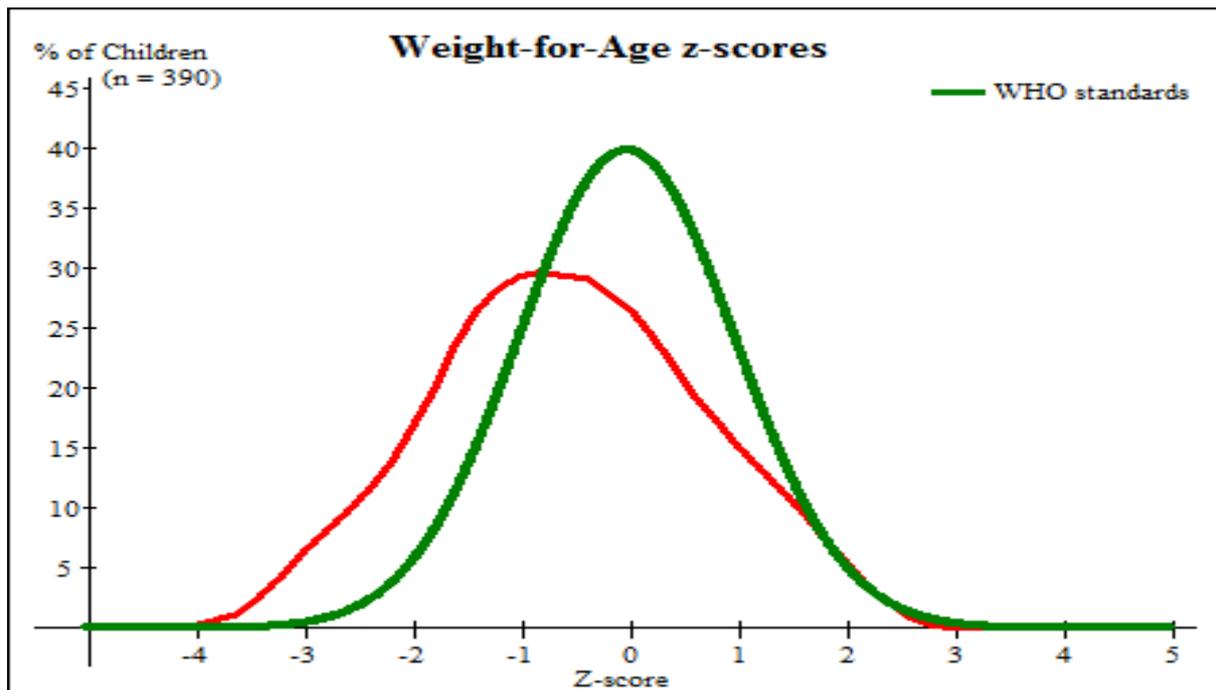


Figure 3.6: *Weight-for-Age Scores for children aged 6-59 months*

3.5.2.4: Height-for-Age Scores (Stunting) for children aged 6-59 months

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 365 children after factoring age errors or outlier figures in a randomly selected survey sample of 860 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.

The MTE results reveal that prevalence of stunting (<-2 z-score) in all the children in the county is currently at 25.7% with 26.4% being boys and girls 24.9%. The prevalence of moderate stunting and severe stunting were 19% and 6.7% respectively. Compared to the baseline figures of 29.7% and 19.3% the prevalence of moderate stunting and severe stunting has dropped. The prevalence of stunting in the county compare with the National average of 26% according to the 2014 KDHS.

Table 3.12: Prevalence of (Stunting) for children aged 6-59 months

	All n=389	Boys n=212	Girls n=177
Prevalence of stunting (<-2 z-score)	(100) 25.7%	(56) 26.4%	(44) 24.9%
Prevalence of moderate stunting (<-2 z-score and >=-3 z-score)	(74) 19%	(41) 19.3%	(33) 18.6%
Prevalence of severe stunting (<-3 z-score)	(26) 6.7%	(15) 7.1%	(11) 6.2%

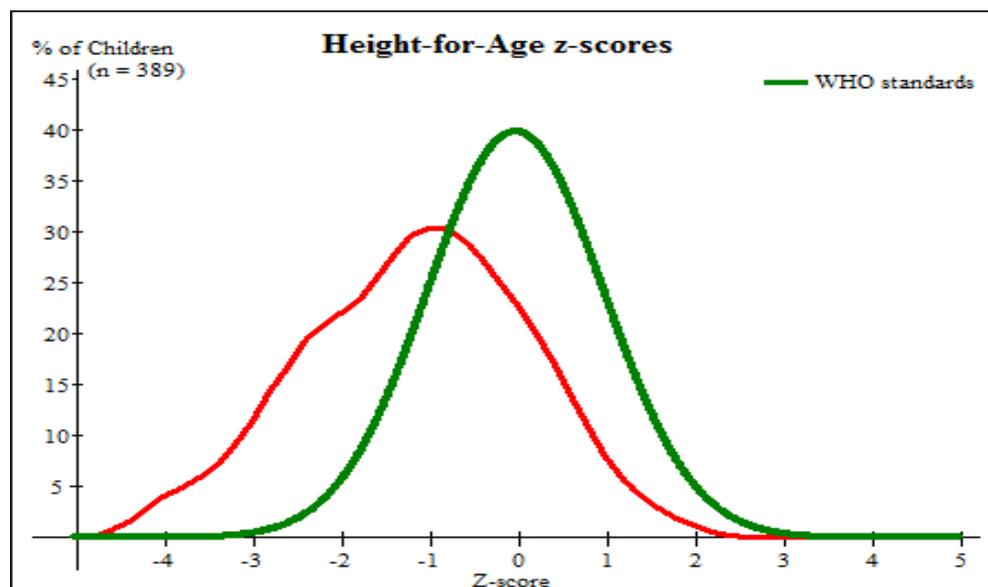


Figure 3.7: Height-for-Age Z-scores for children aged 6-59 months

3.5.2.5: Prevalence of malnutrition (Wasting) among infants (under six Months)

The MTE findings reveal that the prevalence of global acute malnutrition among infants is 3.8% (boys 4.8% and girls 3.1%). The prevalence of moderate and severe acute malnutrition is 3.8% and 0% respectively. The results show a drop in this indicator compared to the baseline where the prevalence of moderate and severe wasting in acute malnutrition at 0–6 months based on weight-for-height was 12.7% and 7.8% respectively.

Table 3.13: Prevalence of Acute Malnutrition among infants (under six Months)

	All n=53	Boys n=21	Girls n=32
Prevalence of global acute malnutrition (<-2 z-score and/or oedema)	(2) 3.8%	(1) 4.8%	(1) 3.1%
Prevalence of moderate acute malnutrition (<-2 z-score and >=-3 z-score, no oedema)	(2) 3.8%	(1) 4.8%	(1) 3.1%
Prevalence of severe acute malnutrition (<-3 z-score and/or oedema)	(0) 0%	(0) 0%	(0) 0%

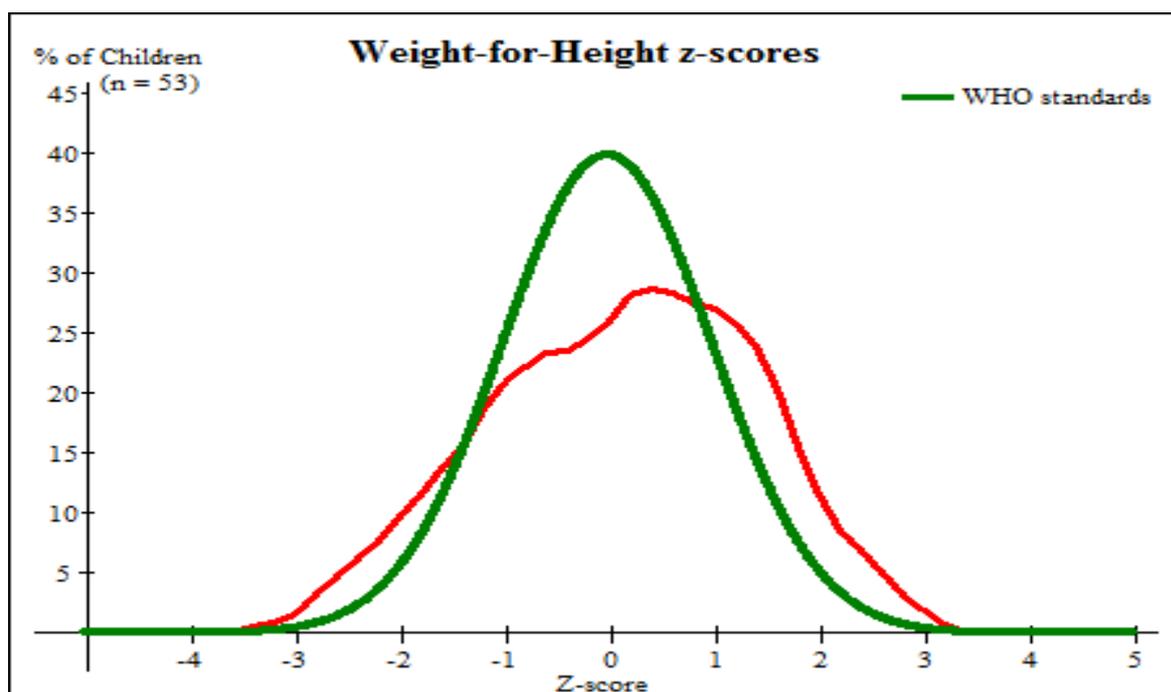


Figure 3.8: Prevalence of Acute Malnutrition among infants (under six Months)

3.5.2.6: Prevalence of Underweight) among infants (under six Months)

The MTE findings reveal that the prevalence of underweight among infants is 5.1% (boys 4.8% and girls 5.3%). The prevalence of moderate and severe underweight is 5.1% and 0% respectively. The results show a drop in this indicator compared to the baseline where the prevalence of Moderate underweight was 10.4% while severe underweight stood at 7.1% for the infants.

Table 3.14: Prevalence of (Underweight) among infants (under six Months)

	All n=59	Boys n=21	Girls n=38
Prevalence of underweight (<-2 z-score)	(3) 5.1%	(1) 4.8%	(2) 5.3%
Prevalence of moderate underweight (<-2 z-score and >=-3 z-score)	(3) 5.1%	(1) 4.8%	(2) 5.3%
Prevalence of severe underweight (<-3 z-score)	(0) 0%	(0) 0%	(0) 0%

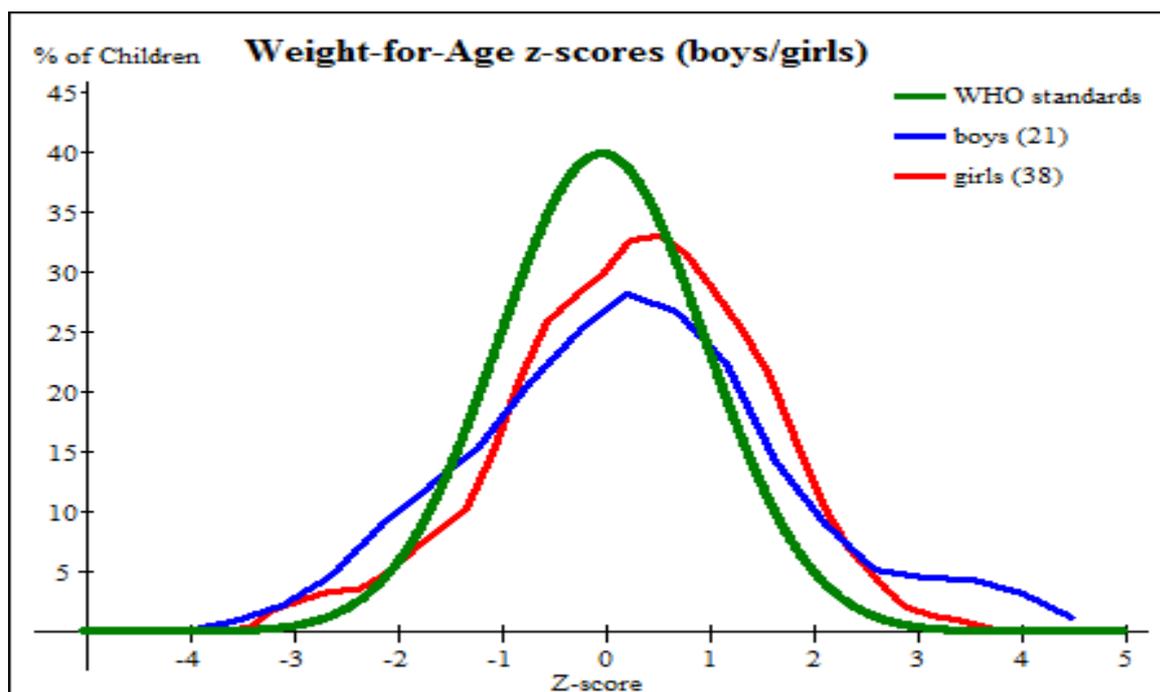


Figure 3.9: Prevalence of (Underweight) among infants (under six Months)

3.5.2.7: Prevalence of (Stunting) among infants (under six Months)

The MTE results reveal that prevalence of stunting (<-2 z-score) in all the children in the county is currently at 1.6% with 5.3% being boys and girls 0%. The prevalence of moderate stunting and severe stunting were 1.6% and 0% respectively. Compared to the baseline figures of 11.9% and 7.9% the prevalence of moderate stunting and severe stunting has dropped.

Table 3.15: Prevalence of (Stunting) among infants (under six Months)

	All n=63	Boys n=19	Girls n=44
Prevalence of stunting (<-2 z-score)	(1) 1.6%	(1) 5.3%	(0) 0%
Prevalence of moderate stunting (<-2 z-score and >=-3 z-score)	(1) 1.6%	(1) 5.3%	(0) 0%
Prevalence of severe stunting (<-3 z-score)	(0) 0%	(0) 0%	(0) 0%

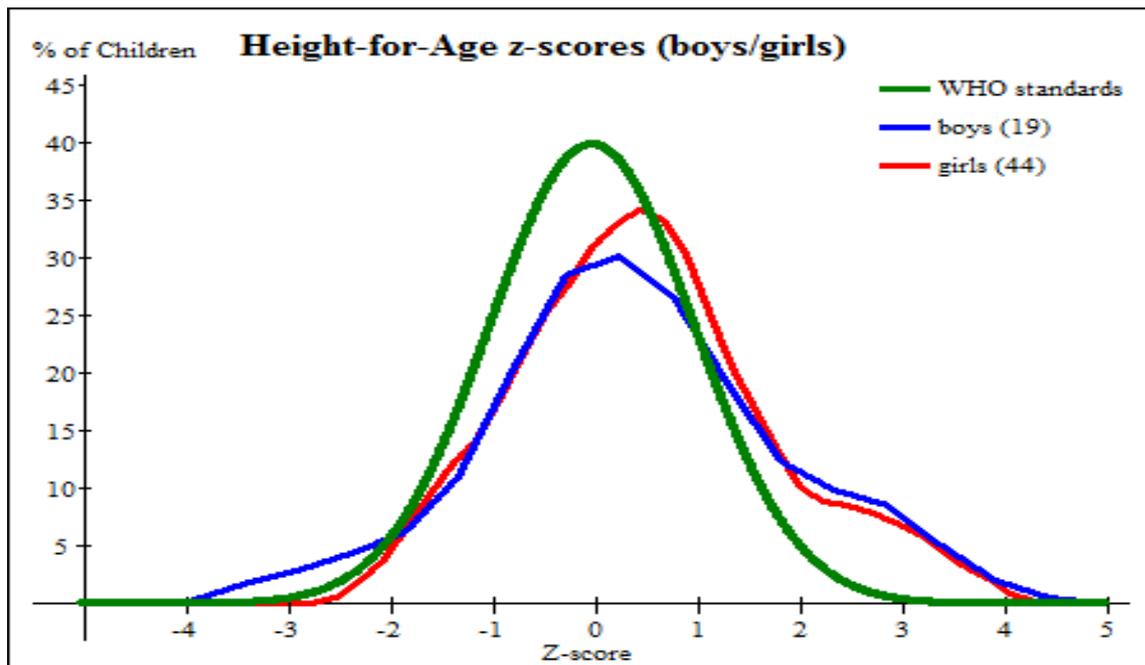


Figure 3.10: Prevalence of (Stunting) among infants (under six Months)

3.5.3 Nutritional Status of Women

3.5.3.1 Physiological status of mother/child care taker

A total of 593 women were surveyed; of these 56.5% were breastfeeding, 38.4% were neither breastfeeding nor pregnant, while 4% pregnant.

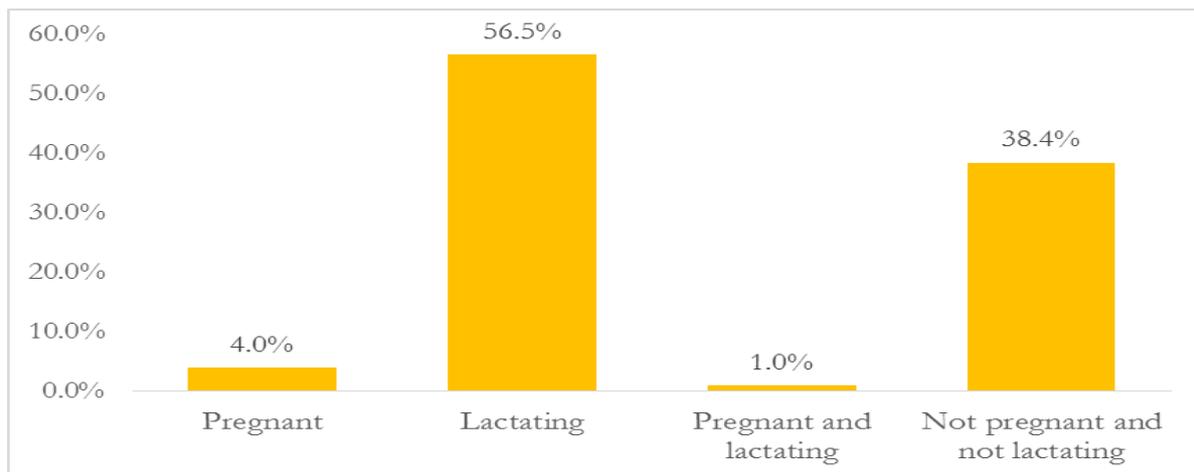


Figure 3.11: Physiological status of mother

3.5.3.2 Nutrition status

MUAC was used to determine the level of under nutrition among pregnant women and mothers. The cut-off used was <21 cm. The results of this survey showed that 16.7% mothers who were pregnant and lactating mothers had poor nutritional status, followed by 4.2% who were pregnant.

Pregnancy imposes a big nutrient-need load on mothers, which in the absence of adequate extra nutrients leads to utilization of body nutrient reserves leading to malnutrition. Gestational malnutrition leads to low birth weights and may ultimately culminate in poor child growth and development, thus there is an urgent need to address high rates of malnutrition among pregnant women. Poor adult nutritional status is a key indicator to household food insecurity. High figures of malnourished PLWs carry a risk of growth retardation of the fetus and consequently low birth weight. If the situation deteriorates, both U5 children and caretakers from the same household are vulnerable to malnutrition, a common scenario during nutrition emergency levels.

3.5.4 Food security and livelihoods

3.5.4.1 Dietary Diversity

The Household Dietary Diversity Score (HDDS) is a widely used proxy measure of household food access where the number of different food groups consumed over the previous 24 hours is recalled by respondents. While a diversified diet is an important outcome in itself it is also correlated with improved outcomes in birth weight, child anthropometric status, caloric and protein adequacy. It is also correlated with household income. Cereals and cereal products are the main foods consumed by at least 95.3% of the households in all the survey zones. This is followed by dark green leafy vegetables (94.7%), fish (88.4%), Vitamin A rich foods (75%). The least consumed foods include organ meat (11.3%). The food consumption patterns compare with those observed at baseline where over three quarters (98.1%) had consumed cereals and cereal products, at most three quarters (74.5%) consumed vegetables and slightly over half consumed fish and sea foods.

3.5.4.2 Household Coping strategies

The MTE also assessed the household food coping strategies and established that most households (66.5%) relied on less preferred and less expensive foods when they did not have enough food or money to buy food. This was followed by limiting portion size at mealtimes (56.3%), reducing the number of meals eaten in a day (50.1%). Restricting consumption by adults in order for small children to eat was the least preferred strategy (35%).

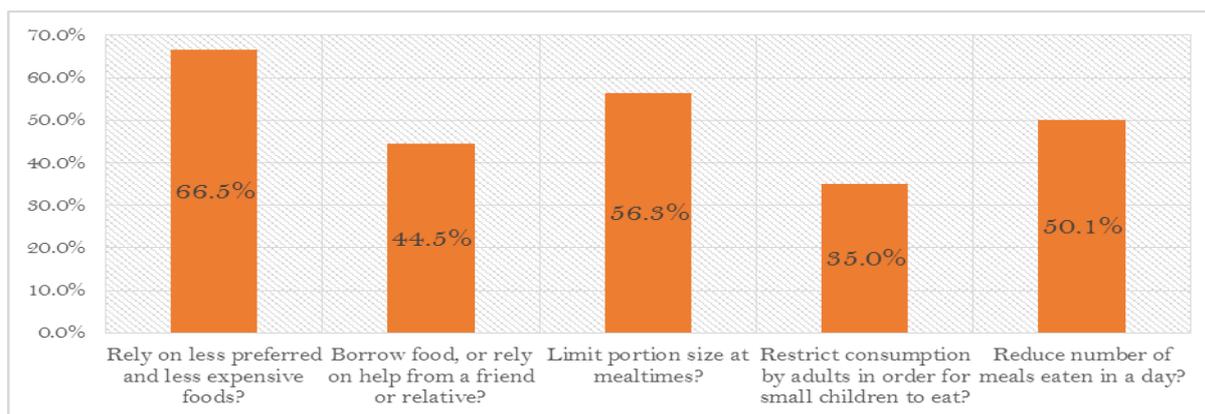


Figure 3.12: Household Coping strategies

3.5.5 Water and Sanitation

Human health is inextricably linked to a range of water-related conditions such as access to safe drinking water, sufficient sanitation, minimized burden of water-related disease and healthy freshwater ecosystems. The project did not have any interventions on WASH per se but some of the activities of the CHVs include promoting WASH in the community offering a fringe benefit to the beneficiaries. Availability of clean drinking water, sanitation and good hygiene practices have direct impact on the health of the people. Positive practices and safe access to the three of them contribute to good health and nutrition.

3.5.5.1 Household Water Sources

The evaluation findings indicate that usage of safe water sources accounted for 51.4% (piped water, public tap, borehole, protected spring, protected shallow wells), while the remaining proportion of households (48.6%) used unsafe water sources (unprotected shallow wells, water vendors, earth pan dam). Access to safe drinking water at baseline was 49.1%.

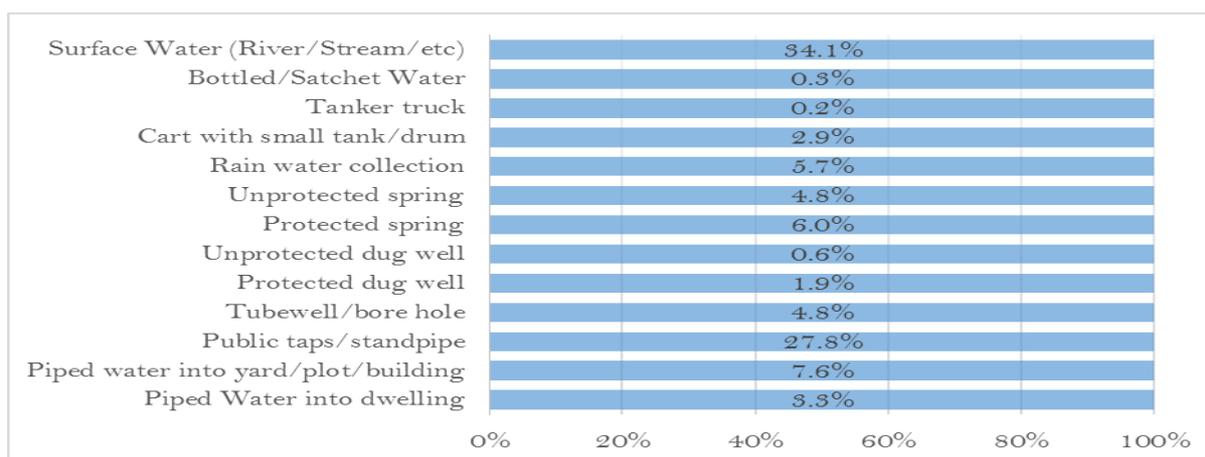


Figure 3.13: Sources of household drinking water

3.5.5.2 Water treatment Methods

Water treatment ensures water is palatable and of sufficient quality to be drunk and used for cooking and personal and domestic hygiene without causing risk to health.

The study findings reveals that despite 48.6% of households getting their water from unsafe water sources, 28% of these households do nothing to their water before drinking. Compared to the situation at baseline, there is an increase in the percentage of households treating water from 43.5% to 72%. Despite the fact that water treatment had improved in the community, it is worth noting that this was not a direct deliverable of the project. The MTE team found out that there exists a CARE Safe WATER PROJECT in Bondo and Gem and that this may be attributed to the change observed as those projects supply the PUR water purifier.

3.5.5.3 Hand washing practices

Better hygiene practices are critical to the health, survival, and development of a community. The lack of basic knowledge and facilities to support these predisposes a community/ individuals to infections. In order to assess hygiene practices, the survey assessed hand washing practices at critical times: before and after particular events. Washing of hands is one of the high impact nutrition interventions that can improve the health and nutrition status of children. The evaluation established that main caregivers (mothers) wash hands before eating or preparing a meal (37.2%), after using the toilet (90.4%), before feeding a child (48.4%) and after attending to a child who had defecated (52.4%).

3.5.5.4 Household Latrine coverage and usage

Inappropriate disposal of human waste is one of major cause of food and water borne illnesses worldwide. Safe disposal of human waste (urine, feaces or both) have a beneficial impact to health and nutrition status at household level. The results depict that the percentage of household members who have access to a latrine was reported at 91% compared to 87.5% established at baseline. Just like at baseline, the majority of respondents (mothers) (83.3%) were found to have traditional pit latrines while 14.9% had ventilated improved pit latrines. Those who had no latrines used alternatives such as bushes, open field and cat method (burying of stool) of disposal. Other uses were neighbors' latrines. The improved latrine coverage may be attributed to the work done by the CHVs by promoting behavior change communication in the community.

3.6 Expected Result 4- “Evidence building”

Evidence on effective nutrition-sensitive and nutrition-specific actions is built, discussed and disseminated

This result area is aimed at supporting CSOs and the health sectors to collect and report on nutrition data in national systems as well as strengthen nutrition Data Demand and Information Use (DDIU) through active sharing of good practices to inform advocacy and policy formulation. Indicators of evidence building included the proportion of county health facilities with source document data matching health facility summary sheet, proportion of county health

facilities with source document data matching DHIS data, proportion of county health facilities timely reporting on nutrition data, and number and type of good practices and research results documented and disseminated for evidence-based advocacy.

3.6.1 County health facilities with source documents data matching health facility summary sheet data

<i>R4-Indicator 1:</i>	<i>Proportion of county health facilities with source documents data matching health facility summary sheet data.</i>
<i>Achievement:</i>	<i>80 percent of health facilities had source documents data matching health facility summary sheet data</i>

The accuracy of data from the source documents mainly the registers and the tally (summary) sheets have greatly improved as a result of the support from the project. It was reported by the County nutrition coordinator that as a result of the capacity building the data reported is accurate.

3.6.2 County health facilities with source documents data matching DHIS2 data

<i>R4-Indicator 2:</i>	<i>Proportion of county health facilities with source documents data matching DHIS2 data.</i>
<i>Achievement:</i>	<i>Proportion of county health facilities with source documents data matching DHIS2 data was at 95.0%</i>

The accuracy of data from the summary sheets and DHIS2 has greatly improved as a result of the support from the project. It was reported by the County nutrition coordinator that as results of the capacity building the data reported is accurate. Apart from trainings, there are routine support supervisions, support in DQA and review leading to improved reporting rates.

3.6.3 County health facilities timely reporting nutrition data

<i>R4-Indicator 3:</i>	<i>Proportion of county health facilities timely reporting nutrition data.</i>
<i>Achievement:</i>	<i>Proportion of county health facilities timely reporting nutrition data was at 75.0%</i>

Interviews with the county nutrition coordinator revealed that as a result of the support from the project and sensitization of the nutrition officers and health workers at the facilities, the timelines of reporting by health facilities stands at 75%. In some health facilities, volunteers have been hired to ensure nutrition data are collected and reported, while in other health facilities, no data clerks are hired causing sometimes delays in timely reporting.

3.6.4 Community Units timely reporting nutrition data

R4-Indicator 4:	<i>Proportion of Community Units timely reporting nutrition data.</i>
Achievement:	<i>Proportion of Community Units timely reporting nutrition data was at 75.0%</i>

The sensitization of the CHVs and provision of the nutrition reporting tools has led to all the supported CUs reporting nutrition data in a timely manner.

During FGD with CHVs at Naya, one discussant reported that:

“We have been trained on how to collect household data and the need to report data timely. Every time we meet, we are given feedback on how we are doing on timely reporting” [CHVs discussant during FGD]

3.6.5 Type of good practices and research results documented, disseminated for evidence-based advocacy

R4-Indicator 5:	<i>Number and type of good practices and research results documented moreover, disseminated for evidence-based advocacy</i>
Achievement:	<i>-reactivation of research committee at the county -development of male involvement module</i>

Towards supporting the county to determine national nutrition research priorities, the project supported consultative meetings organized by the nutrition technical working group. The research forum is in the process of organizing a workshop where the stakeholders will be able to present the nutrition related research findings scheduled for April 2018.



Plate 3.5: Clear signage in every health facility within the project area

4. Synthesis of Project Performance

In-depth analysis and understanding on the outcomes

4.1. Efficiency

Efficiency refers to how well resources were utilised to ensure maximum achievement of the project's goals. All the planned activities were implemented as per the work plan despite few competing activities such as the national polio campaign which partly affected planned project activities. There was also a 4 months Nurses' strike and disruptions following the political situation. Synergy between the consortium partners (CARE, FHOK, and KMET) ensured cost cutting measures in implementation, saving on logistics and human resources. This is because of the joint planning which ensured the same vehicles moving in one particular direction would carry staff of different projects. The project team also mobilized resources from the county government especially in-kind such as through trainings thus reducing the costs.

Through group interviews with County and Sub county health management team as well as with project staff, there was a general consensus that overall, the support team has been efficient in delivery of the intervention within the limitations it faced. Activity and implementation planning was done collaboratively with the MoH county and sub-county teams and reviewed regularly in case of changes. It was highlighted that although the activity planning went smoothly, one of the biggest challenges that hampered implementation was the constantly changing work-plan due to competing priorities of the MoH staff including county wide health campaigns, activities with other partners among others.

4.2 Effectiveness

Effectiveness refers to the extent to which the project has achieved target against the milestone indicators as set in the project log frame. Interviews with the stakeholders at the county and sub county levels revealed that the project interventions have been effective. The following are some of the key issues that emerged.

- ix) *Formation of a county research technical working group:* Interviews with the government officers revealed that the project supported the county to establish a county research technical working group which brought together CARE and the **Kenya Medical Research Institute** (KEMRI). The Technical Working Group (TWG) reviews all potential researches in the county and provides approvals for anyone to conduct studies in the county. The TWG has improved the coordination of research in the county leading to better outcomes. It also helps to avoid duplication of research topics. It also emerged that following this TWG, KEMRI is in the process of establishing a research center in the county. The TWG is in the process of organizing a scientific conference due for April 2018 to provide an opportunity for the researchers to showcase the results.
- x) *Advocacy for increased budgeting for nutrition related activities by the county-* The project through the results area on advocacy has worked with the health committee in the county assembly to advocate for more funding for nutrition related functions in the county.

There is a functional Nutrition advocacy committee in charge of this that is supported by Nawiri and Stawisha, both EU Funded nutrition projects which is promoting advocacy for nutrition in the county. Interviews with CHMT members and health committee members revealed that the budgeting for nutrition has increased from 1 million in the year 2016 to Ksh3,000,000 by the year 2017 .

- xi) *Commodity and equipment supply* – Interviews with the health facility in-charges indicated that most of the health facilities did not have basic commodities like the height boards, weighing scales, and MUAC tapes for measuring the nutritional status before the Nawiri project. The provision of these commodities through the *Nawiri* project has improved diagnosis of nutritional conditions leading to better management of malnutrition.
- xii) *Capacity building for Health workers*- Interviews with health workers revealed that the *Nawiri* project targeted the health workers with CME highlighting key areas on nutrition. As a result of this training the Health Workers (HWs) can now conduct spot diagnosis and refer clients for nutrition related services. This has also helped enhance the knowledge gaps around nutrition. The trainings of trainers targeting the CHVs in the supported CUs enabled them to acquire skills on nutrition including exclusive breastfeeding, MIYCN and breast care. The messages are then cascaded to the households during the household visits. To ensure high quality of delivery and management of nutrition project activities, the project conducted trainings for Nutrition officers from the health facilities supported by the project. Human Resource for Health (HRH) especially Nutritionists is far below the recommended WHO numbers: The county is severely under staffed with only nine (9) nutritionists employed by county government while implementing partners have hired 6 nutritionists. The present nutritionist population ratio of 1:104,000 is extremely below compared to the WHO recommended ratio of 1:50,000. The distribution of these staff is as follows: county level management-2, sub county level management-6, hospitals-9. The health centres and dispensaries have no nutritionists. The nutrition services are thus offered by other cadres in suboptimal levels. For instance in Bondo sub county, there are only four (4) nutritionists; two (2) employed by county government and two (2) by implementing partners. The four nutritionists are diploma level.
- xiii) *Support national days* – The project supported the county and sub counties to commemorate national days such as *Malezi Bora* which has assisted to create awareness to the general public on nutrition matters. Towards increasing uptake of key nutrition behaviors, the project leveraged on campaigns held during the *Malezi Bora* events to provide key messages regarding breastfeeding practices and complementary feeding practices. The County Nutrition Coordinator reiterated that there is World Nutrition day, *Malezi Bora* weeks in May and November each year and World Iodine day, where Nawiri fully takes part in and supports the county with logistics to achieve this.
- xiv) *Development of County Nutrition action plan*- The project supported the development of the county nutrition action plan CNAP which was planned to be launched in January 2018. This document once completed will provide a roadmap for implementing

nutrition interventions in line with the CIDP and annual plans for the county. It will also help to provide synergy and coordinate approach to the interventions.

- xv) *Health education and promotion* – The evaluation revealed that the project has supported the development of key nutrition messages on nutrition which help in addressing the knowledge gap. This is augmented by the supply of IEC materials with health information. It was also reported by CHMT that the radio programs on “NAM LOLWE” supported by the project has increased the reach to the target beneficiaries. The question and answers sessions during the radio shows assist in clarifying myths on nutrition.
- xvi) There has been increased capacity of HWs and CHVs in terms of skills and understanding of processes and tools used for capturing nutrition data. Training of health workers has shown an improvement in documentation and reporting since 2016, improved nutrition services coverage through outreach and mobile services, more regular visits, feedback and follow-up as well as improved commitment to health and nutrition activities. There has been a noted improvement in coverage of IMAM, MIYCN, and health services, particularly, an increased number of households have been reached with MIYCN through the M2MSGs. The M2MSGs have been an avenue of intervention that promise the highest level of sustainable impact thus far particularly because the interviewed groups seem to show a commitment and ability to continue propagating knowledge and practices on MIYCN amongst themselves and the wider communities as well as continuously seeking to sustain nutrition and dietary benefits through strengthening livelihoods based activities.

4.3 Facilitating Factors that Made the Project Achieve Results

- Collaboration with MoH and other stakeholders including community engagement and participation provided smooth implementation of project activities and enhanced partnership. It is noted that there were continuous discussions to draw out challenges and come up with solutions.
- The outreach activities promoted by the project played an important role in enhancing the coverage and accessibility of health care services by the community especially in the hard to reach areas. This led to the services being brought closer to the people.
- Adequate support in terms of resources provided by the project. It was reported that the project consults widely with the CHMTs in prioritization of the support needed and this is very much appreciated by the county.
- Transparency and integrity in engagement with stakeholders cemented close partnership and collaboration towards realization of the project goal. CARE maintained neutrality and professionalism throughout project life.
- Joint work planning between the County and the NGOs ensures a harmonized plan leading to a good working relationship

4.4 Sustainability

- The project has enhanced health system strengthening which ensures that MoH is able to carry out interventions with or without CARE, as well as advocacy initiatives which ensure there is adequate resources for nutrition interventions
- MoH have the capacity to implement nutrition interventions owing to several capacity building initiatives undertaken by CARE under the Nawiri project. In regards to capacity development on nutrition, MoH have capacities to prevent and treat malnutrition. Several advocacy initiatives have seen the county government allocate more resources for health and nutrition. HCW have been trained on community score card (CSC) which is a participatory approach that enhances problem identification and seeking ways of addressing the problems. With skills on CSC, HCW will continue with strategies of community involvement in service delivery at whatever level.
- CARE worked with mother to mother support groups (MTMSGs) and ensured vulnerable women are targeted by the project. The Nawiri project links MtMSGs to livelihood programs such as kitchen gardening, savings and loan activities among others in effort to ensure women are empowered.
- The social and political environment have been supportive, however, the political entity requires a lot of targeted advocacy to reinforce the need for ownership and taking the lead in key sector activities by advocating for prioritization and proper management of county funding. It is critical to note that achieving definite sustainability of project benefits within the institutional, environmental and community context of the project would require a consistent and well-coordinated effort amongst all stakeholders within the County.

4.5 Challenges in Project Implementation

- Despite joint planning between MoH and CARE, a key challenge was the difficulty to adhere to the work-plan due to competing priorities of the MoH staff including county wide health campaigns, activities with other partners among others.
- Nurses' strike and disruption by political activities in the run up to 8th August elections and repeat elections.
- Deep rooted cultural practices and beliefs and lack of committed opinionated leadership to champion optimal nutrition practices. The cultural practice included the kind of meals/or food a woman is allowed to eat; sharing latrine with father-in-law amongst others. This contributed to the slow pace of behaviour change which led to development of social behaviour change strategy that addresses barriers to change process.
- The vastness of the area (three sub-counties) with only one project vehicle sometimes delays implementation of some activities. This challenge has been mitigated by allowing the project officers to use rental cars (taxies) to execute project activities. Also, the project officers must plan jointly and adhere to the plan so that no one is inconvenienced.
- The high expectations of community members to the extent that most of them ask for payment or food supplements whenever they participate in Nawiri related activities.

4.6 Constraining Factors to the Implementation of the Project

- Inadequate resources for nutrition attributed to low budgetary allocation for nutrition by the county government affected the scale of activities and led to over-reliance on donor funding.
- Inadequate access to health and nutrition services attributed to inadequate staffing of nutritionists and poor distribution of health facilities affected project coverage.

4.7 Lessons Learnt

The implementation of the CARE Nawiri project has identified a number of lessons:

- 5) The synergy between project consortium members enhanced impact and quality programming as they would support each other. The joint planning of the activities ensured efficiency in the use of resources such as vehicles.
- 6) Health system strengthening is crucial in building sustainability. Involvement of county coordination structures ensured harmonized implementation and health system strengthening by different actors.
- 7) The use of CHVs in the CUs and the CBOs to pass messages are cost effective strategies.
- 8) Adopting different advocacy strategies constituting social mobilization, communication and political advocacy works.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

- The relevance of the project is relatively high with the programme goal and objectives responding to the serious nutritional conditions of under-five children and pregnant and lactating mothers. There is a clear linkage between the project's general objective of contributing towards reduction in morbidity and mortality associated with acute malnutrition in children under-five and in pregnant and lactating women with the identified needs regarding food and nutrition security of under five children and pregnant and lactating women.
- The project has been effective and has been able to reach some of the identified impact and outcome level changes. In particular the improvements in dietary intake of small children, improved feeding practices among the community members and enhanced use of Iron Folate supplementation and initiation of breastfeeding and exclusive breastfeeding. The changes in knowledge, attitudes and practices on nutrition and hygiene related issues showed mixed results with the communities' knowledge on management of childhood illnesses and feeding practices much more enhanced.
- In terms of efficiency, the project management structure mechanisms set up proved to work well. So did the coordination systems at the Country and County offices. The trainings that were undertaken by the project, the utilisation of knowledge and skills obtained from the project's training effort speak to efficient use of resources. All the planned activities were implemented as per the work plan despite few competing activities such as national polio campaign which partly affected planned project activities.
- For sustainability and impact, a high level of coordination with the implementing partners was noted, in particular, with the MoH. The County MoH officials that were interviewed noted that because of the constant coordination and collaboration amongst partners, there has been a reduction in duplication of activities and an increase in complimentary service provision which has contributed to enhanced effectiveness and efficiency of delivery of nutritional interventions. In addressing sustainability more directly, the CARE/County MoH partnership has been (and continues to be) very relevant as both partners are supporting and strengthening existing MoH systems as opposed to creating parallel systems, and this is more sustainable in MoH's short and long term capacity to deliver services.
- The focus on health system strengthening through capacity development of health workers ensured sustainability and ownership by the county government. The strategy of promoting positive social behavior change is still valid and aimed at addressing poor child care and maternal health due to retrogressive cultural practices.

5.2 Recommendations:

Short Term

- MoH - Community strategy and implementing partners to conduct inter MtMSGs exchange visits for learning purposes with focus on learning good practices between MtMSGs aimed at improving maternal, infant and young child nutrition and promoting

linkages to livelihood or income generation activities. The projects can also carry out a process evaluation to review implementation of the MtMSGs approach/model.

Medium Term

- To alleviate the human resources for health issues relating to nutrition, the project can lobby to the county to employ staff even on short term contracts to help bridge the gaps of few nutritionists in the county.
- MoH and Implementing partners to map out and coordinate implementation of social behaviour change and communication strategy towards promoting positive health and nutrition behaviour change.

Long term

- Continued advocacy targeting county government to support implementation and formation of community strategy that will see improvement in coverage of health and nutrition services. This includes supporting CHIS reporting and CHVs' incentives
- Nutrition actors to intensify advocacy geared towards ensuring there's recruitment of more human resource for health to bridge the current staffing gaps.
- The county government to spearhead a multi-sectoral and multi-stakeholder approach to holistically address under nutrition. This entails use of surveys and surveillance information e.g. annual integrated SMART surveys to develop, implement and monitor a multi-sectoral early warning and response plans.
- Linking MtMSGs to IGAs and VSLA supported by other partners and different government line ministries implementing nutrition sensitive interventions for sustainability. This ensures increased purchasing power of members towards improving optimal complementary feeding for children 6-23 months.
- County government to mobilize resources for establishment of health facilities and outreach services in hard to reach areas following mapping of outreaches by MoH and CARE which highlighted uneven distribution of health and nutrition services. This will contribute to improved access to health and nutrition services

Annex 1: Terms of Reference

Siaya Maternal and Child Nutrition *Nawiri* Project

CSO-LA/2015/368-296

**TERMS OF REFERENCE
TO CONDUCT
A MIDTERM EVALUATION**

Background

The Siaya Maternal and Child Nutrition *Nawiri* Project is a 36-month intervention on maternal and child nutrition. The project is executed in partnership between CARE (the coordinator), Family Health Options Kenya (FHOK) and the Kisumu Medical and Education Trust (KMET) in Siaya County with funding support from the European Commission (EC), the Austrian Development Agency (ADA) and CARE. The overall objective of the project is to contribute to improving maternal, infant and young child nutrition (MIYCN), including nutrition of women of reproductive age, in Siaya County. In order to increase the nutritional status of children under the age of five and of women of reproductive age, the project aims to alleviate the most severe obstacles of poor MIYCN in Siaya County. It will increase the capacity and commitment of Civil Society Organizations (CSOs) and state health actors to provide and facilitate access to coordinated, complementary, quality MIYCN services in Siaya County (specific objective). This project will be implemented in Siaya County, Kenya.

The *Nawiri* project has the following expected results (ER):

- ER1: “Advocacy for political commitment” - Political commitment and good nutrition governance in the Siaya County are strengthened and vulnerable groups are integrated in decision-making processes;
- ER 2: “Capacity-building” - CSOs and state actors have greater capacity (including human capacity) and improved skills and systems to respond to maternal and child nutrition needs in Siaya County;
- ER 3: ”Sensitization and mobilization” - Targeted communities are informed and empowered to demand, access and utilize quality maternal and child nutrition services;
- ER 4: ”Evidence-building” - Evidence on effective nutrition-sensitive and nutrition-specific actions is built, discussed and disseminated

Objectives of the Mid Term Evaluation

The **specific objective** of the mid-term evaluation of the *Nawiri* Project is to (1) assess the process and progress in project implementation and achievement of expected results, (2) provide an opportunity for an in-depth analysis and understanding on any unintended or intended outcomes, (3) as well as provide an opportunity for learning by project teams, partners and other stakeholders.

The midterm evaluation will cover the first one and half years of implementation – 1st May 2016 to 30th November 2017 - and will build upon the baseline survey conducted in 2016.

The **process evaluation** will focus on testing the hypothesis of the project's logic and assessing how and in what ways the program is working (or not), and for whom. It will provide opportunities for feedback and reflection amongst stakeholders in a way that can immediately inform the ongoing implementation and iterative design of the Project. Process evaluation will also assess whether the use of resources is proving to be effective and efficient, and whether the organizational systems and capacities are appropriate for achieving project results.

The evaluation should provide assessment against project goal, objectives and expected results based on the indicators of the project log-frame. Furthermore, the evaluation should follow the CARE International Evaluation Policy (Annex 1). Within the framework of the process evaluation, the logic model should also be assessed, identifying specific gaps and providing lessons learned and recommendations.

What is to be answered by the Mid Term Evaluation (MTE):

- How relevant is the intervention regarding local and national MIYCN requirements and priorities?
- How well did the project respond to the needs of target beneficiaries (direct and indirect), including how these needs evolved over time? To what extent did the project target and reach the poor, and those previously not seeking required health services?
- How effective and efficient are the processes of the project in achieving the project objectives?
- What is the progress towards the project's expected overall and specific objectives, as well as expected results (based on project indicators in the log frame)? What are the reasons?
- To what extent did the project deliver results on time and on budget against agreed plans? How can we accelerate and improve the achievement of the results?
- How well did the project apply value for money principles of effectiveness, economy, efficiency in relation to delivery of its outcome?
- Which unintended (positive and negative) effects did the project have? What are/were the reasons?(opinions of the beneficiaries, state and non state actors and final beneficiaries on the project)

- Which best practices and lessons learned can be identified? What are the key drivers and barriers affecting the delivery of results for the project?
- Are the strategies and approaches deployed sustainable?
- Which gender aspects have been considered and included in the project design and implementation (gender mainstreaming, representation of women, sex-disaggregated data...)?
- Which actions have been taken from a “do no harm” perspective with regard to possible negative effects?
- Which recommendations can be given to improve the relevance, effectiveness, efficiency, impact and sustainability of the project?

Mid term Evaluation Methodology

The evaluation will follow a participatory methodology and will be conducted by an external consultant (or a team of consultants) with full involvement and support from all the three beneficiaries (CARE, KMET and FHOK) in the project, and key stakeholders including the Ministry of Health (MoH) staff, Siaya County Health Representatives, community delegates and select beneficiaries. Note that since this is a Mid-term evaluation, the methodology is expected to be designed in a way that allows comparison between evaluation results of this survey and the baseline.

Specific Tasks to be done by the Consultant(s):

- Develop an inception report clearly demonstrating the full understanding of these Terms of Reference (ToR), clearly outlining the evaluation questions, proposed methodology and relevant instruments/tools to achieve the objectives of the assignment;
- Develop, pretest and review relevant tools for data collection;
- *Train enumerators, identify respondents and coordinate field data collection, ensuring that data collection is done in a consistent, comprehensive and ethical manner;*
- *Analyse the data using appropriate softwares;*
- Present preliminary findings of the assignment to CARE and partners for review;
- *Produce a draft report including findings, conclusions and recommendations;*
- *Make a presentation of draft findings and recommendations to CARE, its partners and other stakeholders of this evaluation;*
- *Compile a final report - The final version of the report will take into consideration feedback provided on the draft report. Annexes can be used to provide additional information to support the report (see final report outline below);*

- *Provide a summarized evaluation (popular) report, policy briefs and advocacy briefs from the study findings;*
- *Hand over to CARE the survey raw data and database, soft copies of all survey tools and detailed information about the location (GPS reference points where possible) of the households included in the survey to allow for replication of the survey at end line stage.*

Please note that the final report must be presented in a layout and format in line with the EU, ADA and CARE guidelines.

Key Deliverables and Expected Outputs

- ***An inception report:*** Upon selection, the consultant(s) shall have an inception meeting with CARE and partners within which he/she/they shall be briefed on the assignment and provided with an opportunity to prepare the inception report, within two days of the assignment. This report will consist of a realistic work plan that will operationalize and direct the exercise. The inception report will articulate how the consultant(s) understand(s) the ToR, a concept on how he/she/they propose to undertake the assignment and articulate his/her/their methodology. The inception report will address the following elements:
 - Relevant documentation which will be reviewed by the consultant(s);
 - Evaluation questions and hypotheses;
 - Methodology (including how to measure all the logical framework indicators);
 - Work schedule with deliverables by date;
 - A refined financial proposal;
 - Study tools and instruments.
- ***Preliminary Findings and a Draft Report:*** The appointed consultant(s) will be expected to provide a report of preliminary findings, likely recommendations and conclusions, which will be presented to the CARE program team and its partners for comments. Subsequently, a draft report will be submitted to CARE that addresses all issues identified in the Terms of Reference and the work plan. The draft report will be informed by feedback processes at all levels.
- ***The Final Report:*** The consultant(s) will submit a complete final report after incorporating comments and feedback from the draft report. The final report should cover all areas in detail with such an outline:

List of acronyms

Acknowledgements

Table of contents

1. Executive summary (including a table summarizing the MTE values for all the logical framework indicators)
 2. Introduction and background
 - a. Objectives of the project
 - b. Program beneficiaries
 - c. Purpose/objectives of the MTE survey
 3. Methodology
 - a. Data collection methods and tools
 - b. Study design
 - c. Sample size determination
 - d. Sampling technique and respondent characteristics
 - e. Data management
 - f. Ethical considerations
 4. MTE assessment findings and discussions – This will be described as per the objectives of this MTE. **The first section should bring out the MTE values/data in line with the logical framework.** The second section should bring out necessary information and give guidance to the refinement of the project intervention strategies, including the project advocacy, capacity-building and social and behavior change strategies.
 5. Conclusions and recommendations
 6. List of Annexes including:
 - Terms of Reference
 - Data collection tools;
 - List of documents reviewed;
 - List of respondents interviewed.
- ***PowerPoint presentation of the survey findings:*** Brief presentation of the key findings and recommendations.
- ***Policy and Advocacy Briefs:*** Provide brief policy and advocacy briefs on various key issues as identified in the mid-term evaluation.

Administrative and Logistical Support

The consultant(s) will be accountable to CARE International in Kenya's Health Sector Manager and will widely consult with and receive support from the Project Manager, Health M&E Coordinator and the project steering committee. In order to support the actualization of this assignment within stipulated timelines, CARE will also provide the following:

- All necessary program reference documents;

- Logistical support including field travel, accommodation and per diems will be provided as per CARE Kenya policy to facilitate field work processes. Therefore, these costs should not be included in the consultant(s)' financial quote.

Mid Term Evaluation Schedule

The evaluation has to be conducted within strict timelines in order to allow for timely completion. The schedule from the **inception meeting** to the **final report** is expected to run from 1st November 2017 - November 30th 2017.

Consultants' Requirements

The consultant(s) should be (a) public health and nutrition expert(s) with extensive experience in research, monitoring and evaluation and with the following profile:

- Master of Public Health, Nutrition, Demography or Social Sciences coupled with extensive training in Monitoring and Evaluation. Holding a PhD in any of the above fields will be an added advantage;
- At least 6 years of demonstrable experience in conducting MTE and other evaluations in health programs, including experience in conducting MTE/endline surveys for EU-funded projects;
- Practical experience working in the areas of maternal and child nutrition as well as gender and male engagement in health settings;
- Proven experience in conducting research and evaluations using quantitative and qualitative methods (including very good knowledge of the EU logical framework);
- Fluency in both written and spoken English and Kiswahili (mandatory);
- Proficiency in the use of statistical packages for data analysis, proficiency in the use of computers and electronic modes of communication;
- Excellent analytical, writing and presentation skills;
- Positive references from institutions provided with similar services;
- Previous experience in a similar EU-funded project will provide an added advantage.

Note: Both individual consultants as well as teams of consultants with complementary skills qualify to apply.

The Expression of Interest (Eoi) should contain:

- **CV of the team leader and all proposed associate consultants** with at least three (3) professional references each;

- **A brief write-up (max 8 pages, font 12, Times New Roman and Double Space)** on the understanding and interpretation of the ToR and how the assignment would be executed including a work plan with clear timelines and a proposed methodology;
- **A financial proposal** that indicates the all-inclusive fixed total contract price in Kenyan Shillings. Fees should be allocated per process, number of days and per individual consultant. The financial proposal shall specify a total lump sum amount, inclusive of the specific and measurable (qualitative and quantitative) deliverables (i.e. whether payments fall in installments or upon completion of the entire contract). Payments are based upon output, i.e. upon satisfactory delivery of the services specified in the ToR. Logistical support including field travel, accommodation and per diems will be provided as per CARE policy to facilitate field work processes. Therefore, these should not be included in the quote.
- **At least 2 reports** of concluded assignments of a similar nature.

Application Procedures

All Expression of Interests should be submitted to CARE by e-mail through bids@care.or.ke and should reach on or before **3rd October 2017 at 1200 Hrs.** The mail should be clearly marked in the Subject line ***“Expression of Interest for Mid Term Evaluation for the Nawiri Project”***.

Please note that applications that are incomplete and/or received past the deadline will not be considered. Only shortlisted, qualified candidates will be contacted.

This document has been produced with the financial assistance of the European Union. The views expressed herein should not be taken, in any way, to reflect the official opinion of the European Union.

CARE International Evaluation Policy

Excerpt:

Principles:

The over-riding principles that should be followed to guide the conduct and content of evaluations are the CI Programming Principles. What follow are some more specific principles that apply to evaluations per-se, while being consistent with the CI Principles.

Relevance (focus on what is important): Evaluations should assess desired as well as unexpected outcomes. They should also examine processes. This includes testing the hypothesis that the one leads to the other -- that the interventions contributed to the achievement of the stated objectives and

goal. Evaluations may also judge whether or not a project's objectives and goal were really relevant to addressing underlying causes of the identified problem(s) and unfulfilled rights of the target population. They should also examine both benefits and harms, including the intended and unintended, positive and negative impacts on specific groups, such as women, ethnic minorities, etc.

Participation (of community representatives): It is integral to a rights-based approach that participants in the project being evaluated should, whenever and as much as possible, be actively included in the planning for, implementation, analysis, reporting and utilization of evaluations. Evaluation findings and recommendations should never placed in the public domain without consultation with such stakeholders.

Focused on impact on the lives of people (significance): The primary concern of all evaluations is the impact of CARE's work on the rights and welfare of poor and marginalized people. This applies to all of CARE's programming, including direct delivery, partnerships, and advocacy. CARE will strive to develop evaluation methods that contribute to the empowerment of the intended beneficiaries, enabling them to articulate their aspirations and opinions regarding the efficacy of CARE's interventions.

Credibility (objective and reliable methods): Evaluators should follow the guiding principles of good practice, such as those promulgated by professional evaluation associations and agencies.

Integrity (ethical standards): Staff members and external evaluators engaged by CARE will maintain the highest possible professional, ethical and personal standards. In particular, they will ensure the honesty and integrity of the evaluation process, and respect the security and dignity of the stakeholders with whom they interact.

Transparency (willingness to share findings): The terms of reference for evaluations are made public; major evaluation contracts are awarded through a process of competitive bidding; evaluation activities are conducted openly. The findings and recommendations are shared in appropriate ways with all stakeholders. Final evaluation reports are placed in the public domain and made accessible to anybody who is interested.

Independence (of evaluators): The findings and recommendations of those conducting an evaluation should be included in their report without interference of managers. However, those implicated by the evaluation should be given the opportunity to respond to the conclusions and recommendations, and their responses included in the final version of the official evaluation report.

Annex 2: List of key Informant Interviewees

A. Government Partners

Sno.	Name	Designation	Representation
1.	Dr Omondi Owino	County Director of Health	CHMT
2.	Oscar Kambona	County Nutritionist	CHMT
3.	Millicent Okwach	County Research Cordinator	CHMT
4.	George Agola	Sub County Nutritionist- Bondo	SCHMT
5.	Amos Oduor	For Sub County Nutritionist-Yala	SCHMT
6.	Lorraine Atieno	Sub County Nutritionist-- Rarieda	SCHMT
7.	Esther Ochieng	Health Facility In charge	Gobei Health Centre
8.	Agnes Ouma	Health Worker	Gobei Health Centre
9.	Fredrick Otieno Odera	Health Facility In charge	Othach Dispensary
10.	Eucabeth Onyango	Nutritionists	Usigu Health centre
11.	Rosemary Akoth Oduor	Member	Jerusalem Ogam CSO
12.	Winnie Odhiambo	Hospital Nutritionist	Yala SCH
13.	Victor Oriema	Nursing officer (MCH)	Ndere Health Centre
14.	Elsa Swero	Nursing officer	Gongo Health Centre
15.	Emma Walo	Nursing officer in charge	Rera Health Centre
16.	George Obunga	Incharge (Nursing Officer)	Lihanda Health Centre

B. Project Implementation Team

Sno.	Name	Designation	Representation
1.	Lilian Kong'ani	Project manager	Care Kenya
2.	Dorothy owiyo	Project officer	Care Kenya
3.	Andrew Ouma	Project Assistant	FHOK
4.	Elsie Achieng	Project officer	FHOK
5.	Oscar Okoth	Project Coordinator	KMET

C. Civil Society Organisations

Sno.	Name	Designation	Representation
6.	Rosemary Akoth Oduor	Member	Jerusalem Ogam CSO
7.	Judith Obimbo	Volunteer	Afya Elimu CBO
8.	Bernard Omondi Otuoma	Coordinator	Siala Kaduol Youth Group (CSO)

Annex 3: Household Survey Tool



WITH FUNDING FROM
**AUSTRIAN
 DEVELOPMENT
 COOPERATION**



**FAMILY HEALTH
 OPTIONS KENYA**



MIDTERM EVALUATION FOR SIAYA MATERNAL AND CHILD NUTRITION PROJECT (NAWIRI) SIAYA COUNTY

Consent Page

INFORMED CONSENT

Hello. My name is _____, and I am working with (MoH and CARE). We are conducting a Mid- term evaluation survey on maternal and child /nutrition 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 **0-59 MONTHS** OF AGE.
- (2) ASK FOR OFFICIAL DOCUMENTATION REGARDING CHILD (ANTENATAL CARDS, IMMUNIZATIONS RECORDS, BIRTH CERTIFICATES, ETC.)
- (3) **CIRCLE THE RESPONSE/S AS MENTIONED BY THE RESPONDENT WHERE APPLICABLE**

SECTION 1: HOUSEHOLD IDENTIFICATION

This section is to be completed for each household visited.

101. Sub County Name	1. Bondo 2.Rarieda 3. Gem
102. Ward	
103. CSO linked	
104. Community Unit Linked.	

105. Household number.

106. Interviewer number.

107. Date of interview.

108. Time interview commenced.

109. Time interview ended.

105 b. Interviewer Name:		
Day:	Month:	Year:
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

	Field supervisor	HH Survey Enumerator	Data entry clerk
Name	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>

No.	Questions and Filters	Coding Categories	Skip
Section 2 Background information			
201	How old are you?	AGE..... <input type="text"/> <input type="text"/> DON'T KNOW.....998	
202	What is your religion	Protestant 1 Muslim..... 2 Roman Catholic..... 3 Adventist..... 4 Traditional religion..... 5 Other (Specify)..... 6 None..... 7	
203	What is your current marital status	Single/never married..... 1 Married.....2 Divorced/separated.....3 Widowed.....4	
204	What is the highest level of education completed by you?	No formal education1 Primary Not Completed 2 Primary Completed3 Secondary Not Completed4 Secondary Completed5 Tertiary college /University.....6	

205	What is your relationship with the household head?	Head.....1 Wife.2 Mother3 Daughter.....4 Grand Mother.5 Daughter-In-Law6 Mother-In-Law..... 7 Sister-In-Law8 Niece.9 Sister.10 Grandchild.11 Other (Specify)16	
206	Who usually lives in this house with you? (tick all that apply: probe for all residents)	Father1 Mother2 Husband3 Children.....4 Brother/s5 Sister/s.....6 Mother-in-law7 Father-in-law.....8 Other relatives9 Other non-relatives10	
207	What is your MAIN source of household income?	No reliable source of HH income.....1 Salaried employment.....2 Casual labor/wage earner.....3 Assistance (hand-outs)4 Business.....5 Crop farming.....6 Animal husbandry7 Others specify8	
208	How old were you when you gave birth to your first child?	AGE..... <input type="text"/> <input type="text"/> DON'T KNOW..... 998	
209	How many biological children have you given birth to (Parity)	Number of Biological children <input type="text"/> <input type="text"/>	
210	Of the biological children whom you have given birth to, how many of them are now below five years?	Number of children under five <input type="text"/> <input type="text"/>	

No.	Questions and Filters	Coding Categories	Skip
305	During your pregnancy with (Name), were you given or did you buy any iron folate tablets ? (<i>Show sample</i>)	YES.....1 NO.....2 DON'T KNOW8	→ 307 → 307
306	During the whole pregnancy, for how many days did you take the tablets? IF THE ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER OF DAYS.	DAYS <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW9998	
307	Where did you give birth to [Name]?	HEALTH FACILITY1 OTHER (SPECIFY)2	

No	Questions and Filters	Coding Categories	Skip
Section 4 Vitamin A Supplementation- (For children 6-59 months only)			
401	Has (Name) ever received a Vitamin A dose (like this/any of these)? SHOW COMMON TYPES OF AMPULES/CAPSULES/SYRUPS (<i>Show sample</i>)	YES1 NO2 DON'T KNOW9	→ 403 → 403
402	In the last one year , how many times did (Name) receive a Vitamin A dose?	Once1 Twice.....2 Thrice.....3 DON'T KNOW9	
403	Has [Name] been dewormed (i.e. given drug to clear worms in the stomach) in the last one year?	YES1 NO2 DON'T KNOW9	

404	How many months ago did [Name] take drugs for intestinal worms	One month ago1 Two months ago2 Three months ago.....3 Four months ago.....4 Five months ago.....5 Six months ago.....6 Don't know8	
Section 5 : Child Immunizations			
501	Do you have a card or booklet for recording immunization received by the [Name]? <i>(Ask to be given the card or booklet)</i>	YES 1 NO2 DON'T KNOW9	
502	[OBSERVE] What type of card or book is the respondent having?	Government book (Mother and Child booklet) 1 Any other Card/booklet2 DON'T KNOW9	
503	[OBSERVE] Are the vaccinations given to [Name] filled in the card or booklet?	YES 1 NO2	
504	[OBSERVE] If the child's growth chart plotted or the weights recorded? <i>(Check the growth chart if plotted or if weight is recorded in the book)</i>	YES 1 NO2	
505	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 NO2 DON'T KNOW9	→ 504 → 504

506	<p>COPY VACCINATION DATE FOR VITAMIN A, DTP1, DTP3 AND MEASLES FROM THE CARD OR BOOKLET</p> <p>IF VACCINES ARE NOT RECORDED IN CHILD HEALTH CARD OR BOOKLET, FILL IN 99/99/9999</p>	<p style="text-align: center;">DAY MONTH YEAR</p> <p>VITAMIN A __ __ / __ __ / __ __ __ __ </p> <p>DTP1..... __ __ / __ __ / __ __ __ __ </p> <p>DTP3..... __ __ / __ __ / __ __ __ __ </p> <p>MEASLES __ __ / __ __ / __ __ __ __ </p>	
507	<p>Has (NAME) received any vaccinations that are not recorded on this card, including vaccinations given during immunization campaigns/outreaches?</p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 9</p>	
508	<p>Has (NAME) received a DTP vaccination, that is, an injection given on the left thigh, sometimes at the same time as polio drops?</p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 9</p>	<p>→ 510</p> <p>→ 510</p>
509	<p>How many times?</p>	<p>NUMBER OF TIMES <input type="text"/> <input type="text"/></p>	
510	<p>Did (Name) ever receive an injection in the right arm to prevent Measles?</p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 9</p>	
511	<p>Did (Name) ever receive an injection in the arm to prevent TB that leaves a scar? Check for BCG Scar</p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 9</p>	
<p>SECTION 6: Control of Diarrhea</p>			

601	<p>Has (Name) had diarrhea in the last two weeks? (Diarrhea is defined as passing of loose bowel/stool 3 or more times in 24 hours)</p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 9</p>	<p>→ 701</p> <p>→ 701</p>
602	<p>What was given to treat the diarrhea?</p> <p>Anything else?</p> <p>If answer pill or syrup, show local packaging for zinc and task if the child received this medicine</p> <p>RECORD ALL MENTIONED</p>	<p>NOTHING A</p> <p>FLUID FROM ORS PACKET B</p> <p>HOME-MADE FLUID C</p> <p>PILL OR SYRUP, ZINC D</p> <p>PILL OR SYRUP, NOT ZINC E</p> <p>INJECTION F</p> <p>IV (INTRAVENOUS) G</p> <p>HOME REMEDIES/HERBAL MEDICINES H</p> <p>OTHER (SPECIFY) I</p>	

Section 7. Water , Sanitation and Hygiene

701	<p>What is the MAIN source of drinking water for members of this household?</p> <p>(CHECK ONE)</p>	<p>PIPED WATER INTO DWELLING 1</p> <p>PIPED WATER INTO YARD/PLOT/BUILDING 2</p> <p>PUBLIC TAP/STANDPIPE 3</p> <p>TUBEWELL/BOREHOLE 4</p> <p>PROTECTED DUG WELL 5</p> <p>UNPROTECTED DUG WELL 6</p> <p>PROTECTED SPRING 7</p> <p>UNPROTECTED SPRING 8</p> <p>RAIN WATER COLLECTION 9</p> <p>CART WITH SMALL TANK/DRUM 10</p> <p>TANKER TRUCK 11</p> <p>BOTTLED / SACHET WATER 12</p> <p>SURFACE WATER (RIVER/STREAM/ETC.) 13</p> <p>OTHER 96</p> <p>(SPECIFY)</p>	
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702	Do you do anything to make your water <u>safe</u> for drinking?	YES1 NO2	→ 704
703	If yes, what do you usually do to the water to make it safer to drink? Anything else? ONLY CHECK MORE THAN ONE RESPONSE IF SEVERAL METHODS ARE USUALLY USED TOGETHER, FOR EXAMPLE, CLOTH FILTRATION AND CHLORINE.	LET IT STAND AND SETTLE/ SEDIMENTATION A STRAIN IT THROUGH CLOTH B BOIL C ADD BLEACH/ CHLORINE D WATER FILTER (CERAMIC, SAND, COMPOSITE) E SOLAR DISINFECTION F OTHER X (SPECIFY) DON'T KNOW Z	
704	Do you know the times when it is <u>important</u> to wash hands? <i>(DO NOT READ THE ANSWERS, ASK RESPONDENT TO BE SPECIFIC. ENCOURAGE "WHAT ELSE" UNTIL NOTHING FURTHER IS MENTIONED AND CIRCLE ALL THAT APPLY)</i>	BEFORE PREPARING FOOD A BEFORE EATING B BEFORE FEEDING CHILD C AFTER CLEANING CHILD'S BOTTOMS D AFTER USING THE TOILET E AFTER EATING F AFTER CLEANING G AFTER TOUCHING SOMETHING STICKY, OILY, SMELLY H OTHER X (SPECIFY)	
705	Can you show me where you usually wash your hands and what you use to wash hands? ASK TO SEE AND OBSERVE	INSIDE/NEAR TOILET FACILITY 1 INSIDE/NEAR KITCHEN/COOKING PLACE 2 ELSEWHERE IN YARD 3 OUTSIDE YARD 4 NO SPECIFIC PLACE 5 NO PERMISSION TO SEE 7	

706	OBSERVATION ONLY: IS THERE SOAP OR DETERGENT OR LOCALLY USED CLEANSING AGENT? 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	SOAP.....1 DETERGENT.....2 ASH.....3 MUD/SAND.....4 NONE.....5 OTHER.....6 (SPECIFY)	
707	Does your household have access to a toilet facility that you use?	1=Yes 2=No	
708	(If yes in Q 707), what type of toilet facility do you have?	1=Bucket 2=Traditional pit latrines 3=Ventilated improved pit latrine 4=Flush toilet 5=Other Specify	
709	(If No Q 707), where do you go/use? (probe further)	1= Bush 2=Open field 3.=Near a water source 4.=Behind the house 5.=Other (specify)	
710	[OBSERVE] how children's faeces is disposed	1= disposed of immediately and hygienically 2= Not disposed (scattered in the compound)	

SECTION 8. CHILD FEEDING PRACTICES- Make every effort to speak with the mother question use the child's name.

801	Did you ever breastfeed [name of child]? _____	Yes.....1 No.....2 Do not Know.....3	→ 803 → 802 → 804
802	If NO, Why?	No milk.....1 Did not want to breast feed.....2 Medical advice.....3 Mother died.....4 Cultural beliefs.....5 Husband's denial.....6	

		Other (specify).....7	
803	If YES, How long after birth did you first put [CHILDS NAME] to the breast?	Within 30 minutes.....3 Within one hour.....2 More than one hour but within 24 hours.....3 More than one day.....4 Does not know.....5	
804	During the first 3 days after delivery, did you give [Name] the yellow fluid/liquid that came from your breasts?	Yes.....1 No.....2 Do not know.....3	
805	In the first 3 days after delivery, was [Name] given anything to drink other than breast milk?	Animal milk.....1 Plain water.....2 Infant formula.....3 Gripe water.....4 Traditional herbs.....5 Not given.....6 Others specify7	
806	Now, I will ask you about what [NAME OF CHILD] drank YESTERDAY during the day and night. During the day and night, did [NAME OF CHILD] receive any of the following fluids?		
A	Breast milk?	1= YES ; 0= NO; 8= DON'T KNOW	
B	Plain water?	1= YES ; 0= NO; 8= DON'T KNOW	
C	Commercially produced infant formula? (Nan, Lactogen, Infacare)	1= YES ; 0= NO; 8= DON'T KNOW	
D	Other milks: animal milk, reconstituted powdered milk (Safariland, Milki,Milksi, Nido, Coast, Cow fresh)	1= YES ; 0= NO; 8= DON'T KNOW	
E	Sweetened flavoured juices (Afia, Vimto, Ananas, Highlands, Savannah) Soda	1= YES ; 0= NO; 8= DON'T KNOW	
F	ORS	1= YES ; 0= NO; 8= DON'T KNOW	
G	Tea/Coffee	1= YES ; 0= NO; 8= DON'T KNOW	
H	Porridge	1= YES ; 0= NO; 8= DON'T KNOW	
807	Now, I will ask you about what solid/semi-solid foods [NAME OF CHILD] ate YESTERDAY during the day and night. YESTERDAY during the day and the night, what food items did [NAME OF CHILD] receive? Did [Name] receive.....		
A	Eggs	1= YES ; 0= NO; 8= DON'T KNOW	
B	Porridge made from CSB/UNIMIX/millet/sorghum/maize flour/cassava	1= YES ; 0= NO; 8= DON'T KNOW	
C	Flesh meats (meat soup, chicken, beef, goat, kidney, liver, fish, paipai)	1= YES ; 0= NO; 8= DON'T KNOW	
D	Legumes and nuts (beans, groundnuts, peas, ndegus)	1= YES ; 0= NO; 8= DON'T KNOW	

E	Dairy products (milk, cheese, ghee, yoghurt)	1= YES ; 0= NO; 8= DON'T KNOW	
F	Grains, roots and tubers (cassava, pasta, rice, posho/ugali, githeri, bread, biscuits, chapatti, mandazi)	1= YES ; 0= NO; 8= DON'T KNOW	
G	Vitamin A-rich fruits and vegetables (pawpaw, melon, sukumawiki, carrots, spinach, avocado, mango,)	1= YES ; 0= NO; 8= DON'T KNOW	
H	Other fruits and vegetables (onions, tomatoes/tomato paste, cabbage, oranges, bananas, wild fruits)	1= YES ; 0= NO; 8= DON'T KNOW	
I	Oils and fats (chipsy, tilly, kimbo, cowboy, golden fry, mafuta ya ng'ombe)	1= YES ; 0= NO; 8= DON'T KNOW	
808	Yesterday (during the day and at night), How many times did you feed (NAME OF CHILD) solid and semi-solid foods? Number of times child was given food to make it full (Frequency of feeding)	Number of times.....	

SECTION 9: INFANT AND YOUNG CHILD FEEDING (IYCF) KNOWLEDGE AND PRACTICES

901	At what age should solid/semi-solid foods be introduced to children?DaysWeeks MonthsYears Don't know998	
902	For how long should a child be breastfed?MonthsYears Don't know998	
903	Can a baby survive on breast milk alone without even water for the first six (6) months of life?	YES.....1 NO.....2 DON'T KNOW.....8	
904	How soon after birth should a baby be put to the breast if the baby and mother are well?	Within 30 minutes.....3 Within one hour.....2 More than one hour but within 24 hours.....3 More than one day.....4 Does not know.....5	
905	What are the sources of information on child feeding in this community? Multiple Responses	No where.....1 Health facility.....2 Community Health worker.....3 TBA.....4 Relatives/friends/neighbours.....5 Mother/mother in law.....6 Spouse/father of child.....7 Mother-to- mother support.....8 Father-to-father support.....9	

		CSO/NGO.....10 Other (specify).....11	
907	Who makes the decision on how your child should be fed? (Circle <i>all that have been mentioned</i>)	Myself.....1 Husband.....2 Mother in law.....3 Grandmother.....4 TBA.....5 Other (specify).....6	
908	What are the benefits of healthy nutrition practices? (Circle <i>all that have been mentioned</i>)	Reduced diseases.....1 Reduced child mortality.....2 Increased productivity among household members.....3 Strong bones and teeth for children.....4 Better brain functioning.....5 Having recommended weight6	

SECTION 10: FOOD FREQUENCY AND HOUSEHOLD DIETARY DIVERSITY

	<p>1001 Did members of your household consume any food from these food groups in the last 7 days?(food must have been cooked/served at the household)</p> <p>1=Yes 2=No</p>	<p>1002 If yes, mark days the food was consumed in the last 7 days?</p> <p>Yes=1; No=2</p>	<p>1003: What was the MAIN source of the dominant food item consumed in the HHD? (DO NOT READ THE CHOICES)</p> <p>1.Own production 2.Purchase 3.Gifts from friends/families 4.Food aid 5.Traded or Bartered 6.Borrowed 7.Gathering/wild fruits 8.Other (specify) 9. Not applicable</p>							
Type of food		D1	D2	D 3	D 4	D5	D 6	D7	TOTAL	
Cereals and cereal products (e.g. sorghum, maize, spaghetti, pasta,Ugali, anjera, bread)?										
Vitamin A rich vegetables and tubers: Pumpkins, carrots, orange sweet potatoes										

White tubers and roots: White potatoes, white yams, cassava, or foods made from roots										
Dark green leafy vegetables: Dark green leafy vegetables, including wild ones + locally available vitamin A rich leaves such as cassava leaves etc.										
Other vegetables (e.g. tomatoes, eggplant, onions)?										
Vitamin A rich fruits: + other locally available vitamin A rich fruits										
Other fruits										
Organ meat (iron rich): Liver, kidney, heart or other organ meats or blood based foods										
Flesh meats and offals: Meat, poultry, offal (e.g. goat/camel meat, beef; chicken/poultry)?										
Eggs?										
Fish: Fresh or dries fish or shellfish										
Pulses/legumes, nuts (e.g. beans, lentils, green grams, cowpeas)?										
Milk and milk products (e.g. goat/camel/ fermented milk, milk powder)?										
Oils/fats (e.g. cooking fat or oil, butter, ghee, margarine, blueband)?										
Sweets: Sugar, honey, sweetened soda or sugary foods such as chocolates, sweets or candies										

SECTION 11: COPING STRATEGIES INDEX		
1101	In the past 7 DAYS, have there been times when you did not have enough food or money to buy food? If No; Move to section 12. If YES, Have you done the following to survive	
A	Rely on less preferred and less expensive foods?	1=Yes 2=No
B	Borrow food, or rely on help from a friend or relative?	1=Yes 2=No
C	Limit portion size at mealtimes?	1=Yes 2=No
D	Restrict consumption by adults in order for small children to eat?	1=Yes 2=No
E	Reduce number of meals eaten in a day?	1=Yes 2=No

SECTION 12: GENDER ATTITUDES ON MIYCN

	ATTITUDES TOWARDS MIYCN	Indicate the extent of agreement? Please tick (✓) appropriately					Remarks
		Strongly agree (1)	Agree (2)	Neutral (3)	Disagree (4)	Strongly disagree (5)	
1201	MIYCN is a women and children issue only						
1202	MIYCN is a very important service to the community						
1203	MIYCN should be a concern for all household members						
1204	Nawiri Project has facilitated health feeding habits in the community						
1205	MIYCN is for those who can afford						
1206	Does your spouse/partner participate in household nutrition activities	Yes1 No.....2					
1207	How often does your spouse/partner participate in household nutrition activities?	Never1 Rarely2 Sometimes.....3 Most of the time/Always4					

SECTION 13: HOUSEHOLD DECISION-MAKING

NO	QUESTIONS AND FILTERS	CODING CATEGORIES				SKIP
1301	Who in your household usually makes the final decision on the following	Myself	Husband	Jointly with My husband	Others (specify)	
	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 food should be cooked each day	1	2	3		

SECTION 14: NUTRITIONAL MEASUREMENTS FOR THE CHILD

1401	Age in Months Months	
1402	Sex of the child	1.Male 2. Female	
1403	Weight in Kilograms (to the nearest 0.1kg =100g)	1 st reading.....KG 2 nd readingKG	

1404	Height/length in Centimeters (to the nearest 0.1cm =1mm)	1 st readingCM 2 nd readingCM
1405	MID Upper arm circumference (MUAC) (to the nearest 0.1cm =1mm)	1 st reading.....CM 2 nd readingCM
1406	Oedema	1. Yes 2. NO

SECTION 15: NUTRITIONAL MEASUREMENTS FOR THE MOTHER (15-49)

1501	Age in Years at last birthday Years
1502	Weight in KilogramsKG
1503	Physiological status of mother/child care taker	1=Pregnant 2=Lactating 3=Preg &lact 4=Not preg/ not lactating
1504	MID Upper arm circumference (MUAC)CM

SECTION 16: PARTICIPATING IN MOTHER TO MOTHER SUPPORT GROUP

1601	Are you aware of any mother to mother support groups in your village? [Excluding HIV/AIDS/Self-help groups, merry-go rounds, home-based care groups]	1. Yes 2. NO
1602	[IF YES], Are you a member of the groups?	1. Yes 2. NO
1603	How often do you participate in the mother support groups in your village activities?	1=Never 2=Rarely 3=Sometimes 4=Most of the time/Always

Thank you for your time

.....END.....

Annex 4: KII- CARE STAFF



MIDTERM EVALUATION FOR SIAYA MATERNAL AND CHILD NUTRITION PROJECT (NAWIRI) SIAYA COUNTY

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 Nawiri Project in Siaya County
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', CAREs 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 Maternal and Child Nutrition services
 - c. How did the project support the improvement of capacity of selected health facilities in the project area to meet Nutrition needs of the community? Explain and give relevant examples
8. To what extent has the project achieved the following results. Give examples and Provide evidence where possible
 - a. *ER1: “**Advocacy for political commitment**” - Political commitment and good nutrition governance in the Siaya County are strengthened and vulnerable groups are integrated in decision-making processes;*
 - b. *ER 2: “**Capacity-building**” - CSOs and state actors have greater capacity (including human capacity) and improved skills and systems to respond to maternal and child nutrition needs in Siaya County;*
 - c. *ER 3: “**Sensitization and mobilization**” - Targeted communities are informed and empowered to demand, access and utilize quality maternal and child nutrition services;*

- d. *ER 4: "Evidence-building" - Evidence on effective nutrition-sensitive and nutrition-specific actions is built, discussed and disseminated*

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 effective 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?
- viii.

SECTION F: CHALLENGES

What have been some of the internal and external obstacles to project implementation?

In your opinion, what would you say are some of the possible areas of improvement?

SECTION G: FACILITATING FACTORS

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

SECTION H: LESSONS LEARNT AND BEST PRACTICES

a) What are some of the key lessons learnt thus far during the project implementation?

b) 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

Any recommendations for the next phase of the Project

Annex 5: KII with GOK



MIDTERM EVALUATION FOR SIAYA MATERNAL AND CHILD NUTRITION PROJECT (NAWIRI) SIAYA COUNTY

INDEPTH INTERVIEWS GUIDE FOR STAKEHOLDERS (LINE MINISTRIES)

- *County Nutritionist*
- *Health Facility In charge (HFI/c)*
- *Health Committee*
- *Nutrition Technical working Group*
- *Trained Health workers*
- *Research TWG members*
- *Interagency Collaborative Committee members*

Consent

Hello. My name is _____. I am here to conduct a **MIDTERM EVALUATION FOR SIAYA MATERNAL AND CHILD NUTRITION PROJECT (NAWIRI) SIAYA COUNTY**. 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?

May I proceed with the interview?

Part A: General Information

Name of Respondent	
Current Role	

Number of years you have been working in collaboration with CARE	
Gender	
Time Interview started	Time Interview Ended
Date	
Name of interviewer	

Discussion questions

1. **Partnership:** How do you partner with CARE in the provision of Maternal and Child Nutrition services to this community? How was the partnership with CARE in this initiated?
2. Has the partnership been strengthened or weakened over the past years? How has this been done?
 - i. *What measures were taken to ensure equity at all stages of the project (assessment, design and implementation) and participation of both males and females?*
 - ii. *How were the vulnerable groups identified in the target project area?*
3. Type of Support- What type of support have you received from care under this project? Trainings, CME, Capacity Building , Outreach, In reach, Supported meeting, Review meetings,
4. Effectiveness: Looking back in the last one year in what ways has CARE supported the county/MOH towards achieving improved Maternal and Child Nutrition? Explain in Detail the type of support received from CARE thus far under the following areas? Probe whether the following activities have been done and what has changed as a result of the intervention.

Expected Result 1 – “Advocacy for political commitment”

- i. *Increase knowledge and understanding among County Executive and County Assembly Members on MIYCN needs, gaps and their roles in positive transformation*
- ii. *Conduct a resource gap analysis and foster County level investment in MIYCN*
- iii. *Development and signing of the County level MIYCN Charter*
- iv. *Integration of nutrition initiatives in Early Childhood Development (ECD) and schools curricula*
- v. *Enhance maternal and child nutrition governance at County level*
- vi. *Enhance accountability through the Community scorecard strategy*

Expected Result 2: “Capacity Building”

- i. *Improving the capacities of 10 CBOs and the County health authorities in implementing MIYCN actions*
- ii. *Support 10 CSOs and the County authorities to develop a costed County Nutrition Strategic Plan*
- iii. *Build the capacities of health workers and Community Health Volunteers on MIYCN*
- iv. *Improve the coordination of MIYCN actions within Siaya County*
- v. *Enhance the supply of MIYCN commodities*

- vi. *Adopt a mobile phone platform (Jamii Smart Initiative e-Health solutions) for registration of clients and dissemination of information on MIYCN*

Expected Result 3: “Sensitization and mobilization”

- i. *Inform and empower communities on MIYCN status, needs, rights and responsibilities*
- ii. *Accelerate Integrated Nutrition Services at health facility and community level*
- iii. *Challenge social and gender norms that influence negative nutritional practices*
- iv. *Increase male engagement and support for maternal and child nutrition*

Expected Result 4: “ Evidence building”

- i. *Set up a coordination structure for generating evidence of nutrition interventions in Siaya County*
- ii. *Documenting, publishing and disseminating outcomes of MIYCN interventions for learning*
- iii. *Improved monitoring and evaluation, accountability and learning systems at county health facilities and community*
- iv. *Document processes on MIYCN referral systems including CSOs and state services*

2. **Relevance:** What is your opinion on the relevance of the project within the prevailing context of **devolved system of governance** as well as national health policies (Probe for the following . Give specific examples)
 - I. *To what extent did the programme respond to the needs and priorities of programme participants?*
 - II. *To what extent are the objectives of the project still valid? Were the objectives, results and activities selected in the implementation of this program relevant to the identified population needs?*
 - III. *Were the most appropriate strategies used in implementation?*

3. **IMPACT:** What would you describe as the **key achievements** of this partnership with CARE funded project thus far? Probe for
 - i. *Who were the direct and indirect/wider beneficiaries of the project, what was the actual coverage?*
 - ii. *What difference/change has been made to the lives of those reached by the project?*
 - iii. *What is the long-term effect of the program at county? Sub-county County ? Individual household level?*

4. What would you consider as **facilitating factors** that made the project achieve the results indicated above? *Probe for Working relationships within the team and also with partners, stakeholders and donors*
5. What were the **constraining factors** to the implementation of the project and how were these handled?
6. **Sustainability :** What is your opinion on the soundness of **mechanisms, plans and strategies** put in place for project **sustainability**
 - i. *To what extent are the benefits of the project likely to be sustained after the completion of this project?*

- ii. *To what extent will the project innovations be sustained after project close-out? What support will the county offer? Is there availability of other sources of funding?*
 - iii. *Did the partners (Ministry of Health) understand the nature of the project and are they likely to sustain their commitment?*
 - iv. *How has the project been able to work with existing Government, community and other stakeholders' structures in building their capacity to be able to sustain the project?*
7. What would you consider to be important lessons worth learning from the manner in which this project was implemented, or from its results, with respect to accountable and effective MCN interventions?
8. **Recommendations for the next phase of the Project: What would you** recommend on the key **strategic options** for the future of the project i.e. exit strategy, scale down, replication, scale-up, continuation, major modifications to strategy. Are there any existing plans?

Annex 6: FGDs Guide

1. Community Health Workers (CHWs)
2. Teen mothers support groups
3. Mothers to Mothers groups
4. Outreach mothers
5. SAA beneficiaries
6. Food demonstrations beneficiaries
7. Men trained on Male involvement

Consent Page

INFORMED CONSENT

My Name is I am working with Care Kenya and the MoH. We are conducting a midterm evaluation of the Nawiri Project on Nutrition Implemented By care Kenya, FHOK , KMET. We are seeking to establish the progress made so far. 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.

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

A. Introduction (Objective of the MTE)

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

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This guide is for use in facilitating discussions with groups of beneficiaries to elicit information on knowledge, attitude, practices / perceptions and practices around maternal and child nutrition services, as well as service provided in the community

Discussion Questions

1. Please tell us a little bit about the work you do in this project implemented by care? How long have you worked/served in this community
2. What Support have you received from the Care Kenya under the NAWIRI Nutrition Project? Dialogue days, Action days, food demonstrations etc
3. What are the Key achievements? IMPACT of the project so far. What have you been able to do differently? Probe for dietary diversity, *Diarrhea management, Deworming, Zinc supplementation, Iodine Supplementation* , Exclusive breastfeeding
4. What do you think are the main barriers to accessing nutrition services in this community? Probe for social/cultural/religious/myths and rumors and any other such as service provider/side effects.
5. In your opinion, do new mothers practice exclusive breastfeeding in your community?
6. What are the common foods normally given to children below 5 years in this community? How many times per day?
7. Has there been any change in food consumption in the last three months? Why?
8. What recommendations can you make to improve the nutrition services offered at the health facility and community level?
9. In your opinion how can MNCH services be improved in this community?

Thank participants for taking part in the discussion. Ask if any participant has a question or comment or any issue or point they would like to make. If not, remind them that this information is confidential and will not be used or shared with anyone.