



MERCY USA FOR AID AND DEVELOPMENT

EMERGENCY NUTRITION AND WASH SUPPORT PROGRAM FOR GARISSA COUNTY

(15th March 2011- 15th March 2012)

END OF PROGRAM EVALUATION

Final Report

March 2012

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ACRONYMS AND ABBREVIATIONS

ANC	Ante-Natal Clinic
ASAL	Arid and Semi-Arid Lands
BSFP	Blanket Supplementary Feeding Program
CSB	Corn-Soya Blend
CTC	Community Therapeutic Care
DNOs	District Nutrition Officers
ENA	Emergency Nutrition Assessment
FGDs	Focused Group Discussions
GAM	Global Acute Malnutrition
GFD	General Food Distribution
HDDS	Household Dietary Diversity Score
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
MUAC	Middle Upper Arm Circumference
NGOs	Non-governmental Organizations
OFDA	USAID Office for Foreign Disaster Assistance
OTP	Outpatient Therapeutic Program
SC	Stabilization Centre
SFP	Supplementary Feeding Program
SMART	Standardized Monitoring and Assessment in Relief and Transition
WFH	Weight for Height
WFP	World Food Program
WHO	World Health Organization
ALRMP	Arid Lands Resource Management Project
CSAS	Centric Systematic Area Sampling

MERCY USA PROGRAM DISTRIBUTION MAP KENYA



Areas in Yellow are active program sites as of March 2012

This End of Program Evaluation of Garissa County's Integrated Nutrition and WASH Program Area was commissioned by Mercy-USA for Aid and Development

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We hope the study findings will be useful in planning and executing similar interventions in the future.

EXECUTIVE SUMMARY

Mercy USA has been implementing an Emergency Nutrition and WASH Program in Garissa County, North Eastern Province in Kenya for a period of 1 year since March 2011 to March 2012. Mercy-USA, initiated an emergency response on the ground supporting both facility and community-based interventions to enable a holistic approach in curative and preventive nutrition rehabilitation interventions for the targeted beneficiaries and improve access to water and sanitation facilities for school going children. The program proposed to expand existing coverage and outreach activities to enable the delivery of services to a wider population currently in need of nutrition support within this County. The MoMS/MoPHS capacity to provide nutrition rehabilitation services within its health facilities are limited hence this program had been designed to strengthen existing ministries of health systems to adequately provide nutrition support to vulnerable groups within the community. The main focus areas of this program was to address management of moderate and severe acute malnutrition through the Integrated Management of Acute Malnutrition (IMAM) approach, building capacity of the MoMS/MoPHS staff through training, supervisory support and mentoring of health workers, promotion of behaviour change at the community level through nutrition and hygiene promotion education sessions and improving access to water and sanitation facilities.

The main responsibility of the consultant was to conduct an assessment of the Nutrition and WASH projects in Garissa, Ijara, Fafi, Balambala and Lagdera Districts within Garissa County.

The Specific objectives of the assessment were: To establish the relevance of project objectives and activities towards meeting the needs identified within the community; establish coverage of the program activities; assess the coherence of the program in relation to other interventions in the geographical area of implementation; establish efficiency; assess the impact of the project on its wider environment, assess the effectiveness of the contribution from the project results and sustainability of the project activities and likelihood of continuation of the benefits produced by the projects to the beneficiaries.

Methodology and tools

There were two levels of sample size calculation, one for the SQUEAC methodology (Semi-Quantitative Evaluation of Access and Coverage where 324 households with children under the age of 5 were sampled) and the other for the household assessment on the Infant and Young Child

Feeding Practice where 400 households were sampled. The first level of the sample size was for the small sample surveys for the SQUEAC and uses a two-stage screening test model which involved the hypothesis generation and thereafter testing the hypotheses through the small area surveys.

Findings

On average the coverage and access to nutrition services were satisfactory at >50% (Recommended by Sphere Standards) in four of the five districts of Garissa, Lagdera, Balambala and Ijara. Only Fafi was unsatisfactory at 45%. Highest coverage was in Lagdera at 71.4%. A large number of children had been admitted and treated during the project cycle whereby IMAM services had been integrated into the health system in Garissa County. However, due to the persisting drought, the GAM rates still remained high in March 2012 as compared to April 2011 as the baseline. The over 20% GAM in March 2012 was also attributed to poor access of health care services which meant no or late treatment of acute malnutrition and diseases such as diarrhoea, malaria and respiratory diseases. As compared to April 2011, these conditions had aggravated. There are also inadequate fully functioning health facilities in the project area. In those that are functioning, there is high staff turn-over even for those already trained in the Integrated Management of Acute Malnutrition.

As a result of strengthening the health system (a key objective of the program), the overall child morbidity declined and deworming coverage improved the same period of between April 2011 and March 2012.

Comparison of baseline findings (April 2011) and Evaluation findings (March 2012)

	April 2011 Baseline %	March 2012 (end line)
Nutritional Status and morbidity		
% Global Acute Malnutrition (GAM)- ALL	16.2	21.0
% Global Acute Malnutrition (GAM)- BOYS	17.2	22.4
% Global Acute Malnutrition (GAM)- GIRLS	15.1	19.6
% Moderate Acute Malnutrition (MAM)	13	17.7
% Severe Acute Malnutrition (SAM)- WHZ <-3	3.2	3.3
% Severe Acute Malnutrition (Oedema)	0.5	0.2

Overall child morbidity	46.1	38
Deworming	46.7	48
Infant and Young Child Feeding		
Initiation of breastfeeding within one hour	40.6	51
Given Colostrum	83.3	85
Exclusive breastfeeding for 6 months	75.7	85
Still breast feeding	77.2	78
Ever breastfed	93.7	95.6
Food Aid received in household	51.7	62.4
Pregnant and lactating women MUAC <23cm	10.8	8.9
WASH indicators		
Access to clean water	48.6	51
Access to proper sanitation	45.4	18
Practice proper hand washing	38.7	34

There was also improvement in all IYCN indicators as shown in the Table above. This was attributed to the increased caregiver education and awareness during the program period. Nutrition education was conducted both at health facility and community level. While access to clean water improved, rates of access to proper sanitation and appropriate hand washing did not – and this may have been partly due to difference in the sampling method for WASH indicators between the baseline and end line surveys. Other reasons to explain the difference are due to the increased mobility (due to drought and insecurity) which limits the use of toilets for those moving and lack of water for hand washing.

It was found that the program supported the provision of the needed (and thus relevant) services in the program area, focusing on the High Impact Nutrition Interventions (HINI). The approaches used to achieve these were appropriate and responsive to the challenges of health care system. The main approach was to scale-up integration of nutrition services into the existing ministries of health systems through support to DHMT and on the job training. The emergency nutrition needs at the time of drought (during the program) were also addressed with total of 8,724 children in SFP, 3,464 in OTP and 5,042 pregnant and lactating women reached as at March 2012.

Other programmatic achievements were:

1. Decentralization of management of acute malnutrition from the district hospital to health facility and community
2. Recovery rates, death rates and default rate for both management of severe and moderate malnutrition were all within the sphere standards at end line.

For even greater impact, it is recommended that:

1. The community mobilization and awareness strategy be extended beyond community volunteer training and leader sensitization meetings, to include creative events such as theatre and jingles, among others.
2. The number of health facilities must be increased in order to ensure that the population has adequate access to treatment. It will therefore be vital to supporting health facility teams to improve service delivery.

1.0 INTRODUCTION

This is a report on an end of program evaluation for the Emergency Nutrition and WASH Support Program in Garissa County, Kenya. The program was launched in March 2011 and ran for a period of one year. The main responsibility of the consultant was to conduct an assessment of the Nutrition and WASH projects in Garissa Ijara, Fafi, Balambala and Lagdera District of Garissa County. Garissa County is within ecological zones V and VI, which fall within the arid and semi-arid lands (ASALs) in Kenya. The ASAL is home to the poorest segments of the population who are trapped in a drought plagued and hostile environment often marginalized from the mainstream of economic activity with issues in the livestock sub sector that include low pastoral production and weak service delivery. This is attributable to unpredictable weather patterns, droughts, and floods that have direct effect on livestock feed and water supply and consequently the quality and quantity of production; forcing drop out of pastoralist who in turn created new settlements of slums where majority live in absolute poverty.

1.1 BACKGROUND INFORMATION

Mercy USA proposed the implementation of the Nutrition and WASH support intervention in Garissa County with primary funding from OFDA. This was initiated in 2011 as an emergency response on the ground supporting both facility and community-based interventions to enable a holistic approach in curative and preventive nutrition rehabilitation measures and WASH interventions for the targeted beneficiaries. The program proposed to expand existing coverage and outreach activities to enable the delivery of services to a wider population currently in need of Nutrition and WASH support within these districts. Additionally, the program provided support to the Ministry of Medical services (MoMS) and Ministry of Public Health and Sanitation (MoPHS) in the district through training of health workers and other community volunteers. The MoMS and MoPHS capacity to provide nutrition rehabilitation services within its health facilities is limited, hence this program had been designed to strengthen existing health systems to adequately provide nutrition and WASH support to vulnerable groups within the community.

The main focus areas of the Nutrition program was to address integrated management of moderate and severe acute malnutrition, support to the MoMS and MoPHS at the district level through training,

supervisory support and mentoring of health workers, and the promotion of behaviour change at the community level through nutrition education activities. WASH interventions focused on; conducting hygiene promotion at community and school levels, providing safe water to school children through construction of rainwater harvesting tanks, installation of sanitation facilities which included hand washing stations and pit latrines.

1.2 PURPOSE OF THE EVALUATION

The purpose of the evaluation was to conduct a summative assessment of the Nutrition and WASH projects in Garissa, Ijara, Fafi, Balambala and Lagdera district within Garissa County. The evaluation was based on the program objectives.

1.2.1 Broad Objective

The goal of this project is to provide access to nutrition rehabilitation services for vulnerable children <5 and Pregnant and Lactating Women (PLW), as well as WASH interventions for children in selected schools.

1.2.2 Specific Objectives

1. To establish the relevance of project objectives and activities towards meeting the needs identified within the community
2. To establish coverage of the program activities; whether specific needs to be addressed were met.
3. To assess the coherence of the program in relation to other interventions in the geographical area of implementation.
4. To establish efficiency (the cost, speed and management efficiency with which inputs and activities were converted into results and the quality of the results achieved)
5. To assess the impact of the project on its wider environment.
6. To assess the effectiveness of the contribution from the project results and how assumptions have affected the project
7. To assess the sustainability of the project activities and likelihood of continuation of the benefits produced by the projects to the beneficiaries.
8. To assess IYCN practices and knowledge gaps in the target communities
9. To assess the coverage of WASH interventions

1.2.3 Focus Areas:

1. Conduct a coverage assessment of the nutrition and WASH activities in line with recommended methodology.
2. Assess the prevailing knowledge, attitude and practice of the target community pertaining to nutrition education and IYCN focus areas such as exclusive breastfeeding, complementary feeding, feeding of sick or malnourished child, health seeking behaviour, micronutrient supplementation, WASH etc.
3. Assessment of processes and systems used by Mercy USA program staff to ensure effective implementation of the program inputs to achieve the desired outcome.
4. Assessment of involvement of all the stakeholders, particularly women, youth and minorities in design, planning, implementation and monitoring stage.
5. Evaluate the integration of cross cutting issues into program activities; gender relations, protection mainstreaming, infrastructure rehabilitation, capacity building/training.

2.0 METHODOLOGY

This was a cross sectional descriptive evaluation study involving both quantitative and qualitative methodologies. There was a desk review of program documents such as program proposal, reports and literature search to inform the quality improvement approaches and applications to such programs. Quantitative methods were used to determine whether the project has achieved sustainable outcomes and impacts. This involved the household survey for the IYCF and the SQUEAC methodology (Semi-Quantitative Evaluation of Access and Coverage) to evaluate access and coverage.

The qualitative methods were employed to assess the quality of the program, efficiency and effectiveness of the program. It also gave the perception and views of the beneficiaries about the Nutrition and WASH program. Furthermore, this evaluation provides recommendations for consideration during the continuation or scale up for other related programs.

2.1 STUDY POPULATION

The study population for the evaluation included care providers, mothers with children under five years of age, pregnant and lactating women. However the unit of analysis was the households with children under five years in the five districts. The survey targeted children 0-59 months and women of reproductive age (15-49 years). The care givers of the children who were not covered in the program were also interviewed to give their reasons for the child's non-attendance. For the WASH program, the schools were sampled as the population and focus was on; the provision of safe water, hand-washing practices and the change in behaviour with regard to water, hygiene and sanitation.

2.2 SAMPLING METHOD AND SAMPLE SIZE DETERMINATION

The SQUEAC (Semi-Quantitative Evaluation of Access and Coverage) methodology was used. The data collected from routine program data and anecdotal data, when combined, provided information about coverage as well as the likely barriers to service access and uptake that exist within a program. This information can be considered as a set of hypotheses that can be tested. The SQUEAC method uses small-area surveys to confirm or deny these hypotheses. The SQUEAC small-area survey was determined by the coverage of the samples areas. For the satisfactory areas, 10% sample was used while for the unsatisfactory areas 50% was covered.

There were two levels of sample size calculation one for the SQUEAC methodology and the other one for the household survey on the Infant and Young Child Feeding Practice (IYCF). The first level of the sample size was for the small sample surveys for the SQUEAC (Semi- Quantitative Evaluation of Access and Coverage) and uses a two-stage screening test model.

STAGE 1: Identification of areas of probable low and high coverage and reasons for coverage failure using routine program data readily available. Quantitative and anecdotal data was collected with little additional work.

STAGE 2: Confirmation of the location of areas of high and low coverage and the reasons for coverage failure identified in Stage 1 using small-area surveys. SQUEAC small-area surveys use the same in-community sampling and data-collection methods as CSAS surveys. Cases were selected using an active and adaptive case-finding method. Whenever a case is found the caregiver was asked whether the child is already in the program. A short questionnaire was administered if the malnourished child was not already in the program. The criteria for assessing coverage was that it had to be regarded as below the SPHERE minimum standard for coverage of therapeutic feeding programs in rural settings of 50% due to:

- a) A mismatch between the program's definition of malnutrition (i.e. anthropometric criteria and problems of food security) and the community's definition of malnutrition (i.e. as a consequence of illness, particularly diarrhoea with fever).
- b) Patchy coverage of outreach services particularly with regard to the on-going follow-up of children with marginal anthropometric status.
- c) Distance to OTP sites and other opportunity costs.

A small-area survey was undertaken in this area to confirm this hypothesis. This survey involved using active and adaptive case-finding in all villages in the area identified in and the application of a questionnaire similar to caregivers of non-covered cases found by the survey. Analysis of the collected data confirmed that coverage in the identified area is likely to be below 50%.

The second level of sample size calculation was for the household survey on the Infant and Young Child Feeding (IYCF), which employed the following formulae to determine sample size for the study.

$$n = \frac{N}{1 + N(e)^2} \quad (\text{Eqn 1})$$

Where;

n=the desired sample size

N= the population size (Estimated number of children under 5 years in Garissa County -66,267)

e=the level of precision (5%)

$$n = \frac{66,267}{1 + 66,267(0.05)^2} = 398 \quad (\text{Eqn 2) (Households for the IYCF and other qualitative$$

assessment information)

n=398 which was rounded off to 400 to address any absenteeism, transfers and any form of attrition (Yamane 1967). The survey targeted 724 households with mothers 15-49 years of age with at least one child under 5 years of age. The 724 households were proportionately distributed in the five districts. The households were selected from the catchment of randomly selected health facilities. The household survey sample was 398 rounded off to 400 and the 324 was the SQUEAC sample adding up to 724 households.

The qualitative sampling method and techniques that were involved were mainly purposive sampling and involved KII and FGDs methodologies. Using the Lot Quality Assurance Sample (LQAS) from the 5 districts, the average coverage assessment of 64 children per district giving a total of 324 children. This survey used cluster sampling. The various villages formed the clusters within a sub-location, villages were listed and 36 clusters were randomly selected from the list. The total number of households targeted per cluster was 20.

2.3 HOUSEHOLD INTERVIEW

Structured questionnaires were administered to 724 randomly sampled households with caregivers 15-49 years old who have children under the age of 5. The aim of household interviews was to collect information on the quality of nutrition and health services provided, intervention strategies implemented, perceived impact of activities, success stories and the achievements, gaps and limitations of the activities as well as existing opportunities for action.

2.4 SELECTION OF HOUSEHOLDS

Each survey team moved to the centre of the assigned cluster. At the centre, a pen was span to determine the direction to be followed to identify households to be surveyed. The selection of the

first household was random and from this, successive households were picked by random walk until 20 households were covered.

2.5 KEY INFORMANT INTERVIEWS (KII)

The aim of the qualitative interviews was to assess the quality of the program, efficiency and effectiveness of the program. A total of seventeen (17) KIIs were done, 5 KII with District Nutrition Officer (DNOs), 3 KII with Head Teachers/committee members, 4 KII with the MOH staff especially the catchment health facilities and 5 KII with Mercy USA staff supporting this program.

2.6 FOCUSED GROUP DISCUSSIONS (FGD)

An FGD guide was used to collect data in the FGDs. A total of 18 FGDs were conducted with caregivers and mothers. The discussions explored views regarding the quality of Nutrition, WASH and Health services provided by the program and their recommendations for improvement.

2.7 OBSERVATION

On site observation was done with the aid of a checklist. The observation was based on the physical appearance especially of the children, service delivery at the health facility, water points provided in the schools and the records at the health facilities. The assessment was carried out at different levels as shown in the sample size table.

Sampling frame

Districts	Divisions	Health facilities	KII	FGD	Household Interview
5	10	5	5DNO 3H/Teacher/ Committee 4 MOH 5Mercy USA staffs	18 with caregivers	724 mothers with children under 5
5	10	5	17KIIs	18 FGDs	724 Households

2.8 DATA COLLECTION TOOLS

Data to be derived from this survey focused on anthropometric measurements and other indicators relevant to nutrition status such as IYCN, household food security, morbidity and other High Impact Nutrition Interventions (HINI). Data collection tools included structured and semi-structured tools that were pre-tested by the consultant. Data was triangulated by both source and method. Data from anecdotal sources and methods was also triangulated with routine program data and data from previous baseline survey.

2.9 ENUMERATORS SELECTION AND TRAINING

The plan for data collection started immediately with the identification, selection and training of enumerators. We had 8 members in each team consisting of 2 supervisors, 1 team leader 5 enumerators for each of the 5 districts. The enumerators were recruited from the community and trained to ensure quality data. The criterion for selection was that enumerators had to be locals who understood the local Somali language and also had technical knowledge in health. They included nutritionists, nurses and Public Health Officers with fluency in both English and local language. The District Health Management Team (DHMT) was also involved in mobilization for quality data collection. The participatory 2 day training culminated in a return demonstration of the data collection exercise amongst the enumerators in order to identify some of the challenges expected and also to assess the level of success of the training.

The pre-test was done on the third day at Bula Iftin which was out of the target survey area. The successful trainees were then considered for data collection exercise with supervision to ensure maintenance of quality and consistency.

2.10 DATA CLEANING

Data was cleaned in two phases. The first cleaning was done immediately from the field where the data collection tools were cleaned on a daily basis. The tools were sorted out according to their categories. The questionnaires were checked for completeness, clarity and the right coding. The second phase of cleaning was done after quantitative data had been entered in the computer.

2.11 DATA ANALYSIS

Quantitative data was analysed using Statistical Package for Social Scientists (SPSS) software (version 19.0, Chicago, Illinois, USA). ENA for SMART 2010 was used to analyse anthropometric data, other data sets and variables collected especially from the IYCF were analysed through the SPSS Version 19. Manual analysis of qualitative data from KIIs and FGDs included coding, summarizing, categorizing, direct quoting, comparisons and manually by theme and sub themes.

3.0 FINDINGS AND ANALYSIS

3.1 DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

A total of 724 households were surveyed with total of 3,735 household members. Each household had an average of 5 household members. Majority 89.8 % (650) of the household heads respondents were male, only 10.2 % were female. Most of the respondent 83 % had no education; only 4.3 % and 2.8 % had some primary incomplete and primary complete education respectively.

Majority of the household members were children under 5yrs 38.2 %. This was the general population covered by the survey in the 724 households. Only 39.9 % of the household members had some form of income as compared to 60.1 % (2244) who were under 24 years indicating a high dependency ratio in households . Fig. 1 below illustrates the household members age by sex.

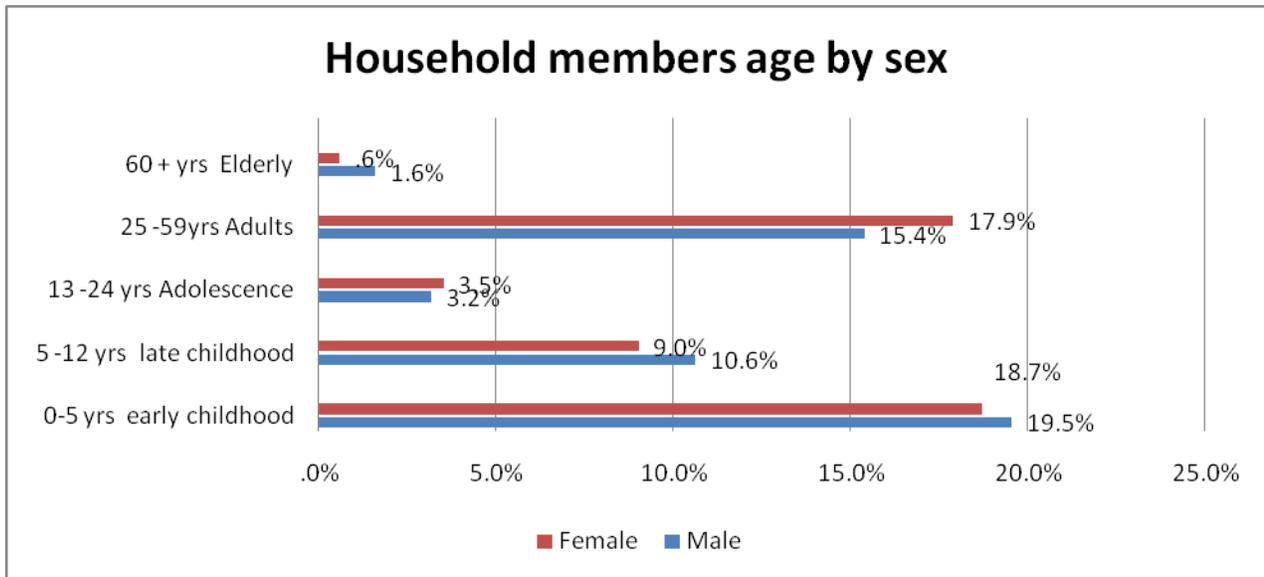


Figure 1: Household member's age by sex

3.2 RELEVANCE OF PROJECT OBJECTIVES AND ACTIVITIES TOWARDS MEETING THE NEEDS IDENTIFIED

The involvement of all the stakeholders, particularly women, youth and minorities in design, planning, implementation and monitoring stage made the project relevant as these provided an opportunity for their inputs in design in their own perspective.

3.2.1 Relevance of Program Components

The program primarily targeted children under 5 years of age and pregnant and lactating women (15-49 years). The Health and Nutrition intervention services package offered to the children with nutritional needs include Outpatient Therapeutic Programs, Supplementary Feeding Program, Inpatient Program(SC), Micronutrient supplementation (iron and folate for pregnant women, Vitamin A supplementation, Zinc), de worming, immunization, growth monitoring, IYCN through individual counselling and community nutrition and health education. Referral systems for children with nutritional needs were done in the community by the Community Health Workers to the health facility. Feedback documentation is done at the health facility. No payments are charged for referrals.

3.2.2 Approaches Being Used to Identify the Beneficiaries

The identification of beneficiaries at the outreach sites and in health facilities was guided by the program guidelines under the IMAM and HINI approach, which define admission criteria for beneficiaries and other groups to be reached by the interventions. It was observed that there was an

integration of nutrition services with Primary Health Care (PHC) services at government health facilities.

The CHWs identifying beneficiaries in their area were trained to apply the criteria and procedures in accordance with the established IMAM and HINI guidelines. Malnourished children were referred to the health facilities and verified by the health workers through facility assessment (anthropometric measurements and clinical observations). At facility level Mercy USA supported the MoPHS in the provision of accessible health care through different approaches. One of them was through the community outreaches. A total of 60 outreaches were identified and supported in consultation with the District Health Management teams (DHMTs), 12 outreaches per district for the 5 districts. The organization had provided on the job training for the health workers at the health facilities, training them on HINI. This included 76 health workers and 84 CHWs.

Mercy USA supported joint supervision with the DHMTs. Mercy USA also supported the facility to engage 2 CHWs at each of the health facilities in Garissa County to help in implementation of the nutrition program. Quarterly review meetings were held in each facility. This was quite relevant in strengthening the functionality of the district health care system at community level.

3.2.3 To what extent does the program address the needs of beneficiaries?

The program managed to reach a vast number of households with children in need of nutrition support. As at the end of March 2012, a total of 8,724 children in SFP, 3,464 in OTP and 5,042 pregnant and lactating women in SFP were reached with nutrition interventions. A total of 3,200 children attending school in Early Childhood Centres (ECD) were also reached by the interventions. While most OTP sites seemed to be well and convincingly rooted in their communities and familiar with the needs and those most in need (*observations by evaluators*), explicit evidence of needs assessments was presented and noted by the evaluators from the desk review of the program records and verification during the field visits.

The Nutrition and the WASH projects are quite relevant. They met the needs of the community especially in addressing malnutrition among the under 5 years of age and also improving accessibility of water and sanitation facilities in schools. In the four schools visited it was noted there was improved hygiene practices and the increased access to clean and safe water.

3.2.4 Relevance of the Approach

This approach was chosen based on a previous study (baseline survey 2011) acknowledging the existence of local responses. The baseline survey found out there was a need for capacity building for health workers to effectively provide nutrition and health services to the vulnerable groups. There is apparently a continued need of strengthening local responses to nutrition care and support, through capacity building of CHWs and the health facility staff.

3.2.5 Coverage of the program activities: were specific needs to be addressed met?

The program addressed the immediate needs of the beneficiaries. The beneficial interventions included; health education, micronutrient supplementation, outpatient therapeutic program, supplementary feeding, screening, de worming, immunization and WASH interventions (supply of safe water, provision of sanitation facilities and hygiene promotion).

Access and coverage of Nutrition services

Table 1: Results from the small-area surveys of the SQUEAC

Results from five small-area surveys from the first SQUEAC use								
OTP Site	True Coverage	Cases Found (n)	Covered Cases (c)	D	$\frac{c}{n} \times 100$	Is c > d?	Classified Coverage	Comments on coverage
Garissa	> 50%	14	8	7	57	Yes	> 50%	Satisfactory
Lagdera	> 50%	7	5	2	71.4	Yes	> 50%	Satisfactory
Mbalambala	< 50%	15	8	7	53	Yes	> 50%	Satisfactory
Fafi	< 50%	20	9	11	45	No	< 50%	unsatisfactory
Ijara	> 50%	6	4	2	66.7	Yes	> 50%	Satisfactory

On average the coverage and access to nutrition services was satisfactory in all the four districts apart from Fafi district based on the sphere minimum for the rural population which is 50%.

3.2.6 Reasons for defaulting (Non Attendance)

The mothers/care givers of the children were asked about the reasons for the non-attendance. The responses are depicted in the figure below. The caregivers of children who had not attended were asked to give a view of their perspective with regard to their non-attendance.

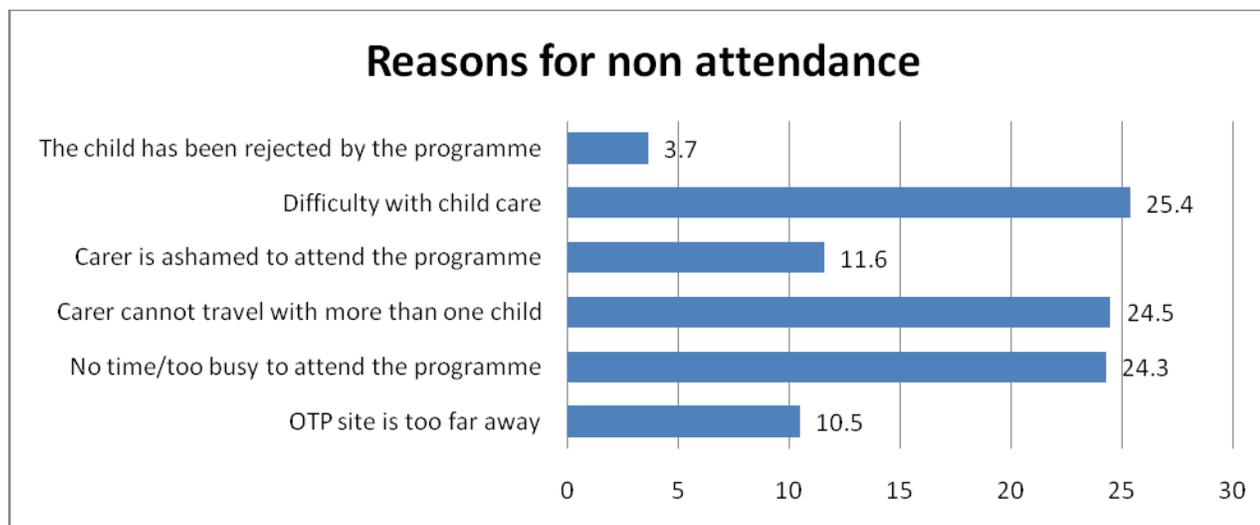


Figure 2: Reasons for defaulting Non Attendance.

The majority of the care givers (75%) had expressed mainly three reasons for their non-attendance. Those who expressed difficulty with child care were 25.4% while some expressed that they did not have time or were too busy to attend(24.3%) and 24.5% said that they could not travel with more than one child.

3.3 COHERENCE OF PROGRAM IN RELATION TO OTHER INTERVENTIONS IN THE GEOGRAPHICAL AREA OF IMPLEMENTATION

Coherence is the integration of relief activities to policy and practice changes needed to address root causes. This refers to the integration of cross cutting issues into program activities; gender relations, protection mainstreaming, infrastructure rehabilitation, capacity building/training.

All Key Informant interviews (KIIs) done with the MoMS/MoPHS reported they had been trained on HINI through classroom training and on job training by different organizations including Mercy USA in collaboration with MoPHS.

The integration of the interventions has been coherent as was outlined in the program proposal in 2011. The implementation of Nutrition and WASH services, Capacity Building / Training and the community involvement complimented each other well.

The direct beneficiaries of nutrition interventions were children under the age of 5. A total of 15,560 children were reached with both Nutrition and WASH interventions. The main focus was to address their current state of malnutrition, reduce levels of malnutrition and prevent future incidences of the same among this vulnerable group through various curative and preventive approaches outlined in HINI. WASH activities at school level were also found to be complimentary to this approach.

With regard to Capacity Building / Training, Mercy-USA provided training to health workers on key areas of nutrition included in HINI and WASH (Participatory Hygiene and Sanitation Training – PHAST) and linked this to IMCI protocol which was also integrated well through the HINI approach. This has improved the capability of health workers to effectively carry out program activities and to provide reflective and accurate reporting on the same.

An integral part of the project was to build the capacity of local communities through training in health and nutrition issues so that they are able to reinforce best practices at the home and community level. Mercy USA staff has been conducting quarterly nutrition and WASH education sessions at facility level which was the main mechanism for community education. At least 3 community sessions were conducted in majority of facilities covered. It was however noted from information through KIIs that there were some challenges especially insecurity in some locations that made it difficult to execute these sessions.

This program has enhanced linkages with CCC, MCH, ANC and other outpatient clinics within the hospitals and health centres that have enabled early nutrition support to the targets, providing them with nutrition education services. From the KII with the DHMTs, they acknowledged this support through the capacity building component of the program to health workers which in turn improved case management at facility level.

3.4 THE IMPACT OF THE PROJECT ON ITS WIDER ENVIRONMENT

The program has integrated well with other stakeholders particularly the community and MoPHS and MoMS. In terms of gender the CHWs training has empowered women, youth and minorities in design,

planning, implementation and monitoring stage. From the KIIs, the key impacts attributed to the program included promotion of health education, promotion, adaption and improved hygiene and sanitation practices in the community as well as reduced malnutrition in the community.

3.5 THE SUSTAINABILITY OF THE PROJECT ACTIVITIES AND LIKELIHOOD OF CONTINUATION OF THE BENEFITS PRODUCED BY THE PROJECTS TO THE BENEFICIARIES

From all the KIIs, informants stated that the nutrition services can be sustained.

The challenges mentioned by the KII included; increased workload to the health workers, inability to meet the target coverage, lack of mobilization and integrating the nutrition with other programs like WASH and HINI.

Capacity building the health workers and hiring a nutritionist would enhance sustainability. Providing more bicycles would also enhance sustainability by improving the means of transporting during the outreaches. Adhering to the MoMS/MoPHS policy and involving the DHMT during the program implementation process.

3.6 THE EFFICIENCY OF THE NUTRITION SUPPORT AND WASH PROGRAM

The efficiency element compares the cost, speed and management of resources with which inputs and activities were converted into results and the quality of the results achieved. This section reflects on the processes and systems used by Mercy USA program staff to ensure effective implementation of the program inputs to achieve the desired outcome. The KII stated that the cost of running the services was fairly expensive in all aspects in terms of material, personnel and logistics. The time allocated for the program is not enough.

3.6.1 Cost Effectiveness

The financial management report gives details of the variability of cost effectiveness among Mercy USA program activities, with several examples. The evaluation found that the following factors influenced cost effectiveness:

- Longer term presence; this was evident by the engagement with already existing government structures,

- Slow scale up; the integration of the nutrition and PHC services was done well, few expatriates, local implementation partners and existing relationships and knowledge of environment.
- Active partners and technical competence.
- The last factor, technical competence, is an important one that is only indirectly referred to in the financial management report.

3.7 THE EFFECTIVENESS OF THE CONTRIBUTION FROM THE PROJECT RESULTS AND HOW ASSUMPTIONS HAVE AFFECTED THE PROJECT

This section focused on the knowledge, attitude and practice of the target community pertaining to Nutrition education and IYCN focus areas such as breastfeeding and complementary feeding, feeding of sick or malnourished children, health seeking behaviour, Water Sanitation and Hygiene promotion and micronutrient supplementation.

3.7.1 How assumptions have affected the project

The main assumptions upon which this project was implemented were that:

- UNICEF and WFP were to continue providing supplies for the nutrition services and no interruption in the delivery of supplies was to be experienced.
- During the project period, no new natural calamities of significant effect that could influence the outcome of the project as planned would be experienced, thus the expected outcomes and benefits would be achieved.
- The impact of the current climatic and food security disaster on the target population would not be compounded by further disasters related to natural elements.
- There was to be adequate funding, human resources, facilities and supplies in the sites throughout the program period to ensure timely service delivery to the intended beneficiaries.

Some of the assumptions affected negatively or positively the achievement of results, for instance,

- Mercy USA received additional funding during the implementation of the program that enabled scale up of activities such as outreaches.

- There was heightened insecurity especially from the Al shabaab threat that resulted in suspension of activities in some locations towards the end of 2011 that slowed down progress.
- Natural calamities such as rains made some places inaccessible for service delivery due to impassable roads.

3.8 KAP ON IYCN

3.8.1 Breastfeeding

Practices of initiation of Breastfeeding

Slightly more than half of the caregivers 51.3 % indicated that the child was put on breast milk within half an hour after birth.

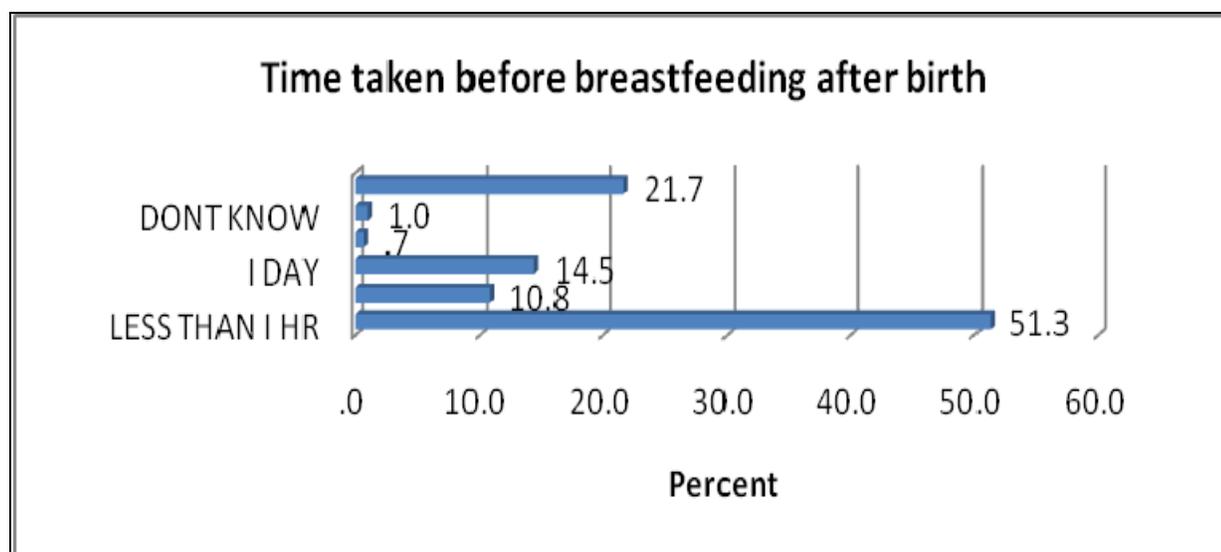


Figure 3: Time taken before breastfeeding the child after birth

Table 2: Reasons for not initiating breastfeeding

Reasons for not breastfeeding	Percent %
No milk	51.3
Did not want to/child refused	19
Traditional beliefs	6.3
medical advice	9.5
mother died	4.8
The child was sick	9.1

Of the mothers who never breastfed their children (51.3%) indicated that it was because of lack of milk while 19% said they (children) just did not want to breastfeed. (Multiple response question)

3.8.2 Pre lacteal feeding practices

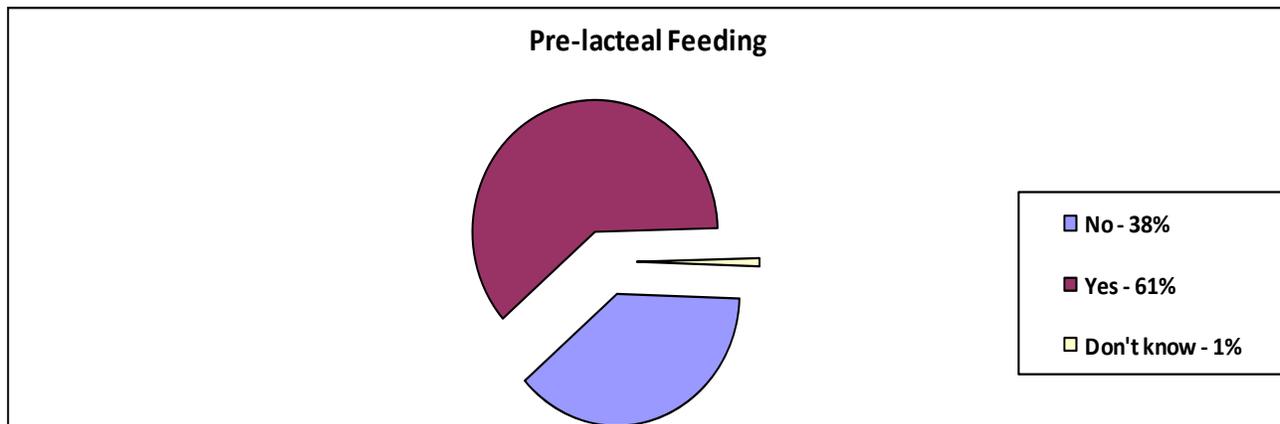


Figure 4: Pre-lacteal feeding

The study revealed that 61% of the caregivers gave other feeds to new-born babies before initiating breastfeeding, 38% did not give pre-lacteal feeds and 1% did not know whether the children had been given pre-lacteal feeds.

3.8.3 Practices of feeding infants with colostrum

The study revealed that 92% of mothers fed the infants with colostrum, 7% did not feed the infants with colostrum while only 1% did not know.

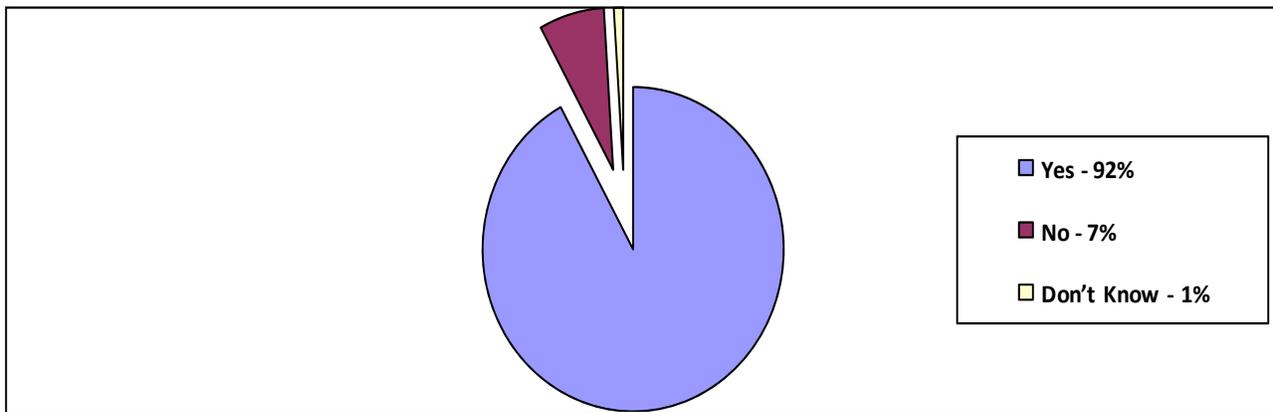


Figure 5: Practices of feeding infants with colostrum

3.8.5 Knowledge on Initiation of Complimentary Foods/ Weaning

Majority of the caregivers, 53% said weaning should start at six (6) months, 36% said at 1 year, 4% said it should start at 3 years and 7% did not know.

3.8.6 Practices of Initiation of Complimentary Feeding/Weaning

The survey found out that 51% of the caregivers initiated complimentary feeding / weaning when the child was six months old, 32% of them started weaning at two years , with 12% at three years and 5% did not know.

3.8.7 Twenty four hour recall on fluids given to children aged 6 to 24 months.

Table 3: Table shows twenty four hour recall on fluids given to children aged 6 to 24 months

Supplementary feeding	Percent %
Infant formula	5.8
Other milk	75
Sweetened flavoured juice	18.5
Oral rehydration salt	8.3
Tea/coffee	7.7
Plain water	53.3
Thin Porridge	43.9

Chicken/egg soup	7.8
Enriched porridge	67.8

67% of young children aged 6 to 24 months were fed with porridge in the last 24 hour recall period. The study also revealed that about 91.2% of these children were not given infant formula while 3% did not know. 75% of the children were fed with other milk like animal and reconstituted powdered milk. Only 18.5% were given flavoured juices.

3.8.7.1 Twenty Four Hour Recall on Solid Foods Given To Children Aged 6 to 24 Months

The study found that only 32% of children aged 6-23 six months were fed on eggs, 33% had been fed on meat, 78% of them did not feed on grains and tubers which are sources of carbohydrates, 63% were also not given vitamins, 75% were not given vegetables and 34% of these children were given oil and fats.

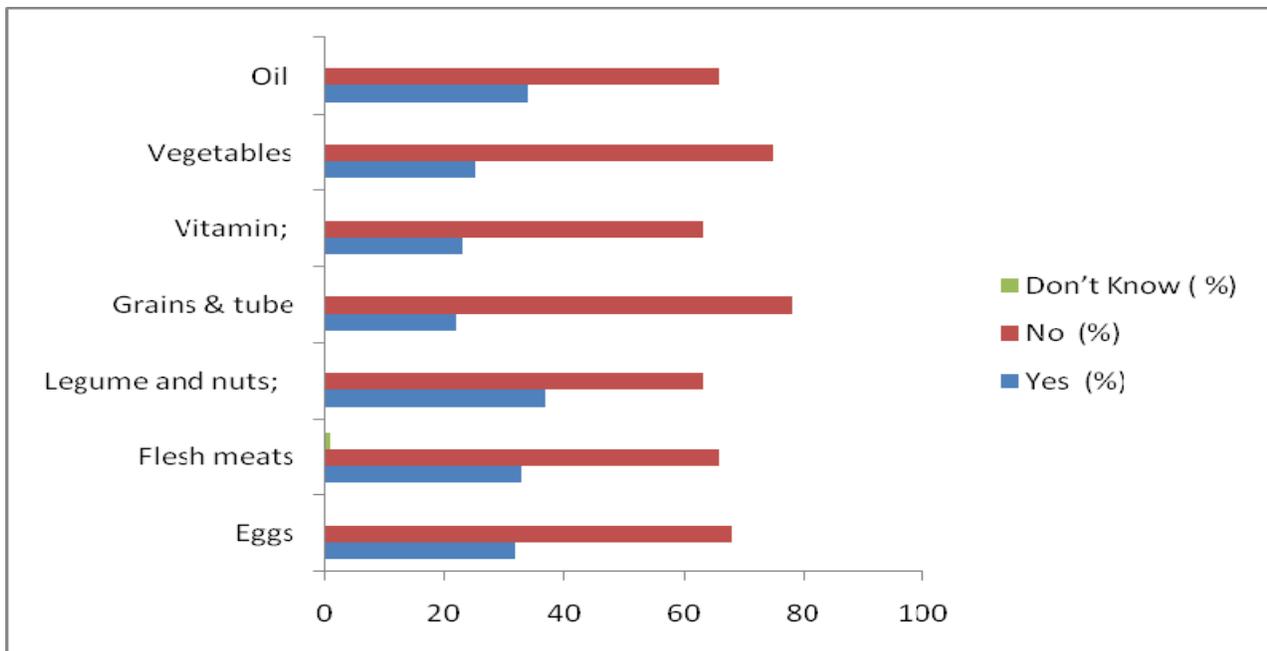


Figure 6: 24 hrs. recall on solid food given to the child

3.8.7.2 Meal Frequency (No Of Meals per Day)

Majority of the children (60%) were fed 4 times in a day while 12% was fed 3 times. Only 4% were fed 6 times.

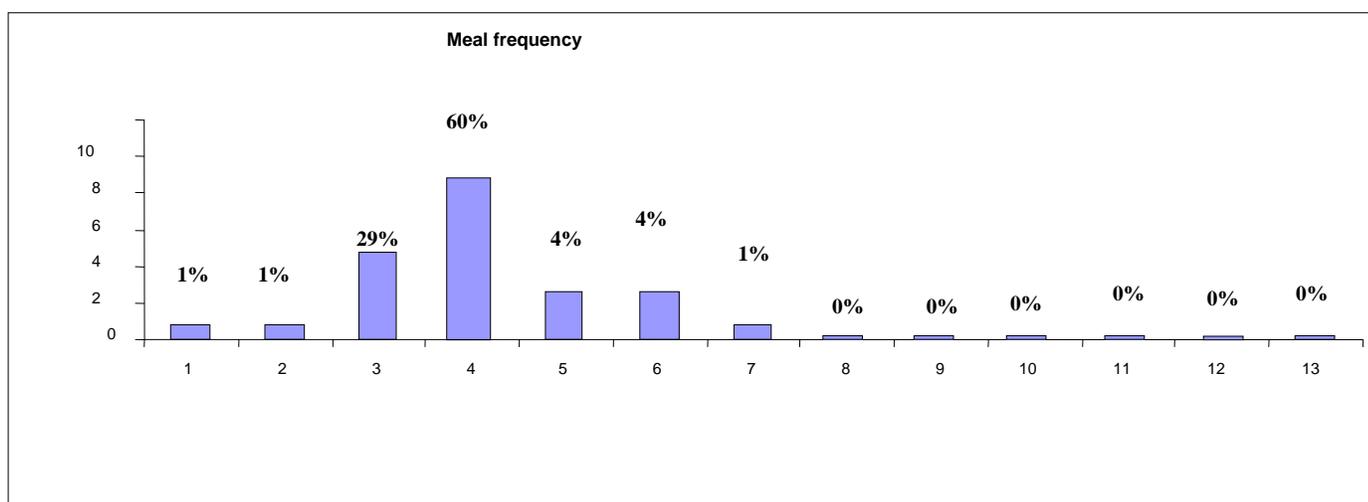


Figure 7: Frequency of meals given to the child per day

3.8.8 Household Food consumption and Dietary diversity

Table 4: HH Food consumption and Dietary Diversity

Type of foods	Yes	No	Don't Know
Cereals and cereal products (e.g. anjera, sorghum, maize, spaghetti, pasta, <i>anjera</i> , rice, bulga wheat, bread)	94.0	6.0	0
Vitamin A rich vegetables and tubers: Pumpkin, carrots, yellow fleshed sweet potatoes	62.7	37.3	0
White tubers and roots: White tubers, white potatoes, white yams , cassava or foods from roots, white sweet potatoes,	81.3	18.5	0.3
Dark green leafy vegetables: Dark green leafy vegetables such as cassava leaves, pumpkin leaves, cowpeas leaves, sukuma wiki, spinach,	41.5	58.5	
Organ meat, (Iron rich): Liver, kidney, heart or other organ meats or blood based foods , spleen	24.4	74.2	1.4
Flesh meat, Meat, poultry, offal (goat, camel, beef, poultry)	72.4	27.6	0
Eggs	53.6	46.4	0
Fish, Fresh or dried fish or shell fish or smoked , salted, fried	8.5	91.5	0
Milk and milk products, (e.g. goat , camel, fermented milk , powdered milk)	89.7	10.3	0
Oil/fats, (e.g. cooking fat or oil, butter , ghee, margarine	83.4	16.2	0.4

Sweets, Sugar, honey, sweetened juice, soda/sugary foods such as sweets, glucose	79.4	20.6	0
Condiments, spices and beverages like royco, garlic, dhania, <i>tangawizi</i> ,	77.9	22.1	0

Most respondents, 94% consumed cereal based food items as compared to Iron rich products like animal organs which only accounted for 24 %.

3.8.9 Health Seeking Behaviour

3.8.9.1 Immunization coverage

There was a marked improvement in the immunization coverage particularly in the PENTA 1 and PENTA 3 as compared to the KDHS 2008/2009, from 85.9% and 57.7% to 91.2% and 86.7% for PENTA 1 and PENTA 3 respectively.

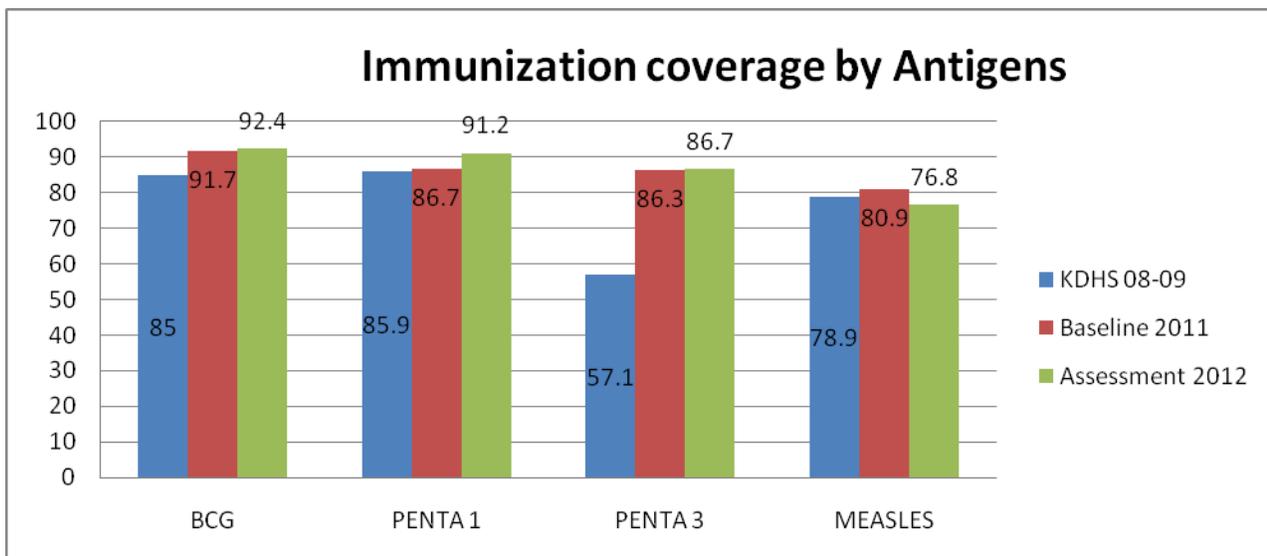


Figure 8: Immunization coverage by Antigen

3.8.10 Knowledge of feeding sick child

Diarrhoea was reported to be the leading (16.5 %) cause of morbidity among the children under five years, as compared to the least (3.8 %) which was skin infections.

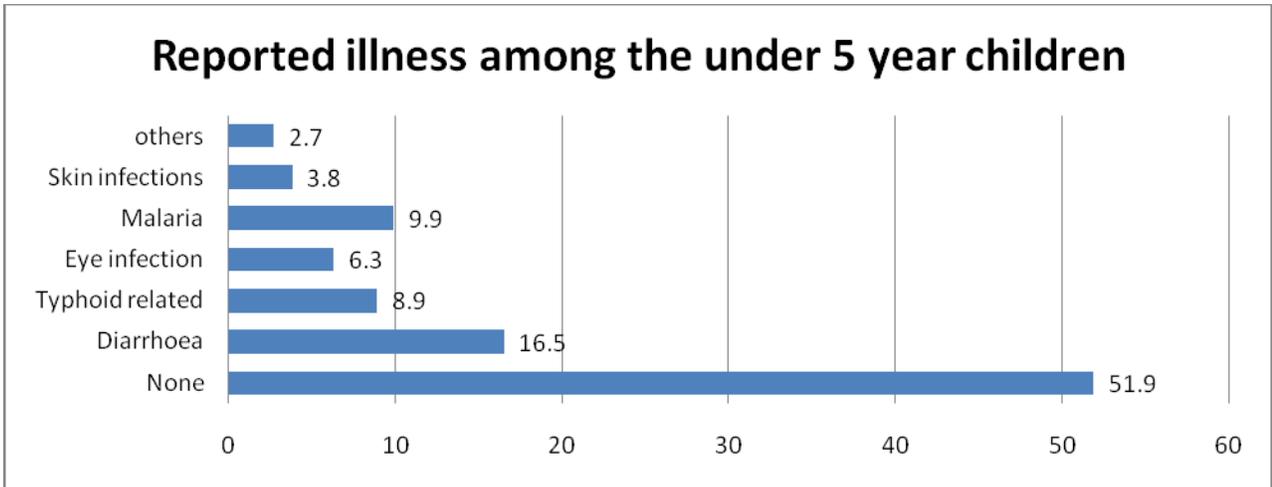
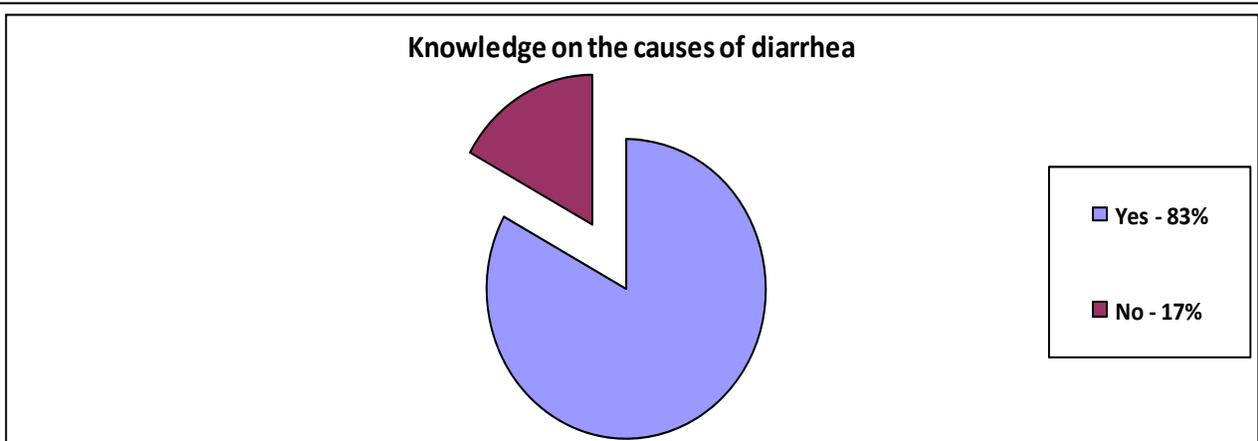


Figure 9: Reported illness among children under 5 yrs.

3.8.11 Level of knowledge of causes of diarrhoea in children

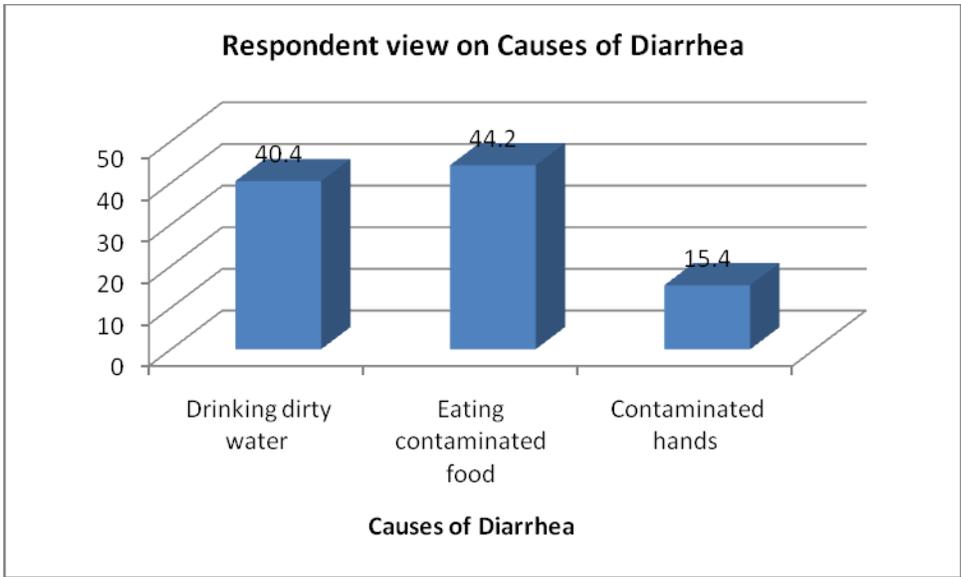
The study showed that majority of the caregivers (83%) were aware of causes of childhood diarrhoea while only 17% were not aware.

Figure 10: Knowledge on the causes of Diarrhoea



The respondents further mentioned the possible causes of diarrhoea as eating contaminated food at 44.2 % as compared to contaminated hands 15.4 %.

Fig. 13 Respondents view on the causes of Diarrhoea.



3.8.12 Intake of Vitamin A

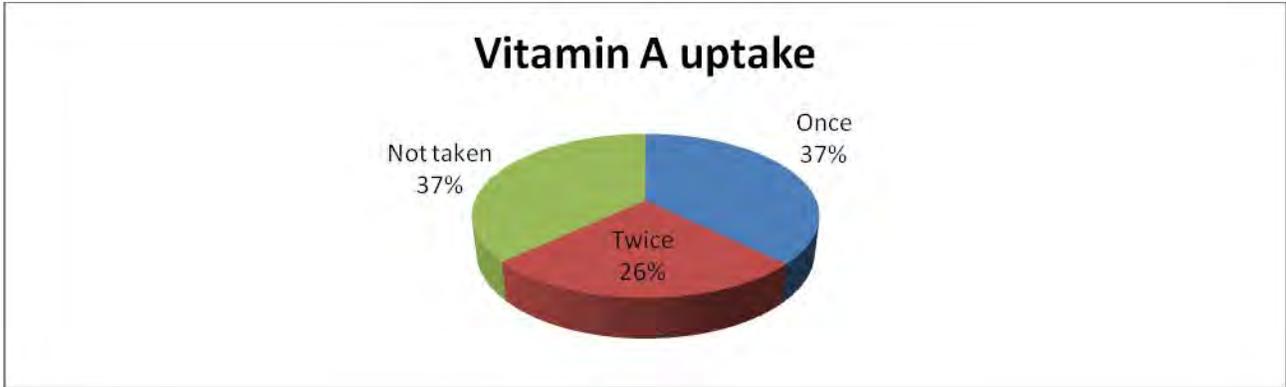


Figure 11: Vitamin A uptake

Overall, 37% of children aged 6-35 months received vitamin A supplementation once and 26 % of children aged 6-59 months received a vitamin A supplementation twice in the six months preceding the survey.

3.8.13 Iron-folate uptake

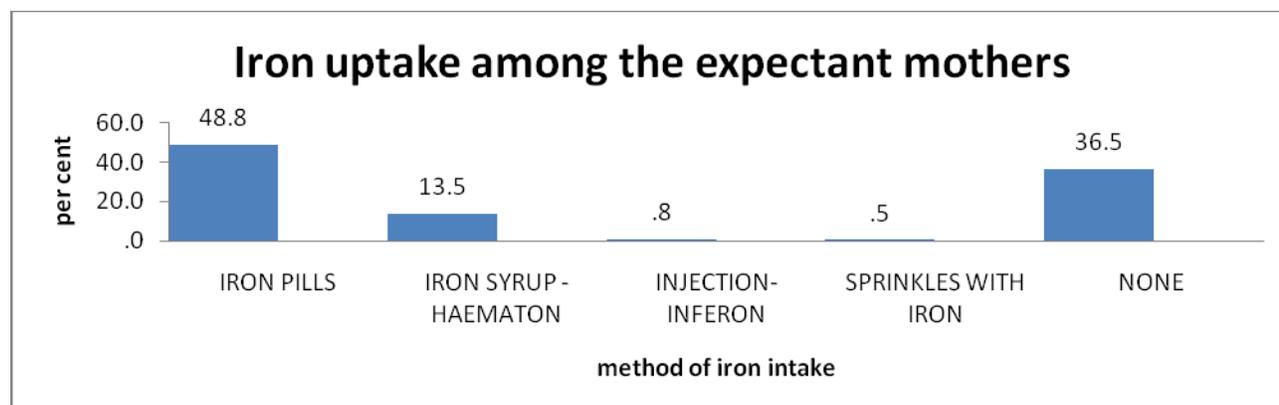


Figure 12: Iron-folate uptake among pregnant women

Nearly half (48.8 %) of the women had received iron tablets as compared to 36.5 % who had not received.

3.8.14 Prevalence of Acute Malnutrition

Due to the persisting drought, the GAM rates still remained high in March 2012 as compared to April 2011 as the baseline. The over 20% GAM in March 2012 was also attributed to poor access of health care services which meant no or late treatment of acute malnutrition and diseases such as diarrhoea, malaria and respiratory diseases. As compared to April 2011, these conditions had aggravated.

Table 5: Acute malnutrition based on weight-for-height z-scores

	All n = 508	Boys n = 268	Girls n = 240
Prevalence of acute malnutrition (<-2 z-score and/or oedema)	(107) 21.0 % (17.5 - 24.6 95% C.I.)	(60) 22.4 % (17.4 - 27.4 95% C.I.)	(47) 19.6 % (14.6 - 24.6 95% C.I.)
Prevalence of moderate malnutrition (<-2 z-score and >=-3 z-score, no oedema)	(90) 17.7 % (8.3 - 19.7 95% C.I.)	(50) 18.7 % (10.4 - 20.2 95% C.I.)	(40) 16.6% (9.9 - 18.3 95% C.I.)
Prevalence of severe malnutrition (<-3 z-score and/or oedema)	(17) 3.3 % (2.4 - 7.7 95% C.I.)	(9) 3.4 % (3.5 - 5.7 95% C.I.)	(8) 3.3 % (2.1 - 6.8 95% C.I.)

Based on the WHO 2006 growth standards, Acute Malnutrition is defined as <-2 z scores weight-for-height and/or oedema while Severe Acute Malnutrition (SAM) is defined as <-3z scores weight-for-height and/or oedema).

Table 6: Distribution of acute malnutrition and oedema based on weight-for-height z-scores

	<-3 z-score	>=-3 z-score
Oedema present	Marasmic kwashiorkor No. 1 (0.2 %)	Kwashiorkor No. 0 (0.0 %)
Oedema absent	Marasmic No. 51 (10.0 %)	Normal No. 457 (90.0 %)

Children were also classified as acutely malnourished based on the presence of oedema. For those with oedema, 0.2% had a combination of marasmus and kwashiorkor while none had kwashiorkor only. The prevalence of oedema had reduced from 0.5% in 2011 to 0.2%

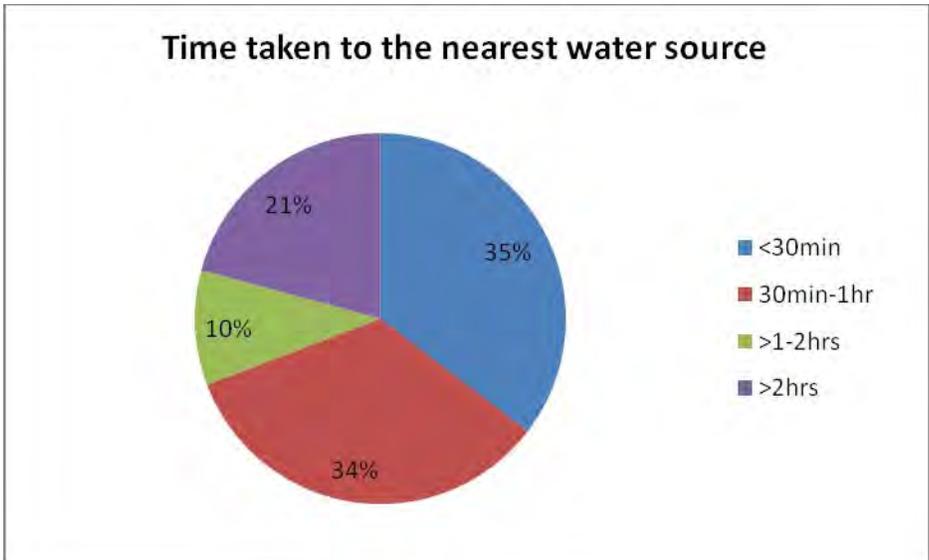
3.9 WATER, SANITATION AND HYGIENE (WASH)

3.9.1 Access to water

The findings of the survey revealed that, 25.9% of the respondents got water from the river through water vendors, and 35% got water from dams.

3.9.2 Time taken to nearest water source

Figure 13: Time taken to the nearest source of water



The findings also showed that majority of the respondents (35.4%) took less than 30 minutes to reach to the water point, 33.8% took between 30 minutes to 1 hour, 20.8% took more than 2 hours and 10.0% took between 1 and 2 hours.

3.9.3 Practices of water treatment

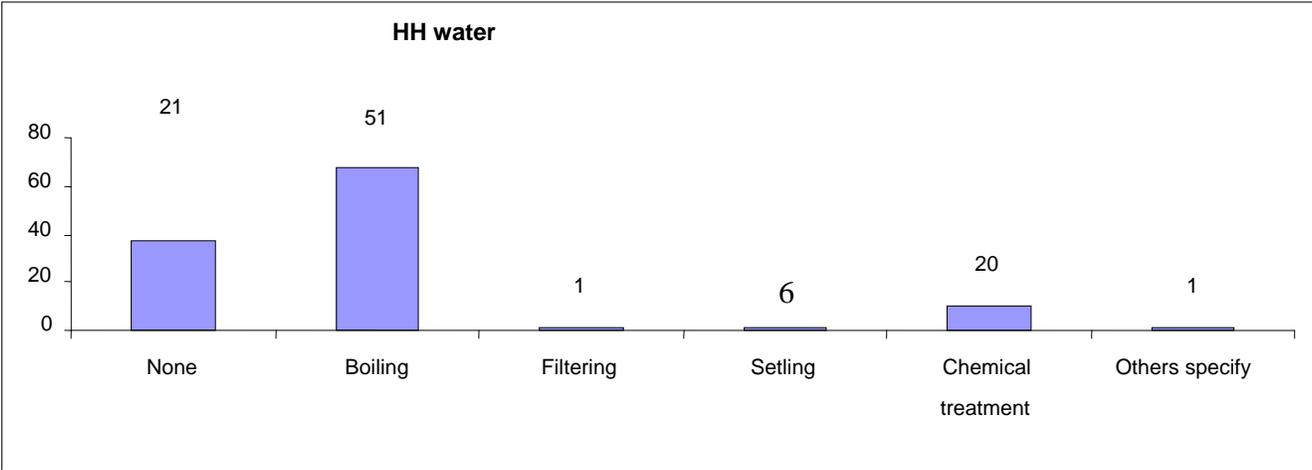


Figure 14: House hold water treatment methods

Majority of the caregivers (51%) treated water for drinking by boiling. However, 21% did not treat water for drinking. 20% use chemical treatment and 7% do filtering and settling. The treatment was due to the fact that many 92 % caregivers did not feel the water was safe.

3.9.4 Knowledge on water safety

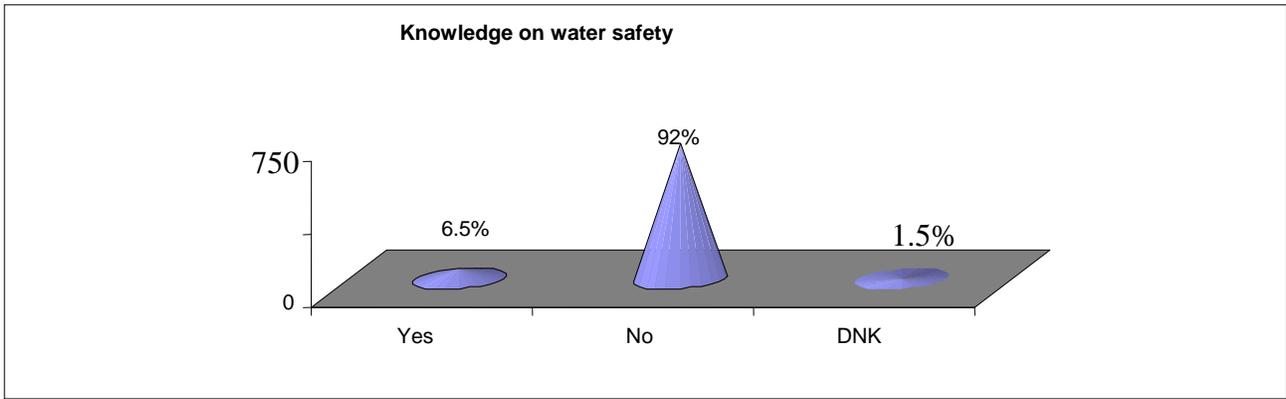


Figure 15: Respondents view on their drinking water safety

92.8% said the water they use is not safe for drinking while only 6.5% indicated that the water was safe for drinking.

3.9.5 Access and types of toilets

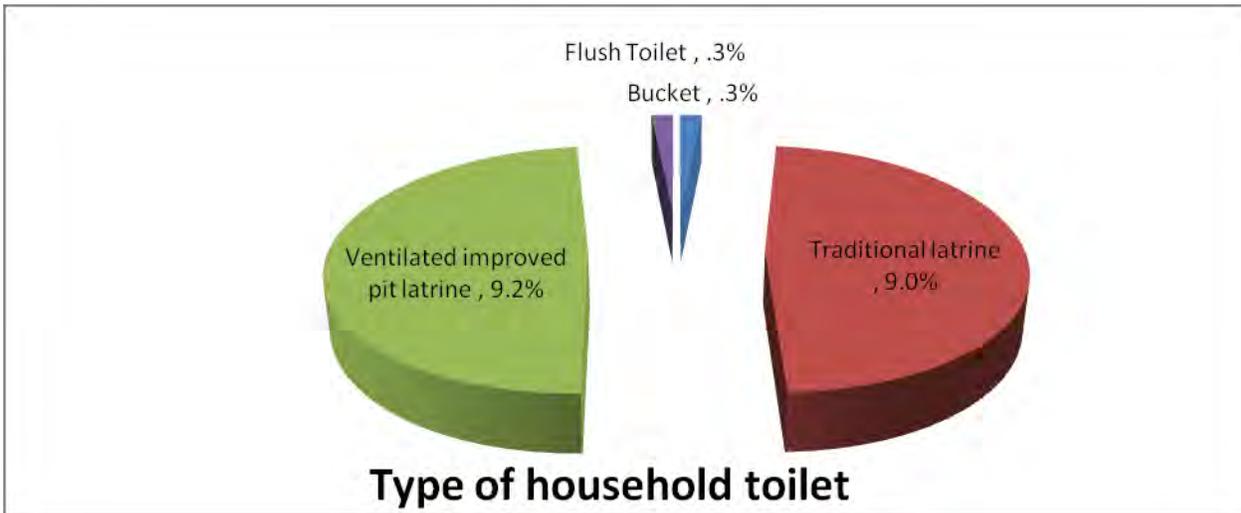


Figure 16: Type of household toilet

Only 18.8 % of households had a toilet as compared to 81.2 % who did not have a toilet and who had most probably adopted open defecation as way of faecal waste disposal. For those who had toilets, traditional pit latrine was the most commonly used toilet type at 75%. Use of bush as alternative to toilet was found to be the second popular type at 16 %.

3.9.6 Child faeces disposal methods

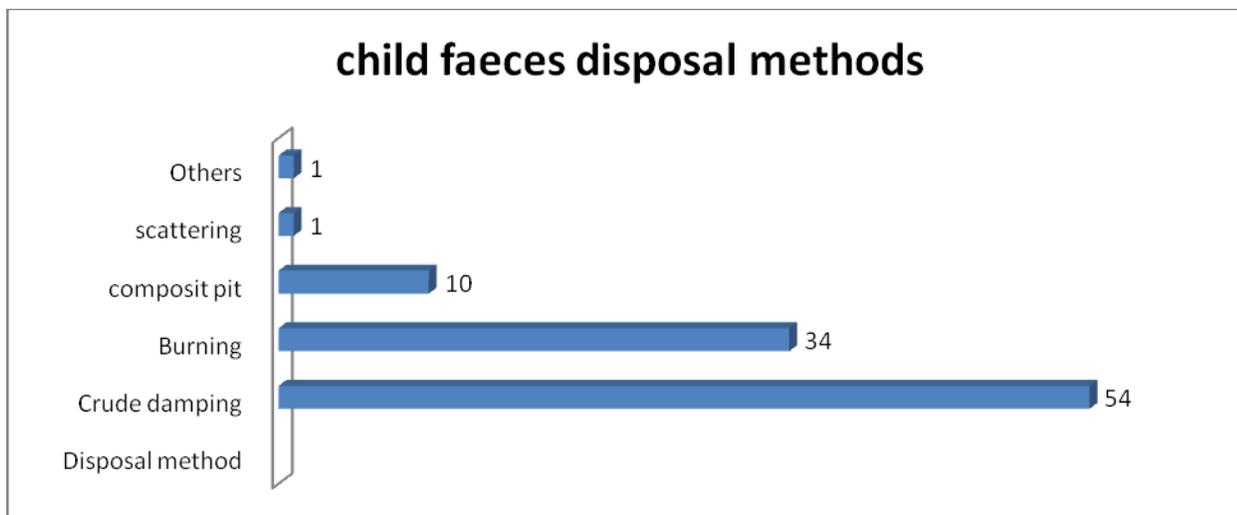


Figure 17: Child faeces disposal methods

The survey found out that close to half (44%) of the respondents disposed of children faeces hygienically (through burning and in compost pit) while 54% dumped the faeces in the nearby garbage and 1% just left it scattered in the compound (open defecation).

3.9.7 Household solid waste disposal methods

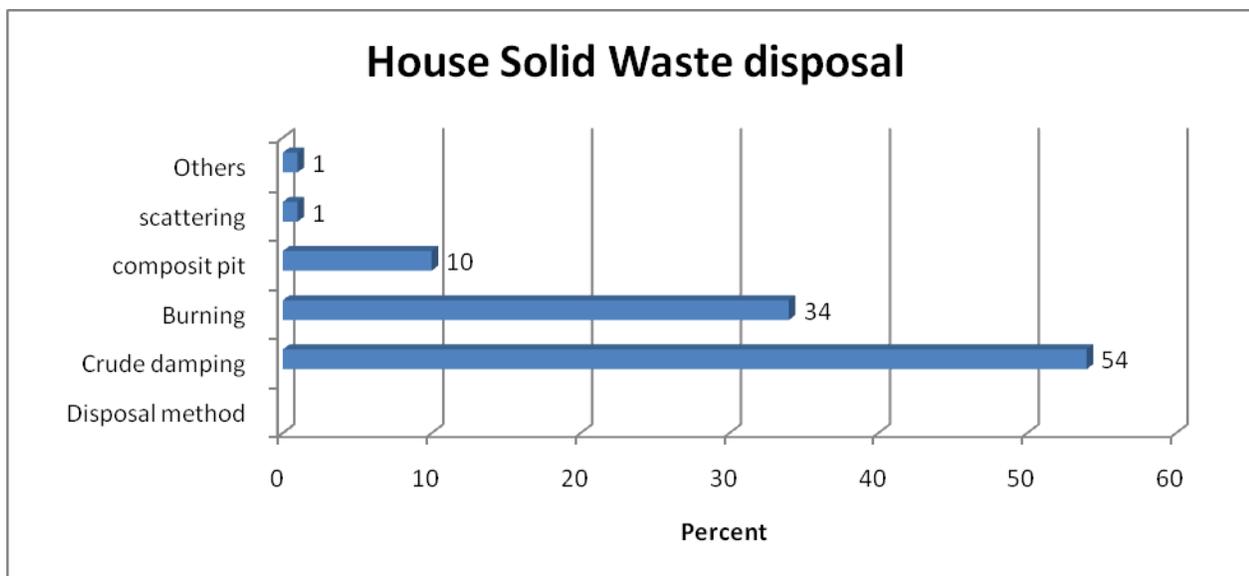


Figure 18: Household solid waste disposal

54% of the caregivers disposed HH waste by crude dumping, 34% disposed by burning, 10% by compost pits, 1% by scattering in the compound and 1% disposed by other methods.

3.9.8 Hand washing practices

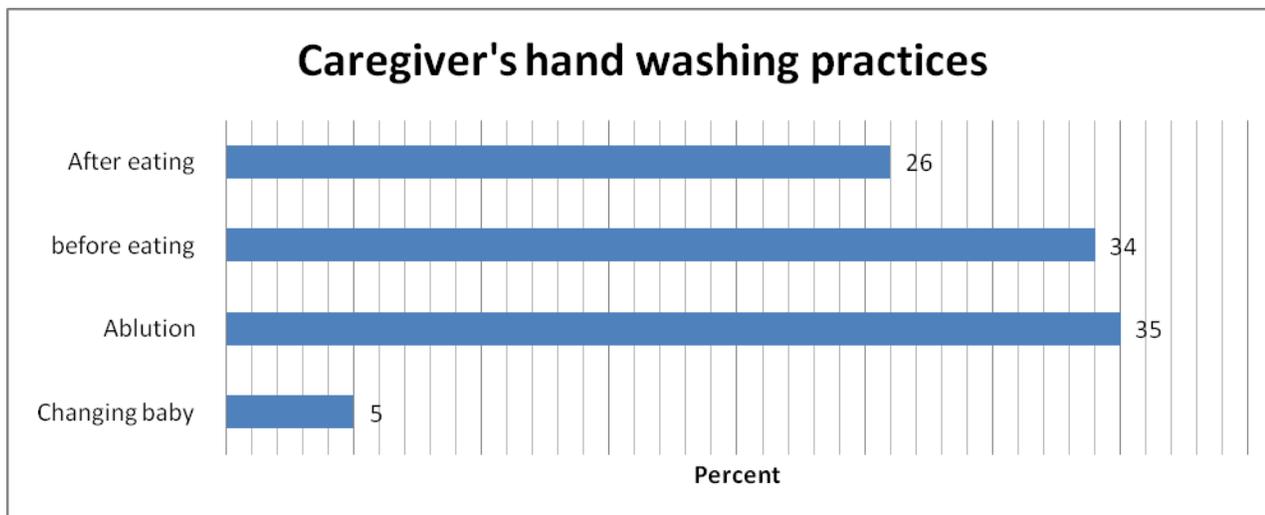


Figure 19: Caregiver's hand washing practices

Most of the caregivers (35%) only washed their hands during ablution for prayers, 34% of them washed before eating food, 26% washed their hands after eating and 5% washed their hands after changing baby.

3.9.9 Methods of hand washing

Majority of the caregivers, 60.5% wash their hands with only water in a basin, 34.2% use water poured from a container to wash their hands, 5.3% use running water from taps to wash their hands.

3.9.10 Dish Rack

About 75% of the households served did not have a dish rack, as compared to 11% who had a dish rack and in use.

Availability and use of Dish rack

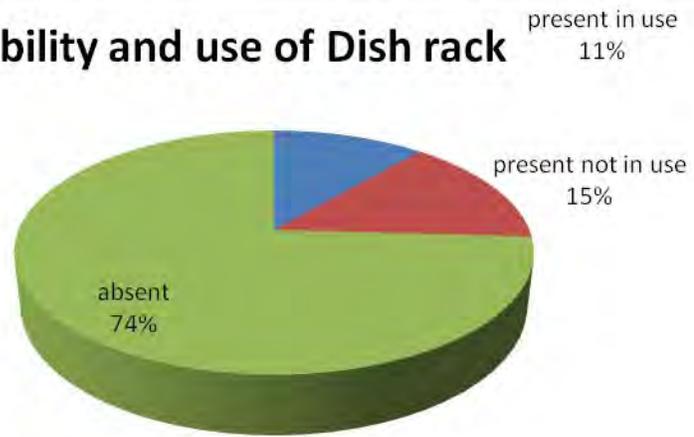


Figure 20: Availability of dish rack

4.0 CONCLUSION

The program coverage and access of services to the target community is satisfactory in four districts in the project area of Garissa County, indicating the achievement of the program. The program reached those who are acutely malnourished impacting on children under-fives and pregnant and lactating mothers as further shown by the recovery rates, death rates and default rates which are all on acceptable Sphere Standards limits. Access to clean water has also improved and the decline in proper sanitation and hand washing could be due to differing assessment methodologies at baseline and end line. The over 20% GAM in March 2012 was also attributed to poor access of health care services which meant no or late treatment of acute malnutrition and diseases such as diarrhoea, malaria and respiratory diseases. There are also inadequate fully functioning health facilities in the project area. In those that are functioning, there is high staff turn-over even for those already trained in the Integrated Management of Acute Malnutrition.

It was found that the program supported the provision of the needed (and thus relevant) services in the program area, focusing on the High Impact Nutrition Interventions (HINI). The approaches used to achieve these were appropriate and responsive to the challenges of health care system. However, the nutrition status has not improved due to the persisting drought and household practices such as those linked to infant feeding and hygiene. There is need to continue education and awareness on infant feeding practices. Also, only two-thirds are receiving food aid and there is need to continue advocating for increased food aid.

It has been learnt that there is more need for community sensitization, awareness and education on appropriate infant and young child feeding practices including those on hygiene and sanitation to improve on children nutrition status. There is also need to increase the number of active health facilities to promote access to health and nutrition services.

5.0 RECCOMENDATIONS

The number of health facilities must be augmented in order to ensure that the population has adequate access to treatment. It will therefore be vital to work with health facility teams to improve service delivery. This may involve provision of double rations, organizing more than one day a week for follow-up or other modifications as may be provided by the health workers themselves.

It is important that the planning and implementation in improving interface is done jointly, in close partnership with health facility teams, to ensure ownership of the adaptations they identify.

Thus, the community mobilization and awareness strategy must be further elaborated beyond community volunteer training and leader sensitization meetings, to include creative and unforgettable events, such as theatre, jingles, as well as stronger sensitization of alternative key stakeholders, such as traditional healers.

There is need to hire a nutritionist at the health facility, involving the local key persons and the MOH personnel to take a key lead to oversee and support nutrition and WASH program and improve coordination of the program.

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7.0 APPENDICES

Appendix 1: Evaluation Tools

ANNEX 1: a)



Government of Kenya

Ministry of Health

Mercy- USA for Aid and Development

INTERIM ASSESSEMENT OF EMERGENCY NUTRITION SUPPORT PROGRAM FOR
GARISSA COUNTY

HOUSEHOLD QUESTIONNAIRE-IYCF KAP

SECTION A: Introduction and Consent

Hallo, my name is _____. I am among a team in this area carrying out an evaluation on Nutrition and WASH Program being supported by Mercy USA. Your household has been selected by chance from all households in the area. I would like to ask you some questions related to the life and health of your household members. Whatever you tell me will be kept completely confidential. If there are some questions that you do not wish to answer, just tell me and we will skip them.

Information you provide will be useful to find out the status of quality of life in your community and will be used for planning future programs in this area Do you have any questions?

If yes kindly clear the issues before proceeding with the interview.

Do you agree to participate? Yes/No... [___]. If No end interview and thank the interviewee

Name of Location	Name of Village	Household Number	Name of supervisor	Name of Interviewer	Date of Interview (dd/mm/yy)

SECTION B: Socio Demographic Information

Household data

1.1.1 How many people live in this household together and share meals? (Household size)

HH Socio demographic information

1.1.2.1 Person's code	1.1.2.2 Person's Name	1.1.2.3 Approx.* Age Enter months for children up to 24 months and years for over 2 yrs. Verify age by 1=Health card 2=Birth certificate/ Notification 3=Recall	1.1.2.4 Sex 1= Male 2= Female	1.1.2.5 Relationship to HH Head 1. Head 2. Spouse 3. Child by Birth 4. Grand child 5. Other children by relation 6. House help 7.Others specify	1.1.2.6 Education Level 1= None 2=Some Primary. 3= Completed Primary 4=Some secondary 5=Completed Secondary. 6=College/University/Grad uate 7=Adult Education 8=Other (Specify)	1.1.2.7 Marital Status 1= Married. 2= Single. 3=Divorced. 4= Widowed. 5=Separated. 6= Others specify. 7. NA	1.1.2.8 Religion Muslim Christian Other

1.1.3 Income and Livelihood

Source of income

1.1.3.1 What were your sources of income the last three months (please indicate the three most important in order of priority)
1=Sale of livestock,2=Sale of livestock product,3=Sale of ration food,4=Sale of own crop,5=Wage labor,6=Remittance,
7=Charcoal/firewood,8=Basket weaving,9=Petty trade,10=Others (specify)

1.1.3.2 In the last 3 months, what was your MAIN expenditure? 1=Food, 2=Clothing/HH Items, 3=Rent, 4=School Fees, 5=Purchase of Livestock, 6=Others (Specify)

Livelihood

1.1.3.3 What is the MAIN source of livelihood for the household?

1=Pastoralism, 2=Agro-pastoralism, 3=petty-trading, 4=Agriculture, 5=Formalemployment, 6=Informalemployment 7=natural resource dependents

1.3.4 Status of the Household: 1=Resident 2=IDP 3=Temporary resident 4=Resettled 5=Refugee

1.1.4: Food Aid

<p>1.1.4.1 Has your HH received food aid in the last three (3) months?</p> <p>1= Yes 2=No</p>	<p>1.1.4.2 If Yes, what were the sources?</p> <p>1=M-USA 2=Government 3=Redcross 4=Others(specify)</p>	<p>1.1.4.3 What food commodities were received</p> <p>1=CSB(„Uji“) 2=Oil 3=Pulses 4=Maize/Maize Meal 5=Rice/Wheat/Sorghum 6. Others (specify)</p>	<p>1.1.4.4 Of the food aid received for what purpose was it used?(multiple answers allowed)</p> <p>1=Resold in the market 2=Bartered for other item 3=Shared with kin 4=Saved for seed 5=Consumed by the HH members 6=Fed the Animals (Goats/Cow) 7=Other</p>	<p>1.1.4.5 How many days on average did the food commodities last?</p> <p>1=1 Week 2=2 weeks 3=3 weeks 4=4 weeks and more</p>
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1.1.5 Respondent (Primary Caregiver) code

1.2 Data on Children aged 0 – 24 months and Immunization

1.2.2 Child Name	1.2.3 Im- mu- niza- tion card : 1.Pr- ese- nt 2. Not pres- ent	1.2.4 Child 's age in mont- hs	1.2.5 Sex 1= M 2= F	1.2.6 MUAC (0.1C M)	1.2.7 Oedema in both feet	1.2.8 Weigh- t (0.1kg)	1.2.9 Height (0.1 cm)	1.2.10 Currentl- y enrolled feeding program (confirm by card) 1=Yes 2=No	1.2.11 BCG (Injection on left arm, leaves a scar 1=given 2=not given 3= DK	1.2.12 Polio (Drop from bottle given) 1=give- n 2=not given 3= NA	1.2.13 PENTA- VALEN- T (Injection on the thigh) 1=given 2=not given 3= NA	1.2.14 Has the child received measles immuniza- tion? (enter code) (U2 only) 1=Yes 2=No 3=Don't know 4= N/A	1.2.15 Has [NAME] already received Vitamin A supple- mentation in the last 6 month (show the capsule) 1=Yes 2=No 3=Don't know 4= N/A (if yes proceed to 1.2.16)	1.2.16 How many times did the child receive Vitamin A the last six months? (U2 only) (Show the mother the capsule so that she recalls or understand) Indicate the number of times the child has received 0=Not taken 1= Once 2= Twice	1.2.17 Has any under- five in this fam- ily suffered from disease in the one month 1. Diarrheal diseases 2. Typhoid related fevers 3. Eye infection 4. Malaria 5. Skin infection 6. Others spec-

Anthropometric status of the women:

Measure MUAC of the child's caregiver

Caregiver must be female between 15 and 49 years of age

If there are multiple caregivers, interview only the one who is a primary caregiver

61. What is the woman's current physiological status? (ask carefully and circle)

1. Pregnant

2. Breastfeeding (< 6 months child)

3. Breastfeeding (6-23 months child)

4. Pregnant and breastfeeding

62. MUAC: _____ cm

63. Is the woman currently enrolled in a feeding program: 1. SFP 2. GFD.....3. No

SECTION C: NUTRITION

2.0 INFANT AND YOUNG CHILD FEEDING (IYCF) (This section will only be filled in if there are children 0 to 23 months).

2.1 Infant and young child breastfeeding information

Make every effort to speak with the mother. If she is not available, speak with the primary caregiver responsible for feeding of the child. Take the child number from the table above. For every question use the child (Name)

Background Information					Infant Breastfeeding information											
2.1.1	2.1.2	2.1.2	2.1.4	2.1.5	2.1.6	2.1.7	2.1.8	2.1.9	2.1.10	2.1.11	2.1.12	2.1.13	2.1.14	2.1.15	2.1.16	2.1.17
Child's code	Child's date of Birth: dd/mm/yy	Source of birth date (Record the approp. code) 1 = CARD 2= RECALL 3 = DNK	Age of child in months	Sex of child 1 = M 2 = F	How long after birth do you think a child should be put on the breast? See code below for the answers	How long after birth did you put (child's name) on the breastfeed? See code below for the answers	If Never, why? See code below for the answers	If yes, How long after birth did you put (name) on the breast? See code below for the answers	During the first 3 days after delivery, did you give (Name) the fluid/liquid that came from your breasts (Dambar)? 1= Yes, 2= No, 3= DNK	If no, why was the colostrum not given to [NAME]?	During the first 6 months after delivery, did you give (Name) anything to drink or eat other than breast 1.Yes 2.No 3. DK	If fluids were given during first 6 months, why were they given? (To understand the knowledge or attitudes on EBF)	If yes, what did you give (Name of child) See codes below for answers	Are you still breastfeeding (Name)? 1= Yes 2= No 3= DK	If yes, how many times in a day do you breastfeed (Name)?	Normally up to what age of a child should one stop breastfeeding? See code below for the answers

Question 2.1.6: 1= Less than 1 Hr ; 2= 1 hr ;3=1 day 4= 1 week; 5= Don't know; 6= Others specify

Question 2.1.7: 1= Less than 1 Hr ; 2= 1 hr ;3=1 day 4= 1 week; 5= Don't know; 6= never, 7= Others specify

Question 2.1.8: 1= No milk; 2= Did not want to breast feed;3=Traditional beliefs (specify) 4= Medical advice 5= Mother died 6. Other;

Question 2.1.9: 1. Less than 1 hr, 2. Less than 24 hrs, 3. More than 24 hrs, 4. DK, 5. Others specify

Question 2.1.11: 1. Dangerous for child 2. Traditional 3. Don't know 4. Other:

Question 2.1.12: 1. Nothing, 2. Plain water; 3. Sugar water or glucose water; 4. Powdered milk (name), Fresh milk, 5. Infant formula (name), 6. Gripe water; 7. Other (specify)

Question 2.1.13:1.Thirsty 2. Helps colic/constipation 3. Helps to get out meconium 4. Tradition/cultural 5. Makes baby healthy 6. Told by the health worker 7. Baby was hot 8. Baby not breastfeeding 9. Don't know 10. Other

Question 2.1.15: 1. Less than 1 month; 2. 6 months; 3. 1year, 2years; 4. Don't know; 5. Others specify

Question 2.1.16: 1. Less than 1mth, 2. 6mths, 3. 1 yr. 4. Still breastfeeding

Question 2.1.17. 1= No milk; 2= Did not want to breast feed; 3= Beliefs (specify) 4= Medical advice 5= Mother died 6. Other specify

2.2 Complimentary Feeding information

Since this time yesterday (day and night), has [NAME] received (FOOD/LIQUID)? (Ask the mother /caregiver response to mention all foods given to the child and record as mentioned in the appropriate category)Note: Please wait for the mothers response after asking the questions other than reading out the various foods

Child's code	2.2.1	2.2.	2.2.3	2.2.3	2.2.4	2.2.5	2.2.6	2.2.7
	Breast milk Only one answer coded as below: 1. Yes 2. No 3. DNK	Infant formula (S26, Nan) 1. Yes 2. No 3. DNK	Other milks: - animal milk, - reconstituted powdered milk,(Hilwa, Milki, Nido, Safari land, Hayat, Coast) - Sour milk. 1. Yes 2. No 3. DNK	Sweetened flavoured juices (Quencher, Juice for you, Zeitun, Altuza, Mushakil, vimto, Ananas, Savannah,) Soda 1. Yes 2. No 3. DNK	ORS 1. Yes 2. No 3. DNK	Tea/Co ffee 1. Yes 2. No 3. DNK	Plain water 1. Yes 2. No 3. DNK	Thin porri dge 1. Yes 2. No 3. DNK
codes								
At what age								

Child's code	2.2.8	2.2.9	2.2.10	2.1.11	2.2.12	2.2.13	2.2.14	2.2.15	2.2.16	2.2.17
	Eggs 1. Yes 2. No 3. DNK	Porridge made from CSB/ Unimix/ millet/ sorghum/ maize flour Use the correct code. Only one answer. 1. Yes 2. No 3. DNK	Flesh Meats (Chicken, beef, Goat, Kidney, Liver, Mutton, Camel, Donkey, Fish,) 1. Yes 2. No 3. DNK	Legumes and Nuts (Beans, Groundnuts, Cowpeas, Lentils, Green Grams) 1. Yes 2. No 3. DNK	Dairy Products (Milk, cheese, Ghee, fermented milk) 1. Yes 2. No 3. DNK	Grains, Roots & Tubers (Pasta, rice, bread, potatoes, biscuits, mandazi, chapatti, anjera, ugali) 1. Yes 2. No 3. DNK	Vitamin A Rich fruits & Vegetables (pawpaw, melon, Sukuma wiki, carrots, cowpea leaves, spinach, Avocado) 1. Yes 2. No 3. DNK	Other Fruits and Vegetables (onions, tomatoes, cabbage, Oranges, bananas Okra, wild fruits) 1. Yes 2. No 3. DNK	Oil (Salad oil), fats, Zeitzun, simsim, (camel fat) 1= Yes 2= No 3= DNK	Yesterday (During the day and at night). How many times did you feed (Name) solid and semi-solid foods? No. of times child was given food to make it full.
Codes										
At what age										

Childs code	2.2.18	2.2.19	2.2.20	2.2.21	2.2.22	2.2.23
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	Other water-based liquids ie. Broth 1. Yes 2. No 3. Don't know	Fresh or dried fish, shellfish? 1. Yes 2. No 3. Don't know	Any sugary foods such as sweets, pastries, cakes or biscuits? 1. Yes 2. No 3. Don't know	Condiments for flavor such as chillies, spices, herbs? 1. Yes 2. No 3. Don't know	CSB? 1. Yes 2. No 3. Don't know	Plumpy nut? (Show one packet) 1. Yes 2. No 3. Don't know
Codes						
At what Age						

We would like to know at what age these foods were introduced (Fill in the table above)

2.2.24. Are there foods you believe children are not to be given and why?.....

2.2.25. Did (Name) drink anything from a nipple? 1=yes 2=No

2.2.26. When [NAME] is sick, how much was he given to drink?

- Same as usual
- Less than usual
- More than usual
- Don't know

2.2.27. When [NAME] is sick, how much was he given to eat?

- Same as usual
- Less than usual
- More than usual
- Don't know

2.2.28 What can a woman do to have more breast milk?

- Increase frequency of child suckling
- Reduce stress or not worry
- Eat special foods/soup/drinks Increase quantity of food/liquids
- Massage breasts
- Rest
- Don't know
- Other: _____

2.2.29 Why should caregivers introduce complementary foods to infants?

Breast milk is not sufficient anymore

To make him/her strong

He/she is hungry

Don't know

Other: _____

2.3 Household Food Consumption and diet diversity

Twenty four hour and seven day recall for food consumption in the households. The interviewers should establish whether the previous day and night; seven days and nights were usual or normal for the households. If unusual feasts, funerals or most members absent, then another day should be selected

2.3.1. Food group consumed Type of food	2.3.2. Did any member of your household consume any food from the groups in the last 24 hrs 1. Yes 2. No	2.3.3. If yes how many time was the food consumed in the last 7 days?
Cereals and cereal products (e.g. sorghum, maize, spaghetti, pasta, <i>anjera</i> , rice, bulga wheat, bread)		
Vitamin A rich vegetables and tubers: Pumpkin, carrots, yellow fleshed sweet potatoes		
White tubers and roots: White tubers, white potatoes, white yams , cassava or foods from roots, white sweet potatoes,		
Dark green leafy vegetables: Dark green leafy vegetables including wild ones + locally available vitamin A rich leaves such as cassava leaves, pumpkin leaves, cowpeas leaves, sukuma wiki, spinach,		
Other vegetables (e.g. tomatoes, egg plant, onions, cabbages)		
Vitamin A rich fruits: Ripe mangoes , papayas + others locally available like watermelon,		
Other fruits like		
Organ meat (Iron rich): Liver, kidney, heart or other organ meats or blood based foods , spleen		
Flesh meat and offal's: Meat, poultry, offal (goat, camel, beef, poultry)		
Eggs		
Fish: Fresh or dried fish or shell fish or smoked , salted, fried		
Pulses legumes or nuts (e.g. beans , lentils, green grams, cowpeas, dried peas,		
Milk and milk products (e.g. goat , camel, fermented milk , powdered milk)		
Oils/ fats (e.g. cooking fat or oil, butter , ghee, margarine)		
Sweets: Sugar, honey, sweetened juice, soda/sugary foods such as sweets, glucose		
Condiments, spices and beverages like royco, garlic, dhania,		

SECTION D: FOOD SECURITY

2.4.0 Food Shortage Coping Strategies

	In the previous month, has the household done any of the following? Tick as appropriate	Tick Below
2.4.1	Reduction in the number of meals per day	
2.4.2	Skip food consumption for an entire day	
2.4.3	Reduction in size of meals	
2.4.4	Restrict consumption of adults to allow more for children	
2.4.5	Feed working members at expense of non-working	
2.4.6	Swapped consumption to less preferred or cheaper foods	
2.4.7	Borrow food from a friend or relative	
2.4.8	Purchase food on credit	
2.4.9	Consume wild foods (normal wild food)	
2.4.10	Consume immature crop	
2.4.11	Consume decomposed food	
2.4.12	Send household members to eat elsewhere	

SECTION E: WATER, SANITATION AND HYGIENE

3.1 HH Water

3.1.1 What is your main current water source for household use? (Probe for the <u>Main source</u>) 1= River 2=Lake 3= Water tap 4=Borehole 5= Unprotected well 6= Protected well 7= Public pan 8= Water tanks 9= Dam 10= Laga 11= Other	3.1.2 How long does it take to go to the main source of water, fetch and come back (in minutes) (In case you approximate in hours kindly note (Hrs))	3.1.3 How much do you pay for a 20lt jerrican (enter zero if water is free)	3.1.4 On average, how many LITRES of water does the household use per day?	3.1.5 Based on your own perception is water from the primary source safe for drinking? 1.YES 2.NO 3.DK	3.1.6 If No, what action do you take to make it safe 0. None 1. Boiling 2. Filtering 3. Settling 4Chemical treatment 5. Others specify	3.1.7 Does your household store water? 1.Yes 2. No	3.1.8 (If yes) what type of storage facilities do you have? 1. Overhead tank 2. Underground tank 3. Ordinary iron tank 4. Drum/Jerricans 5. Other, specify
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3.2 HH Sanitation

<p>3.2.1 Does your household have access to a toilet/ latrine facility?</p> <p>1=Yes 2=No</p>	<p>3.2.2 If yes, what type of toilet facility do you have? (Please observe)1=Bucket latrines 2=Traditional pit latrines 3=Ventilated improved pit latrine 4=Flush toilet 5=Other Specify</p>	<p>3.2.3 If No, where do you go/use? (probe further) 1= Bush 2=Neighbour's toilet 3=Open field 4=Near the river 5=Behind the house 6=Other (specify)</p>	<p>3.2.4 How is children's faeces disposed (Probe and OBSERVE) 1=Disposed of immediately and hygienically in the latrine 2= Disposed of immediately in the nearby bushes 3= Not disposed (scattered in the compound) 4= Use of dogs</p>	<p>3.2.5 How do you dispose off your household solid waste? (Ask for the main method) 1=Burn 2=Rubbish pit 3=Compost pit 4=Scattering 5=Others (Specify</p>	<p>3.2.6 Is the compound clean?(By observation) (No visible faeces near the house, No Rubbish all over) 1 = Yes 2 = No</p>

3.3 HH Hygiene

<p>3.3.1 When do you wash your hands (Probe – without reading alternatives) 1. Before eating 2. After toilet use 3. After changing baby 4. Before feeding young children 5. Ablution 6. before food preparation 7. Others Specify</p>	<p>3.3.2 How do you wash your hands? 1. Using running water 2. Using running water with soap 3. Using water in a basin 4. Using water in a basin with soap 5. Others (Specify)</p>	<p>3.3.3 How often do you practice the following activities? a) Washing fruits before eating b) Covering cooked food 1. Always 2. Never 3. DK 4. Others specify</p>	<p>3.3.4 How do you clean baby's feeding utensils 1. water only 2. Water and soap 3. Boil to sterilize 3. DK 4. Others specify</p>	<p>3.3.5 Please observe/ask presence of dish rack 1. Present in use 2. Present not in use 3. Absent</p>	<p>3.3.6 Are you aware of the causes of childhood diarrhoea? 1. Yes 2. No</p>	<p>3.3.7 If yes, what are the causes? 1. Drinking dirty water 2. Eating contaminated food 3. Contaminated hands 4. Others (specify)</p>	<p>3.3.8 What preventive and control measure against diarrhoea are you aware of? 1. Boiling drinking water 2. Use of toilets to dispose of human faecal matter 3. Cover cooked food and drinking water 4. Wash hands after using toilet and before eating 5. Wash hands before food preparation with soap 6. Wash child's hands before and after feeding with soap 7. Wash hands with soap after attending to a child who has</p>
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							defecated. 8.Exclusively breastfeed up to first 6 months 9.Don't know 10.Other

SECTION F: HEALTH SEEKING BEHAVIOUR

4.0GENERAL HOUSEHOLD MORBIDITY AND HEALTH SEEKING BEHAVIOUR

4.1 Has anyone been ill in this household in the last two weeks?

Yes

No

If yes enter all of them in the table below.

4.1.1	4.1.2	4.1.3	4.1.4	4.1.5	4.1.6	4.1.7	4.1.8	4.1.9
Enter the complete individual number, (Cluster, HH, No., individual code)	Duration of illness 1.Less than 4 weeks 2.4 weeks or more	Type of illness encountered 1. Malaria 2. ARI 3. Diarrhoea 4. AIDS related 5. Pregnancy related 6. Don't know 7. Others, specify	If s/he had diarrhoea was any of these fluids given 1.Afluide from a special packet called oralite (ORS) 2.home-made sugar salt solution 3.another home-made liquid such as porridge soup, coconut water 4.zinc 5.others (specify)	Frequency of illness 1. Daily 2.weekly 3.monthly 4.Quaterly (4 months) 5. Yearly. 7. N/A	Where was treatment sought 1. No treatment 2. Health facility 3CHW/referral/extension 4. Self medication 5.Traditional healer 6. Faith healing 7. Counselling 8. Others, specify	What was the outcome 1. Recovery 2. Still sick on treatment 3.Still sick not on treatment 4. Others specify	How much was paid for treatment 0=No cost 1. Less 100/= 2. 100-500/= 3. 501-1000/= 4. Over 1000/= 5.Don't know 6. Others specify.	Time taken to walk to nearest facility 1.less than 30min 2.30 min-1hr 3.More than 1hr

4.2 SUPPLEMENTATION

<p>4.2.1 In your last pregnancy, did you take Any of the following</p> <ol style="list-style-type: none"> 1. Iron pills 2. Iron syrup—Haematon 3. Injection—Inferon 4. Sprinkles with iron 5. None of the above 	<p>4.2.2 Ask the Breastfeeding/lactating mother only. “Have you received any vitamin A supplements?”</p> <ol style="list-style-type: none"> 1. Yes 2. No 3. Don't know
--	---

4.2.3 Deworming

Has the child taken any drug for intestinal worms in the last six months? (Show tablet or syrup)

Yes

No

Don't know

4.2.4 Salt Iodization

Is the salt consumed at home iodized? Please request for a packet of the salt, if they don't have it, ask for the brand name of the salt they use or show them a sample of salt in packets

Where do you get your salt; (market, shop etc)?

Did you buy the salt in a packet

Do you store the salt in a sealed container?

4.3.1 Mosquito Control/ Bed net use and treatment

<p>4.3.1. Does this household have a mosquito net?</p> <p>1 = Yes 2 = No</p> <p>(IF NO, GO TO 9.1)</p>	<p>4.3.2 Where did you get it from:</p> <p>1 = A Shop 2 = An agency 3 = Ministry of Health 4 = Others (specify) _____</p>	<p>4.3.3. If you got it from the shop, have you ever treated your net (soaked or dipped it in dawa or chemical to repel mosquito or insects)?</p> <p>1 = Yes 2 = No 3. DK</p>	<p>4.3.4. If YES, When did you last treat it? (Enter code)</p> <p>Less than one month ago Between one and six months ago More than six months ago Cannot remember</p>	<p>4.3.5. Who slept under the mosquito net last night? (Probe - enter all responses mentioned)</p> <p>Everybody Children less than 2 years Children over 2 years Pregnant woman Mother Father Nobody uses</p>

SECTION G: IMPACT

3.5.1. What changes /benefits have you experienced from the M-USA project? (Individual, household and community)

3.5.1.1 Individual- level

3.5.1.2. Household level

3.5.1.3 Community level

3.5.2. Do you have any general suggestions and recommendations regarding M-USA Activities?

Thank you

ANNEX 1: b)

CLASSIFICATION OF COVERAGE IN INDIVIDUAL CLINIC/OTP CATCHMENT AREAS

#	Name of Clinic	Name of clinic catchment area	OTP Site 1=Yes 2=No	Sample size or cases found (n)	Number of covered cases (c)	Threshold level $d=[n/2]$	Classification (Classified coverage = 50%)	
							$c < d$	$c > d$

ANNEX 1: c)

TOOL F1: FGD GUIDE FOR MOTHERS

Do you face any challenges in giving care to your children?
 {If yes probe for them, causes and possible solutions}

.....

What do you know about M- USA as an organization working in this community (probe for programmes and target group, when it was started?)

.....

How are mothers involved in these programs?

Nutrition

.....

WASH

.....

What are beneficial things that you can remember since the Program started?

.....
.....

How has your ability to care for children improved as a result of this Program? {If not probe on specific services received}

What problems/challenges does the community have regarding Nutrition

.....
.....

WASH

.....
.....

How have you benefited from the project in addressing these challenges? Nutrition

.....
.....

WASH

.....
.....

What other types of care and support are most needed by parents and guardians in this community?

.....
.....

2.0 Establishment of Rural Community Support Centers, providing information, education and Referral

Are you aware of community support centres established by M- USA to provide information and referral for nutrition and WASH issues?

.....
.....

How has the setting up of these centres helped the community in improving Nutrition and WASH?

.....
.....

Of what benefit are the centres to mothers and children in particular (probe for services or support a particular group gets from the centres)

.....
.....

What are your opinions on access, relevance, and sustainability of the centres?

.....
.....

.....
.....
How do you rate the public awareness about Nutrition and WASH now as compared to the past
(probe for community's perception and participation)
.....
.....
.....

2.0 Improvement of the Skills and capacity of the community in Nutrition and WASH

What types of support and services does the program offer towards improving of Nutrition and WASH?
.....
.....
.....

How is the support provided (probe for channels of service delivery such as home visits,)
.....
.....
.....

How is the support/services channeled to reach mothers/guardians?
.....
.....
.....

How have your nutritional skills improved in handling care and support to children under your care?
.....
.....
.....

What training, support, assistance is available?
.....
.....
.....

What changes are there due to the above?
.....
.....
.....

What are the impacts of these activities on the community
Nutrition programme
.....
.....

WASH

.....
.....
4.0 Enhancement of the sustainability of community activities through training in income generation

What are your sources of income (IGA, Salary, external support, farming e.t.c?) (probe where support is gotten)

.....
.....
.....

Have you received any training or support from M- USA on Microfinance Management?

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.....

If yes, how has it helped you improve your household income and in particular on Nutrition and WASH?

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.....

5.0 Establishment of mother to mother services

What is your opinion on the mother to mother services introduced by M- USA programme on?

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.....

How have they helped change the lives of children under your care and others in the community?

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.....

How sustainable are these programmes?

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.....

What would you like done differently to achieve higher results

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.....

6.0 Facilitation of raising levels of awareness in the community

How do you rate the public awareness about Nutrition now as compared to the past (probe for community's perception and participation)

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.....

In your opinion what is the prevalence rate of malnutrition as compared to two years ago (probe for frequency of deaths, symptoms associated with)

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.....
.....

7.0 General Improvements, Networking and Best Practice

How has life of children changed in terms of:
Their Health

.....
.....

Children accessing schooling

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.....
.....

For the time M- USA has been working what positive impacts have you seen in terms of Nutrition and WASH (probe for indicators)

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.....
.....

What can the community do/contribute to ensure the Program will continue to assist the family?

Which other groups are working in the area towards nutrition and WASH?

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.....

Are there groups specifically for children?

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.....

If yes, how do there collaborate with M- USA?

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.....
If no, do you feel there is need for these groups and why?
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What would you recommend in terms of sustainability of the programme (probe for less or no support from M-USA)
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.....
What are your general comments on these Programs?

Nutrition
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WASH
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ANNEX 1:d)

TOOL2: FGD Guide for School Committee

What do you know about MERCY USA?
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2. What activities does M-USA implement in your schools to create Nutrition and WASH awareness among the pupils? (Probe for more)
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.....

.....
How does M-USA help children in school and out of school? {Probe for food and nutrition, WASH}
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.....
2.0 Establishment of Rural Community Support Centers, providing information, education and Referral

Are you aware of Community support centre established by MERCY USA to provide information and referral (probe for location, mode of operation, services offered to various groups, etc.)

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.....

How has the setting up of these centres helped the children in Nutrition and WASH

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.....

Of what benefit are the centres to Children in particular (probe for services or support that particular groups gets from the centres

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.....
.....

What are your opinions on access, relevance, and sustainability of the centres?

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.....

What is the community's awareness now as compared to the past (probe for community's perception)

Nutrition
WASH)

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.....

3.0 Improvement of the Skills and capacity of the community in Nutrition

What types of support and services towards improving the livelihood of children, are offered by MERCY USA?

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.....

How is the support provided (probe for channels of service delivery such as through schools, home visits,)

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.....
.....

How is the support/services channelled to reach children

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.....

What training, support, assistance is available to improve Nutrition.....

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.....

.....
WASH

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.....

How have your skills improved through this program?

Nutrition

WASH

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.....

What changes are there due to the above at home, and community at large?

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.....

What are the impacts of these activities on the community

Nutrition programme

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.....

B) WASH

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4.0 Enhancement of the sustainability of community activities through training in income generation for mothers

What are your sources of income?

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.....

Have you received any training or support from MERCY USA on income generation?

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.....

If yes, how has it helped you improve the livelihood status of the community?

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.....

5.0 Establishment of mother to mother services

What is your opinion on the mother to mother services introduced by MERCY USA programme on?
What benefits have you seen as a result of these services? Probe for: Creating awareness on Nutrition and WASH

Nutrition.....
.....

.....
WASH

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.....

How has these helped change the lives of children and others in the community?

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.....

How sustainable are the programmes?

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What would you like done differently to achieve higher results

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.....

7.0 General Improvements, Networking and Best Practice

Impacts
Their Health

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.....

Children accessing schooling

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.....
Community acceptability of the program
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Formation of groups to help in access to services
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.....

Other groups they know of working in the area
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What do they like about the groups
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.....

Are they aware these groups work with MERCY USA, and on what issues
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If no, do you feel there is need for these groups and why?
.....
.....

What would you recommend in terms of sustainability of the programmes (probe for less or no support from M-USA)
.....

ANNEX 1:e)

GUIDE FOR MOH STAFF

What Special Health Package does this facility offer the OVCs? What children would be eligible for the Services mentioned and how do you identify them?

What do you consider to be the Special Health needs of the OVCs in this community?

Do you have a Special Referral System for OVCs? Can you describe the Process? If not mentioned then probe:

Who refers

Who receives the referral
Verbal paper or Physical
Documentation, filing and feed back to the source of the referral
How is the payment of the referrals managed

In your opinion is this structure /system for Home Based Care working well? Probe for
Success
Challenges
How it can be improved

Does your Health Facility support a HBC Program for PLWHA? Probe further

HBC Services
HBC Components

What are the Structures for Community-Facility Engagement for HBC? Probe on
HBC committee?
HBC Coordinator?

Referral system for patients referred to and from the community– describe the system (who refers, who receives the referral, verbal, paper or physical referral, documentation, filing and feedback to the source of the referral, how is the payment managed?)

Role of the Mentors in HBC
Training and Supervision of the Mentors
Provision and Monitoring of HBC kits – how is it handled?

How can we ensure the sustainability of this Program?
What are your challenges in HBC? How can these be overcome?
ANNEX 1:f)

TOOL KII 2 = HEADTEACHERS

Do you have M-USA program supporting Nutrition and WASH in your school?

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What do you consider to be the special needs of the children in your school that affects their education?

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Do you hold meetings concerning this project?

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What are the other teachers' involvement and attitudes towards these projects?

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.....

Do you have committees and active clubs concerning this Program?

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How has this Program enhanced the children's knowledge, attitude and practices towards Nutrition and WASH? (Probe)

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In your opinion what are more important ways that the program can assist the pupils' access and excel in their education.

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Are you aware of examples where a school committee member have come to school to follow up the pupils' educational progress on behalf of the family

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Do you have challenges in implementing this program?

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In your opinion, how can the children's educational support be improved?

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ANNEX 1:g)

As a partner in this programme, how have you participated or been involved in the programme (probe for location and target groups – widows, PLWA, OVC etc.?)

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TOOL K1: GUIDE FOR KEY INFORMANT INTERVIEWS MOH Staff

What special health package does this facility offer the OVC? What children would be eligible for the services mentioned and how do you identify them?

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.....

Do you have a special referral process for OVC? Can you describe the process? (If not mentioned then probe: who refers, who receives the referral, verbal paper or physical, documentation, filing and feed back to the source of the referral, how is the payment of the referrals managed)

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In your opinion, how is the referral system for OVC healthcare working? How can it be improved?

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Does your health facility support a HBC program for PLWHA? Please describe the HBC services/components provided at this facility?

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.....

What are the structures for community-facility engagement for HBC?

Referral system for patients referred to and from the community– describe the system (who refers, who receives the referral, verbal, paper or physical referral, documentation, filing and feedback to the source of the referral, how is the payment managed?)

Role of the HBC//MENTOR?

Training and Supervision of the HBC/mentors?

Provision and Monitoring of HBC kits – how is it handled?

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What can you comment on with regard to the changes and trends in stigma and discrimination in this community? Probe on acceptance, knowledge on HIV and AIDS, response to VCT, disclosure, Living positively and community support

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In your opinion is this structure /system for Home based care working well? How can we ensure that these things continue to work well/are sustained?
(Probe for achievement and sustainability)

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.....

What are your challenges in HBC? How can these be overcome?

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8. Comment on the trend incidence and prevalence of STI and HIV infection since 2004 (Check the records)

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ANNEX 1: (H)

1.0 Introductory Questions

In your opinion how would you rate the prevalence of malnutrition in this area

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What are the possible causes of the above?

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Are there affordable, accessible, adequate health care facilities in the area?

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If there are shortages, how severe is it?

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What are the health trends of PLWA and OVC in the area?

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How would you rate the awareness level of Nutrition among the community here?

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What is the community's knowledge, attitude and practices about Nutrition?

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What are the challenges of adapting the recommended nutritional practices in this community?

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What efforts are undertaken by M-USA and other actors to mitigate the effects of malnutrition in the community?

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2.0 Establishment of Rural Community Support Centers, providing information, education and Referral

How does M-USA generally provide support to mitigate the impacts of malnutrition among the people in the community (probe for channels of service delivery)

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How are community members involved in provision of this support for sustainability and ownership purposes (Probe for community contribution)

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How do you facilitate service delivery to the community (probe for community support centres ,training, awareness)

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What is your opinion on the effectiveness of Community Support Centers

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3.0 Improvement of the Skills and capacity of the community in Nutrition

How does M-USA deliver capacity building on nutrition and WASH?

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What support do you give as M-USA to enable you deliver on the above and how effective is it?

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.....

What are some of the successes you see among the communities due to this component of the project?

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.....
.....

If it were to be done all over again, what would you recommend (approach, activities, and sustainability?)

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.....

4.0 Enhancement of the sustainability of community activities through training

How does M-USA deliver training in Nutrition and WASH? (Probe Content, method of training, Adequacy, preparedness, Feedback and Impact)

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How are you involved in the activities?

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What support do you receive from M-USA to enable you deliver on the above and how effective is it?

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What are some of the successes you see among the communities due to this component of the project?

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If it were to be done all over again, what would you recommend (approach, activities, and sustainability?)

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Establishment of mother to mother services

What is your opinion on the mother to mother services introduced by M-USA?

How have M-USA services brought about change in the lives of children and the community in general?

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How sustainable are the programmes?

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What would you like done differently to achieve higher results

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6.Facilitation of raising levels of awareness in the community

How do you rate the public awareness about nutrition now as compared to the past (probe for community's perception and participation)

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.....

How are you responding to these issues in as M-USA?

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.....

How has life of children changed in terms:
Their Health

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.....

Children accessing schooling

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For the time M-USA has been working what positive impacts have you seen in terms of the nutrition and WASH (probe for indicators)

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Networking and Collaboration

Which other groups, partners, people, organizations are collaborating in this programme and in which way

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How are these partnerships between M-USA and these groups structured?

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How successful has M-USA steered this networks and partnerships

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Would you say the networks (if any) are guided by programmatic issues (the felt need) on mitigating or prompted by organisational missions and objectives?

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What working relationship exists between M-USA and;
The areas health infrastructure (government, private and NGO led)

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Children's department

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Ministry of education

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Community leaders

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In what areas do you think the programme has made progress in Nutrition and WASH?

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What would you like to say on the programmatic approach M-USA has deployed in implementing the project?

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Achievements and Recommendations

What can you say the programme has achieved so far especially on
Training in Nutrition and WASH

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Mother to mother awareness

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Provision of Nutritional supplements

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What challenges have been experienced in the programme both from internal and external to M-USA
and partners?

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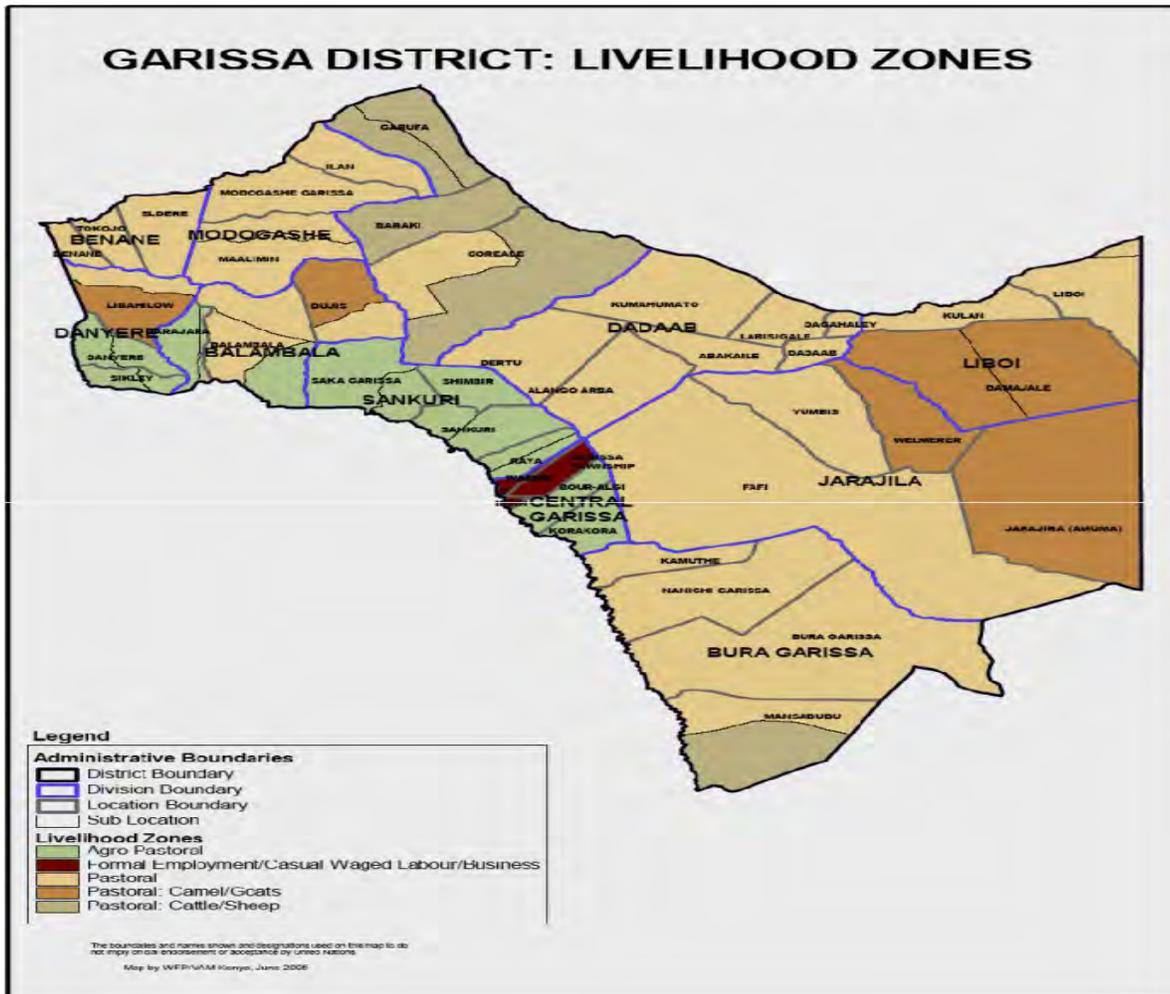
Comment on M-USA'S nutrition and WASH (Probe for its integration in the community, degree of
success in implementation)

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What are your recommendations for future programming?

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Appendix 2: Map of Garissa County



Appendix 3: List of Supervisors and enumerators for the Garissa County Evaluation 29th-7th March 2012

	Adan Hussein Ibrahim –DPHN Garissa	Survey coordinator
Garissa District (Team 1)		
	Mohamed Abdille Noor	Supervisor
	Abdifatah Hussein	Team leader
	Pamela Kaguri	Enumerator
	CarolynePuti	Enumerator
Garissa District (Team 2)		
	Lisa Muthoni	Team leader
	CarolyneMaiyo	Enumerator
	Abshira Hussein Abdi	Enumerator
Mbalambala (Team 3)		
	ShahmatYussufWarsame	Supervisor
	Mohamed HaretLohos	Team leader
	ZeinabJilleAbdulahi	Enumerator
	Hussein Hure	Enumerator
IJARA (Team 4)		
	Adam	Supervisor
	LydiaHosiboriNyamoko	Team leader
	Felicity NdegeKinya	Enumerator
	Issa Ahmed	Enumerator
IJARA (Team 5)		
	Dr Priscilla chepkemboi	Team leader
	Henry JumaNgweiyo,	Enumerator
	Amina Hassan Ibrahim	Enumerator
Lagdera (Team 6)		
	Leyla Ahmed	Supervisor
	Osman Kotebe	Team leader
	Hamed Hassan	Enumerator
	Japheth Malombe	Enumerator
FAFI (Team 7)		
	Mohamud Osman	supervisor
	Siat Hassan	Team leader
	Florence NjeriGitumbo	Enumerator
	Ahmed nor Abdullahi	Enumerator
FAFI (Team 8)		
	David MbuguaNgige	Team leader
	FatumaDiis Mohamed	Enumerator
	JulitaKathabikaburu	Enumerator

Appendix 4: Summary of expected tasks, information required, sources of information and methods and tools

Expected tasks	Information required	Sources of information	Methods and Tools
Establish the relevance of project objectives and activities towards meeting the needs identified within the community	What are they promising practices for maternal and child health. projects in Kenya implemented by Mercy USA	DHMT, HFMC, CHW, NGOs, schools, children homes, social development worker, care givers, guardians, DNO, project staff, beneficiaries, project documents, government policy documents.	-Desk review: Checklist -KII:KII Guide -FGD: FGD Guide.
Efficiency (the cost, speed and management efficiency with which inputs and activities were converted into results and the quality of the results achieved)	The overall budget, the outputs, the duration, the unit costs, the quality versus the cost	DHMT, HFMC, , CHW, NGOs, schools , children homes, social development worker, care givers, guardians, , project staff, beneficiaries, project documents, government policy documents.	-Desk review of policy guidelines : FGD:FGD guides -KII:KII Guide
Impact of the project on its wider environment. ;	Anthropometric measurements Age, Height, Weight ,MUAC What are the innovations of promising practices that should be scaled up to better the lives of the under 5 year children	DHMT, HFMC, , CHW, schools , children homes, social development worker, care givers, guardians, project staff, beneficiaries, project documents, government policy documents.	-Desk review: -KII:KII Guide -FGD: FGD Guide. Body measurements for the Under 5yr children and PLW
Effectiveness of the contribution from the project results and how assumptions have affected the	What lessons have been learned through these promising practices (salient positive change in peoples practice)	DHMT, CHW, schools, children homes, social development worker, care givers, guardians, project staff,	Desk review: -KII:KII Guide

project		beneficiaries, project documents, government policy documents.	
Sustainability of the project activities and likelihood of continuation of the benefits produced by the projects to the beneficiaries	What lessons have been learned through these promising practices (salient positive change in peoples practice)	DHMT, HFMC, CHW, schools, children homes, social development worker, care givers, guardians, project staff, beneficiaries, project documents, government policy documents.	FGD:FGD guides -KII:KII Guide Household interviews
Relevance of the program to the needs and priorities of the community.	The immediate needs of the beneficiary compared to how the prog meets these needs	PROG STAFF Beneficiaries and other focal people in the community. Also the health workers and DHMTs	FGD:FGD guides -KII:KII Guide
Coherence of the program in relation to other interventions in the geographical area of implementation.		Program staff Stakeholders ()	-KII:KII Guide FGD:FGD guides
Coverage of the program activities; whether specific needs to be addressed were met.	The coverage assessment methodology IYCF- High Impact Nutrition Interventions (HINI)	Program staff Community Beneficiaries and facility reports	-KII:KII Guide FGD:FGD guides