EVALUATION SERVICES AND PROGRAM SUPPORT (ESPS)

APHIAPLUS IMARISHA END-OF-ACTIVITY PERFORMANCE EVALUATION

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ACRONYMS AND ABBREVIATIONS

AIC	African Inland Church
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
APHIA	AIDS, Population, and Health Integrated Assistance
BEmONC	Basic Emergency Obstetric and Neonatal Care
BRHC	Broad Reach Healthcare
CAC	Community Advisory Committee
CBO	Community-Based Organizations
CCC	Comprehensive Care Clinics
CD4	Cluster of Differentiation 4
CHMT	County Health Management Team
CHS	Community Health Strategy
CHU	Community Health Unit
CHV	Community Health Volunteer
CI	Confidence Interval
CME	Continuing Medical Education
COP	Chief of Party
CRS	Catholic Relief Services
CSI	Child Status Index
DBS	Dried Blood Spot
DHIS	District Health Information System (Kenya's National Health Information System)
DHS	Demographic and Health Survey
EBI	Evidence-Based Intervention
EID	Early Infant Diagnosis
EmONC	Emergency Obstetric and Neonatal Care
ESPS	Evaluation Services and Program Support
ET	Evaluation Team
ETE	End-Term Evaluation
FBO	Faith-Based Organization
FGD	Focus Group Discussion
GoK	Government of Kenya
HCW	Health Care Worker
HES	Household Economic Strengthening
HEI	HIV-Exposed Infants
HIV	Human Immunodeficiency Virus
HPN	Health Population and Nutrition
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HSSF	Health Sector Services Fund
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
IBTCI	International Business & Technical Consultants, Inc.
IGA	Income-Generating Activity
IP	Implementing Partner
KAP	Knowledge, Attitudes, and Practices
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Supplies Authority
KII	Key Informant Interviews
KMMP	Kenya Mentor Mother Program

LIP	Local Implementing Partner
LOL	Land O' Lakes
MARPs	Most-at-Risk Populations
M&E	Monitoring and Evaluation
MM	Mentor Mother
MNCH	Maternal, Newborn, and Child Health
MoH	Ministry of Health
NAL	Northern Arid Lands
NASCOP	National AIDS and STI Control Program
OCA	Organizational Capacity Assessment
OI	Opportunistic Infection
OJT	On-the-Job Training
OLMIS	OVC Longitudinal Management Information System
OPH	USAID Kenya Office of Population and Health
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counseling
PLHIV	People Living with Human Immunodeficiency Virus
PMP	Performance Management Plan
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNC	Postnatal Care
PSSG	Patient Social Support Group
QIT	Quality Improvement Teams
RDT	Malaria Rapid Diagnostic Test
RMNCH	Reproductive, Maternal, Newborn and Child Health
SCHMT	Sub-County Health Management Team
SILC	Savings and Internal Lending Communities
SIMS	PEPFAR's Site Improvement through Monitoring System
SOP	Standard Operating Procedures
TOT	Training of Trainers
USAID/KEA	United States Agency for International Development Kenya and East Africa
VMMC	Voluntary Medical Male Circumcision
WASH	Water, Sanitation, and Hygiene

GLOSSARY OF TERMS

Activity: USAID-funded program; referred to in this report as APHIAplus Imarisha

Antiretroviral drugs (ARVs): Tested and approved drugs that prevent HIV (and other retroviruses) from replicating.

Antiretroviral therapy (ART): Use of a combination of ARVs to achieve viral suppression.

CD4: Also known as T-helper cells: A form of white blood cell that is important for immune system functioning; used to determine the stage of HIV infection.

Community Health Extension Worker (CHEW): An employee of the Government of Kenya, a trained health worker who supervises the work performed by Community Health Workers assigned to a particular Community Health Unit.

Community Health Strategy: A nationwide strategy adopted in 2006–2007 by the Kenyan Ministry of Health to accelerate the achievement of Millennium Development Goals 4 and 5 by extending community access to health care; community participation is a pillar of the strategy.

Community Health Unit: Within Kenya's health system, a level I health unit comprising about 5,000 individuals, with oversight by a Community Health Extension Worker (CHEW), supported by a cadre of Community Health Workers; fulcrum of the Community Health Strategy.

Community Health Volunteer (CHV): An individual, male or female, recruited and trained to provide basic home-based and community-based health services; community mobilization and referral is a central function, with a focus on maternal and child health, community hygiene and sanitation, and family planning. Each CHW is assigned to a specific Community Health Unit and supervised by a Community Health Extension Worker; they are generally regarded as volunteers though some CHWs receive stipends.

Continuing Medical Education (CME): In-service training and updating of knowledge and skills to maintain a certain standard of clinical proficiency for different cadres of health professionals.

County Health Management Team (CHMT): Entity created under devolution to provide technical and management coordination and oversight of health service delivery within a particular county.

Devolution: In Kenya, a political reform that transferred authority and financial responsibility from central government structures to autonomous, sub-national administrative units known as counties.

Dried Blood Spot (DBS): Blood samples that are blotted and dried on filter paper; DBS samples are easy to prepare and store in resource-limited settings and have shown promise for use in Polymerase Chain Reaction (PCR) testing for diagnosis of HIV-exposed infants.

End-of-activity evaluation, end-of-term evaluation and end-of-project evaluation were used interchangeably to mean evaluation of the APHIAplus Imarisha at post intervention phase.

Household Economic Strengthening: Activities that link vulnerable families to economic services and/or opportunities that expand their assets and/or promote their market participation.

Mentor Mothers: A peer-support approach that involves training and supporting mothers who are living with HIV to provide basic health education and psychosocial support to other HIV-infected mothers, one-on-one and in groups.

Mentorship: A form of strengthening the capacity of health service providers and/or technical staff through one-to-one pairings with APHIAplus technical advisors and SCHMTs.

On-the-Job Training: Individualized training that occurs within the confines of the clinic environment to minimize service disruptions often associated with off-site training.

Opportunistic Infections (OIs): Various types of infections (e.g., viral, bacterial, fungal) associated with a weakened immune system.

Output-Based Aid: A form of results-based financing that aims to increase access to health services for the poorest segments of society; usually achieved through a combination of subsidies, rewards, and performance-based incentives.

Quality Improvement (QI): A series of techniques and/or methods employed to maximize high standards and performance at health service delivery sites and/or by persons involved in community-based service delivery.

Skilled Delivery: When a delivery/birth event is assisted by an individual who is trained and qualified to manage both normal and complicated deliveries. Doctors, nurses, and midwives qualify as "skilled birth attendants." Traditional birth attendants (TBAs), regardless of years of experience and/or ad hoc training or support received, are not recognized as skilled birth attendants.

Sub-County Health Management Team (SCHMT): Under Kenya's devolved governance system, the team provides coordination/oversight of community health services. In theory, it is akin to the District Health Management Team, an entity that existed before devolution.

Traditional Birth Attendant (TBA): An unskilled individual, usually an elderly female, who resides within a community and has established a reputation as a source of delivery assistance when mothers deliver their babies at home; TBAs are not sanctioned delivery providers by the Government of Kenya or the World Health Organization.

EXECUTIVE SUMMARY

The United States Agency for International Development / Kenya and East Africa (USAID/KEA) commissioned an end-of-activity evaluation in January 2018 of the APHIAplus Imarisha program, a five-year cooperative agreement funded by USAID/KEA that started on March 1, 2012. APHIAplus Imarisha was implemented by African Medical and Research Foundation (AMREF) in collaboration with consortium partners including Catholic Relief Services (CRS), Land O' Lakes (LOL), FHI360, Broad Reach Healthcare (BRHC), and University of Maryland working with local implementing partners (LIPs). The evaluation covered the period from March 2012 through March 2017 and was carried out targeting two counties of the program activity: Turkana and Samburu.

Evaluation Services and Program Support (ESPS) received a Task Order (TO) from USAID/KEA to conduct the end-term evaluation of three of the health flagship activities noted above. The reference period for the evaluation is March 15, 2012, through March 14, 2017. The evaluation served two main purposes: (1) To learn to what extent the activities' objectives and expected health outcomes at county, sub-county, health facility, and community levels were achieved, including effectiveness of APHIAplus model, key lessons learned and challenges; and (2) to identify implementation strategies in terms of the "what" and the "how to" that have a high likelihood of achieving sustainable health and institutional strengthening outcomes for the Northern Arid Lands (NAL) region.

The evaluation utilized both qualitative methods (document review, key informant interviews, focus group discussions) and quantitative methods (household surveys and organizational capacity assessment) approaches to collect data from primary and secondary sources with a contribution analysis case study looking at both annual work plans and progress reports to understand what worked and what did not work. A total of 979 mother-child pairs, 537 orphans and vulnerable children (OVC) caregivers, 68 key informant interviews (KIIs), 38 Organizational Capacity Assessments (OCAs) (17 with health facilities, 13 with community units, 8 with CHMT) responded to the evaluation from January 18, 2018, through February 8, 2018. In addition to descriptive statistical analysis the evaluation used grounded theory analysis, comparative analysis, content and triangulation, and inferential analysis to analyze the collected data. Two validation workshops held in the two focus counties helped ground evidence that led to the development of conclusions from the validated findings and resulted in the development of the suggested relevant recommendations.

The key findings of the evaluation are as follows:

- Over the life of the project, HIV positivity yield at antenatal care (ANC) decreased from 5.5 percent (95 percent CI: 4.6 percent, 6.4 percent) in 2012–2013 to 3.7 percent (95 percent CI: 3.2 percent, 4.2 percent) in 2016-2017.
- There was a scale-up of HIV testing among adults and children. HIV positivity yield (overall) decreased from 4.3 percent (95 percent CI: 4.0 percent, 4.6 percent) to 1.4 percent (95 percent CI: 1.38 percent, 1.45 percent).
- The proportion of positive clients initiated on antiretroviral therapy (ART) increased from 52.1 percent (95 percent CI: 48.6, 55.6 percent) in 2012–2013 to 85.5 percent (95 percent CI: 83.1, 87.9 percent) in 2015–2016. Out of all clients initiated on testing HIV positive, the proportion of adults initiated on treatment increased from 46.3 percent (95 percent CI: 42.6 percent, 49.9 percent) to 83.8 percent (95 percent CI: 81.2 percent, 86.4 percent).
- Among prevention of mother-to-child transmission of HIV (PMTCT) clients, the proportion on ART with viral load suppression is 58.3 percent (95 percent CI: 32 percent, 80.7 percent).
- Over the life of the project, polymerase chain reaction (PCR) positive results at 8 weeks increased from none in 2012–2013 to 7.7 percent (95 percent CI: 3.1 percent, 12.3 percent) in 2016–2017.

- There was a scale-up of PCR results at 8 weeks among children. However, PCR results positivity yield (overall) decreased from 8.9 percent (95 percent CI: 1.5 percent, 16.4 percent) in 2014 to 7.7 percent (95 percent CI: 3.1 percent, 12.3 percent) in 2016–2017.
- The proportion of children initiated on ART increased from none in 2012 to 79.3 percent (95 percent CI: 64.6 percent, 94.0 percent) in 2016–2017.
- Voluntary male medical circumcision (VMMC) uptake was highest among the 15- to 24-year-old clients compared with males aged 25 and above; this is due to the activity focus on teenagers and school-going children and can be attributed to the project interventions. VMMC positivity yield dropped from 2.59 percent (95 percent CI: 1.7 percent, 3.4 percent) in 2012-2013, and 0.38 percent (0.05 percent, 0.7 percent) in 2016–2017.
- Coverage levels for fully vaccinated children under 1 were the lowest in Loima (2.4 percent), followed by Turkana Central (9.1 percent) and Turkana West (9.4 percent). The highest proportion of fully immunized children under 1 was in Samburu West (21.4 percent) and Samburu East (19.6 percent).
- Assisted birth delivery was on average high in Samburu County, ranging from 63.5 percent in Samburu East to 74.1 percent in Samburu West, while in Turkana, skilled birth attendance varied (lowest coverage in Turkana West (47.4 percent) and the highest in Turkana Central (72.1 percent)).
- Postnatal care within 48 hours after birth varied from 44.4 percent (95 percent CI: 34.6 percent, 54.7) in Turkana East to 69.6 percent (95 percent CI: 60.6 percent, 77.2 percent) in Turkana North. In Samburu, the lowest coverage was observed in Samburu East 47.9 (95 percent CI: 38.2 percent, 57.8 percent), and was highest in Samburu North 59.9 percent (95 percent CI: 51.6 - 67.5 percent).
- Capacity assessment of health facilities shows varied services offered by CHV as well as gaps in quality improvement initiatives. The assessed Sub-County Health Management Team (SCHMT) had low levels of enabling environment for sustainability. The Ministry of Health (MOH) CU functionality scorecard pointed to noticeable gaps in access to equitable health services.
- Testing at ANC increased over the evaluation period, from 2,397 in 2012 to 5,834 in 2017, with decreasing positivity rates (HIV positivity yield at ANC decreased from 5.5 percent (95 percent CI: 4.6 -6.4 percent) in 2012–2013, to 3.7 percent (95 percent CI: 3.2 - 4.2 percent) in 2016–2017).
- The proportion of pregnant women initiated on ART also increased. The proportion of ANC clients on ART increased from 25.8 percent (95 percent CI: 18.3 percent, 33.2 percent) in 2012–2013 to 33.3 percent (95 percent CI: 27.0 percent, 39.6 percent) in 2016–2017. The increase in the number of pregnant women tested and the proportion of those initiated on ART can be credited to the program's strategies to improve PMTCT outcomes, among them mentor mothers (MMs). These results indicate that MMs and the roles they play were positively received by clients, communities, and health care workers (HCWs). MMs were noted to be approachable and well informed on matters pertaining to PMTCT. The absorption of the MMs into the county staffing has not yet been adopted, which means the role is donor supported with no ownership from the county government.
- The block grant not only provided alternative livelihoods but also increased OVC caregivers' resilience. It has provided evidence of successes in supporting OVC household economic strengthening (HES) and made them resilient, and increased retention and progression in schools has been made possible by the partnership between OVC caregiver groups and the schools. However, reduction of provided services and number of LIPs due to funding constraints resulted in less success for the direct support to OVC to meet their immediate and critical needs. In addition, there was not a clear sustainability and exit strategy: the OVC support was not owned by the county government and was donor-dependent.

In conclusion, the end-of-activity evaluation established that the activity was in line with the national and county strategies and policies that aim to address health for the marginalized NAL counties. The end-term evaluation (ETE) further established that the activity had laid a strategic foundation in its initial years for attainment of sustainable outcomes. It was also established that the activity approaches used

contributed largely to the achievement of the positive outcomes witnessed. Some of the lessons learned are that partnerships and networking with local stakeholders and the community are key to increase reach, sustainability, and ownership. Specific partnership models that showed contribution to the achieved health outcome include involvement of community health volunteers (CHVs), expert patients/clients, peer volunteers, and MMs who were crucial, particularly in reaching the PMTCT outcomes. In addition, creating community demand for health services must be matched with the availability of improved services within health facilities. Further, community participation and involvement in the strengthening of health care delivery elicits grassroots acceptance creating a sense of ownership and increased utilization of health services.

The evaluation strongly recommends the need for developing and implementing a joint action plan/memorandum of understanding as well as a robust exit and sustainability strategy that clearly links the phase-out of project activities to county governments' interventions, including OVC support. This would ensure that the county governments together with other partners actively participate and take over the continued implementation of the project interventions and activities for sustaining the gains achieved by the project. Further, there is need to ensure that an integrated project like APHIAplus Imarisha takes into account all health focus areas without over-delivery on one at the expense of the other areas. Success stories should be widely shared within counties and scaled up to other counties. To address immediate food needs, small-scale vegetable and poultry farming should be considered and promoted. There is need to invest more resources and for more collaboration between stakeholders to ensure access to all immunizations especially OPV3, DTP3, and measles vaccines. VMMC needs to focus on all sexually active age groups rather than targeting only the children attending school.

1 INTRODUCTION

Evaluation Purpose: The United States Agency for International Development Kenya and East Africa (USAID/KEA) commissioned an end-of-activity evaluation in January 2018 of the APHIAplus Imarisha program, a five-year cooperative agreement, to determine the extent to which the activities have met the expected health outcomes as were expressed in the five-year implementation framework. It looked at all aspects of the activity that have direct and indirect bearing on the anticipated health outcomes. The information therein will inform future direction in activity design, development, implementation, and management strategies.

Audience: The primary audience for the findings of this evaluation is USAID/KEA, Health Population and Nutrition (HPN) leadership, USAID technical team, and the implementing partner (AMREF) and its consortium partners. USAID/KEA's Office of Strategic Planning and Analysis, Office of Economic Growth, Education and Youth Office, and Democracy and Governance Office are part of the next level of primary audience for the evaluation findings. Secondary users of the evaluation findings include key stakeholders that implemented activities in national and county governments, MOH programs such as the National AIDS and STI Control Program (NASCOP), Family Health Programs, Ministry of Gender and Social Services/Department of Children Services, National Water and Sanitation Programs within the Ministry of Health, among others. Finally, the donor communities supporting health programs are also consumers of the evaluation findings.

Synopsis of tasks: The end-of-project evaluation serves two main purposes: (1) to learn to what extent the activities' objectives and expected health outcomes at county, sub-county, health facility, and community levels were achieved, including effectiveness of APHIAplus model, key lessons learned, and challenges; and (2) to identify implementation strategies in terms of the "what" and the "how to" so as to ascertain the likelihood of achieving sustainable health and institutional strengthening outcomes for the NAL region. Through a two-phase approach, the evaluation sought to respond to these objectives by answering the following key questions:

1. What is the current coverage/improvement status on the priority health outcomes in HIV/AIDS; Reproductive, Maternal, Newborn, and Child Health (RMNCH); Nutrition, Water, and Sanitation; and institutional/organizational capacity building? To the extent possible, determine the activity's contribution to the observed health outcomes.
2. To what extent has the activity increased the capability of health community, health facility, and county health management teams to sustain the gains in the observed health outcomes?
3. What implementation challenges did the activity face during the implementation period and how were these challenges addressed? *(This question examined successes; challenges with the primary outcomes being programmatic and management lessons learned, especially on institutional capacity building; sustainable household economic strengthening (HES) models for OVC vulnerable households; and overall sustainability of implemented strategies to guide future programming decisions).*

Additionally, using a case study approach, key analysis questions informed by evidence coming out of phase I were developed as well as an in-depth content analysis of the annual work plans for years 1–5 and corresponding quarterly progress/annual progress reports and documents. This was to ascertain what appeared to have worked and what did not work.

2 BACKGROUND

Development Problem: The Northern Arid Lands (NAL) comprise eight counties characterized by harsh climatic conditions that are economically stagnated. The region covers about 70 percent of Kenya's land mass with an estimated population of 4,469,174. Communities are predominantly nomadic or semi-nomadic and conservative, and the population is sparsely distributed (1 to 2 persons per sq. km). The availability and quality of health services in the NAL is poor. Barriers to health—including harmful cultural attitudes, social stigmas, limited financial resources, high illiteracy levels, and low education levels—often prevent people from accessing quality health services even where they are available. Most of the health indicators fall far below the national average. In all regions except North Eastern (67 percent), 94 percent or more of women received antenatal care from a skilled provider (Demographic Health Survey, DHS2014). Less than 90 percent of women in Garissa, Marsabit, West Pokot, and Samburu and less than 60 percent in Mandera and Wajir received antenatal care from a skilled provider; 47 percent of women in Mandera received no antenatal care at all (DHS2014). HIV prevalence varied greatly by region with a low of 2.1 percent in Eastern North region to 15.1 percent in Nyanza region; North Eastern had the lowest prevalence for both rural and urban areas at 1.5 percent and 3.6 percent respectively (KAIS 2012).

USAID Kenya Response: Design and Implementation Approach: Broadly, APHIAplus Imarisha activity has a regional/county and sub-county focus, working closely with county and sub-county health management teams to support provision of integrated health services at health facilities and the community level. Specifically, these include HIV/AIDS; malaria; Family Planning/ Reproductive Health (FP/RH); Maternal, Newborn, and Child Health (MNCH); Water, Sanitation, and Hygiene (WASH); Orphans and Vulnerable Children (OVC); and other social determinants of health. These activities are implemented by a consortium of several local and international partner organizations that bring specialized expertise to contribute to the achievement of the overall goals and objectives. Specific activity design and implementation approaches are described below.

In order to sustainably improve the health outcomes and create impact among the residents of the NAL, the implementing partner proposed to build on more than 30 years of development experience in the region. The African Medical and Research Foundation (AMREF) proposed to deploy a holistic program design intended to empower and strengthen health service delivery and social development structures in the region to sustainably fulfill their mandate of providing health and development services while

integrating their actions for synergy. This design was informed by participatory consultations with NAL health and development stakeholders through the activity jointly with stakeholders' identified needs, gaps, and practical solutions. Using this program design, the activity set out to (i) strengthen the capacity of community to county (levels 1 to 4) health systems to deliver high-quality services, products, and information and create demand for the same; (ii) strengthen the ability of local social and economic development structures to create positive change in livelihoods, food security, education, and social protection; and (iii) through proven approaches such as the Saving and Internal Lending Communities (SILC) model by CRS and the value chain approach by Land O' Lakes, foster multi-sectoral integration by creating practical and synergistic linkages between actions at the health system level and among social and economic development initiatives in order to improve health outcomes. Social and economic development initiatives were to have a significant impact on health in the medium and long term and form an important entry point for health development in the NAL region.

In the health system, the activity proposed to strengthen the capacity of District and later County Health Management Teams (CHMTs); health facility staff and management committees; Community Health Units (CHUs) and civil society organizations (CSOs). Key target development structures for capacity strengthening included local CSOs, local cooperatives, county leadership, women's and youth groups, livestock and other cooperatives, religious structures, cultural fora (e.g., elders' fora), primary and ECD schools, and water management committees. Integrated actions were to include joint outreach actions on livestock and human health as well as joint MNCH and WASH actions. The activity proposed to work with government departments—Ministry of Health (MOH), Ministry of Education (MOE), Ministry of Livestock, National Drought Management Authority (NDMA), and Ministry of Public Services; Youth and Gender Affairs—CSOs, livestock and other cooperatives, schools, water management committees, and cultural structures to integrate interventions that were expected to strengthen the health system with those that were to address social health determinants. The activity was to work with the ministries of Health and Livestock at local levels to combine efforts with mobile pastoral training units to deliver integrated human health and animal health outreach, starting with areas such as Isiolo and Wajir where pastoral training units were already active. The activity was to prioritize the Annual Operating Plan (AOP) cycle and empower sub-county and county health management teams to prepare SMART plans and supervise, document, monitor, and review implementation of a multi-sectoral approach to attain health and developmental results.

End-of-Activity Performance Evaluation - Purpose: Evaluation Services and Program Support (ESPS) received a Task Order (TO) from USAID/KEA to conduct the end-term evaluation of three of the health flagship activities noted above from March 15, 2012, through March 14, 2017. The end-of-project evaluation serves two main purposes: (1) to learn to what extent the activities' objectives and expected health outcomes at county, sub-county, health facility, and community levels were achieved, including effectiveness of APHIAplus model, key lessons learned, and challenges; and (2) to identify implementation strategies in terms of the "what" and the "how to" so as to ascertain the likelihood of achieving sustainable health and institutional strengthening outcomes for the NAL region.

3 METHODOLOGY

In addressing the three key evaluation questions the evaluation team employed a nonexperimental post-intervention design using a mixed-methods approach that used both quantitative and qualitative elements as described below. The methodology was informed by the evaluation requirement in focus counties: that is HIV (*Voluntary Medical Male Circumcision; HIV testing; Elimination of Prevention of Mother to Child Transmission of HIV*) in Turkana County only; and the Orphans and Vulnerable Children (OVC) program and Maternal, Newborn, and Child Health (MNCH) in both Turkana and Samburu.

3.1 Sources of Data: The following data sources were used for this end-term evaluation:

- **Document review:** The document review provided the Evaluation Team with background information on activity during the life of the activity—March 2012 through March 2017. Specifically, the document review enabled the team to better understand the activity's goals, objectives, and interventions; inform the design of the data collection tools and instruments; and determine the characteristics of both stakeholders and activity beneficiaries that were interviewed. Activity documents served as secondary data sources for trends analysis when possible. Annex 5 provides the complete list of the documents reviewed for the evaluation.

- **Key Informant Interviews/Panel Discussions:** A cross-sectional design using qualitative methods was used to conduct key informant interviews (KIIs) and panel discussions with various stakeholders and Implementing Partners (IPs) in the NAL region and at national level. Panel discussions/KIIs were conducted with CHMT, SCHMT, LIPs, and CUs to elicit expert opinion on the implementation of the activities, outputs, outcomes, and impacts of the Activity in the NAL region.

- **Focus Group Discussions:** The Evaluation Team conducted focus group discussions (FGDs) with the following five target groups: Maternal Newborn and Child Health (MNCH) clients; Comprehensive Care Clinics (CCC) clients, and Youths (15- to 24-year-olds) who participated in HIV prevention services (restricted to Turkana County); OVC caregivers supporting orphans and vulnerable children; and Community Health Workers (CHW).

- **District Health Information System (DHIS2) and the Early Infant Diagnosis/Viral Load (EID/VL) System:** These were used to abstract HIV program data from the 17 counties supported by the Activity between 2015 and 2017.

- **Household Surveys and Observations:** This evaluation included two cross-sectional household surveys targeting women of reproductive age (15- to 49-year-olds) and OVC households. The objectives of these surveys were to: (a) measure population health estimates guided by some specified key priority indicators on fourth ANC attendance; delivery under skilled attendant; immunization coverage; proportion of children who receive postnatal care (PNC) within 48 hours after birth; skilled birth attendance; family planning uptake specifically for MNCH/FP; and OVC school enrollment, attendance, and progression under OVC support; (b) assess community-based household economic strengthening initiatives; (c) assess water, sanitation, and improved hygiene; (d) assess food security and sustainable livelihoods; (e) assess adoption of health behaviors; and (f) assess barriers to accessing and utilizing health services.

- **Organizational Institutional Capacity Assessment:** This evaluation included an organizational capacity assessment (OCA) of the county health management teams (CHMT), health facilities and community units.

- **Case Study:** Using the priority outcomes and expected health outcomes, the Evaluation Team used a case study approach and analyzed the APHIAplus Imarisha work plans and the corresponding quarterly and annual work plans to determine what worked/not worked over the Life of the Activity. Evidence from the case studies augmented information obtained from primary data obtained during fieldwork (KIIs, FGDs, household surveys, and OCAs).

Two validation workshops—one in Maralal (Samburu County), the other in Lodwar (Turkana County) — were conducted to capture stakeholders' views on implementation strategies and discuss the findings. The validation workshops informed the conclusions of the evaluation and led to the suggested recommendations.

3.2 Sampling strategy

Selection of health facilities: The health facilities were first stratified by county/sub-county and type of facility. The population of supported health facilities (PMTCT or PMTCT/ART sites) in FY 2015–2016. All were high-volume, as defined by facilities with ANC/PMTCT client load of >200/year for health centers/ dispensaries. The sample included 17 health facilities (eight in Turkana, and nine in Samburu). These provided sites for KIIs, FGDs, and OCAs for this evaluation (see Annex 5 – List of Health Facilities). Note: HIV data (from DHIS and EID/VL databases) for all 17 health facilities supported by the Activity in Turkana between 2015 and 2016 was included in the analysis.

Selection of LIPs: All community-based organizations (CBOs) supporting OVC in the target counties supported by the Activity were included in this evaluation.

Selection of community units: This was restricted to those linked to a sampled health facility. Each community unit in the sample was purposively selected based on (i) its community work with a sampled health facility, (ii) its functionality, (iii) the community unit's catchment population, (iii) its proximity to the sampled health facility and/or CBO (in case of more than one CU) and, (iv) its geographical location to ensure a good representation of the activity's geographic coverage. Thirty-eight OCAs (17 with HFs, 13 with CUs, 8 with CHMTs) were completed during this evaluation.

Selection of FGD participants: The Evaluation Team liaised with the MNCH clinics, CCCs, CUs, and CBO in-charges to estimate the average number of clients seen per day (for facility beneficiaries), the number of OVC caregivers (for CBOs supporting OVCs), the average number of Youth (15- to 24-year olds) who participated in HIV prevention services in a month (for CBOs supporting evidence-based interventions targeting youths) and the number of community health workers supporting community work within each sampled facility. A total of 41 FGD were completed (22 in Turkana and 19 in Samburu).

Sample for the household survey: A cross-sectional study design was used to estimate the priority health outcome indicators at the household level. This evaluation included two household surveys in the targeted sub-counties: (1) a household whose target population was mother-child (under 5 years) pairs; and (2) a household survey whose target population was OVC–Caregiver pairs. Within each sub-county, cluster random sampling approach with Lot Quality Assurance Sampling (LQAS) technique was used to provide sub-county-specific population health estimates and identify wards within the target sub-counties that could be lagging behind on program targets.

Stratification by wards: Within each sub-county, all wards were identified. The wards served as the primary units (distinct strata) for the survey. Stratification by wards was applied to (i) minimize sampling errors; (ii) ensure proper representation; and (iii) identify wards that are below the program coverage levels.

Supervision Areas: All wards served as the LQAS supervision areas (SA) for this end-term evaluation. LQAS samples of 19, 24, and 30 were selected depending on the number of SA in each sub-county. This ensured that the final sample size per SA is sufficient for LQAS classification and estimation purposes at the county level (i.e., on aggregating LQAS sample within each county). A total of 979 for mother-child pairs and 537 OVC caregivers were interviewed.

Key informants/panel discussion participants were purposively selected for this evaluation. Representatives of key institutions, government departments, and developmental partners, as well as IP/consortium members who are most informed about APHIAplus Imarisha activity were sampled. In total, 68 key informant interview (KII) sessions (9 at national level, 26 in Turkana County, and 33 in Samburu County) were conducted.

3.3 Data management and analysis

Household survey data: Data collection used handheld devices (Android-enabled mobile phones) to collect the survey data. The survey questionnaire was programmed/administered electronically using

Survey ToGo Dooblo Software. Relative frequencies with 95 percent Wilson Score Confidence Intervals were used in analysis. The results were classified by constituencies, as well as by indicator definition. All analysis was conducted using STATA 15 (*StataCorp. 2015. Stata Statistical Software: Release 14. College Station, TX: StataCorp LP*).

Routine program HIV data: The team downloaded District Health Information System (DHIS2), and Ministry of Health's Early Infant Diagnosis/Viral Load (EID/VL) program data from 17 health facilities on selected priority outcome indicators (March 2012 through March 2017). In addition, the evaluation teams conducted data quality assessment to verify the accuracy of the data obtained from DHIS2. Proportions (HIV positivity yield) and 95 percent Wald Confidence Intervals were computed for each priority outcome indicator. All data analysis (graphics) were conducted using R Statistical Programming (v.3.3.3).[i]

Qualitative data analysis relied on content and triangulation analysis, which was adopted as an analysis tool to identify key thematic areas. Triangulation from the different data sources above was used to build a coherent justification for the themes/evidence emerging from desk reviews, interviews with various target respondents, and work plan analysis.

Analysis of case studies: The analysis focused on the annual work plans for years 1–5 and the corresponding quarterly progress/annual progress reports, and documents the intended interventions and implementation strategies.

3.4 Organization of fieldwork

Timelines: A pre-fieldwork phase desk review (January 2–January 6, 2018) and team planning meeting (January 8–January 13, 2018) were conducted. Research training was conducted within the counties in Turkana (January 14 –January 18, 2018) and Samburu (January 18–January 22, 2018). Fieldwork was conducted from January 18, 2018, through February 8, 2018. The Activity period under review was March 2012 through March 2017.

Team composition: IBTCI assembled a team of professionals to conduct the end-term evaluation in the two counties. A senior local public health expert and four local experts led the team. John Paul Oyore, BSc, MSc, PhD, a senior public health expert, served as the team leader and brought both evaluation and HIV technical expertise. He worked with four other Kenyan experts—an RMNCH specialist (Angela Nguku, BSN, MSc, MA), a social scientist (Grace Jowi-Jobita, BA, MA), a public health specialist (Philip Wambua, BSc, MPH), and a monitoring and evaluation (M&E) specialist (Nelly Yatich, BSc, MSc, PhD). Two sub-team leaders coordinated the fieldwork; 36 research assistants (RAs) collected field data and were responsible for gathering household survey data. The sub-team leaders and two capacity assessors collected qualitative data and organizational capacity assessment data. The RAs interviewed mother-child pairs and OVC caregivers while the sub-team leaders and the capacity assessors interviewed health facility staff and county health management teams and conducted FGDs with beneficiaries. ESPS recruited the RA team through the Kenya National Bureau of Statistics, selecting RAs who had prior experience in conducting national surveys and carrying out field-related data collection activities specifically in the assigned counties.

3.5 Limitations

The non-experimental post-intervention design used doesn't account for non-APHIAplus Imarisha activity influences on outcomes because there are no comparison sites or groups; casual attribution is not possible but inferential analysis and triangulation led to an attempt to establish relationship among relevant variables. On immunization, there was a possibility of recall bias for the household survey data since the data collected was based on mother's report only. The quality of the secondary data sources from the DHIS2 data on HIV led to values of more than 100 percent as a result of poor quality data coming from health facilities. The number of household economic support (HES) groups per ward could

not be ascertained, especially in Turkana, thus an estimate of the proportion of HES groups per ward could not be computed. However, the number of HES groups by LIP is presented in the findings section.

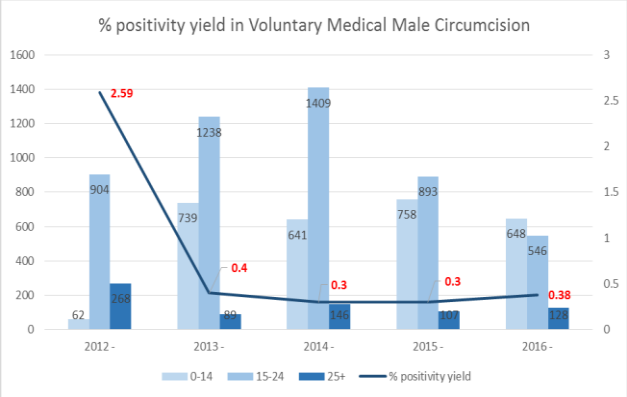
4 FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

PHASE I: EVALUATION QUESTIONS

EVALUATION QUESTION 1: What is the current coverage/improvement status on the priority health outcomes in HIV/AIDS, RMNCH, Nutrition, Water and Sanitation, and institutional/ organizational capacity building? To the extent possible, determine the activity's contribution to the observed health outcomes.

Voluntary Medical Male Circumcision (VMMC)

Figure 1 – % Positivity Yield in Voluntary Medical Male Circumcision



Source: DHIS (March 2012–March 2017)

VMMC activities scaled up between 2012 and 2014; however, after 2014, there was a notable drop in the number of VMMC clients. Uptake was generally low among males aged 25 and above, and highest among the 15- to 24-year-old clients. VMMC positivity yield dropped from 2.59% (95% CI: 1.7%, 3.4%) in 2012–2013 and 0.38% (0.05%, 0.7%) in 2016–2017. Only five of the sampled facilities reported on VMMC, with reporting rates ranging from 50% to 83.3%.

Activity's contribution: The APHIAplus Imarisha activity supported resuscitation of VMMC activities in Turkana through partnership with a local implementing partner, African Inland Church (AIC)–Turkana West sub-county; renovation of the theatre at AIC Lokichoggio; recruitment of a skilled VMMC team (surgeons, nurses hygiene promoters, HIV Testing and Counseling (HTC) counselor, and community mobilizers); provision of logistics for community entry; community mobilization/awareness activities (during school holidays, through VMMC champions); and post-circumcision support.[ii] However, there was a lack of MOH ownership of implementation at the county level—the activity implemented the services through their staff deployed by the project with minimal involvement of MOH staff. Therefore, when the activity came to an end there was a lack of continuity and the VMMC services stalled. This applied to other HIV service delivery areas. [iii] VMCC is considered a new practice within the Turkana community, and the use of VMMC champions aided in increasing its acceptability.[iv] The activity mostly targeted teenagers and the school-going population rather than more sexually active older boys and men,[v] as evident in the trends in Figure 1 above.

HIV Testing

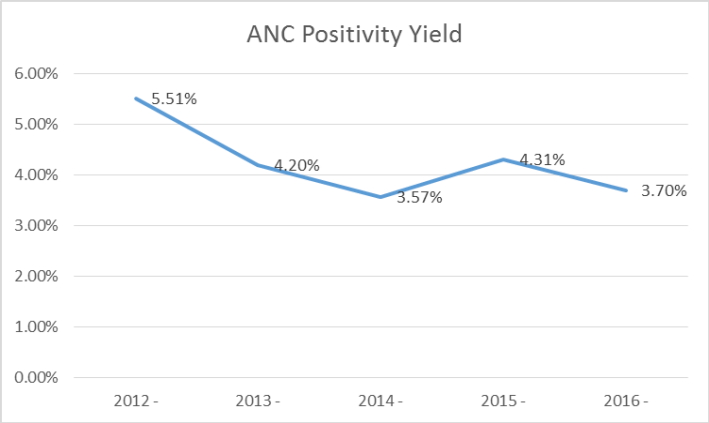
In each program year except for 2015–2016, the HIV positive rate across all age categories was generally higher among females than males. HIV positive rates were generally higher among clients aged 25 years and above than for other age categories.

Table 1 – Antenatal HIV Testing

Year	ANC Testing	Testing HIV Positive	Known HIV Positive Status	Total HIV Positive (at ANC)	% Positivity Yield
2012	2397	59	73	132	5.51%
2013	3501	48	99	147	4.20%
2014	5156	72	112	184	3.57%
2015	5128	80	141	221	4.31%
2016	5834	58	158	216	3.70%

Source: DHIS (March 2012–March 2017)

Figure 2 – Proportion of Pregnant Women Testing Positive at ANC
Source: DHIS (March 2012–March 2017)



Over the life of the project, HIV positivity yield at ANC decreased from 5.5 percent (95% CI: 4.6%, 6.4%) in 2012–2013 to 3.7% (95% CI: 3.2%, 4.2%) in 2016–2017. There was a scale-up of HIV testing among adults and children. HIV positivity yield (overall), decreased from 4.3% (95% CI: 4.0%, 4.6%) to 1.4% (95% CI: 1.38%, 1.45%).

HIV Care and Treatment

The proportion of positive clients initiated on ART increased from 52.1 percent (95 percent CI: 48.6, 55.6 percent) in 2012–2013 to 85.5 percent (95 percent CI: 83.1, 87.9 percent) in 2015–2016.

Table 2 – HIV Testing in Adults and Children

Year	Total Tested for HIV	Total HIV Positive	% Testing HIV Positive						
			Overall	Female			Male		
				< 15 YRS	15–24 YRS	25+ YRS	< 15 YRS	15–24 YRS	25+ YRS
2012	20130	789	4.3%	4.6%	15.3%	34.0%	4.2%	13.8%	28.1%
2013	38718	1075	2.8%	5.9%	14.9%	39.2%	4.6%	5.8%	29.8%
2014	40611	817	2.0%	4.5%	13.2%	38.6%	4.8%	6.2%	32.7%
2015	36542	822	2.2%	3.2%	11.6%	35.3%	5.1%	5.1%	39.8%
2016	71004	972	1.4%	6.8%	12.7%	36.9%	5.1%	3.0%	35.5%

Source: DHIS (March 2012–March 2017)

Table 3 – Adults and Children HIV Treatment

Year	Total Tested for HIV	HIV Positive Clients			Clients Initiated on ART			% Initiated on ART		
		Overall	Children	Adults	Overall	Children	Adults	Overall	Children	Adults
2012	20130	789	69	720	411	78	333	52.1%	113.0%	46.3%
2013	38718	1075	112	963	564	90	474	52.5%	80.4%	49.2%
2014	40611	817	76	741	621	82	539	76.0%	107.9%	72.7%
2015	36542	822	68	754	703	71	632	85.5%	104.4%	83.8%
2016	71004	972	116	856	1066	142	924	109.7%	122.4%	107.9%

Source: DHIS (March 2012–March 2017)

Out of all clients initiated on testing HIV positive, the proportion of adults initiated on treatment increased from 46.3 percent (95 percent CI: 42.6 percent, 49.9 percent) to 83.8 percent (95 percent CI: 81.2 percent, 86.4 percent).

Activity's Contribution

The activity offered regular technical assistance to HCWs through trainings, mentorships, and supervisory visits;[vi] and supported HTC through the deployment of short-term HIV Testing Services (HTS) lay counselors who were enrolled in the national HTS proficiency testing for quality assurance. The activity supported the CMLTs and SCMLTs to enroll and distribute the PT panels to the HTC

providers, conduct the HTS Direct observations assessment coupled by periodic support supervision to monitor the competency of the HTS providers and collect the PT feedback from the HTS providers.[vii] HTC provided outreaches (e.g., community HTC in Kalokol Division among the fisher folk and during cultural festivals such as the *Tobongu Lore*).[viii] The activity invested (coordinated and provided technical assistance) to the Turkana County Laboratory technical working group and the sub-county Medical laboratory Coordinators to conduct monthly forecasting, quantify rapid test kits, and submit the monthly reports through the rapid test kit online reporting system. This was in an effort to ensure a steady supply of rapid test kits in the county.[ix]

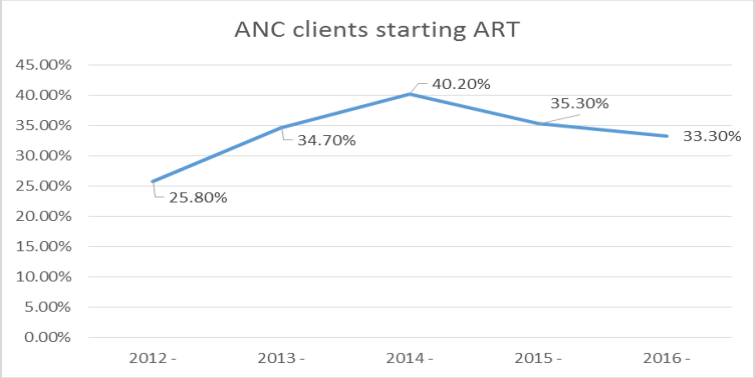
Elimination of Mother-to-Child Transmission of HIV

Table 4 – PMTCT

Year	ANC HIV Testing	Testing HIV Positive	Known HIV Positive Status	Total HIV Positive (at ANC)	ANC Positivity Yield	Starting ART	% Starting on ART
2012	2397	73	59	132	5.5%	34	25.8%
2013	3501	99	48	147	4.2%	51	34.7%
2014	5156	112	72	184	3.6%	74	40.2%
2015	5128	141	80	221	4.3%	78	35.3%
2016	5834	158	58	216	3.7%	72	33.3%

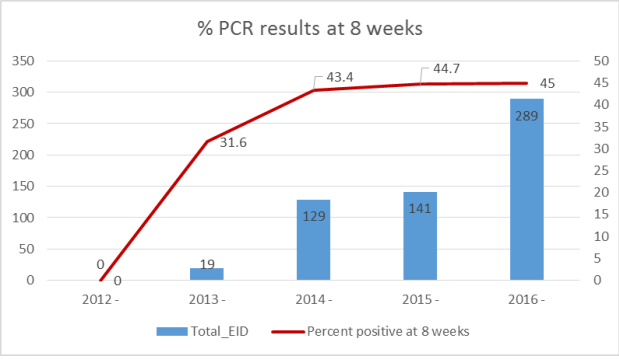
Source: DHIS (March 2012–March 2017)

Figure 3 – ANC Clients Starting on ART
Source: DHIS (March 2012–March 2017)



The proportion of ANC clients starting ART increased from 25.8% (95% CI: 18.3%, 33.2%) in 2012–2013, to 33.3% (95% CI: 27.0%, 39.6%) in 2016–2017. However, the proportion of ANC clients starting ART has been gradually decreasing during the past two years, from 40.2% in 2014 to 35.3% in 2015 and down to 33.3% in year 2016. This could potentially be the result of stigma, discrimination, and nondisclosure in the NAL.[1]

Figure 4 – % PCR Results at 8 Weeks
Source: EID/VL NASCOP System

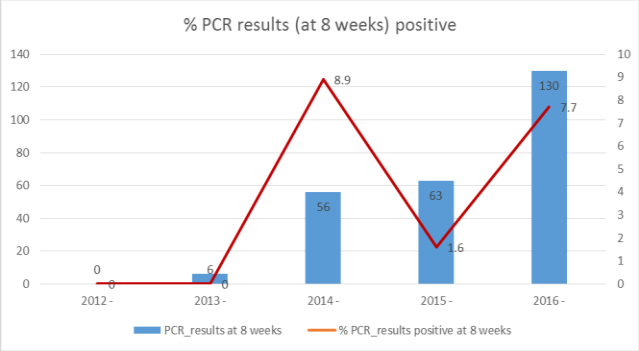


The proportion of PCR results at 8 weeks for the EID tests has progressively increased during the life of the project from none in 2012 to 45% in 2016. There has been a scale-up on the EID testing over time.

Figure 5 – % PCR Results (at 8 weeks) Positive

[1] IMARISHA Quarterly reports (Oct–Dec 2013, Jul–Sep 2016).

Source: EID/VL NASCOP System



Over the life of the project, PCR positive results at 8 weeks increased from none in 2012–2013 to 7.7% (95% CI: 3.1%, 12.3%) in 2016–2017. There was a scale-up of PCR results at 8 weeks among children. However, PCR results positivity yield (overall) decreased from 8.9% (95% CI: 1.5%, 16.4%) in 2014 to 7.7% (95% CI: 3.1%, 12.3%) in 2016–2017.

Figure 6 – % Initiated on Treatment
Source: EID/VL NASCOP System

The proportion of children initiated on ART increased from none in 2012 to 79.3% (95% CI: 64.6%, 94.0%) in 2016–2017.

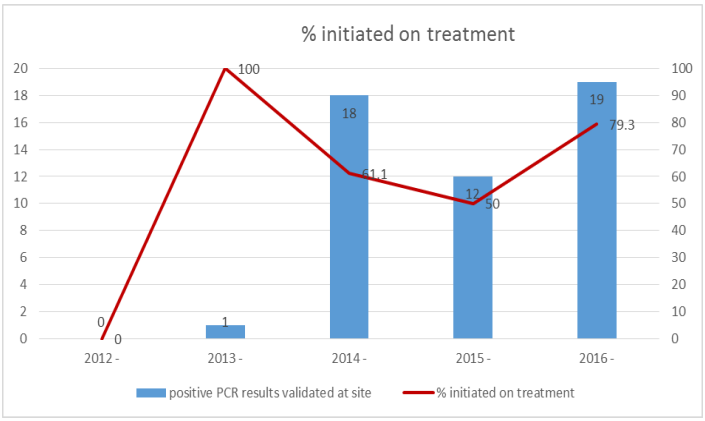


Table 5 – Percentage of patients on treatment with viral load suppression

% patients (PMTCT clients) with viral suppression					
Source: EID/VL NASCOP System	2012	2013	2014	2015	2016
Total VL tests done:	0	0	0	0	12
Routine VL Tests with Valid Outcomes:	0	0	0	0	12
Valid Tests > 1000 copies/ml	0	0	0	0	5
Valid Tests < 1000 copies/ml	0	0	0	0	7
Baseline VLs					
Non-Suppression	-	-	-	-	5 (41.7%)
Suppression	-	-	-	-	7 (58.3%)

Among PMTCT clients, the proportion on ART with viral load suppression is 58.3 percent (95 percent CI: 32 percent, 80.7 percent).

Activity's contribution:

Dissemination of new guidelines: The activity provides technical assistance (TA) through the support of the latest national guidelines and standard operating procedures (SOPs) on HTS, ART, Kenya Mentor Mother Program (KMMP) guidelines. Whenever a new guideline was in place the activity organized dissemination and rollout activities across the county and supported in the distribution of the new guidelines and SOPs.[x]

Mentor Mothers/Link Desk Volunteers: The activity deployed and supported mentor mothers to act as case managers in high-volume facilities. In addition, they trained eight KMMP training of trainers (TOTs) to help in the rollout mentorship of the mentor mothers in the county. Expert patients were also engaged to help educate patients in the health facilities. This was critical in ensuring adherence to and compliance with PMTCT treatment guidelines for HIV-infected pregnant women during pregnancy, delivery, and until 18–24 months postnatal. In addition, the activity also deployed link desk volunteers

within the supported health facilities to help support and direct patients in navigating the health facility as they reached the various points of health care provision within the facility.[xi]

The activity **trained and supported Community Health Volunteers (CHV)** to sensitize the community on HTS and also conducted defaulter tracing and linked the mothers back to the health facilities.[xii] The activity also invested in defaulter tracing for HIV-exposed infants through trainings, deployment of expert patients, mentor mothers, and peer volunteers to ensure that they were traced and brought back to health facilities.[xiii] This was achieved through the activity's support for psychosocial support groups.[xiv] These efforts in defaulter tracing ensured retention of HIV-infected mothers and subsequent enrollment and follow-up of their infants. The activity **capacity built the Health Care Workers (HCWs)** through regular trainings, mentorships, continuing medical education (CMEs), and support supervisory visits on pediatric HIV care and treatment and management of HIV-exposed infants as per the national guidelines;[xv] as well as on orientations, and mentorships on collection of high-quality dried blood spot (DBS) samples for early infant diagnosis (EID).[xvi]

The activity **deployed, trained, and supported adherence counselors** to help address the low viral load suppression. The adherence counselors provided treatment preparation sessions in the supported health facilities. The activity also supported the dissemination of the national standard operating procedures (SOPs), sensitization and mentorship of the HCWs and CHVs on treatment preparation, and treatment literacy.[xvii] These efforts were key in ensuring adherence to treatment guidelines and therefore ensuring client retention into care and treatment and subsequent adherence monitoring that ultimately ensures viral load suppression targets are achieved. To further support treatment adherence, the activity provided logistical support by providing required supplies and stationaries such as airtime, mobile phones, appointment diaries to strengthen the appointment system, and fuel for motorcycles.[xviii]

The activity supported **laboratory sample networking for dry blood spot (DBS) and viral load (VL) testing** to improve access to EID and VL testing. They supported sample storage, transportation, and documentation, and ensured a reasonable turnaround time for the results to get back to the facility for prompt patient management. The activity supported the printing and distribution of VL and EID results in addition to developing the facility line lists for clients due for routine and repeat VLs and EID tests. The activity also improved the skills of HCWs on DBS and VL sample collection, storage, and transportation through continuous orientations, CMEs, and on-the-job training (OJT).[xix]

The activity supported the **monitoring and evaluation function by ensuring proper documentation as per the MOH guidelines and timely and accurate facility reporting**. This also included conducting data reconstruction to ensure quality data are in use for decision-making at the facility and county levels.[xx] The activity also provided logistical support by providing modems and airtime bundles to the MOH to facilitate timely online reporting. In addition, the activity conducted OJT on completion of the HMIS tools and registers and also supported in the distribution of the HMIS tools, registers, and Job Aids from the national/county level to the health facilities in a timely manner.[xxi]

Conclusion

- The activity supported resuscitation of VMMC activities, mainly working with AIC Lokichoggio HC through deployment of facility and community VMMC staff. This led to a notable increase in VMMC activities in 2012–2014 reporting periods.
- There was lack of local ownership of implementation at the county, sub-county, and facility levels. The VMMC uptake was highest among the 15- to 24-year-old clients compared with males aged 25 and above; this is due to the activity focus on teenagers and school-going children.
- Over the life of the activity, there has been an upscale of HTS among adults and children with a corresponding reduction in the HIV positivity rate. This can be attributed to deployment and regular capacity building of HTS lay counselors through trainings, mentorships and support of the HTC outreaches (e.g., *Tobongu Lore).*

- VL testing has yielded valid outcomes only since 2016. The proportion of PCR/viral load suppression among PMTCT clients on ART was 58.3 percent (95 percent CI: 32 percent, 80.7 percent).
- The ANC positivity rate declined from 5.5 percent to 3.7 percent. The proportion of adults (including ANC clients) and children enrolled into care and treatment increased over time, possibly as the result of continuous TA provided by the activity to HCWs (including adherence counselors) through dissemination of the new national guidelines and SOPs; deployment and support to mentor mothers, expert patients, and link desk volunteers; and support provided to the Community Health Volunteers to sensitize the community on HTS and conduct defaulter tracing in the community.

Recommendations

- To ensure sustainability, the programs should continue capacity building of CHMT, SCHMTS, and local MoH HCWs in service delivery as opposed to focusing capacity building on the activity deployed staff;
- VMMC needs to focus on all sexually active age groups (i.e., 15- 49-year-olds) rather than targeting the school-going children.
- Work closely with the county government and advocate for absorption of the deployed staff (e.g., HCWs, adherence counselors, HTS counselors, Mentor Mothers, expert patients, and CHVs) for sustained health outcomes.

Maternal, Neonatal, and Child Health/Family Planning

Table 6 – ANC attendance, assisted delivery, and postnatal care within 48 hours

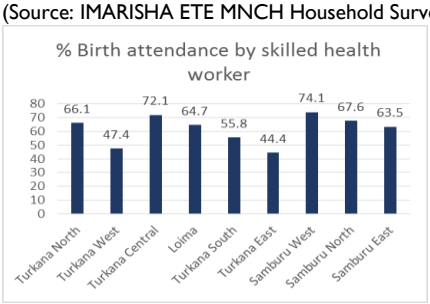
Constituency	N	Pregnant women with 4 or more visits		Skilled birth attendance		Children receiving post-natal care within 48 hours after birth	
		Proportion	**95% CI**	**Proportion**	**95% CI**	**Proportion**	**95% CI**
Turkana North	115	61.7	(52.6, 70.1)	66.1	(57.0, 74.1)	69.6	(60.6, 77.2)
Turkana West	133	58.6	(50.1, 66.6)	47.4	(39.1, 55.8)	48.1	(39.8, 56.5)
Turkana Central	111	51.3	(42.2, 60.4)	72.1	(63.1, 79.6)	64.9	(55.6, 73.1)
Loima	85	65.9	(55.3, 75.1)	64.7	(54.1, 74.0)	65.9	(55.3, 75.1)
Turkana South	95	67.4	(57.4, 76.0)	55.8	(45.8, 65.3)	53.7	(43.7, 63.4)
Turkana East	90	74.4	(64.6, 82.3)	44.4	(34.6, 54.7)	44.4	(34.6, 54.7)
Samburu West	112	62.5	(53.2, 70.9)	74.1	(65.3, 81.3)	58.9	(49.7, 67.6)
Samburu North	142	62.0	(53.8, 69.5)	67.6	(59.5, 74.7)	59.9	(51.6, 67.5)
Samburu East	96	57.3	(47.3, 66.7)	63.5	(53.6, 72.5)	47.9	(38.2, 57.8)

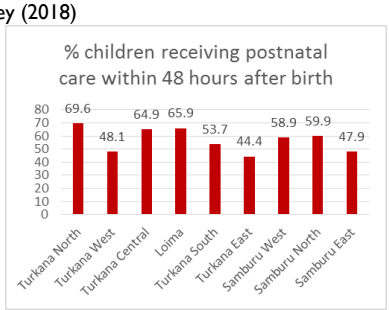
Source: IMARISHA ETE MNCH Household Survey (2018)

In Turkana County, ANC attendance among pregnant women (four or more visits) varied from 51.3 percent (95 percent CI: 42.2 percent, 60.4 percent) in Turkana Central to 74.4 percent (95 percent CI: 64.6 percent, 82.3 percent) in Turkana East; in Samburu, an even distribution was observed, with the lowest coverage in Samburu East 57.3 (95 percent CI: 47.3, 66.7 percent) and the highest in Samburu West 62.5 percent (95 percent CI: 53.2 percent, 70.9 percent). Assisted birth delivery was on average high in Samburu County, ranging from 63.5 percent in Samburu East to 74.1 percent in Samburu West; in Turkana, skilled birth attendance varied, with lowest coverage observed in Turkana West (47.4 percent) and the highest in Turkana Central (72.1 percent).

Figure 7 – Assisted delivery and postnatal care within 48 hours

(Source: IMARISHA ETE MNCH Household Survey (2018)





Postnatal care within 48 hours after birth varied from 44.4 percent (95 percent CI: 34.6 percent, 54.7) in Turkana East to 69.6 percent (95 percent CI: 60.6 percent, 77.2 percent) in Turkana North; in Samburu, the lowest

coverage was observed in Samburu East 47.9 (95 percent CI: 38.2 percent, 57.8 percent) and the highest was in Samburu North 59.9 percent (95 percent CI: 51.6 percent, 67.5 percent).

Activity's Contribution

APHIAplus Imarisha was mainly an HIV activity with minimal MNCH activity support.[xxii] The Government of Kenya (GoK) through the Ministry of Health introduced free maternity services in all public health facilities in June 2013, and services were expanded in October 2016 to include antenatal care, delivery, postnatal care, and emergency referrals for pregnancy-related conditions as well as complications dubbed Linda Mama.[xxiii]

Samburu County: In Samburu County, the activity built the capacity of HCWs on MNCH and Basic Emergency Obstetric and Neonatal Care (BEmONC) through trainings, mentorships, and CMEs.[xxiv] They also supported integrated outreaches in the community that were meant to increase access and utilization of the health services in the vast county and also because of the nomadic lifestyle of the inhabitants.[xxv]

The activity constructed and supported maternal shelters to improve skilled deliveries [e.g., Kisima HC maternal shelter, Lesidai Dispensary maternal shelter (Samburu Central) and Nachola Dispensary maternal shelter (Samburu North)]. The activity also provided supplies such as mattresses, solar lighting, and washing basins to the maternal shelters and the community provided labor.[xxvi] The activity also helped develop SOPs and data capture tools for the maternal shelters to standardize the practice as the service expands. It is worth noting that the fact that health facility deliveries were free of charge also encouraged many pregnant women to deliver at the health facility.[xxvii]

The Activity trained and supported CHVs to educate mothers on the importance of skilled deliveries and to refer them to the nearest health facility for deliveries.[xxviii] The CHVs would also refer mothers to attend the ANC and subsequently PNC services after deliveries. To further boast skilled birth attendance, the activity provided free mother-baby packs (e.g., shawls, soap, and baby bags).[xxix] The activity also supported BOMA model implementation, for instance, through the support of Bendera CU.[xxx] In addition they implemented the UMATI concept through facilitation of the HCWs to provide services during various community forums.[xxxi]

Turkana County: In Turkana County, APHIAplus Imarisha engaged, trained, and supported CHVs as community advocates and as referral agents to support MNCH services.[xxxii] This helped in community mobilization and in creating demand for MNCH services. Integrated outreaches were also supported by the activity in Turkana County to reach women in marginalized areas.[xxxiii] To address the supply side of service delivery, the activity built HCWs' capacity through regular mentorships, CMEs/orientations, and trainings on Emergency Obstetric and Neonatal Care (EmONC) to improve their knowledge and skills to offer EmONC services at the supported health facilities.[xxxiv] This helped build the HCWs' capacity to manage EmONC and refer as appropriate and in a timely manner. In addition, the activity supplied MNCH equipment and supplies that were done through the county.[xxxv] Patient social support groups (PSSGs) were also supported[xxxvi] and these helped promote skilled birth deliveries.

Status of Expected Health Outcomes of Fully Immunized Children Under 1 Year

Table 7 shows the percentage of children under 1 who received specific vaccinations at any time before the survey, according to the mother's report by constituency. The Kenyan immunization program considers a child to be fully vaccinated if the child has received all basic vaccinations [including BCG, three doses each of the DPT-HepB-Hib (also called pentavalent) and polio vaccines, and a vaccination against measles] and three doses of the pneumococcal vaccine (KDHS, 2014).[xxxvii] Coverage levels for fully vaccinated children under 1 were the lowest in Loima (2.4 percent), followed by Turkana Central (9.1 percent) and Turkana West (9.4 percent). The highest proportion of children under 1 in Samburu West (21.4 percent) and Samburu East (19.6 percent) were fully immunized. Coverage levels for fully

vaccinated children under 1 were identical with the coverage level for all basic immunizations in all constituencies except in Turkana South, Turkana East, and Samburu East.

Table 7 – Vaccinations, percentage of children under 1-year

				PENTAVALENT			OPV							PCV			%	95%CI
Constituency	n	% with card	BCG	1	2	3	0	1	2	3	Measles	ALL basic immunizations		1	2	3	Fully vaccinated	
Turkana North	55	92.7	92.7	67.3	56.4	38.2	58.2	72.7	45.4	27.3	36.4	10.9	(2.7, 19.1)	70.9	49.1	38.2	10.9	(2.7, 19.1)
Turkana West	64	87.5	95.3	73.4	51.6	43.8	67.2	84.4	54.7	46.9	25.0	9.4	(2.2, 16.5)	78.1	48.4	42.2	9.4	(2.2, 16.5)
Turkana Central	44	97.7	95.5	81.8	61.4	45.5	79.5	84.1	70.5	54.5	20.4	9.1	(0.5, 17.6)	84.1	65.9	43.2	9.1	(0.5, 17.6)
Loima	40	100	97.5	50.0	40.0	35.0	69.2	92.3	71.8	50.0	30.9	2.4	(0.0, 7.0)	71.8	50.0	45.0	2.4	(0.0, 7.0)
Turkana South	38	89.5	100	71.1	47.4	39.5	78.9	89.5	47.4	42.1	23.7	13.2	(2.4, 23.9)	84.2	44.7	34.2	10.5	(0.7, 20.2)
Turkana East	50	96.0	98.0	78.0	66.0	48.0	62.0	90.0	68.0	44.0	36.0	16.0	(5.8, 26.2)	82.0	68.0	46.0	14.0	(4.4, 23.6)
Samburu West	47	97.9	97.9	76.6	71.3	57.4	54.2	83.3	71.4	57.1	42.9	21.4	(9.0, 33.8)	76.6	73.4	59.6	21.4	(9.0, 33.8)
Samburu North	41	89.7	96.6	87.9	68.4	53.4	67.2	87.9	68.4	53.4	26.6	10.3	(3.2, 18.5)	79.3	65.5	51.7	10.3	(3.2, 18.5)
Samburu East	61	95.1	95.1	80.3	76.1	50.7	63.4	89.6	76.1	52.2	34.8	21.7	(9.8, 33.6)	78.3	71.7	54.3	19.6	(8.1, 31.0)

Source: IMARISHA ETE MNCH Household Survey (2018)

In a given constituency, more children under 1 have received their first dose of the DPT vaccine than their third dose of the DPT. Differentials in coverage across constituencies showed lower proportions of children had received either their first or third DPT dose in Loima (50 percent for DPTI and 35.7 percent for DTP 3) and Turkana North (67.3 percent for first dose and 38.2 percent for the third dose of the DTP). Measles coverage fluctuated between 20.4 percent in Turkana Central and 42.9 percent in Samburu West.

Activity's contribution to children under 1 fully immunized

a) Turkana County: The activity provided TA through regular mentorship, CMEs, and supportive supervisory visits to the HCWs on immunization.[xxxviii] In addition, It supported the county to ensure against stockout of vaccines and for proper maintenance of cold chain.[xxxix] Given the vastness of the county and nomadic lifestyle of the population, the activity invested in outreaches (e.g., supported FBOs and MOH facility outreaches).[xl] This was critical in increasing access to immunization services. They also offered targeted support to national immunization campaigns (e.g., polio campaigns).[xli] To improve the demand of immunization services, the activity trained and supported CHVs to be advocates of immunization. The CHVs provided health education, mobilized mothers and referred them to the health facility to seek immunization services.[xlii]

b) Samburu County: The activity provided TA through routine mentorship, CMEs, and supportive supervisory visits to the HCWs on immunization.[xliii] They invested in outreaches (e.g., supported FBOs and MOH facility outreaches).[xliv] To increase the demand for services, the activity trained and supported CHVs to be advocates of immunization. The CHVs provided health education, mobilized mothers, and referred them to the health facility to seek immunization services.[xlv]

Conclusion

APHIAplus Imarisha was heavier on HIV activity than MNCH activity support over the life of the activity in regard to resource allocation and focus outreach interventions. The activity used CHVs as advocates and referral agents for ANC, SBA, PNC, and immunization services in the community; however, the role of CHV is not institutionalized. The GOK free maternity care, coupled with activity's provision of maternal shelters, free mother-baby packs, and awareness creation through the UMATI concept helped promote skilled birth attendance. Capacity building of the HCWs and provision of EmONC equipment and supplies improved availability to services. In addition, due to the nomadic lifestyle of the population, integrated outreaches helped improve access to ANC and PNC services; however, immunization coverage was significantly low.

Recommendations

- There is a need to allocate more resources toward MNCH activity support to improve and sustain MNCH indicators.
- The role of the CHVs needs to be institutionalized to advocate and mobilize for the MNCH services.
- Integrated outreaches should continue to be promoted to increase access to ANC, PNC, and immunization attendance.
- There is a need to further investigate the reason for such a low yield for immunization services despite the implementation of integrated strategies. Furthermore, more resources and collaboration between stakeholders is needed to ensure access to all immunizations, especially OPV 3, DPT3, and measles vaccines.

Orphans and Vulnerable Children

OVC program outcome indicators were assessed in wards where IMARISHA implemented its OVC program (see Annex 2 – Methodology).

School enrollment, attendance, and progression

Table 8 below shows the status of OVC school enrollment, attendance, and progression as of February 2018. In Turkana County, Loima constituency recorded the lowest rate of OVC school attendance at 86.7 percent (95 percent CI: 70.3 percent, 94.7 percent) while Turkana West had the highest enrollment rate of 97.7 percent (95 percent CI: 84.4 percent, 95.7 percent). In Samburu County, enrollment rates were Samburu West 84.3 percent (95 percent CI: 75.0 percent, 90.6 percent); Samburu North, 84.8 percent (95 percent CI: 71.8 percent, 92.4 percent); and Samburu East, 92 percent (95 percent CI: 81.5, 96.9 percent). The lowest school attendance rate was recorded in Loima constituency at 60 percent (95 percent CI: 42.3, 75.4 percent), and highest was in Samburu North, 78.3 percent (95 percent CI: 64.4 percent, 87.7 percent). School progression rate was lowest in Turkana Central at 72.9 percent (95 percent CI: 59.0 percent, 83.4 percent) and highest in Turkana North, 93.3 percent (95 percent CI: 78.7 percent, 98.1 percent).

Table 8 – OVC school enrollment, attendance, and progression

Source: IMARISHA ETE OVC Household Survey (2018)

Constituency	% Enrollment						% Attendance						% Progression					
	N	Female	N	Male	Cumulative Proportion	95% CI	N	Female	N	Male	Cumulative Proportion	95% CI	N	Female	N	Male	Cumulative Proportion	95% CI
Turkana North	12	83.3%	18	100.0%	93.3%	(78.7, 98.1)	12	66.7%	18	77.8%	73.3	(55.5, 85.8)	12	83.3%	18	100.0%	93.3%	(78.7, 98.1)
Turkana West	49	89.8%	47	93.6%	97.7%	(84.4, 95.7)	49	65.3%	47	76.6%	70.8	(61.1, 79.0)	49	87.8%	47	93.6%	90.6%	(83.1, 95.0)
Turkana Central	25	84.0%	23	73.9%	79.2%	(65.7, 88.3)	25	80.0%	23	65.2%	72.9	(59.0, 83.4)	25	76.0%	23	69.6%	72.9%	(59.0, 83.4)
Loima	18	88.9%	12	83.3%	86.7%	(70.3, 94.7)	18	55.6%	12	66.7%	60.0	(42.3, 75.4)	18	88.9%	12	83.3%	86.7%	(70.3, 94.7)

Turkana South	5 2	94. 2%	4 4	97.7 %	95.8%	(89.8, 98.4)	5 2	71. 1%	4 4	86. 4%	78.1	(68.9, 85.2)	5 2	88. 5%	4 4	95.4 %	91.7%	(84.4, 95.7)
Turkana East	3 6	91. 7%	2 4	91.7 %	91.7%	(81.9, 96.4)	3 6	80. 6%	2 4	66. 7%	75.0	(62.8, 84.2)	3 6	86. 1%	2 4	87.5 %	86.7%	(75.8, 93.1)
Samburu West	4 2	80. 9%	4 1	87.8 %	84.3%	(75.0, 90.6)	4 2	71. 4%	4 1	75. 6%	73.5	(63.1, 81.8)	4 2	80. 9%	4 1	85.4 %	83.1%	(73.6, 89.7)
Samburu North	2 2	90. 9%	2 4	79.2 %	84.8%	(71.8, 92.4)	2 2	86. 4%	2 4	70. 8%	78.3	(64.4, 87.7)	2 2	90. 9%	2 4	79.2 %	84.8%	(71.8, 92.4)
Samburu East	3 1	90. 3%	2 0	95.0 %	92.2%	(81.5, 96.9)	3 1	80. 6%	2 0	70. 0%	76.5	(63.2, 86.0)	3 1	90. 3%	2 0	95.0 %	92.2%	(81.5, 96.9)

Activity Contributions

There was a focus on the girl child necessitated by the low enrollment, attendance, and progression rates in the NAL region. The Activity promoted girl-friendly policies, held monthly mentoring sessions for girls, distributed sanitary towels, and supported progression of girls with comparatively lower marks to post-primary institutions.[2] In Turkana County, the Activity provided education and training services to increase school enrollment, ensure school retention and transition by paying school fees to OVC in secondary schools and vocational training institutes, and by distributing school uniforms, scholastic materials, and sanitary pads. OVCs who passed KCPE were linked to Presidential Bursary fund.[xlvi] This helped reduce absenteeism and school dropouts. To further support retention in schools, the activity adopted AMREF's 4 R model (Rescue, Reintegrate, Rehabilitate, and Re-socialize) to improve referral mechanisms and case management for school dropouts.[xlvii] The activity also supported life skills by holding OVC station days during school holidays.[xlviii] In Samburu County, the activity supported school fees payment to OVC and distribution of school uniforms and shoes, sanitary pads, and life skills messages during OVC station days. In collaboration with the county government, the activity supported the enrollment of OVCs in a bursary fund.[xlix] This was aimed at increasing OVC enrollment, retention, and progression in schools. The activity supported life skills, sexual and reproductive health, and better hygiene practices in schools through health clubs.[l]

Household Participation in Community-Based HES Groups

Table 9 – OVC Household participation in community-based HES groups

Constituency	Ward	N	Goat Rearing	Poultry Production	SILC	Vegetable Production	Animal Lodging	Other	None
Source: IMARISHA ETE MNCH Household Survey (2018)									
Turkana North	Lake Zone	30	0.0%	0.0%	3.0%	0.0%	0.0%	2.0%	83.3%
Turkana West	Lokichoggio	96	1.0%	0.0%	3.1%	2.1%	0.0%	8.3%	85.4%
Turkana Central	Lowdar Township	25	0.0%	0.0%	4.0%	0.0%	0.0%	0.0%	96.0%
	Kanamkemer	23	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Loima	Turkwel	30	0.0%	3.3%	16.7%	3.3%	0.0%	0.0%	76.7%
Turkana South	Kaputir	25	4.0%	0.0%	8.0%	8.0%	0.0%	8.0%	72.0%
	Katilu	23	0.0%	0.0%	17.4%	0.0%	0.0%	0.0%	82.6%
	Lobokat	24	0.0%	0.0%	8.3%	4.2%	0.0%	4.2%	83.3%
	Lokichar	24	0.0%	0.0%	16.7%	0.0%	0.0%	4.2%	79.2%
Turkana East	Katilia	30	0.0%	0.0%	6.7%	0.0%	3.3%	0.0%	90.0%
	Lokori/Kochodin	30	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	96.7%
Samburu West	Lodokejek	18	0.0%	0.0%	5.6%	0.0%	0.0%	0.0%	94.4%
	Suguta Marmar	19	5.3%	5.3%	21.0%	10.5%	0.0%	5.3%	52.6%
	Maralal	25	0.0%	0.0%	12.0%	0.0%	0.0%	0.0%	88.0%
	Poro	21	9.5%	0.0%	4.8%	0.0%	0.0%	4.8%	81.0%
Samburu North	El-Barta	25	0.0%	0.0%	4.0%	0.0%	0.0%	4.0%	92.0%
	Nachola	21	0.0%	0.0%	14.3%	14.3%	0.0%	0.0%	71.4%
Samburu East	Waso	24	0.0%	4.2%	12.5%	8.3%	0.0%	20.8%	54.2%
	Wamba East	24	0.0%	0.0%	11.1%	3.7%	0.0%	7.4%	77.8%

[2] Year 1 Work Plan; Annual Report (2015); FGD OVC Caregiver RCEA Watoto Wazima Initiative (2018).

Number of Functional Household Economic Strengthening Groups within Each County

Table 10 – Number of HES groups

County	LIP	# of HES support groups
Samburu	CDM	6
	KIBA	3
	SAIDIA	4
	SCAAP	11
	SOL	4
	Total	**28**
Turkana		-

Source: Catholic Relief Service

Activity Contribution

In Turkana County, the activity supported LIPs to deliver economic strengthening services with a focus on capacity building of the groups to improve household nutrition and increase income. Under SILC, the project offered training on savings and loans and linked the SILC groups with microfinance institutions. The Beneficiaries were also trained on business skills (soap making, greenhouse farming) and given irrigation kits and drought-resistant seeds. They were given rainbow roosters, dairy goats, and poultry management.[li] In addition, the activity also provided seed capital to business development groups.[lii] However, the LIP that took over from APHIAplus Imarisha reported directly to USAID and did not therefore continue with CRS-initiated activities. All HES activities ceased in 2015. After group formation and initial investments to the HES activities, no reports were made through APHIAplus Imarisha.[3]

In Samburu County, the activity provided food preservation methods and trained on improved poultry management, dairy goats, and small business management.[liii] The activity supported livelihood activities through group activities. Groups received greenhouses, water tanks, seeds for horticultural production, chicks, goats, and grants[liv]. In Samburu, the block grants were successful in the institutions where they were initiated. The OVC caregiver support groups and the OVC households learned to replicate the same initiatives to benefit the OVC in their households.[4] The activity identified 10 institutions that benefited from a block grant that helped them establish economic initiatives that provided food to the OVC household and excess products sold and the money use to pay OVC school fees and buy other scholastic materials. The institutions were to partner with OVC caregivers groups.[lv] The activity also provided seed capital to OVC caregivers to start small businesses.[lvi] Barriers mentioned by OVC caregivers during FGD include high cost of farm inputs, drought, low or no agricultural extension support, lack of markets for products, and loans defaulting under SILC.[5] Possible strategies for increasing uptake include mapping and identifying viable HES initiatives to be supported until the beneficiary is stable; incorporating sustainable technical support in HES initiatives (e.g., linkages to relevant national/county government departments) and empowering LIPs; and gradually phasing out direct support to OVC when the household is economically more stable to stand on its own.[6]

Conclusion

School enrollment and progression was generally high. In support of school enrollment, attendance, and progression, the activity invested in capacity building through school fee payments, bursary funds, vocational skills training, and life skills training (including sexual and reproductive health). The activity also provided scholastic and other needed materials (e.g., sanitary pads).

[3] FGD OVC Caregivers – RCEA Watoto Wazima; FGD CHV Kanamkemer; KII CRS
[4] KII – CRS; SAIDIA LIP (Samburu)
[5] FGD OVC Caregivers – RCEA Watoto Wazima LIP in Turkana, SAIDIA LIP, CARITAS LIP, and KIBA LIP in Samburu
[6] KII with CRS, QR3 2016 Progress Report, KII with SAIDIA LIP Manager Samburu

To support HES, the activity provided capacity building on SILC, small business skills, agro-business, and livestock rearing trainings. In addition, the activity procured and distributed drought-resistant seeds, dairy goats, poultry, and irrigation kits to support OVC households. The activity also provided seed capital to business development groups and block grants to schools that were a success.

Recommendations

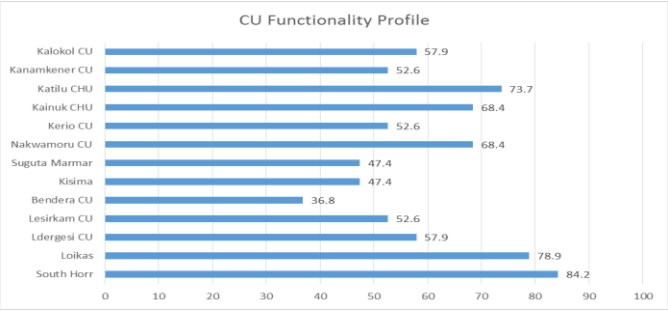
- There is a need to allocate more resources to block granting because it was successful in meeting the educational and nutritional needs of the OVC in the beneficiary institutions during the life of the activity. The resources should focus on granting OVC caregiver business groups and OVC households.
- To strengthen the household economics, there is need to invest in more income-generating activities (IGAs) suitable for this population to enhance their resilience.
- Increase the OVC services offered beyond Education and HES per the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) OVC 2012 guidelines.
- County government needs greater involvement and ownership for the sustainability of the HES initiatives, particularly the block grant.
- Focus more effort on school attendance to improve/sustain school progression.

EVALUATION QUESTION 2: To what extent has the activity increased the capability of health community, health facility and county health management teams to sustain the gains in the observed health outcomes?

The findings below show the capacity of community units, health facilities, and CHMTs to sustain gains in the health outcomes.

Community Health Unit Capacity to Sustain Health Gains: The MOH CHU functionality scorecard was adapted in this ETE to assess a CU's performance management, resource allocation, and decision-making. Nineteen parameters (11 process indicators, five performance indicators, and three cardinal elements for basic functionality) were used to score a CU.[lvii]

Figure 8 – Community Unit Functionality Profile



Source: IMARISHA ETE: Institutional Capacity Assessment (2018)

CU Functionality Score	Turkana	Samburu	No. of CU
Score			
80 & Above	0	1	1
50%–79%	6	3	9
< 50%	0	3	3
Total	6	7	13

Of the sampled CUs, 3/13 were non-functional and 9/13 were semi-functional; only one CU (South Horr CU) was classified as functional.

More than 50 percent of the sampled CUs did not have CHV kits (i.e., a kit per CHV based on content agreed upon by the project and CHMT as guided by the national policy); 8/13 (61.5 percent) did not have a chalk board (MOH 516); 11/13 (93 percent) reported that CHVs do not receive a monthly stipend of Kshs. 2000; 8/13 (61.5 percent) did not have means of transport (bicycles) available for use by CHVs; and 7/13 (54 percent) did not hold quarterly meetings to review CU work plans with minutes. The Activity identified "Expert Clients" from among the PLHIV who were contracted to work at the CCC centers. The Expert Clients were trained and remunerated to work as CHVs while a large percentage of them were not linked to the CHUs as indicated by the stakeholders in Turkana and

Samburu in the validation workshops and the CHVs in all FGDs. The Expert Clients took over the responsibilities of the CHVs at the facility and occasionally at the household during defaulter tracing.

Health Facilities Capacity to Sustain Health Gains: Capacity of health facilities was assessed using eight parameters: governance/planning (management, planning, and financing), financing, human resources (availability of medical officers, nurse/midwife, clinical officers, counselors, nutritionists, pharmacists, lab technicians/technologists, health records officers, PH officers/technicians, CHEW), service availability (family planning, antenatal care, postnatal care, immunization, PAC, maternity, TB prevention and treatment, EID, HIV testing, HIV care and treatment, VMMC, PEP, malaria prevention and treatment, and nutrition), staff training, CHV services (FP, immunization, well-baby care, TB-DOTS, health education, HTS, and malaria prevention), quality improvement (number of supervisory visits, QI team in place, availability of guidelines for the implementation of standards, and QI meetings), and physical office space/furniture.[lviii] Health facilities that scored below the 25th percentile on each parameter were classified as having no capacity. The table below shows the number of health facilities in each category.

Table 11 – Capacity of Health Facilities

	NUMBER OF HEALTH FACILITIES			
	No Capacity	Low Capacity	Moderate Capacity	High Capacity
Governance/Planning	0	3	5	10
Financing	1	3	6	8
Human Resources	1	5	2	10
Service Availability	0	1	1	16
Staff Training	2	4	2	10
Services Offered by CHV	5	4	4	5
Quality Improvement	4	3	4	7
Physical Space (Office space/Furniture)	0	6	1	11

Scoring criteria: Score below 25th percentile – No capacity; 25th–50th percentile – Low capacity; 50th–75th percentile – Moderate capacity; Above 75th percentile – High capacity; Source: IMARISHA ETE ICA (2018)

More than half of the assessed health facilities had moderate to high capacity to sustain the observed health outcomes. The table below shows individual facility scores on the assessed parameters.

The assessed health facilities scored at least 50 percent on governance/planning, service availability, and existence of physical space. There were varied outcomes on financing with capacity scores ranging between 14.3 percent and 100 percent. On human resources, all except South Horr dispensary scored at least 50 percent. Staff training scores were varied, ranging from 15.8 percent and 100 percent; services offered by CHV ranged from 0 percent to 100 percent. The facilities scored between 25 percent and 100 percent on quality improvement.

S/CHMT Capacity to Sustain Health Gains: The ETE assessed the County and Sub-County health management teams' ability to sustain gains in health using three sets of nine parameters: (**1) governance/policy**, which included governance (demonstrated capacity to develop health strategy, implementation of the strategy, capacity to engage with the health and other relevant sectors within the county, capacity to develop health policies, and ownership of the health system), human resources (ability to recruit/deploy/retain staff; conduct performance appraisal; undertake staff capacity development based on identified need; planning for the entire health system; equitable distribution of staff), and health financing (develop evidence-based budgeting; source for sustainable budget; availability of financial policies, procedures, and compliance; and ability to monitor/ensure accountability for county finances); (**2) medical products and technologies**, including access to products and commodities

(ability to provide oversight for product and commodity management, oversight for health supply chain management, developing/adapting county-owned logistics information management, and ability to oversee quality of products); delivery of health services (develop/distribute policies, strategies, guidelines on standard of care; effectively implement policies and strategies; deliver HIV/AIDS, TB, RMNCH, Nutrition, WASH, and Malaria programs; supervise use of health delivery policies, strategies and guidelines, and standard operating procedures; and demonstrated equity strategies in service provision); and health information systems (timely linking/reporting of county data with DHIS; provision of oversight on data quality assurance; and ability to monitor/evaluate key program performance indicators, and use in planning); and (3**) enabling environment for sustainability** including innovations (development/adaptation of innovations; scaling up innovations; and harness impacts from the innovations); networking, linkages, collaboration and partnership (ability to hold multi-sectoral stakeholder forum; coordination of various sectors aligned to health; and implementation of stakeholders resolutions); and sustainability (ability to sustain technical competencies to deliver projects after phase-out; financial leverage; and creation of an enabling environment to sustain programs). The table below shows the individual institutional scores on the nine parameters.

Table 12 –Capacity of Health Facility to Sustain Gains in Health

	Governance / Planning	Financing	Human Resources	Service Availability	Staff training	Services offered by CHV	QI	Physical space
	4	7	4	14	19	8	4	6
Catholic Hospital Wamba	4 (100%)	4 (57.1%)	4 (100%)	14 (100%)	19 (100%)	0 (0.0%)	4 (100%)	6 (100%)
SAMBURU COUNTY REFERRAL HOSPITAL	4 (100%)	2 (28.6%)	4 (100%)	14 (100%)	19 (100%)	7 (87.5%)	3 (75.0%)	6 (100%)
Katilu District Hospital	2 (50.0%)	5 (71.4%)	2 (50.0%)	14 (100%)	15 (78.9%)	7 (87.5%)	4 (100%)	6 (100%)
Kisima Health Centre	3 (75.0%)	5 (71.4%)	4 (100%)	13 (92.8%)	16 (84.2%)	8 (100%)	2 (50.0%)	6 (100%)
Suguta MarMar	4 (100%)	5 (71.4%)	4 (100%)	11 (78.6%)	15 (78.9%)	7 (87.5%)	3 (75.0%)	4 (66.7%)
Lesirikan	3 (75.0%)	3 (42.8%)	2 (50.0%)	12 (85.7%)	6 (31.6%)	4 (50.0%)	2 (50.0%)	3 (50.0%)
Wamba Health Centre	4 (100%)	6 (85.7%)	4 (100%)	14 (100%)	17 (89.5%)	2 (25.0%)	2 (50.0%)	6 (100%)
Sereolipi Health Centre	4 (100%)	5 (71.4%)	4 (100%)	14 (100%)	16 (84.2%)	2 (25.0%)	1 (25.0%)	6 (100%)
Archer's Post Health Centre	4 (100%)	2 (28.6%)	4 (100%)	12 (85.7%)	12 (63.1%)	3 (37.5%)	1 (25.0%)	3 (50.0%)
Kerio HC	3 (75.0%)	7 (100%)	2 (50.0%)	14 (100%)	6 (31.6%)	5 (62.5%)	4 (100%)	3 (50.0%)
AIC Kalokol HC	4 (100%)	7 (100%)	4 (100%)	13 (92.8%)	15 (78.9%)	2 (25.0%)	4 (100%)	6 (100%)
Lokichar RCEA HC	2 (50.0%)	6 (85.7%)	2 (50.0%)	14 (100%)	18 (94.7%)	7 (87.5%)	4 (100%)	6 (100%)
Nakwamoru HC	2 (50.0%)	6 (85.7%)	3 (75.0%)	12 (85.7%)	5 (26.3%)	5 (62.5%)	1 (25.0%)	6 (100%)
Kainuk HC	3 (75.0%)	7 (100%)	4 (100%)	14 (100%)	11 (57.9%)	6 (75.0%)	4 (100%)	6 (100%)
South Horr GOK Dispensary	4 (100%)	1 (14.3%)	1 (25.0%)	13 (92.8%)	17 (89.5%)	4 (50.0%)	1 (25.0%)	3 (50.0%)
St. Mary's Kalokol Primary HC	3 (75.0%)	4 (57.1%)	2 (50.0%)	7 (50.0%)	4 (21.0%)	1 (12.5%)	3 (75.0%)	3 (50.0%)
Lokori Primary Health Programme	4 (100%)	6 (85.7%)	3 (75.0%)	11 (78.6%)	3 (15.8%)	6 (75.0%)	4 (100%)	6 (100%)
St.Patrick	4 (100%)	6 (85.7%)	4 (100%)	10 (71.4%)	9 (47.4%)	4 (50.0%)	3 (75.0%)	3 (50.0%)

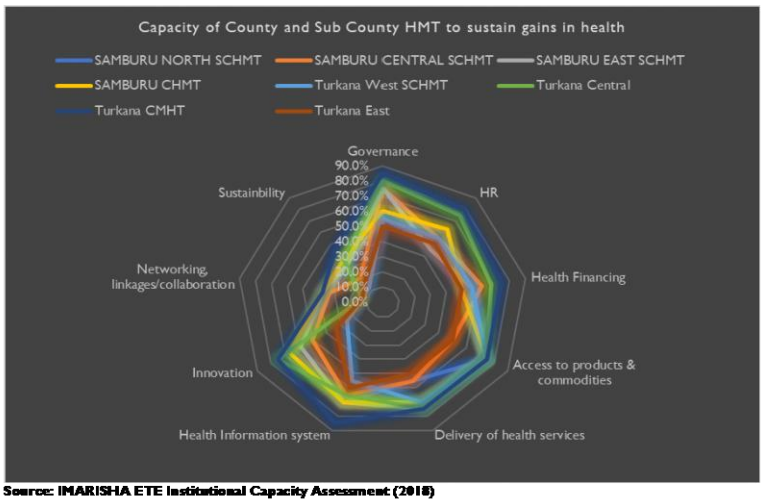
Source: IMARISHA ETE Institutional Capacity Assessment (2018)

Table 13 – Capacity of County and Sub-County HMT to Sustain Gains in Health

Source: IMARISHA ETE Institutional Capacity Assessment (2018)

	Governane	HR	Health financing	Access to products & commodities	Delivery of health services	Health information system	Innovation	Networking, linkages/ collaboration	Sustainability
Samburu North SCHMT	55.0%	50.0%	50.0%	75.0%	55.0%	70.0%	66.7%	33.3%	33.3%
Samburu Central SCHMT	75.0%	54.2%	62.5%	50.0%	55.0%	65.0%	50.0%	33.3%	20.8%
Samburu East SCHMT	75.0%	45.8%	56.3%	75.0%	75.0%	70.0%	58.3%	37.5%	33.3%
Samburu CHMT	60.0%	62.5%	50.0%	75.0%	70.0%	70.0%	66.7%	37.5%	37.5%
Turkana West SCHMT	55.0%	54.2%	56.3%	75.0%	70.0%	55.0%	25.0%	12.5%	12.5%
Turkana Central SCHMT	80.0%	75.0%	68.8%	75.0%	75.0%	65.0%	75.0%	12.5%	37.5%
Turkana CMHT	85.0%	79.2%	75.0%	75.0%	75.0%	85.0%	75.0%	37.5%	45.8%
Turkana East SCHMT	50.0%	50.0%	50.0%	50.0%	50.0%	60.0%	33.3%	12.5%	16.7%

Figure 9 – Capacity of County and Sub-County HMTs to Sustain Gains in Health



Source: IMARISHA ETE Institutional Capacity Assessment (2018)

For governance, Samburu North SCHMT and Turkana Central SCHMT score over 80 percent; for HR, only Turkana Central SCHMT and Turkana CHMT score above 75 percent; and for health information systems, only Turkana CHMT scored above 80 percent. None of the assessed S/CHMTs scored above 80 percent on health financing, access to health products and commodities, delivery of health services, innovation, networking/linkages/collaboration, or sustainability.

Conclusions

- The Activity strategy for expert clients to serve as the link between the facilities and the community affected the role of CHVs within a CU.
- Capacity assessment of health facilities depicts varied services offered by CHVs across the sampled health facilities as well as gaps on quality-improvement initiatives.
- Low capacity exists among the S/CHMTs to develop/adapt innovations, form networks, and coordinate multi-sectoral forums on health-related issues.

Recommendations

- S/CHMTs should consider incorporating quality-improvement initiatives at health facilities.
- Future programming or investment should focus on building the capacity of the S/CHMT to develop/adapt innovations, form networks, and coordinate multi-sectoral forums on health-related issues.

EVALUATION QUESTION 3: What implementation challenges did the activity face during the implementation period and how were these challenges addressed? *(This question will examine successes and challenges with the primary outcomes and is expected to be key to programmatic and management lessons learned especially on institutional capacity building, sustainable household economic strengthening (HES) models for OVC vulnerable households, and overall sustainability of implemented strategies to guide future programming decisions.)*

Challenges and How They Were Addressed

Result 3

- Vastness of the areas. This posed transportation challenges for patients seeking health services.[lix] This also posed a challenge in coordination of the implementation activities. The activity established and supported county offices to minimize implementation costs.
- HCWs strikes. Nurse and doctor strikes happened in 2015 and 2017. This affected provision of services in the public health facilities and reduced utilization of services. This remained underutilized for a number of weeks as the situation slowly returned to normal;[lx] the activity deployed staff at the supported health facilities continued to offer services during this period.
- Rampant insecurity.[lxi] The activity installed satellite-based vehicle tracking, VHF radios, and satellite phones to complement GSM networks in all its fleet of vehicles. The activity regularly updated the Team Communication tree and the emergency contact list. The activity developed project security protocols and had affirmative action favoring locals in staff recruitment.

- High poverty levels.[lxii] IGA training was held for most vulnerable households with the priority focus on empowering women and girls.
- Poor infrastructure and harsh terrain.[lxiii] The activity procured a fleet of hard-top Land Cruisers and held regular joint review and planning sessions with the MOH and other stakeholders;
- Reduced funding for community health strategy. Reduced funding to CHUs affected the service delivery with many of the CUs facing attrition after the stipend previously received by CHWs was stopped. This was partially addressed by providing the CHVs with non-monetary incentives as well as supporting them to have IGAs as a form of alternative income.
- Reduced funding midstream for activity implementation that led to some consortium members pulling out (e.g., FHI360, BroadReach Health Care, University of Maryland). To address this AMREF Health Africa (the Prime Partner) absorbed most of the staff that had been employed by the partners to ensure that the technical skills that they were bringing on board continued.
- Inequalities that resulted from the activity focused on high-volume health facilities and some health facilities felt left out.[lxiv] This was due to the interest in achieving numbers (activity targets) due to donor requirements.
- The activity transport refunds for the laboratory sample networking were inconsistent, which led to delays in turnaround time.[lxv] The Activity formed and supported the County Laboratory Technical Working Group.

Result 4

- Strategic changes (some initiated by the USAID/USD such as the new PEPFAR OVC guidelines for 2012) laid more emphasis on HES than focusing on the relief model. Reduced funding to CHUs affected the service delivery since the CHVs could no longer receive stipends, leading to attrition.

Sustainability of Implemented Strategies

Result 3

- Lack of MOH ownership of implementation at the county level – The activity implemented the services through their staff deployed by the project with minimal involvement of MOH staff (e.g., VMMC was implemented through AIC with minimal involvement of the Turkana West SCHMT and the local staff). This applied to other HIV service delivery[lxvi] – When the activity came to an end there was lack of continuity and the VMMC services stalled.
- Based on the lessons learned from the Activity, Turkana County government had a Bill in County Assembly that sought to formalize the Community Health Strategy by employing CHVs.
- Sporadic shortages of rapid test kits for HIV testing[lxvii] – The activity established and supported Turkana County Laboratory Technical Working Group to conduct month to month forecasting and quantification of test kits and delivered five modems to the sub-county medical laboratory coordinators to aid timely submissions of reports through the rapid test kit online reporting system in Turkana.
- Deployment of extra staff (HTS, adherence counselors, clinicians, nurses) and training and mentorship by the Activity built the capacity of health workers; some were absorbed by the county government and will have the skills and knowledge to continue offering the services beyond the activity period.

Result 4

- There was poor linkage of OVC interventions with the Ministry of Health; this was confirmed by participants in both Samburu and Turkana validation workshops.
- The APHIAplus Imarisha approach of working with local implementing partners (LIPs), has not only built local capacity but also they are able to compete for funding to continue offering services, hence showing prospects for sustainability.

- The household economic strengthening (HES) initiatives supported by the activity under the block grant ensured that the targeted beneficiary households are able to sustain the interventions and continue to take care of the OVC beyond the life of the activity.

Key Programmatic Lessons Learned

Result 3

- County and sub-county CHMTs should be supported to provide technical assistance to low- volume and far-flung facilities.
- Entrenching HTC counselors in the HTC to take care of the referral and linkage system for HIV-positive clients ensures high enrollment in HIV care and treatment. The HTC counselors are able to walk the journey to enrollment with the client, providing the initial psychosocial support required.
- Use of maternal shelters in a predominantly pastoralist community and where distance to the nearest health facility is large increases access to skilled delivery and improves both maternal and newborn outcomes (prompt management of maternal complications reduces mortality).
- Linking and integrating private health facilities in the County MOH infrastructure and forums improves private health sector engagement and the expanded access to essential MNCH/FP/HIV/TB services in private health facilities.

Result 4

- Household economic strengthening is a blueprint for improving nutritional support for vulnerable groups in the community, which are primarily women and children. Therefore, establishment of kitchen gardens and provision of clean and safe drinking water for PLHIV and other vulnerable groups should be emphasized at all levels of project implementation.
- HES and food security initiatives provide more sustainable ways to support and strengthen families. OVC caregivers undertaking viable initiatives become more empowered and self-reliant and regain their lost dignity as a result. These initiatives need to be supported by allocation of additional resources.
- The quality improvement process is a key aspect in OVC programming. It encourages participation of communities in identifying and addressing children's issues, thus promoting ownership and sustainability of program interventions. Child Status Index as a step in QI provides a clear and deeper analysis and understanding of issues and a basis to measure improvement in children's well-being.
- Agro-based and livestock-based economic initiatives can succeed in the NAL region but require sustained technical extension services form the Ministry of Agriculture staff until the beneficiaries are competent enough to work with minimum support.
- Reducing direct support to OVC households in favor of household economic strengthening initiatives works best if the OVC caregiver has stabilized enough and can take over providing the OVC household with basic needs including school fee payment. Otherwise the number of OVC dropping out of school or who fail to progress in school increases.

Key Management Lessons Learned

- Working closely with the county government and the local health authorities is key in terms of building the local capacity and also ensuring that some of the best practices are infused, owned, and financed by the local government (e.g., the county bill that attempts to regularize the work of the CHVs as part of the Community Health Strategy, and absorption of the HCWs deployed by the Activity into the county government).

Recommendations for Sustainability

- Consider developing joint action plan/memorandum of understanding with CHMTs and ensure that each team is aware of what the other is doing in future activities. This will enhance active participation

of the CHMTs, SCHMTs, and HCWs. In the plan, document roles and responsibilities of each partner and the stakeholders and level of their mandates.

- Consider the participation of the CHMTs and SCHMTs in the recruitment of staff in future activities employment and deployment of HRH that are seconded or employed to the county by USAID funds.

PART II: CASE STUDIES

CASE STUDY 1: ROLE OF MENTOR MOTHERS (MMs) IN ELIMINATION OF MOTHER-TO-CHILD TRANSMISON OF HIV (eMTCT) IN TURKANA COUNTY

BACKGROUND AND INTRODUCTION: The prevention of mother-to-child transmission (PMTCT) of HIV has been lauded as one of the greatest public health successes in recent years, with significant reductions in the number of positive children born to HIV-positive women. Without preventive interventions, the risk of HIV transmission in utero or at birth ranges from 15 to 30 percent, increasing to 20 to 45 percent with breastfeeding.[lxviii] HIV prevalence in Turkana is reported to be 4.0 percent, which is lower than the national prevalence (5.9 percent). Compared to other counties, Turkana county is still lagging behind in PMTCT coverage, with a reported coverage of 46 percent in 2015, and was ranked 44th of out the 47 counties.[lxix] However, this was an improvement from 2013, where coverage was reported at 14 percent. Turkana County contributed 1.4 percent of the total new HIV infections among children in Kenya.[lxx] Many initiatives have led to the marked improvement in PMTCT in Turkana County. These include increased investments by the county government, introduction of Option B+ through Bring Back the Mothers campaign, free maternity and Beyond Zero, and partner-specific interventions (e.g., the mentor mothers program).

The activity adopted a case management approach in eMTCT, where women found to be HIV infected were identified and immediately attached to a case manager at the community and facility level (as part of the KMMP) to ensure uptake of recommended interventions, follow-up of HIV-positive pregnant women to delivery, and tracking mother-baby pairs through early infant diagnosis and exit of uninfected children. These were augmented with support groups that offered health education on PMTCT and also allowed sharing of experiences from MMs as well as learning from each other

THE INTERVENTION: MENTOR MOTHERS: Mentor Mothers (MMs) is a peer-based task-shifting approach, where HIV-positive mothers are recruited and deployed to provide counseling, psychosocial support, and assistance in navigating and accessing HIV care for their HIV-positive peers (pregnant women) and their exposed or infected children. MMs are HIV-positive mothers who have successfully completed the PMTCT cascade (ANC, ART use, infant feeding counseling, and HIV-exposed infant (HEI) follow-up). This model was designed to improve ART adherence, strengthen referral linkages, and increase enrollment in care and treatment. The APHIAplus IMARISHA activity worked with MMs to improve quality of HIV and AIDS care and treatment services. Through mentorship sessions conducted by health workers, the mentor mothers were identified and trained to mentor HIV-positive pregnant women to enhance linkage to care and treatment, retention, monitoring viral load suppression, and sustained adherence counseling sessions. They were then supported to form patient social support groups (PSSG). In Turkana County, rollout of the KMMP program saw training of eight KMMP TOTs and sensitization of Turkana County CHMT/ SCHMTs on the KMMP approach in order to get administrative support for the same. Eight MMs were recruited to act as case managers in the high-volume facilities. Their role was to provide psychosocial support to the mothers and ensure follow-up of the mother-baby pairs up to 18 months. In year 4, the activity supported recruitment of mentor mothers in eight selected high-volume facilities (Kalokol AIC, St. Mary's PHC, Namukuse, St. Patrick's, St. Monica, Lokichar RCEA, Katilu, and Lokori PHC) to support PMTCT uptake.[lxxi] The project sustained investment in the defaulter tracking system through provision of airtime for reminder phone calls,

provision of appointment diaries, deployment and facilitation of MMs, and provision of support for patient psychosocial support groups.[lxxii]

Table 14 – Annual Work Plan Analysis

Annual Work Plan		Progress
Timeline	Planned Activity	Achievement
Mar 2012–Dec 2012	Train champions of the mother-to-mother approach (8 training sessions held)	No documentation
	Support existing PLHIV support groups established during APHIA+ NAL	No documentation
Jan 2013–Dec 2013	Use MM in PMTCT support groups	No documentation
	Form 28 PLHIV support groups and strengthen 56 PLHIV support groups	
Jan 2014–Dec 2014	Facilitate the adaption of the KMMP model, and engage MMs	Working with CHVs who are linked to priority facilities with specific deliverables in defaulter tracing and community referrals
	Capacity building of MMs	In partnership with the Mothers-to-Mothers project, APHIAplus Imarisha facilitated the training of 10 TOTs on the Kenya Mentor Mother Program to prepare for program rollout in priority facilities in the county in year 3
	Host 96 monthly mother-to mother facility-based EBF support group meetings in 43 HFs	The CHVs collaborated with TBAs and other community resource persons such as mother-to-mother support groups to refer and/or accompany pregnant mothers to the ANC
Jan 2015–Dec 2015	Support MM and PLHIV support groups to augment patient retention efforts Facilitate the formation of 8 Mother-to-Mother Support groups Place mentor mothers at all P1 facilities for support counseling/default management	Engaged MMs to help improve follow-up and psychosocial support (in Turkana) Trained 8 KMMP TOTs and sensitized CHMTs and SCHMTs; recruited 8 MMs; trained CHVs The project also identified MMs who will be engaged and deployed by the project to support ACT strategy implementation TA to RCEA Lokichar health center on identifying mentor mothers to assist in defaulter tracing and patient education; sensitization of Turkana County CHMT/ SCHMTs on the KMMP approach; 8 mentor mothers recruited to act as case managers in the high-volume facilities (Kalokol AIC, St. Mary's PHC, Namukuse, St. Patrick's, St. Monica, Lokichar RCEA, Katilu, and Lokori PHC); 8 KMMP TOTs trained 45 CHVs/mentor mothers sensitized on pediatric ACT initiative strategy, treatment preparation, stigma and discrimination, defaulter management, and their roles and responsibilities in achieving the 90-90-90 targets; In Turkana, 9 additional MMs were formally recruited to act as case managers
Jan 2016–Dec 2016	Train CHVs and MMs	Supported monthly psychosocial support groups (PSSGs) in Turkana
	Support KMMP, MMs, PSSGs in Turkana	Sustained support to MMs in Turkana county
	Place mentor mothers at all supported facilities for support counseling/default management Support KMMP Mentor Mother PSSGs in Turkana	Supported CHVs in defaulter tracing through trainings and material support The program will sustain support for the MMs in Turkana County to ensure that all pregnant women get tested at 1st ANC and all positive women are followed up to delivery to ensure adherence to highly active Antiretroviral Therapy (HAART). After delivery, the mentor mothers (who are the case managers) will follow up on the other baby pairs until 18 months. The project team mentored and technically supported MMs to mobilize people for HTS, linkage to care, treatment and retention, monitoring viral load suppression, and sustained adherence counseling sessions for unstable clients.

MENTOR MOTHERS: WHAT APPEARS TO HAVE WORKED

- Sensitization of Turkana CHMT/SCHMT on the KMMP approach.
- The rollout of KMMP in partnership with mothers-to-mothers projects saw the training of 10 TOT on KMMP.
- Recruitment of eight mentor mothers to act as case managers in high-volume facilities (Kalokol AIC, St. Mary's PHC, Namukuse, St. Patrick's, St. Monica, Lokichar RCEA, Katilu and Lokori PHC).
- Provided TA on identification of MMs who are to assist in providing psychosocial support to the mothers and ensure follow-up of the mother-baby pairs up to 18 months.
- Working with CHV linked to priority facilities to conduct defaulter tracing, health education, and community referrals.
- These observed results indicate that MMs and the roles they play were positively received by clients, communities, and HCWs. MMs were noted to be approachable and well informed on matters pertaining to PMTCT.
- For communities, MMs provided a friendly, reliable alternative source of information on PMTCT. Among HCWs, MMs were available for task shifting, mainly for documentation, client counseling, and tracing. This enhanced service delivery to HIV-positive pregnant women.
- This case study highlights the need for adequate training, supervision, and remuneration for mentor mothers. The available literature demonstrates the positive impact of MM interventions on PMTCT program outcomes.[lxxiii]

MENTOR MOTHERS: WHAT APPEARS TO HAVE NOT WORKED: MMs have not yet been absorbed into the county staffing. This means the role is donor-supported with no ownership from the county government and therefore little prospect for sustainability once the donor funding ceases.

CONCLUSIONS: In conclusion, well-trained and supported mentor mothers contribute to the elimination of HIV infection for infants born to HIV-positive mothers through adherence, retention to care, and treatment. There were limited MM activities especially in the first two years of implementation. Continued support to MMs is critical to ensure increased HIV testing, treatment initiation, and retention to sustain eMTCT gains. The county government has not yet demonstrated ownership of the KMMP by absorbing the skilled MMs already trained and mentored by the activity.

RECOMMENDATION: There is need to advocate for the institutionalization of MMs into the county's human resources for health. The Activity and/or donors should increase support for the MM.

CASE STUDY 2: BLOCK GRANT IN SAMBURU COUNTY

BACKGROUND TO THE PROBLEM: The PEPFAR OVC Guidelines of 2012 recommended eight categories or domains of interventions to reduce vulnerability of OVC: Food and Nutrition, Shelter and Care, Protection, Health, Psychosocial, Education and Life Skills, Capacity Building, and Household Economic Strengthening (HES).[lxxiv,lxxv,lxxvi] The project worked with local implementing partners (LIPs) to implement OVC/HCBC interventions in both Turkana and Samburu.[lxxvii] New PEPFAR OVC guidelines of 2012 emphasized HES more than focusing on the relief model. Therefore, to promote family strengthening and self-reliance as a sustainability strategy to transition families out of project support, there was a shift from providing other direct support to OVC to strengthening the OVC household capacity to provide basic needs to the OVC through household economic strengthening. All other interventions (education, health, nutrition, food security, shelter, and care) were linked to economic strengthening initiatives.[lxxviii]

THE CASE – BLOCK GRANT: With support from the USAID-funded APHIAplus Imarisha project, five local implementing partners (LIPs) worked with the OVC/HCBC households to implement the block grant initiative whose aim was to inculcate agribusiness skills and improved nutrition to OVCs as well as generate income toward the education and livelihood support of children from extremely vulnerable households.[lxxix] Ten learning institutions with the highest number of OVC were identified to benefit from the block grant for various household economic strengthening initiatives.[lxxx] The institutions were linked to the OVC households through the economic strengthening groups.

The OVC households were already organized into three main economic strengthening initiatives: Savings and Internal Lending Communities (SILC), small business development, and livelihood opportunities (agro-based, livestock-based, and handcraft). The institutions contributed in various ways depending on the IGA identified, by giving land for cultivation and land for greenhouses, building a poultry house and goat shed, and paying the staff working in the IGAs and the teachers to give technical support. The IGAs were managed by OVC caregivers who also benefit from the training and management skills as well as income to support their household.[lxxxi]

Table 15 – Annual Work Plan Analysis

Timeline	Planned Activity	Achievement
Mar 2012– Dec 2012	Targeted grants to assist in IGA establishment	No documentation
Jan 2013– Dec 2013	Support 80 LIPs/CBOs to establish livestock/agro-based enterprises and IGA demonstration sites through in-kind grants. Establish 24 IGA/Demonstration livestock/agro-based enterprises sites for the 80 LIP/CBO through in-kind grants.	No documentation
Jan 2014– Dec 2014	Provide matching in-kind grants to support groups identified, taken through IGA self-selection process and provided with training on enterprise development.	No documentation
Jan 2015– Dec 2015	Facilitate disbursement of in-kind grants to 23 beneficiary groups to expand and grow IGAs. Support the selected beneficiary groups in establishing and/or expanding small enterprises in poultry farming, small livestock trade, fodder establishment demonstrations, meat value addition, hides and skins, small trade and handcrafts.	Piloted the school block grants model and provided three schools in Samburu County with poultry and drip irrigation kits to initiate poultry projects and school gardens.
Jan 2016– Dec 2016	Disburse in-kind grants (drip irrigation and improved indigenous poultry) for food security, nutrition and economic strengthening. The block grant model started in year 4 in three secondary schools in Samburu County will be scaled up to 10 more schools that will be provided with drip irrigation kits, supplied with poultry, and trained on agribusiness to initiate school farms and poultry projects that will be used to kick-start IGAs and provide a platform for practical business development training.	Ten learning institutions received block grant for various household economic strengthening initiatives (poultry, drip kits and a multistory garden).

WHAT WORKED FOR THE BLOCK GRANT: Three drum kits provided to both Wamba Girls and Wamba Boys secondary schools are fully functional, and income from the sale of produce to be harvested from the school farms will support in the payment of school fees of the OVC enrolled in the program and attending school in the two schools.[lxxxii] The yield from these kits supported OVCs in the two schools. **The OVCs were allowed to take home some vegetables for home consumption once a week**. Any profits from sale of the excess vegetables by the school went to supporting the OVC to offset some of their scholastic needs.[lxxxiii]

Two secondary schools in Wamba and Maralal that received improved poultry benefited from poultry produce—the eggs laid were consumed at the household and the surplus sold for income.[lxxxiv] One secondary school with 14 OVCs that received 450 rainbow roosters reported some remarkable outcomes; the birds are **laying eggs, which are consumed by the OVC households** and the excess sold for revenue.[lxxxv] Maralal Girls Secondary School, which had eight OVC, received 100 improved indigenous chickens. The school generated a total of Kshs 16,000 net profits from the sale of 1,000 eggs. The money was used to **pay school fees for the three OVC in the school**. This contributed to retention in the school, and as a result, the **eight OVC registered improved performance in school.**

Maralal Mixed Secondary School was supported with 100 improved "Kienyeji" KARI and 100 rainbow roosters. Through the sale of eggs and mature cocks, **10 OVC have been supported with school fees**. As a result of the project the school also **created employment for some OVC caregivers** who utilize part of the salary to pay school fees for their children. Wamba Boys Secondary school was supplied with 200 birds, and they are able to sell both eggs and cocks. **The income supports the needy OVC to pay for their school fees.**[lxxxvi] Learning institutions supported under block granting models to cater for 185 OVC (83M/102F) have started to provide OVC with scholastic materials. Proceeds from the Wamba Boys poultry project have been used to pay for OVC with school fee subsidies worth Kshs 7,850 ($77.72). Other **students have acquired practical skills in poultry production from the project, thus preparing them for future endeavors**.[lxxxvii]

WHAT DID NOT WORK

- The direct support to OVC to meet immediate and critical needs did not work because of funding constraints and withdrawal of partners critical to success of the chosen intervention. For example, in Samburu county, the activity started by sub-granting the LIP to provide OVC services (between 3+2 and 6+1 services), but this was reduced to only education and HES- related services by 2015; in Turkana county the five LIPs were reduced to one LIP. Reduced funding affected implementation of some activities, mainly capacity building/training of beneficiary groups and administration of in-kind grants (2015 Annual Work Plan).
- Upscaling successes for adoption by caregiver groups was not possible due to reduced funding as stated in the 2016 Annual Work Plan.
- There is no clear sustainability and exit strategy. The OVC support was not owned by the county government and is donor-dependent.

CONCLUSIONS ON BLOCK GRANT: Partnership between the OVC caregiver groups and the school where the targeted OVC were attending greatly contributed to the success of the project. Increased retention and improved performance was reported among OVCs supported in Maralal Girls Secondary School. The block grant not only provided alternative livelihood but also increased OVC caregivers' resilience.

RECOMMENDATIONS: Block grant successes should be shared widely within the county and the practice replicated as part of OVC HES support to increase their resilience, retention, and progression in school. To improve food security among OVC households, all Economic Strengthening (ES) initiatives must be looked at through a nutrition lens. Proven interventions such as small-scale vegetable and poultry farming should be promoted to address immediate food needs and the surplus sold for household income. OVC support should be owned and funded by the county governments to better address the long–term needs of OVCs.

ANNEX 1: USAID/KEA APHIAPLUS IMARISHA SOW

USAID | KENYA AND EAST AFRICA
FROM THE AMERICAN PEOPLE

RFTOP Issuance Date: **March 14, 2017, Revised July 19, 2017**

RFTOP Closing date: **April 13, 2017 8:00 a.m. Nairobi local time**

SUBJECT: Request for Task Order Proposals (RFTOP) No. SOL-615-17-000010. End-of-project evaluation for the APHIAplus Imarisha Activity under AID-623-I-13-00001 Single award IDIQ.

Subject to availability of funds, the Government plans to award a firm-fixed fee contract. The anticipated period of performance is on/about April 01, 2017–August 15, 2017.

Any questions regarding the RFTOP's requirements must be submitted via e-mail to Winnie Hinga, A&A Specialist, at whinga@usaid.gov and Nya Kwai Boayue, Contracting Officer, at NBoayue@usaid.gov

The proposals must be received electronically on or before the closing date and time stipulated above. Proposals must be sent via e-mail to A&A Specialist, at whinga@usaid.gov and Nya Kwai Boayue, Contracting Officer, at NBoayue@usaid.gov and must conform to all requirements outlined herein.

This RFTOP does not obligate the United States Government to award a contract, nor does it commit USAID to pay for any costs incurred in the preparation or submission of proposals. USAID reserves the right to award this contract without discussions and any resultant contract is subject to the availability of funds.

Sincerely,

Nya Kwai Boayue

Contracting Officer
USAID/KEA

SECTION B – SUPPLIES OR SERVICES AND PRICE/COSTS

B.1 PURPOSE

This Task Order must provide all evaluation services as described in detail in Section C.

B.2 CONTRACT TYPE

Firm-Fixed-Price Task Order.

B.3 PRICE

The total price of this Task Order is **TBD**.

B.4 APPLICABILITY OF IDIQ

All Sections from the Indefinite Delivery Indefinite Quantity (IDIQ) are hereby incorporated. If there are any discrepancies between IDIQ and the Task Order, then the Task Order shall take precedence.

[End of Section B]

SECTION C – STATEMENT OF WORK

Purpose:

The purpose of this Statement of Work (SOW) is to seek services from qualified contractors to conduct an end-of-project evaluation that will seek to determine the extent to which the activities have met the expected health outcomes as were expressed in the five year implementation framework. It will look at all aspects of the activity that have direct and indirect bearing to anticipated health outcomes. This information will inform future direction in activity design, development, implementation, and management strategies.

Evaluation Focus and Geographical Scope:

Despite HIV/AIDS and FP/RMNCAH/Nutrition and WASH geographic targeting that have resulted into less focus in North Eastern region with an exception of Turkana county, it's critical that USAID KEA documents key factors that have worked for and/or against the achievement of intended results, key lessons learned and key challenges. More importantly, the documentation of the well triangulated and grounded "how to" strategies from a broad-based stakeholders working in the region will provide learning platform for future programming for USAID KEA, other development partners and their respective projects. This evaluation is therefore expected to spend considerable level of efforts in the analysis of the "what" and "how to" implementation strategies that AMREF and its sub-partners used; facilitate subject matter experts' panels discussions individually and through validation workshops, and document workshop outputs into well synthesized strategic directions for future programming. Discussions on the future "what" and "the how" program implementation strategies and their cost feasibilities will form part of this panel analysis. The geographical scope for this evaluation will be limited to **Turkana and Samburu counties**.

A. BACKGROUND INFORMATION

A.1: Evaluation Purpose: The evaluation will serve two main purposes: (1) to learn to what extent the activities' objectives and expected health outcomes at county, sub-county, health facilities, and community levels have been achieved, including effectiveness of APHIAplus model, key lessons learned, and challenges; and (2) to identify implementation strategies in terms of the "what" and the "how to" that have high likelihood of achieving sustainable health and institutional strengthening outcomes for the Northern Arid Lands (NAL) region.

A.2: Audience and Intended Uses for the Evaluation: The primary audience for the findings of this evaluation is USAID/Kenya and East Africa, Health Population and Nutrition (HPN) leadership, and its technical team and the implementing partner – AMREF. USAID/Kenya and East Africa's Strategic Planning and Analysis office, Office of Economic Growth, Education and Youth Office, and Democracy and Governance Office are part of the next level of primary audience for the evaluation findings. The first line secondary users of the evaluation findings will include key stakeholders that implement activities in national and county governments, national Ministry of Health programs such as National AIDS & STI Control Program, Family Health Programs, Ministry of Gender and Social Services/ Department of Children Services, National Water and Sanitation Programs within the Ministry of Health, among others. Civil Society Organizations and researchers from the local and international universities as well as research organizations will form part of the second line users of the findings. Finally, the donor community supporting health programs will also be consumers of the evaluation findings.

A.2: Background Information:

A.2.1: Project Description

USAID/Kenya and East Africa's Health Population and Nutrition Office's current strategic objective is to, "*Reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services*." It directly supports the Government of Kenya's (GOK) efforts toward reducing unintended and mistimed pregnancies, improving infant and child health, reducing HIV/AIDS transmission, and reducing the threat of infectious diseases. While APHIAplus service delivery program description was developed in line with HPN's Implementation Framework (2010–2015), its results areas are consistent with the current Health Program Approval Document's results. HPN's Program Approval Document was designed to support the achievement of the Country Development and Cooperation Strategy (CDCS) Goal by contributing to DO2, *Health and Human Capacity Strengthened*, and more specifically by contributing to increased use of quality health services (DO2 IR 2.2) and increased Kenyan ownership of health (DO2 IR2.1). HPN's Health PAD is contributing to CDCS's intermediate results through strengthened county health systems and strengthened county health service delivery. The primary focus for the Kenya Health PAD will be at the county level with activities encompassing family planning and reproductive health (FP/RH); maternal, newborn and child health (MNCH); nutrition; malaria; tuberculosis (TB); water, hygiene, and sanitation (WASH); HIV/AIDS prevention, care, and treatment; and health systems strengthening (HSS). APHIAplus Imarisha activity primarily focused in these areas through an integrated model of service delivery. Specifically, it responded to social determinants of health in the technical areas of HIV and AIDS, malaria, family planning, tuberculosis, MNCH, and water and sanitation.

Basic Activity Information:

Activity Name	Activity Number	TEC	Period of Performance
APHIAplus Imarisha	AID – 623 – A – 12 – 00015	$49,985,210.	March 15, 2012 to March 14, 2017

APHIAplus Imarisha Consortium members:

1. Catholic Relief Services
2. Land O" Lakes Inc. (LOL)
3. University of Maryland Baltimore (UMB)
4. Family Health International (FHI360)
5. BroadReach Healthcare (BRHC)

A.2.2: Problem Statement, Activity Development Hypothesis, Design and Implementation Approach:

A.2.2.1: Problem Statement:

The Northern Arid Lands (NAL) of Kenya comprise eight counties that are under- developed, and characterized by harsh climatic conditions. The region covers about 70 percent of Kenya's land mass with an estimated population of 4,469,174 which is sparsely distributed (1 to 2 persons per sq. km) and predominantly ***nomadic*** or ***semi-nomadic*** and conservative communities. The availability and quality of health services in the NAL is poor. Social barriers to health including harmful cultural attitudes, social stigma, financial, education and literacy challenges often prevent people from accessing quality health services even where they are available. Most of the health indicators are far worse than the national average. In all regions except North Eastern (67 percent), 94 percent or more of women received antenatal care from a skilled provider (DHS2014). Less than 90 percent of women in Garissa, Marsabit,

West Pokot, and Samburu and less than 60 percent in Mandera and Wajir received ANC from a skilled provider; 47 percent of women in Mandera received no ANC at all (DHS2014). HIV prevalence varied greatly by region with a low of 2.1 percent in Eastern North region to 15.1 percent in Nyanza region; North Eastern had the lowest prevalence for both rural and urban areas at 1.5 percent and 3.6 percent respectively (KAIS 2012).

A.2.2: Development Hypothesis

DO2's development hypothesis states "if health and human capacity in Kenya are sustainably strengthened, then Kenyans will be able to effectively participate in and contribute to the transformation of their governance and economy." Besides Kenya Health PAD primarily contributing to DO2's intermediate results focused on health; it will also contribute to initiatives that relate to education and youth to strengthen HIV/AIDS and life skills curricula and policies, and improve government capacity to provide quality gender sensitive health care and education. It also supports the implementation of the new Adolescent Sexual and Reproductive Health Policy that provides a framework for the allocation of resources toward access to information and support for a variety of services for example: contraception to reduce unwanted pregnancies; prevention programs to reduce risky behaviors leading to HIV and substance abuse; and creation of opportunities to enhance their autonomy, decision-making capabilities, and economic prospects including for vulnerable OVC households through household economic strengthening sustainable community-based models.

A.2.3: Activity design and implementation approach

Broadly, APHIAplus Imarisha activity has a regional/county and sub-county focus, working closely with county and sub-county health management teams to support provision of integrated health services at health facilities and the community level. Specifically these include HIV/AIDS, Malaria, FP/RH, MCH, Water, Sanitation and Hygiene, OVC and other Social Determinants of Health. These activities are a consortium of several local and international organizations that bring specific expertise to contribute to the achievement of the overall goals and objectives. Specific activity design and implementation approaches are described below:

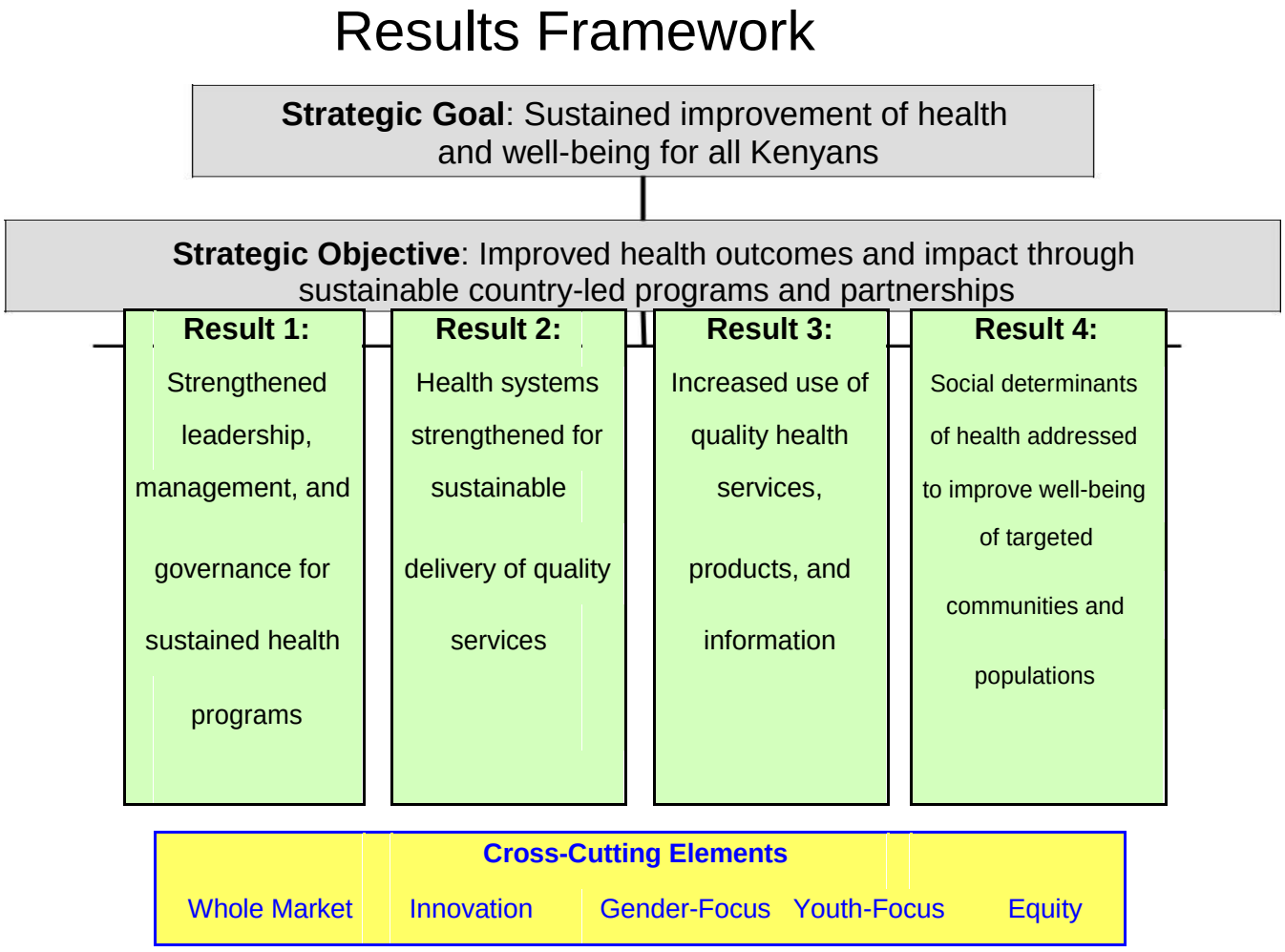
In order to sustainably improve the health outcomes and create impact among the residents of NAL, the activity proposed to build on its more than 30 years' experience in the region. AMREF proposed to deploy a holistic program design that was meant to empower and strengthen health service delivery and social development structures in the region to sustainably fulfill their mandate of providing health and development services, while integrating their actions for synergy. This design was informed by participatory consultations with NAL health and development stakeholders, through the activity jointly with stakeholders identified needs, gaps and practical solutions. Through this program design, the activity set out to (i) strengthen the capacity of community to county (level 1 to 4) health systems to deliver high quality services, products, and information and create demand for the same; (ii) strengthen the ability of local social and economic development structures to create positive change in livelihoods, food security, education, and social protection; and (iii) through proven approaches such as the SILC model by CRS and the value chain approach by Land O' Lakes, foster multi-sectoral integration by creating practical and synergistic linkages between actions at the health system level and among social and economic development initiatives in order to improve health outcomes. Social and economic development initiatives were to have a significant impact on health in the medium and long term, and form an important entry point for health development in the NAL region.

In the health system, the activity proposed to strengthen the capacity of District and later County Health Management Teams; health facility staff and management committees; Community Health Units and civil society organizations. Key target development structures for capacity strengthening included local civil society organizations; local cooperatives; county leadership; women and youth groups; livestock and other cooperatives; religious structures; cultural fora (e.g. elders fora); primary and ECD schools and water management committees. Integrated actions were to include joint outreach actions on livestock

and human health as well as joint MNCH and WASH actions. The activity proposed to work with government departments (MOPHS, MOMS, MOE, Ministry of Livestock, NDMA, and MOGSD), CSOs, livestock and other cooperatives, schools, water management committees and cultural structures to integrate interventions that were expected to strengthen the health system with those that were to address social health determinants. The activity was to work with the Ministries of Health and Livestock at local levels to combine efforts with mobile pastoral training units to deliver integrated human health and animal health outreach, starting with areas such as Isiolo and Wajir where pastoral training units were already active. The activity was to prioritize the Annual Operating Plan (AOP) cycle and empower sub-county and county health management teams to prepare SMART plans and supervise, document, monitor, and review implementation of a multi-sectoral approach to attain health and developmental results.

A.3: Activity Results Framework:

The theory of change that was envisioned for the APHIAplus Imarisha activity was that depicted in the Results Framework below. Specifically for the USAID/Kenya and East Africa to achieve its mandated strategic goal of sustained improvement of health and well-being for all Kenyans, the APHIAplus Imarisha activity were to directly and indirectly contribute to health outcomes in results 3 and 4. Collaboration, coordination and synergy among the activities implementing all the result areas were to result in the achievement of strategic objective and in long term result in the achievement of the strategic goal as presented on the framework below:



A.3.1: Program Goal: The goal of the APHIAplus Imarisha activity is improved health outcomes and impact through sustainable country-led programs and partnerships.

A.3.1.1: Program Results:

APHIAplus Imarisha was designed to respond to Result 3 and 4 (see results framework above) of the 2010 – 2015 Implementation Framework, the Activity was to primarily support technical areas of HIV/AIDS, malaria, family planning, and tuberculosis, and, to the extent that funds are available, MNCH and nutrition, food security, water and sanitation, and selected interventions related to the social determinants of health. The Implementation Framework allowed for additional technical areas to be added should an emergency occur or additional technical priorities be identified and funding available. Over the implementation period, several shifts in strategic directions informed by changes in national HIV/AIDS, RMNCH, and/or nutrition policy/guidelines, adoption of county-level government, and changes in Ministry of Health division/departmental leadership that were not initially envisioned and may have impacted on the observations made or implementation plans developed by the APHIAplus Imarisha Activity. To the extent possible, programs in these technical areas were to be ***integrated*** in order to ***reduce vertical programming and avoid duplication of effort.***

The primary beneficiaries of the Activity under the five-year framework were to include the poor and underserved (particularly from the lowest two quintiles); vulnerable and marginalized groups; those most at risk for contracting HIV/AIDS including young women and adolescent girls, people living with HIV/AIDS (PLHA), commercial sex workers (CSWs), men who have sex with men (MSM), truck drivers, discordant couples, and substance abusers; OVC; youth; young couples and/or newlyweds; women of childbearing age and their partners; pregnant and postpartum women; newborns and children under five years of age; and those at risk by health condition, age, gender, social, and religious determinants or other circumstances.

A.3.1.2: Expected Health Outcomes by IRs

RESULT 3: Increased Use of Quality Health Services, Products, and Information

- Improved capacity of public sector facilities to provide reliable and consistent high quality package of high-impact interventions at community, dispensary, health center, sub-county hospital and county level hospital.
- Increased capacity of the CHMTs to plan and manage service delivery, including effective linkages with health activities to support drought response.
- Increased number of functional community units to promote preventive health behaviors, identify and refer/manage complications
- Increased availability of essential newborn care and resuscitation, nutrition, safe and clean water at point of use, and prevention and management of childhood illnesses
- Expanded coverage of high-impact interventions for women and men of reproductive age, youth, vulnerable groups, MARPs, mothers, newborns and children

Intermediate Result 3.2: Increased demand for an integrated package of quality high-impact interventions at community and health facility levels

Expected health outcomes:

- Reduced social, economic, and geographic barriers to accessing and utilizing services
- Increased capacity of districts to organize appropriate communications strategy
- Increased capacity of facilities to provide client-centered, humane, and dignified care
- Increased capacity of community units to mobilize communities

Intermediate Result 3.3: Increased adoption of healthy behaviors

Expected health outcomes:

- Improved appropriate health care seeking behavior
- Improved home-based healthy practices with a special focus on the high-impact interventions
- Improved compliance with preventive and curative protocols

Intermediate Result 3.4: Increased program effectiveness through innovative approaches
Expected health outcomes:

- Innovative approaches developed to increase the use of quality services at community and facility levels, especially among the marginalized, poor, and underserved populations
- Data analysis and of best practices institutionalized
- Increased coverage of services among marginalized, poor, and underserved populations

RESULT 4: Social Determinants of Health Addressed to Improve the Well-Being of Targeted Communities and Populations

Intermediate Result 4.1: Marginalized, poor, and underserved groups have increased access to economic security initiatives through coordination and integration with economic strengthening programs
Expected health outcomes:

- Marginalized, poor, and underserved groups accessing economic security initiatives
- Target groups actively participating in viable economic activity

Intermediate Result 4.2: Improved food security and nutrition for marginalized, poor and underserved populations
Expected health outcomes:

- Increase in food security, improved nutrition and sustainable livelihoods among the target groups

Intermediate Result 4.3: Marginalized, poor and underserved groups have increased access to education, life skills, and literacy initiatives through coordination and integration with education programs
Expected health outcomes:

- Increased access to education, life skills, and literacy initiatives for highly marginalized children, youth, and other marginalized populations
- Increased school preparedness; enrollment and retention in quality education marginalized, poor and underserved children and youth
- Increased preparation for primary school achievement through regular participation in quality early childhood development programs
- Increased completion of life skills curriculum offered through primary or secondary levels
- Increased enrollment and retention in primary and secondary schools
- Increased transition to post primary and/or secondary education
- Reduced reliance on individual scholarships and provision of quickly expended supplies to secure educational access

Intermediate Result 4.4: Increased access to safe water, sanitation, and improved hygiene
Expected health outcomes:

- Integration of key hygiene practices into HIV and MNCH activities at the community level
- Increased access to improved water sources
- Increased utilization of POU water treatment

Intermediate Result 4.5: Strengthened systems, structures, and services for protection of marginalized, poor and underserved populations
Expected health outcomes:

- Quality protective services available to survivors of sexual assault, child maltreatment and children without adequate family care
- MGCSD supported to develop policies, protocols, and guidance to support quality social services
- Eligible children and families are identified and linked to available government social protection initiatives through CHWs, CSOs, volunteers, and local government representatives
- Strengthened referrals between police, court, health, and social services established

Intermediate Result 4.6: Expanded social mobilization for health
Expected health outcomes:

- Improved financial, managerial, and technical capacity of indigenous organizations serving social and health needs of marginalized, poor, and underserved populations
- District, sub-district, and village health committees plan and coordinate implementation of effective multi-sectoral partnerships for health
- Women, youth, children, and MARP groups meaningfully participate in the design, delivery, and monitoring of interventions on their behalf
- Increased social inclusion and reduced stigma and discrimination against MARPs

A.3.1.3: Priority Outcome level Indicators

The evaluation team will apply both quantitative and qualitative data analysis techniques. In as much as possible, the evaluation team is required to refer to and use all different sources of data including District Health Information System II (DHIS2); NASCOP's National EID System; NASCOP's National Viral Load System; primary data sources such as Knowledge, Attitude, Practice, and Coverage (KAPC) survey; and the Health Facility Assessment in conducting indicator level comparative analysis on current and baseline values. Using a logic model that links interventions to intermediate outcomes and then to end outcomes, analyze the observed trends and or changes in intermediate and end outcome levels through contribution analysis to try and establish what input(s)/ interventions the activity did provide and the extent to which the observed trends in intermediate and end outcomes are a result of the inputs provided by the activity. Reliable results on some indicators such as viral load suppression might not be available for all the Activity's performance years; the evaluation team is therefore required to document such limitations. Some quantitative indicators will be analyzed for a period of five years, while some longitudinal quantitative indicators such as MTCT rate will be analyzed into cohorts of 18 months to determine the extent to which the desired outcomes were achieved. The following are the priority intermediate and end outcome level indicators the evaluation is required to study/explore:

VMMC (limited to Turkana County only)

- % positivity yield in VMMC
- Improvement in institutional capacity to conduct VMMC

HIV Testing (limited to Turkana County only)

- Positivity yield disaggregated by adults, pregnant women and pediatrics
- Positivity yield initiated into HIV treatment disaggregated by adults, pregnant women, and pediatrics **eMTCT (limited to Turkana county only)**
- ***PCR results at 8 weeks; Proportion +ve; % PCR +ve initiated on Treatment; % patients on treatment with viral load suppression***

OVC program: Turkana and Samburu

- Enrollment, attendance, and progression disaggregated by gender
- Proportion of vulnerable OVC households actively participating in community-based household economic strengthening groups disaggregated by wards within each county
- Functional household economic strengthening groups disaggregated by wards within each county

MNCH and FP: (Turkana and Samburu)

- % of births attended by skilled health care worker
- Proportion of pregnant women with 4+ ANC visits

- Proportion of children under 1 year fully immunized
- DPT1 coverage; DPT3 Coverage; Measles Coverage
- Proportion of children that receive postnatal care within 48 hours after birth

Existence of established systems for program quality improvement at health facility (Turkana and Samburu)

- Existence of Quality Improvement Multi-Disciplinary Committee
- Use of performance measurement data to improve quality of services
- Use of national guidelines/protocols by health care workers
- Use of program data for developing work plans, and plan supportive supervision by health managers

A.3.1.4: Existing Data Sources

Primary sources of data for the priority indicators will be the Health Information System for HIV, RMNCH, and TB programs at the facility; CHMT support supervision records; and the implementing partner quarterly/annual progress reports, program records/reports generated through child status index assessments, household vulnerability assessment report and any other reports that implementing partner might have access to. Other facility-level data sources will include NASCOP's National EID system, NASCOP's National Viral Load System, and DHIS2. Data from various existing data sources have varied data quality limitations, with HIV/AIDS data having a relatively better quality than FP/ RMNCAH/Nutrition, and WASH data. The Contractor should therefore try as much as possible to validate data especially from health facility registers, monthly summaries, activity quarterly progress reports, and county/sub-county quarterly performance review reports through triangulation approaches. Known data limitations and their effects on the findings and conclusions should be documented in the report.

USAID KEA will provide the following documents and encourage the evaluation team to gather other documents relevant to this evaluation:

- Activity description documents
- Annual work plans years 1–5
- M & E Plans and PMPs
- Kenya Health Strategic and Investment Plan 2014–2018
- Kenya AIDS Strategic Plan (KASP) 2014–2019
- Kenya Population Projections 2009–2030
- Activity quarterly reports, annual reports
- USAID Evaluation Policy Revised October 2016
- Checklist for Assessing Evaluation Reports
- Other technical/implementation strategy documents for every activity included as an annex

B.2: Evaluation Questions

The following questions are numbered in terms of priority, with a lot of interdependency and must as much as possible be answered with total empirical evidence. IBTCI is required to develop sub-questions that would add details for each main question:

Phase I: Evaluation Questions (40% of LOE)

1. What is the current coverage/improvement status on the priority health outcomes in HIV/AIDS, RMNCH, Nutrition, Water and Sanitation and institutional/ organizational capacity

building? To the extent possible, determine the activity's contribution to the observed health outcomes.

2. To what extent has the activity increased the capability of health community, health facility, and county health management teams to sustain the gains in the observed health outcomes?
3. What implementation challenges did the activity face during the implementation period and how were these challenges addressed? **(This question will examine successes; challenges with the primary outcomes expected to be key programmatic and management lessons learned, especially on institutional capacity building; sustainable household economic strengthening models for OVC vulnerable households; and overall sustainability of implemented strategies to guide future programming decisions.)**

Phase II: **Required Qualitative and/or Quantitative Analytic and Documentation (60% of LOE)**:

1) Using a Case Study approach on every yearly work plan and accompanying progress reports, develop key analysis questions informed by evidence coming out of process I: Conduct an in-depth content analysis of the annual work plans for years 1–5 and corresponding quarterly progress/annual progress reports and document:
    a. What appears to have worked?
    b. What appears not to have worked?

2) Public consultations and discussions with the development experts/organizations working in the Northern Kenya using various methods such as panel discussions, round table discussions, key informant interviews among other technically and financially feasible data collection methods and:
    a. Document the possible successful and unsuccessful implementation strategies around the priority health outcomes for the Northern Arid Lands (NAL) counties, and
    b. Validate the findings from the rigorous analytical work through stakeholders validation workshop to facilitate the development of well-grounded "the what" and "the how to" implementation strategies that are more likely to be most appropriate for the NAL region.

B.3. EVALUATION DESIGN AND METHODS

B.3.1: Evaluation Design

The contractor is encouraged to propose innovative ways of using qualitative and quantitative approaches in similar complex evaluations that could enhance better and well-grounded evidence especially on the possible "how to" strategies appropriate for the NAL region. However, the contractor must consider the Government's evaluation design recommendations as stated below. Where "must" is written the contractor must include these approaches in their proposed approach.

A non-experimental evaluation design that uses pre- and post-analysis of project health outcomes to analyze and determine the current status of health outcomes is recommended for this evaluation with a mixed of both qualitative and quantitative methods to strengthen the rigor of the evaluation design. This must include content review/analysis of resource documents; Mini Rapid Knowledge, Attitude, Practice and Coverage (KAPC) Survey; Mini Rapid Health Facility Assessments; reviews of quantitative data from reports and data collection systems [National AIDS & STI Control Program (NASCOP) Early Infant Diagnosis (EID) system and District Health Information System2 (DHIS2)]; Focus Group Discussions; Key Informant Interviews; and records from meeting minutes held by CHMTs and various health facility management committees. A sequential mixed method design is recommended, and the contractor must sequentially use qualitative–quantitative–qualitative approaches in data collection. A sequential approach starting with qualitative may help the contractor to form foundational understanding by reviewing and analyzing available reports and guidelines, and to form preliminary guiding questions around key result areas. Quantitative approaches such as analysis from KAPC, Health Facility Assessments, and use of

available databases to extract quantitative values would provide the status and help in the crafting of further questions for use in the next round of qualitative analysis. This sequential approach is proven to help focus evaluations and to facilitate efficient use of LOE by the evaluation team. It may further help the Evaluation Team in grounding evidence around the key priority health outcomes.

The contractor must utilize key informant interviews and focus group discussions with health care workers that provide baseline, intermediate, and end-term coverage information on knowledge, attitudes, and practices upon which to conduct trend, content analysis, and triangulation of results to determine the extent of contribution that APHIAplus Imarisha activity inputs had on the observed outcomes. A validation workshop must also be conducted for another source of local and expert opinions that would be valuable in the identification, prioritization, and validation of the "what and the "how to" strategies. The contractor must also collect data on quality improvement utilizing, at the least, the following methods: through review of records held by health facility in-charges, meeting minutes from facility program performance review committees, focus group discussions and/or key informant interviews with members of the quality improvement committee; and health care workers on availability and use of national service delivery guidelines.

B.3.2: Data Collection Methods

It is generally stated in the literature that the manageable number of Focus Group Discussions (FGDs) ranges between 7 and 10 participants largely because large groups of more than 10 participants are difficult to control and they also limit each of the participants' opportunity to actively share insights and observations. It is understood on this evaluation that the sample size for FGDs is not meant to support making any inferences neither is it to support generalization of issues into the general population. It is largely to provide insights and observations critical for grounding evidence emerging from the quantitative and from other forms of qualitative data.

1) Content Analysis of the scope of work in the agreement, national program guidelines, annual work plans and implementation strategies developed in the course of activity implementation and determine the extent to which technical strategy and national policy/guidelines documents informed work plan development and implementation. Review of the key documents such as baseline assessment reports, quarterly and annual progress reports, any mini-household survey such as LQAS reports, CSI reports, programmatic quality assessment reports, etc. conducted by the activity during the implementation period.
2) Review of quantitative data posted on the National AIDS and STI Control Program's (NASCOP) Early Infant Diagnosis (EID) database, NASCOP's National Viral Load database and District Health Information System 2 (DHIS2) and associated health information system primary data sources.
3) Rapid Mini Knowledge, Attitude, Practice, and Coverage Survey to measure the current status of priority health outcomes at the household level. Using Lots Quality Assurance Sampling Methodology, the Contractor should develop appropriate sampling design with the number of sampled households per Supervision Area maintained between 19 and 25. The appropriate geographic area/administrative boundaries to be used Supervision Areas should be discussed with the AMREF team to ensure that the decision makes programmatic sense. Results of LQAS will be reported at County and Project Level. Confidence Intervals will be included for all reported outcome indicators.
4) Mini Rapid Health Facility Assessment to document organizational and institutional capacity improvements that include a look into the quality improvement systems that the Activity supported and their contribution to quality service delivery in the focal counties. The Contractor will develop an appropriate sampling strategy for health facilities that ensures a good mix of health facilities based on the size of their catchment area population classified into high, medium and low population densities. Other considerations such as health facility

classifications of county and sub-county hospitals, health centers, and dispensaries as well as facility ownership (public, private, and faith-based) could also be used.

5) Panel Discussions with 3–5 people representing organizations that have worked in the region for a long time such UN family, Save the Children, and AMREF, among others.
6) Focus Group Discussions (FGD) with two small groups of 7–10 health facility beneficiaries (1 MNCH group and 1 CCC), one group of 7–10 OVC Care Givers attached to every sampled CBO, one group of 7–10 youths who participated in HIV prevention services supported by every sampled CBO, and one group of 7–10 Community Health Workers (CHWs) attached to every sampled CU to collect data about specific and appropriate priority outcome indicator of interest in evaluation.

7) Key Informant Interviews (KII) with (1) USAID technical staff from HIV, Family Health, Malaria, HSS, and SI teams; (2) implementing partner technical staff; (3) health facility in-charges and departmental heads; (4) county and sub-county health management team members; and (5) staff from collaborating institutions.

8) Validation Workshop. Organize two validation workshops (one in Samburu and the other in Turkana) and invite people whose background and experience and expertise covers the key thematic areas for discussions and validation. Recruit and use a facilitator with good facilitation, communication, and negotiation skills to manage the two workshops.

B.3.3: Data Analysis Approaches

The Contractor must propose an appropriate data analysis technique. These approaches must be informed by techniques that have more likelihood of affecting expected program outcomes such as types of program activities/interventions, level of intensity (amount of services, number of contacts/sessions held), and the length of the intervention just to mention a few. These characteristics will aid in analyzing the extent to which they affected the observed outcomes. Gender analysis (including disaggregation of results) must be incorporated in all the analytical work as much as possible.

The proposed and illustrative data analysis approaches in this evaluation include:

Trend analysis – Determine the overall change in key quantitative indicators over the past five years of activity implementation, comparing/plotting year by year to assess the level of the quantitative indicators using basic statistical analysis methods. Reconstructed baseline values will be required for indicators with no baseline values from implementing partners.

Coverage and Effectiveness Analysis – Examination of coverage and effectiveness is critical in understanding the contribution that APHIAplus Imarisha has made toward the reductions in MTCT rates and generally toward the reductions in neonatal and infants mortality. Available evidence suggests that low coverage of programs for early infant diagnosis of HIV is one of many gaps in the EMTCT cascade contributing to lower coverage of ART and high mortality among children infected with HIV (Wettstein et al. 2012). Understanding program and/or intervention(s) coverage (for example the level as supported by the APHIAplus Imarisha) is an important factor of analysis in providing evidence on what level of contributions that APHIAplus Imarisha has made. Elimination of MTCT involves multiple program elements, ranging from primary prevention of HIV infection among women of reproductive age to prevention of unwanted pregnancies among women living with HIV to ART for women and their children (UNAIDS 2011). Therefore, an attempt to understand the extent of program coverage of such multiple program elements is suggested. Using program coverage analytical framework that is built around the four-pronged approach to PMTCT to understand coverage and effectiveness is suggested.

Comparative analysis – Analyze knowledge gains and application, adopted best practices, and application among health care workers that benefited from interventions and programs supported by

APHIAplus Imarisha such as mentorship programs, and service delivery quality improvement programs at the facility and community levels.

Grounded theory analysis – This technique will help build a well-grounded body of evidence from the insights, perceptions and observation from the participants. Summarize observations and insights from different FGD/KII groups into thematic issues/categories and test theories from the start to the end; where possible make follow-ups to support the refinement of conceptual/thematic categories. Other techniques such as ethnographic and case study analysis approaches will be used in data analysis. This analytical technique is expected to develop very substantive and evidence-based conclusions.

Content and Triangulation Analysis to Develop Contribution Analysis Framework –Using a Case Study Approach, the Contractor is expected to develop questions to guide the content review and analysis of implementation strategies that the Activity used in every Annual Work Plan and results reported in quarterly and annual progress reports to determine to the extent possible the extent to which USAID KEA contributed to the observed health outcomes through the Activity. Using content analysis as an analysis tool to identify key thematic and categories for triangulation with evidence from the quantitative data from other sources of data, evaluation team is expected link implemented strategies to the observed health outcomes. This technique will help the evaluation team to better understand the technical support that was provided over time by APHIAplus Imarisha and as much as possible attempt to associate the observed health outcomes with the strategies implemented by the Activity. From the analysis of the causal logic models evaluation team should also establish if the observed health outcomes would have occurred even without the inputs/outputs from the activity.

B.3.4: Sampling Strategy

A mix of multi-stage, systematic and purposive sampling strategy is recommended in this evaluation. Multi-stage systematic sampling is adopted as a way of ensuring that more representation is achieved at the ward level and/or sub-county level in developing sampling frames by wards and selecting health facilities to create a more representative sample of the health facilities and CDBOs implementing OVC programs in Turkana and Samburu counties. Purposive sampling is then introduced as way of ensuring that all county and sub-county hospitals and CBOs that serve between 2000 and 3000 OVC are included in the sample. This mix will help reduce costs and reduce challenges largely associated with logistics of reaching to service delivery points. USAID KEA expects that whatever sampling designs that the Contractor proposes would ensure good representation of urban and rural populations as well as health facilities; and at a minimum would meet the rigor required to accurately estimate the values of interest in the assessment. Sampling design must ensure quality results while taking into account cost feasibility. To ensure that the breadth and depth of the APHIAplus Imarisha activity is included in the data collection process, different sampling strategies are suggested for different points of data collection as detailed below:

1. Rapid Mini Health Facility Assessment: County, sub-county, health center and dispensaries. All county and sub-county hospitals will be purposively included in the sample; while only high-volume health centers/dispensaries (ANC/PMTCT clients – 300 per year) and dispensaries (ANC/PMTCT clients 200+ per year) are included. (AMREF to provide: List of PMTCT/ANC sites based on FY 15 and FY 16 APR that they support in Turkana and Samburu). The list from the two reporting periods will be considered since some facilities were dropped in FY 16. IBTCI team will first stratify facilities into rural and urban and then use systematic random sampling to select required sample size that includes all sub-county hospitals, health centers and dispensaries. Catchment area population for the sampled health facilities should also consider factors besides the patient volume. All county and sub-county hospitals will purposively be included in the sample.
2. Rapid Mini Knowledge, Attitude, Practice, and Coverage Survey: A representative sample of households with women of reproductive age (15–49 years) is recommended, preferably developed using Lots Quality Assurance Sampling Methodology. Appropriate designation of

Supervision Areas is required and should be determined in consultation with AMREF team. Sample size of 19–25 per Supervision Area is recommended and the reported results are expected to include confidence intervals.

3. Community Based Organizations (CBOs) supporting Orphans and Vulnerable Children (OVC) will purposively be selected based on (1) number of years implementing OVC program, (2) total number of OVC that it supports, and (3) geographical location to ensure good representation of the Activity's catchment area. APHIAplus Imarisha will provide a detailed list of CBOs in each ward from which a suitable sample of CBOs will be obtained. Systematic random sampling method will be used in the selection of OVC households to participate in the data collection processes as determined most appropriate by IBTCI. (AMREF and RCEA/Watoto Wazima Initiative teams to provide: List of CBOs and the wards they cover with OVC activity.)
4. Collaborating/partner institutions/county MOH program representatives. These partners will be selected based on the length of time in months/years that it has been closely working with the Activity. Those that worked with the activity for a period of 2–3 years will be accorded high priority in the selection process. AMREF team to provide a list of collaborating/partner institutions/MOH representatives for every focal county (Turkana and Samburu). IBTCI will make determination on the level of efforts after consulting with AMREF Activity team. Respondents from the collaborating/partner institutions will be selected using a purposive sampling method and will be guided by the potential number of key respondents with relevant knowledge about the Activity performance on thematic areas of interest.
5. IBTCI is required to use its technical judgment on the right mix of respondents for Focus Group Discussions (FGD), Panel Discussions, Round Table Discussions (RTD), Key Informant Interviews (KII) sessions and validation workshop participants. Targeted respondents should include but not be limited to women with children under five years, people living with HIV, youths 15–24 years, OVC, and OVC Caregivers.

B.3.5: Synthesis of Conclusions and Recommendations on Future Implementation Strategies

The Contractor must develop strategies that would ensure that for every key finding, explanations are sought from key sources to better present it and also contribute to the development of substantive conclusions. These follow up data collection strategies (Key Informant Interviews, Subject Matter Expert Consultations, Panel Discussions, Focus Group Discussions) should narrow down to specific factors both external and internal that might have contributed to the observed results. Guided analysis at this stage is expected to result in well-synthesized conclusions upon which recommendations are developed. The contractor must develop 3–5 key recommendations on the "what" and the "how to" strategies for every evaluation question, that are well-thought out, action-oriented, and practically possible to implement. Recommendations are required around thematic areas of sustainability, promising implementation strategies for scale- up, institutional/organizational strengthening and management, and coordination/ collaboration and partnerships among other areas that will come up.

B.3.6: Threats to validity

The Contractor must guard against any possible threats to validity of findings, conclusions and recommendations drawn from the qualitative and quantitative methods. Any conclusion drawn from the qualitative and quantitative data sources must be supported by well-grounded body of evidence that is triangulated and confirmed. The Contractor must adhere to USAID's "Checklist for Reducing Threats to Validity for Qualitative Methods."

B.3.8. Limitations to the Proposed Evaluation Design and Methodology

The known data limitations are twofold: data quality and availability from the national health information system. Given that the public health sector still relies on the paper-based system (except for a few high-volume sites that use electronic medical systems) to collect, collate, and report data, data are always incomplete (especially longitudinal data) and do not reflect the actual outputs. Availability of health records at health

facilities is a major limitation, especially for the records that cover earlier periods going back to 2010. Recall bias from health care workers is another major limitation, especially in situations where facilities have gone through staff transitions. Contribution analysis is based on the activity's theory of change and determination of the actual inputs, activities, and outputs that are directly linked to correspond to the every priority outcome indicator could prove challenging. The validity and reliability of the used baseline data on selected indicators from various data sources is another potential limitation. IBTCI is expected to propose ways through which such limitations will be addressed and/or minimized to the extent possible.

Evaluation Management and Participation:

USAID KEA through the designated Contracting Officer's Representative (COR) will provide technical direction within the scope of work. The contractor shall be responsible for arranging all focus group discussions, roundtable discussions, panel discussions, Key Informant Interviews (KII), and validation workshops and for booking meeting places. The Evaluation Team must include the following skill sets (Team leader; Public Health evaluation expertise; Reproductive, Maternal, and Child Health Evaluation expertise; social scientist expertise; M&E expertise; and facilitation skills). IBTCI must arranging all domestic travel and hotel arrangements for the selected county health executives listed below.

Format of Final Evaluation Report

IBTCI is responsible for ensuring that the final evaluation report meets all quality criteria listed in **Appendix I** of USAID's Evaluation Policy. The final evaluation report shall have a maximum of 30 pages:

1. Executive Summary—concisely states the most salient findings and recommendations (2pg)
2. Table of Contents (1pg)
3. Introduction—purpose, audience, and synopsis of task (1pg)
4. Background—brief overview of development problem, USAID project strategy and activities implemented to address the problem, and purpose of the evaluation (3pg)
5. Methodology—brief description of the evaluation methods, detailed presentation on the analytical methods used including data triangulation analytical processes, description of data limitations, impact of any on drawn conclusions/recommendations, constraints, and gaps (3pg)
6. Key Findings/Conclusions/Recommendations—organized by Part I and Part II (11–30pg)
7. Annexes —including the full evaluation SOW, a summary of the evaluation methods used and data collection schedules and instruments. Annexes will also include interview lists and tables that are succinct, pertinent, and readable; references to bibliographical documentation consulted; and focus group discussion notes and/or transcripts.

The first section should focus on achievements on the expected health outcomes, key lessons learned, and challenges, and the second section must focus on outputs of the analytical work that documents what worked and what didn't work, to demonstrate as part of Contribution Analysis Framework what has been USAID KEA's contribution to the observed health outcomes. The analytical work should present the "what" and the "how to" implementation strategies with high likelihood of achieving sustainable results in the NAL region. The "what" and the "how to" strategies are expected to inform programs/activity designs by multiple development partners and other civil society organization that program interventions in the NAL region for the final evaluation report as outlined in Section F.

USAID Evaluation Policy standards must be met by the offeror throughout the contract.

[End of Section C]

SECTION F – DELIVERIES OR PERFORMANCE

F.1 INCORPORATION OF IDIQ CLAUSES

The clauses included in the IDIQ are hereby incorporated by reference.

F.2 PERIOD OF PERFORMANCE

The period of performance will be on/about October 15, 2017 (October 23, 2017)–January 15, 2018. (February 28, 2018)

Note: In the original issuance the POP was 4.5 months from April 1, 2017 to August 13, 2018; ESPS aims to start on October 23 after the October 17 Kenyan Election (see illustrative work plan, Annex 11) and to end about February 28, 2018.

F.3 PLACE OF PERFORMANCE

The place of performance is **Kenya** (**Turkana and Samburu counties**.)

F.4 DELIVERABLES

All reports are subject to approval by the Contracting Officer's Representative (COR). Updates shall be provided to the COR on all Task Order deliverables, and discussions will be held upon USAID request, between the Chief of Party and COR on progress and implementation issues.

All reports shall be submitted electronically using Microsoft Word, Excel, PowerPoint software, or any other USG SIMS reporting system. All reports shall comply with the standards at Section C.3.2 of the IDIQ AID-623-I-13-00001. All products produced by the Contractor and submitted to USAID shall:

- Be written in proper American English with correct spelling and grammar
- Be written in Plain English, as defined at http://www.plainlanguage.gov/
- Be submitted on time
- Be accurate, with all data substantiated

TASKS AND DELIVEABLES:

A. **In Briefing/Team Planning Meeting**: Contractor to propose dates.

B. **Work plan**: The evaluation team will provide a detailed work plan to USAID KEA before commencing the evaluation. The work plan will outline how the evaluation will be undertaken, the evaluation design and methods to be used considering the evaluation questions and the data collection and analysis plan for every main question. The work plan will also include detailed data collection instruments, including FGD and KII questionnaire guides. The work plan must be approved by USAID KEA before commencing field work.

C. **Briefings**: The Evaluation team will provide regular in-country briefs to USAID/Kenya and East Africa on progress and discuss problems and issues on a bi-weekly basis via email communications and/or meeting to brief USAID KEA on the fieldwork progress, any implementation challenges and how they are being addressed, A mid-term briefing must be held at the mid-point of data collection process on the progress made by mid-point and include any data collection challenges that would require USAID KEA's attention.

D. **In-Country Presentation**: The contractor must make an in-country PowerPoint presentation with handouts to USAID Kenya and East Africa on the main preliminary findings at the end of the evaluation.

E**. Draft Evaluation Report**: Acceptance of the draft report by USAID/Kenya and East Africa will be contingent upon the report adequately fulfilling the scope of work and addressing major important areas of inquiry outlined in the SOW. The format of the draft and report must contain the required format and content as indicated the statement of work.

F. **Final Evaluation Report.** Upon final approval of the content by USAID/Kenya and East Africa, IBTCI will have the report edited and formatted. The final report must be submitted both electronically and in hard copy. Four hard copies of the report will be provided to USAID/Kenya and East Africa. In addition, all the raw data will be submitted to USAID on CD labeled "APHIAplus Imarisha Data" for future reference. Once USAID approves the final report, IBTCI must load the report to the Development Experience Clearinghouse (DEC).

F.5 KEY PERSONNEL

Team Leader (TL): The TL must be a senior local (Health/Population/Nutrition/HIV-AIDS Analyst) expert in public health with strong program management and team leadership experience, especially managing evaluation teams in developing countries. S/he will have overall responsibility for fulfilling the requirements of this SOW. S/he must have a master's degree and experience in program management, team leadership, and evaluation. Ten years and above of extensive international experience related to health programs and at least seven years in evaluating donor funded activities is required. S/he will have experience in leading evaluation teams, and drafting high-quality evaluation reports. **IBTCI will present to USAID for review a copy of the last three evaluation reports that he/she wrote and a reference for each.** S/he will ensure that each technical area expert leads a well-guided process of developing substantive conclusions and recommendations on the "what" and the "how to" strategies.

Other Key Personnel

The other key personnel must process the following skills:

Senior Local Expert (Health/Population/Nutrition/HIV-AIDS Analyst), a clinician with a master's degree in Public Health, International Development, Social Science, or a closely related field is required. S/he will have significant work experience in HIV/AIDS programing especially in HIV care and treatment and HIV/TB program areas. Experience in participatory evaluation methodologies, design, and end-of-program evaluations with 6–8 years' experience in conducting NGO/CBO/FBO level research in Sub-Sahara Africa is highly desirable. S/he will take full responsibility for leading evaluation of HIV/AIDS programs at the facility and community, while working with the other two team members. S/he will have strong demonstrated experience in the use of social science qualitative research methods in the collection and analysis of data. S/he will provide technical area leadership in the data collection, analysis of key findings, development of substantive and evidence-based conclusions and action-oriented and practical recommendations, and on facilitating technical discussions geared toward developing implementing strategies on a broad range of development programs.

A senior local expert (Health/Population/Nutrition/HIV/AIDS Analyst), a Reproductive Health, Maternal **Newborn and** Child Health (RMNCH) expert with a master's degree in Public Health or International Development is required. S/he will have significant work experience in RMNCH programming areas. Experience in participatory evaluation methodologies, design, and end-of-program evaluations with between 6 and 8 years' experience in conducting NGO/CBO/FBO level research in Sub-Sahara Africa is highly desirable. S/he will be responsible for leading other members of the team in evaluating RH/MNCH/Nutrition components of the APHIAplus activities. S/he will have strong demonstrated experience in the use of social science qualitative research methods in the collection and analysis of data. S/he will provide technical area leadership in the data collection, analysis of key findings, development of substantive and evidence based conclusions and action-oriented and practical recommendations, and on facilitating technical discussions geared toward developing implementing strategies on a broad range of development programs.

Senior local (Social Scientist/Other Technical Advisor) with strong understanding of OVC, especially in the development, evolution and transitioning of community-based household economic strengthening models in Sub-Saharan Africa. S/he will have a master's degree in public health, agriculture, nutrition, anthropology, social work/sociology and/or any other related field with a working experience in participatory evaluation methodologies, design, and implementation of program evaluations with 5–6 years in Sub-Saharan Africa is highly desirable. S/he will have requisite skills and experience in evaluating nutrition and livelihoods, and must have extensive experience using a range of sound social science research methods and analysis. S/he will provide technical area leadership in the data collection, analysis of key findings, development of substantive and evidence-based conclusions and action-oriented and practical recommendations and on facilitating technical discussions geared toward developing implementing strategies on a broad range of development programs.

Senior local (Monitoring and Evaluation or Research Specialist) with a master degree in public health, statistics and/or information management. S/he will have significant M&E, Research work experience in integrated HIV/AIDS, MNCH/FP/Nutrition/Malaria programming, with at least 7–10 years' experience. Experience in a wide range of evaluation methodologies, qualitative and quantitative data analysis techniques that include ability to triangulate findings from different methods. Proof of participation in end-of-program evaluation.

Other personnel:

Validation Workshop Facilitator (1): This person must **have the ability to facilitate a Validation Workshop.** Experience facilitating meetings/workshops where participants are expected to contribute to and develop consensus on technical program implementation strategies.

Research Assistants (36): Must be local junior professionals with past experience in conducting national and/or county-level cross-sectional household surveys. Preference should be given to those who have participated in household surveys organized and conducted by Kenya National Bureau of Statistics (KNBS). As the majority of the Research Assistants with experience from KNBS may not meet the labor qualifications for local junior professionals, IBTCI will require a blanket waiver to USAID Contracting Officer in order to expedite the recruitment process and be responsive to USAID expected time frame for conducting the overall evaluation.

[End of Section F]

ANNEX 2: METHODOLOGY

The evaluation team used both quantitative and qualitative methods to gather data to answer the three key evaluation questions.

The evaluation team conducted a document review and household surveys; gathered data from the District Health Information System (DHIS2); conducted organizational capacity assessments; performed qualitative research that included key informant interviews, focus groups, panel discussions, and developed a case study—performing quality control through triangulating information from multiple sources.

Data sources and quality control

A document review enabled the team to better understand the activity's goals, objectives, and interventions; inform the design of the data collection tools and instruments; and determine the characteristics of both stakeholders and activity beneficiaries that were interviewed.

Qualitative methods included KIIs and panel discussions with various stakeholders and IPs in the NAL region and at national level. Panel discussions/KII were conducted with CHMTs, SCHMTs, LIPs, and CUs to elicit expert opinion on the implementation of the activities, outputs, outcomes, and impacts of APHIAplus Imarisha in NAL region.

In addition, the team conducted **focused group discussions** (FGDs) with five target groups: Maternal Neonatal and Child Health (MNCH) clients; Comprehensive Care Clinic (CCC) clients; youth (15–24 years) who participated in HIV prevention services in Turkana County; caregivers supporting orphans and vulnerable children; and community health workers (CHWs).

Household surveys and observations queried women of reproductive age (15 – 49 years) and OVC households. These two surveys measured population health according to key priority indicators on:

a) Fourth ANC attendance, delivery under skilled attendant, immunization coverage, proportion of infants receiving postnatal care within 48 hours after birth, skilled birth attendance, family planning uptake specifically for MNCH/FP; OVC school enrollment, attendance, progression under OVC support
b) Community-based household economic strengthening initiatives
c) Water, sanitation and improved hygiene
d) Food security and sustainable livelihoods
e) Adoption of health behaviors
f) Access barriers to accessing and utilizing health services

The evaluation included **organizational capacity assessments** (OCA) of the County Health Management Teams (CHMT), health facilities, and community units.

Data Quality Assessment

This evaluation used routine program data (source: DHIS2) to assess the activity's performance on priority indicators relating to HIV testing, treatment, HIV-exposed infants (HEI), and antenatal care (ANC) attendance. Data on infant testing using Polymerase Chain Reaction (PCR) was obtained from the National AIDS & STIs Control Program (NASCOP) – Early Infant Diagnosis (EID) database.

Case Study

Using the priority outcomes and expected health outcomes, the evaluation team used a case study approach, analyzing APHIAplus Imarisha work plans and the corresponding quarterly and annual work plans to determine what worked and what did not during the activity. Evidence from the case studies augmented information from primary data obtained during fieldwork (KII, FGD, household surveys and OCA).

Validation Workshops

The team conducted validation workshops in Maralal (Samburu County) and Lodwar (Turkana County) to elicit stakeholders' views on implementation strategies and findings.

Sampling strategy

Key informants/panel discussion participants included representatives of key institutions, government departments, and developmental partners as well as implementing partners

The **health facilities** were stratified by county/sub-county and type of facility. The team selected a sample of 24 facilities distributed across three counties. All are high-volume, as defined by an ANC/PMTCT client load of more than 200/year.

The evaluation included **all community-based organizations supporting OVC** in the project.

All **community units** selected had links to a sampled health facility and were functioning. The team also considered the following criteria:

i) the unit's catchment population
ii) proximity to the sampled health facility and/or CBO (in case of more than one CU)
iii) geographical location, to ensure broad of geographic coverage

Focus group members The Evaluation Team liaised with the MNCH clinics, CCCs, CUs, and CBO in-charges to estimate the average number of clients seen per day (for facility beneficiaries), the number of OVC caregivers (for CBOs supporting OVCs), the average number of Youth (15-24) that participated in HIV prevention services in a month (for CBO supporting evidence-based interventions targeting youths) and the number of community health workers supporting community work within each sampled facility.

Focus group discussions with youths (15–24 years) and CCC clients were restricted to Turkana County.

For the household survey, a cross-sectional study design was used to estimate priority health outcome indicators at the household level, among mother-child pairs, with children under five, and among OVC-caregiver pairs.

Lot Quality Assurance Sampling: Within each sub-county, cluster random sampling approach with Lot Quality Assurance Sampling (LQAS) technique was used to provide sub-county-specific population health estimates and to identify wards within the target sub-counties that could be lagging behind on program targets.

Stratification by wards: Within each sub-county, wards served as the primary units (distinct strata) for the survey. Stratification by wards was applied to minimize sampling errors, ensure proper representation, and identify wards that are below the program coverage levels.

Supervision Areas: All wards served as the LQAS supervision areas (SA) for this end-term evaluation. LQAS samples of 19, 24, and 30 were selected depending on the number of SA in each sub-county. This ensured that the final sample size per SA is sufficient enough for LQAS classification and estimation purposes at the county level (i.e., on aggregating LQAS sample within each county).

Data management and analysis

Household survey data

Data collectors used Android-enabled mobile phones. The survey questionnaire was programmed and administered electronically using Survey To Go Dooblo Software.

Routine program HIV data

The evaluation team used the District Health Information System (DHIS2) to download health facility data on selected outcome indicators (March 2012 through March 2017). In addition, teams conducted data quality assessment and discussed any discrepancies with the implementing partner responsible for that health facility. The final dataset for each health facility was shared with the IP and sent to the M&E specialist.

Qualitative data

Triangulation from the different data sources helped back up qualitative information from the desk reviews, interviews, and work plan analysis.

Contribution Analysis – Case Study

We developed a logic model for contribution analysis to help draw conclusions about APHIAplus Imarisha's contribution to the expected health outcomes. We analyzed the five annual work plans, quarterly progress reports and other, documents to discern intended interventions, implementation strategies, gaps in outputs and the observed health outcomes in a particular case.

ANNEX 3: RESEARCH TOOLS

Contents

TOOL 1:

KNOWLEDGE, PRACTICES, AND COVERAGE (KPC) SURVEY FOR MATERNAL, NEWBORN, CHILD HEALTH & NUTRITION (MNCHN) IN TURKANA AND SAMBURU COUNTIES

(28 pages)

Identification	
County	1. Samburu 2. Turkana
Sub-County	
Ward	
Community Unit Name	
Household Number	
Village Name	
Name of Mother	
Name of Interviewer	

Interview date	___/___/____ day/month/year	*For Supervisor*				
		Day				
Name of STL		Month				
		Year				

Consent Page

INFORMED CONSENT

Hello. My name is…….. and I am here on behalf of IBTCI/USAID. We are conducting an evaluation of the just concluded AMREF led APHIA Imarisha project. I would like to ask you about your health and the health of your youngest child under the age of five. This information will help (MoH and USAID) to plan health services and assess whether it is meeting its goals to improve women and children's health in this community. The interview will take about 40 minutes to complete. Whatever information you provide will be kept strictly confidential.

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

Are you willing to participate in this survey?

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

Signature of interviewee: _____ Date: _____

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

INSTRUCTIONS:

(1) ALL QUESTIONS ARE TO BE ADDRESSED TO MOTHERS WITH A CHILD LESS THAN 59 MONTHS OF AGE.

(2) ASK FOR OFFICIAL DOCUMENTATION REGARDING CHILD (MOTHER AND CHILD BOOKLET)

SECTION 1: DEMOGRAPHICS				
101	In what month and year were you born?	……/……..(MM/YYYY) Don't Know	 99	
102	Confirm that respondent is aged between 15 and 49 years	Yes No	1 2	**If "2" End Interview**
103	How long have you been living continuously in this village?	More than 9 months Less than 9 months	1 2	
104	What is the highest level of schooling you attended?	None /never went to school Nursery/pre-unit/ kindergarten Primary (no certificate/incomplete) Primary (Certificate /complete) Secondary/A level (no cert/incomplete) Secondary/'A' level (Certificate /complete) College/Tertiary (no certificate/incomplete) College/Tertiary (Certificate /complete) Other (specify)……	0 1 2 3 4 5 6 7 88	
105	What is your religion?	Catholic Protestant/ Pentecostal Muslim Traditional No religion Other (specify)……..	1 2 3 4 5 88	
106	What is your marital status currently?	Single and not in a regular relationship Single but with a regular partner Married, monogamous Married, polygamous Divorced/Separated Widowed Other (specify)……	1 2 3 4 5 6 88	
107	What is your **MAIN** occupation? **[DO NOT READ LIST. CIRCLE**	Unemployed, looking for work Unemployed, not looking for work	1 2	

	ONLY ONE RESPONSE]	Informal micro trading (e.g. hawker, kiosks) Formal trading (with business permit) Employed professional (skilled labor) Employed (unskilled labor) Student Other (specify)……..	3 4 5 6 7 88	
108	Who is the **MAIN** breadwinner in your household?	Myself Partner Parent Other relative (specify)……..……	1 2 3 88	**IF "1" Skip to 110**
109	What is the **MAIN** occupation of the MAIN breadwinner in your household? **[DO NOT READ LIST. CIRCLE ONLY ONE RESPONSE]**	Unemployed, looking for work Unemployed, not looking for work Informal micro trading (e.g. hawker, kiosks) Formal trading (with business permit) Employed professional (skilled labor) Employed (unskilled labor) Student Other (specify)……..	1 2 3 4 5 6 7 88	
110	From all the sources of income, what is your average household income per month?	Kshs……..		
111	What is the total number of people who normally live with you in this household?	……Adults, ……Children		
112	Who is the head of the household? **RECORD THE GENDER & WHETHER ADULT OR CHILD**	Adult male Adult female Male child Female child Other (specify)…….	1 2 3 4 88	
SECTION 2: FERTILITY				
201	During the **last FIVE years**, how many children have you given birth to?	……. children		
201	What is the age of your last born child?			

		..……Months ……..……Years		
202	At the time you became pregnant [with NAME)], did you intend to become pregnant then, or did you want to wait until later, or did you not want to have any (more) children?	Wanted to be pregnant then Wanted to wait until later Did not want any (more) children	1 2 3	
203	Do you intend to have (more) children in future?	Yes No Not decided	1 2 99	
204	How long would you like to wait before having (another) child?	……..……Months …….. Years		
205	What is your desired number of children?	[…….]		
SECTION 3: FAMILY PLANNING				
301	Which ways or methods have you heard about that a couple can use to delay or avoid a pregnancy? **[FOR METHODS NOT MENTIONED SPONTANEOUSLY, ASK: Have you ever heard of (METHOD)?]**	Tubal ligation Vasectomy Pill IUD Injectable Implants Condom Female condom Lactational amenorrhea method (LAM) Rhythm method Cycle beads Withdrawal Emergency contraception Other (specify…….		1 2 3 4 5 6 7 8 9 10 11 12 13 88
302	Do you know of a place where you can obtain any of the family planning/child spacing methods you have heard about?	Yes No	1 2	**IF "2" Skip to 304**
303	Where is that? Any other place? **[CIRCLE ALL MENTIONED]**	Public health facility Private health facility FBO/NGO facility	1 2 3	

		Chemist/pharmacy/shop	4	
		CHV	5	
		Other (specify)……..	88	
304	Have you at any time, wished to delay pregnancy or space your births?	Yes	1	**IF "2" Skip to 308**
		No	2	
305	When you wished to delay pregnancy or space your births did you use any method?	Yes	1	**IF "2" Skip to 307**
		No	2	
306	Which method did you use? **[DO NOT READ OPTIONS]**	Tubal Ligation		1
		Vasectomy		2
		Pill		3
		IUCD		4
		Injectables		5
		Implants		6
		Condom		7
		Female condom		8
		Lactational amenorrhea method (LAM)		9
		Rhythm method		10
		Cycle beads		11
		Withdrawal		12
		Emergency contraception		13
		Other (specify…….		88
307	What made you not to use any method? Any other reason? **[PROBE WITHOUT READING OPTIONS. CIRCLE ALL MENTIONED SPONATANEOUSLY]**	I didn't know of any method		1
		I didn't know where to get method		2
		My preferred method was not available		3
		Could not afford the cost		4
		Not allowed by our culture		5
		Not allowed by my religion		6
		Fear of side effects		7
		Fear of embarrassment/ stigma		8
		Partner refused		9
		Other (specify)……		88
		I don't know		99
308	Are you and your partner currently doing something or using any method to delay or avoid getting pregnant?	Yes	1	**IF "2" Skip to 401**
		No	2	

309	Which method are you and/or your partner currently using? **[ASK ANY OTHER?]** **[CIRCLE ALL MENTIONED]**	Tubal Ligation Vasectomy Pill IUD Injectables Implants Condom Female condom Lactational amenorrhea method (LAM) Rhythm method Cycle beads Withdrawal Emergency contraception Other (specify……..	 2 3 4 5 6 7 8 9 10 11 12 13 88	1
310	Does your husband/partner know that you are using a method of family planning?	Yes No	1 2	
311	Would you say that using family planning is mainly your decision, mainly your husband's/partner's decision, or did you both decide together?	My decision My husband's decision We decided together Decision of other people Other (specify)……..	1 2 3 4 88	
SECTION 4: ANTENATAL CARE				
401	During your pregnancy with (NAME), did you receive any antenatal checkups?	Yes No	1 2	**IF No Skip to 419**
402	How many times did you receive antenatal care checkups before you gave birth?	…….. Times		
403	How many months pregnant were you when you **FIRST** received antenatal care?	……..Months		
404	Where did you receive the antenatal care services?	MOH health facility Private health facility FBO/NGO health facility At home by CHV At home by TBA	1 2 3 4 5	

		Don't Know	88	
		Other (specify)……		
405	The last time you went for antenatal care, who examined you? **[PROBE: WAS IT A MALE OF FEMALE HEALTH PROVIDER?]**	Male	1	
		Female	2	
406	Would you have preferred being examined by a male or female health provider?	Male	1	
		Female	2	
		I am fine with any/ no preference	3	
407	During the last visit to the ANC clinic did the provider talk to you about any signs of complications (danger signs) that should warn you of problems with the pregnancy?	Yes	1	
		No	2	
		Don't know	99	
408	Please tell me any signs of pregnancy complications (danger signs) that you know of. **[ASK ALL RESPONDENTS EVEN THOSE WHO ANSWER NO/DON'T KNOW IN QUESTION E7. DON'T READ CHOICES. PROBE BY ASKING ANYTHING ELSE? CIRCLE ALL MENTIONED]**	Vaginal bleeding		1
		Fever		2
		Swollen face or hands		3
		Tiredness or breathlessness		4
		Headache or blurred vision		5
		Convulsions		6
		Baby stops moving/reduced fetal movement		7
		Water breaking/Gush of fluid from vagina		8
		Other (specify……		88
		Don't know		99
409	What should a pregnant woman do if she experienced any of the danger/ warning signs? **[DO NOT READ ANSWERS. PROBE BY ASKING WHAT ELSE?]**	Seek care at a facility	1	
		Seek the help of a TBA	2	
		Decrease activity	3	
		Take bed rest	4	
		Change diet	5	
		Prayers	6	
		Other [specify)…….	88	
410	Now, tell me whether you received the following services as part of your ANC services? **[READ CHOICES AND CIRCLE ALL CHOICES THAT GET A YES ANSWER]**	Advice about breastfeeding	1	
		Tetanus injection (in the arm)	2	
		Iron folate tablets	3	
		Were you weighed?	4	
		Was your blood pressure measured?	5	
		Did you give a urine sample?	6	
		Did you give blood sample?	7	

		Medicine to prevent malaria	8	
		Bed net/ mosquito net	9	
411	During your pregnancy with (NAME), how many times did you receive an injection in the arm to prevent tetanus?	Once	1	
		Twice	2	
		Three times	3	
		More than 3 times	4	
		Never/was not injected	5	
		Don't know/ can't remember	99	
412	During any of the antenatal visits for (NAME) were you given any information about babies getting HIV from their mother?	Yes	1	
		No	2	
		Don't know	99	
413	During any of the antenatal visits for (NAME) were you given any information about things that you can do to prevent transmitting HIV to a baby?	Yes	1	
		No	2	
		Don't know	99	
414	Were you offered a test for HIV as part of your antenatal care?	Yes	1	
		No	2	
		Don't know	99	
415	I don't want to know the results, but were you tested for HIV as part of your antenatal care	Yes	1	**If No or Don't Know, Skip to 420**
		No	2	
		Don't know	99	
416	Where was the test done?	MOH health facility	1	
		Private health facility	2	
		FBO/NGO health facility	3	
		At home by CHW	4	
		At home by TBA	5	
		Other (specify)……	6	
			88	
417	I don't want to know the results, but did you get the results of the test?	Yes	1	
		No	2	
		Don't know	99	
418	All women are supposed to receive counseling after being tested. After you were tested, did you receive	Yes	1	
		No	2	

	counseling?	Don't know	99	
419	Why did you not attend/ receive Antenatal care services? **[MULTIPLE ANSWERS POSSIBLE. CIRCLE ALL MENTIONED]**	ANC not important Lack of transport Long distance High cost of care I was okay all through Spouse refused Other (specify)……	1 2 3 4 5 6 88	
420	During your pregnancy with (NAME), did you take any drug for intestinal worms?	Yes No Don't know	1 2 99	
421	During your pregnancy with (NAME), did you take any drugs to prevent you from getting malaria?	Yes No Don't know	1 2 99	
422	During your pregnancy with (NAME), did you sleep under a mosquito net?	Yes No Don't know	1 2 99	
423	During your pregnancy with (NAME), did you know the date that the baby was expected to arrive?	Yes No	1 2	
424	During your pregnancy with (NAME) did anyone discuss things you should have in preparation for the delivery?	Yes No Don't know	1 2 99	
425	Please tell me any things you know of that you should have in preparation for your delivery. **[ASK ALL, EVEN THOSE WHO ANSWERED NO/DON'T KNOW IN QUESTION ABOVE. CIRCLE ALL RESPONSES. PROBE BY ASKING ANYTHING ELSE?]**	Emergency transport Money Disinfectant Sterile blade/scissors to cut cord Baby cloths and toiletries Other (specify)…….. Don't know	1 2 3 4 5 88 99	
426	Did you have money set aside for the delivery?	Yes, enough Yes, but not enough No Can't remember	1 2 3 99	
427	During the last visit to the ANC clinic did the provider talk to you about	Yes No	1 2	

	where you plan to deliver your baby?	Don't know	99	
428	Where did you deliver (NAME)?	At public health facility At private health facility At FBO/NGO health facility At home Other (specify……	1 2 3 4 88	If they **delivered at home skip to 430**
429	For what reasons did/do you prefer to deliver in a health facility?	Safer to deliver there Skilled care from health workers Health facility is near Recommended by relative Services are free Other (specify)……	1 2 3 4 5 88	**Skip to 431**
430	For what reasons did you deliver at home?	I did not have money for the health facility I prefer to deliver at home High transport costs Health facility was too far Do not trust/like health facility Better care at home To attend to my other children Recommended by relative Other (specify)……	1 2 3 4 5 6 7 8 88	
431	When you were pregnant with (NAME), who made the final decision on where you would give birth?	Myself My husband/Partner My mother/mother in law Other relative Other (specify)……	1 2 3 4 88	
SECTION 5: CARE DURING DELIVERY				
501	During your pregnancy with (NAME), where did you deliver?	At home GOK/MOH health facility (Name……..… Private health facility (Name……...… FBO/NGO health facility (Name…… Other specify (……..……..……	1 2 3 4 88	
502	Why didn't you deliver in a health facility?	Baby came abruptly	1	

	DO NOT READ THE RESPONSES BUT CIRCLE THE RESPONDENTS ANSWERS EVEN WHEN MORE THAN 1 **Any other reason?**	Cost at health facility unaffordable Facility closed at time of delivery Didn't have means of transportation Health Facility too far Don't trust facility/Poor quality service No privacy at health facility Husband/family did not allow Not necessary Not customary Religion doesn't allow TBA services better Other (specify)…….	2 3 4 5 6 7 8 9 10 11 12 88	
503	During your last birth with (NAME) who assisted with delivery?	Doctor/Nurse/Clinical officer Community Midwife Traditional Birth Attendant (TBA) Relative/ friend/neighbor Other (specify……..…….	1 2 3 88	
504	Between the times you went for delivery but before the baby was born, were you offered an HIV test?	Yes No Don't know	1 2 99	
505	I don't want to know the results, but were you tested for HIV at that time?	Yes No Don't know	1 2 99	**If NO skip to 508**
506	Where was the test done?	MOH health facility Private health facility FBO/NGO health facility Private clinic At home by CHW At home by TBA Other (specify)……	1 2 3 4 5 6 88	
507	I don't want to know the results, but did you get the results of the test?	Yes No Don't know	1 2 99	
508	At any point during labor and delivery of (NAME) were you mistreated in any way?	Yes No	1 2	If NO, SKIP to 601

509	What exactly happened? **(DO NOT READ, CIRCLE ALL THAT APPLY, PROMPT FOR ANY MORE)**	Confidentiality breached Privacy breached Abused verbally Abused physically Left unattended Detained because couldn't pay Procedures done without consent Other (specify)……	1 2 3 4 5 6 7 88	
SECTION 6: POSTNATAL CARE- MATERNAL & NEWBORN				
601	After birth of (NAME), did any health care provider check **on your health?**	Yes No Don't know	1 2 99	**If "2" or "99" Skip to 607**
602	Who checked on your health at that time?	Doctor/Nurse/Midwife/clinician TBA CHW Other (specify……..	1 2 3 88	
603	How long after delivery of (NAME) did your first check take place?	……Hours ……Days ……..Months		
604	How many times after delivery of (NAME) did you get checked?	…….Times		
605	During the postnatal checkup/ visit were you advised on danger signs to look out for baby (NAME)?	Yes No Don't know	1 2 99	
606	Which are the danger signs you should look out for baby (NAME)? **[ASK ALL RESPONDENTS EVEN THOSE WHO ANSWER NO/DON'T KNOW IN QUESTION 706]**	Difficulty breathing/ rapid breathing Difficulty feeding/ poor suckling High or low temperature/fever Skin color change/ Jaundice Abnormal crying Vomiting Diarrhea/ dehydration Other (specify…….……..	1 2 3 4 5 6 7 88	
607	After birth of baby (NAME), did any health care provider check on his/her	Yes	1	**If "2" or "99" Skip to 612**

	health?	No Don't know	2 99	
608	Who checked on (NAME) health at that time?	Doctor/Nurse/Midwife/clinician TBA CHW Other (specify……..	1 2 3 88	
609	How long after delivery did baby (NAME) first check take place?	……Hours ……Days ……..Months		
610	How many times after delivery did baby (NAME) get checked?	…….Times		
611	During the first two months after delivery of baby (NAME), did you receive a vitamin A dose looking like this? [**SHOW VITAMIN A CAPSULE]**	Yes No I don't know	1 2 99	
612	When baby (NAME) was newly born tell me how you cared for the umbilical cord. **[DO NOT READ CHOICES, PROBE WITH WHAT ELSE AND CIRCLE ALL MENTIONED]**	Applied Vaseline/ jelly/lotion Applied baby powder Applied methylated spirit Cleaned with water Kept cord dry Kept cord covered Chlorhexidine/ tube gel given at health facility Traditional remedies (herbs, ash, oil etc.) Other (specify……	1 2 3 4 5 6 7 8 88	
613	During the last visit to the ANC clinic did the provider give you advice on the importance of exclusively breastfeeding—that is, about giving your baby nothing apart from breast milk?	Yes No I don't know If No or Don't Know, Skip to 615	1 2 99	
614	For how many months did the provider recommend that you exclusively breastfeed, that is, that you do not give your baby liquid or food in addition to your breast milk?	…… Months		

615	Did you ever breastfeed baby (NAME)	Yes No	1 2	If No Skip to 701
616	How long after delivery of (NAME) did you breastfeed?	……Hours ……Days ……..Don't know		If within ONE HOUR Skip to 618
617	Why was the baby not put on breast within 1 hour?	Mother was unwell Taboo Breast not producing milk Colostrum not good for baby Other (specify…… I don't know	1 2 3 4 88 99	
618	Did you ever **exclusively** breastfeed (NAME) —that is, giving (NAME) nothing apart from breast milk?	Yes No	1 2	**IF No, Skip to 620**
619	For how many months did you **exclusively** breastfeed?	……Months		**If 6 months or more, skip to 701**
620	Why didn't you exclusively breastfeed for 6 months? **[ASK WHAT ELSE, CIRCLE ALL MENTIONED]**	Breast milk not enough I was too busy/ was working Did not know importance I was advised by relative I was advised by friend Other (specify……	1 2 3 4 5 88	
SECTION 7: CHILD HEALTH & NUTRITION				
701	Do you have a mother child booklet indicating vaccinations for (NAME) **IF YES: May I see it please?**	Yes No	1 2	
702	Since birth, has (NAME) received any of the following immunizations? **[IF CARD IS AVAILABLE CHECK AND CIRCLE APPROPRIATELY].** **[IF CARD NOT AVAILABLE, ASK THE MOTHER AND DESCRIBE VACCINATON FOR**	BCG Birth Polio (Polio 0) Polio 1 Polio 2 Polio 3 Pentavalent 1	**YES DUE** **NO** **NOT** 1 2 99 1 2 99 1 2 99 1 2 99 1 2 99	

	CLARITY THEN CIRCLE APPROPRIATELY)	Pentavalent 2	1	2	99
		Pentavalent 3	1	2	99
		Measles	1	2	99
		Pneumococcal Vaccine (PCV) 10 1	1	2	99
		PCV10 2	1	2	99
		PCV10 3	1	2	99
		Rotavirus	1	2	99
		Other (specify)	1	2	99
			……		
703	**[IF THE CARD INDICATES SOME VACCINATION WERE NOT GIVEN** **OR** **[IF ANY OF THE ANSWERS TO QUESTIONS ABOVE IS NO ASK THE MOTHER THE FOLLOWING QUESTION].** I see your baby (NAME) is not up-to-date with his/her immunization. Can you tell me why? **[MULTIPLE ANSWERS POSSIBLE. DON'T READ ANSWER. CIRCLE ALL MENTIONED]**	Cannot afford to pay cost/expensive	1		
		Unaware of need for immunization	2		
		Unaware of need for completing all doses	3		
		Not aware of place or time of immunization	4		
		Time of immunization inconvenient	5		
		Health facility too far	6		
		Vaccinator absent	7		
		Vaccine not available	8		
		Mother too busy/sick	9		
		Long waiting time on the queue	10		
		Unpleasant treatment by health worker	11		
		Fear of side effects	12		
		Child ill	13		
		Other (specify)……..	88		
		I don't know/ no reason	99		
704	Has (NAME) been dewormed in the last six months?	Yes	1		**If "1" or "99" skip to 706**
		No	2		
		Don't know	99		
705	Why has (NAME) not been dewormed in the last 6 months? **[MULTIPLE ANSWERS POSSIBLE. DON'T READ ANSWER. CIRCLE ALL MENTIONED]**	No need	1		
		Didn't know it is necessary	2		
		Cannot afford	3		
		I don't have time/busy	4		
		No reason	5		
		Others (specify……	88		

706	Has (NAME) been sick for the last 2 Months?	Yes No	1 2	**If "2" skip to 901**
707	What type of illness did s/he have **Tick as many symptoms and signs as apply**. **PROBE ANYTHING ELSE**	Fever Hot body Weakness Cough Rapid/difficult breathing Headache Loss of appetite Vomiting Diarrhoea Convulsions Loss of consciousness or coma Diarrhea Joint pains Yellow eyes	1 2 3 4 5 6 7 8 9 10 11 12 13 14	
708	Did you seek advice or treatment from any source when (NAME) was sick?	Yes No Don't know	1 2 99	
709	Where did you seek advice or treatment?	Government health facility Private clinic FBO/NGO health facility CHV TBA Traditional healer	1 2 3 4 5 6 7	
710	After you noticed signs and symptoms of sickness in (NAME) how long did you take before first seeking advice or treatment?	Sought advise/treatment immediately Within 3 hours 3-12 hours 12-24 hours 2-3 days More than 3 days Other (specify…….	1 2 3 4 5 6 88	
SECTION 8: MANAGEMENT OF DIARRHOEA				
801	Has (NAME) had diarrhea in the last 2 weeks?	Yes No Don't Know	1 2 99	**If 2 or 99 Skip to 809**

802	What was (NAME) given to treat the diarrhea? Anything else? **If answer pill or syrup, show local packaging for zinc and task if the child received this medicine** **RECORD ALL MENTIONED**	NOTHING FLUID FROM ORS PACKET HOME-MADE FLUID PILL OR SYRUP, ZINC PILL OR SYRUP, NOT ZINC INJECTION IV (INTRAVENOUS) HOME REMEDIES/HERBAL MEDICINES OTHER (SPECIFY)	A B C D E F G H I	
803	Who provided the remedy/treatment?	CHV Health facility/Health worker Pharmacy Others Specify	1 2 3 4	
804	Did a CHV visit NAME at home while he/she was sick?	Yes No Don't Know	1 2 99	
805	How long after providing the treatment did the CHW visit you?	Same day Next day 2 days later 3 days later 4 days later 5 or more days later Don't know	1 2 3 4 5 6 7	
806	When (NAME) had diarrhea, did you breastfeed him/her less than usual, about the same amount, or more	LESS SAME MORE CHILD NOT BREASTFED DON'T KNOW	1 2 3 4 5	
807	When (NAME) had diarrhea, was he/she offered less than usual to <u>DRINK,</u> about the same amount, or more than usual to <u>drink?</u>	LESS SAME MORE CHILD NOT BREASTFED DON'T KNOW	1 2 3 4 5	
808	When (NAME) had diarrhea, was he/she offered less than usual to <u>EAT,</u> about the same amount, or more than	LESS SAME	1 2	

	usual to eat?	MORE CHILD NOT BREASTFED DON'T KNOW	3 4 5	
809	Have you heard of ORS? IF YES, ASK MOTHER TO DESCRIBE ORS PREPARATION FOR YOU If no, circle 3 (never heard of ORS) once mother has provided a description, record whether she described ORS preparation correctly or incorrectly circle 1 [correctly] if the mother mentioned the following: •USE 1 LITER OF CLEAN DRINKING WATER (1 LITER=3 SODA BOTTLES) •USE THE ENTIRE PACKET •DISSOLVE THE POWDER FULLY	DESCRIBED CORRECTLY DESCRIBED INCORRECTLY NEVER HEARD OF ORS	1 2 3	
SECTION 9: MANAGEMENT OF ARI/PNEUMONIA				
901	Has (Name) had an illness with a cough that comes from the chest at any time in the last two weeks?	Yes No Don't Know	1 2 99	**If 2 or 99, skip to 1001**
902	When (Name) had an illness with a cough, did he/she have **trouble breathing** or **breathe faster** than usual with **short, fast** breaths? **Probe for in drawing of the chest while (NAME) was breathing?**	Yes No Don't Know	1 2 99	
903	Did you seek advice or treatment for the cough/fast breathing/chest in drawing for (NAME)?	Yes No Don't Know	1 2 99	
904	How long after you noticed (NAME's) cough and fast breathing did you seek treatment?	Same day Next day 2 days later 3 days later	1 2 3 4	
905	Who gave you advice or treatment of (NAME)? Anyone else? RECORD ALL MENTIONED	CHV Health facility/Health worker Pharmacy Others	1 2 3 4	

		Specify		
906	Did the CHV visit (NAME) at home after providing treatment?	Yes No Don't Know	1 2 99	
907	How long after providing the treatment did the CHV visit you?	Same day Next day 2 days later 3 days later 4 days later 5 or more days later Don't know	1 2 3 4 5 6 7	
Section 10: WATER AND SANITATION				
1001	What is the **MAIN** source of drinking water for members of this household? (CHECK ONE)	PIPED WATER INTO HOMESTEAD PIPED WATER INTO YARD/PLOT/BUILDING PUBLIC TAP/STANDPIPE TUBEWELL/BOREHOLE PROTECTED DUG WELL UNPROTECTED DUG WELL PROTECTED SPRING UNPROTECTED SPRING RAIN WATER COLLECTION CART WITH SMALL TANK/DRUM TANKER TRUCK BOTTLED / SACHET WATER SURFACE WATER (RIVER/STREAM/ETC) EARTH PAN OTHER _____ (SPECIFY)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	
1002	Do you treat your water in any way to make it safe for drinking?	YES NO	1 2	**If NO, skip to 1004**
1003	If yes, what do you **USUALLY** do to the water to make it safer to drink?	LET IT STAND AND SETTLE/	1	

	Anything else? ONLY CHECK MORE THAN ONE RESPONSE IF SEVERAL METHODS ARE USUALLY USED TOGETHER, FOR EXAMPLE, CLOTH FILTRATION AND CHLORINE.	SEDIMENTATION STRAIN IT THROUGH CLOTH BOILINGC ADD BLEACH/ CHLORINE(PUR/ AQUATAB) WATER FILTER (CERAMIC, SAND, COMPOSITE) SOLAR DISINFECTION OTHER _____ (SPECIFY) DON'T KNOW	2 3 4 5 6 7 8 9 99	
1004	Do you know the times when it is <u>important</u> to wash hands? IF FOR WASHING MY OR MY CHILDREN'S HANDS IS MENTIONED, PROBE WHAT WAS THE OCCASION, BUT DO NOT READ THE ANSWERS. (DO NOT READ THE ANSWERS, ASK RESPONDENT TO BE SPECIFIC. ENCOURAGE "WHAT ELSE" UNTIL NOTHING FURTHER IS MENTIONED AND CIRCLE ALL THAT APPLY)	BEFORE PREPARING FOOD BEFORE EATING BEFORE FEEDING CHILD AFTER CLEANING CHILD'S BOTTOMS AFTER USING THE TOILET AFTER EATING AFTER CLEANINGG AFTER TOUCHING SOMETHING STICKY, OILY, SMELLY OTHER (SPECIFY)	1 2 3 4 5 6 7 8 9 10	
1005	Can you show me where you usually wash your hands and what you use to wash hands? **ASK TO SEE AND OBSERVE**	INSIDE/NEAR LATRINE/TOILET FACILITY INSIDE/NEAR KITCHEN/COOKING PLACE ELSEWHERE IN YARD OUTSIDE YARD NO SPECIFIC PLACE NO PERMISSION TO SEE	1 2 3 4 5 6	
1006	**OBSERVATION ONLY**: IS THERE SOAP OR DETERGENT OR LOCALLY USED CLEANSING AGENT? THIS ITEM SHOULD BE EITHER IN PLACE OR BROUGHT BY THE INTERVIEWEE WITHIN ONE MINUTE. IF THE ITEM IS NOT PRESENT WITHIN ONE MINUTE CHECK NONE, EVEN IF BROUGHT OUT LATER	SOAP DETERGENT ASH MUD/SAND NONE OTHER (SPECIFY)	1 2 3 4 5 6	
1007	Do you have soap in your household?	YES NO	1 2	**If NO skip to 1009**

1008	When you used soap today or yesterday, what did you use it for? IF FOR WASHING MY OR MY CHILDREN'S HANDS IS MENTIONED, PROBE WHAT WAS THE OCCASION, BUT DO NOT READ THE ANSWERS. (DO NOT READ THE ANSWERS, ASK TO BE SPECIFIC, ENCOURAGE "WHAT ELSE" UNTIL NOTHING FURTHER IS MENTIONED AND CHECK ALL THAT APPLY)	WASHING CLOTHS WASHING MY BODY WASHING MY CHILDREN WASHING CHILD'S BOTTOMS WASHING MY CHILDREN'S HANDS WASHING HANDS AFTER DEFECATING WASHING HANDS AFTER CLEANING CHILD WASHING HANDS BEFORE FEEDING CHILD WASHING HANDS BEFORE PREPARING FOOD WASHING HANDS BEFORE EATING OTHER _____ (SPECIFY)	1 2 3 4 5 6 7 8 9 10 11	
1009	The last time [NAME] passed stool, where did he/she defecate?	USED LATRINE/TOILET USED POTTY USED WASHABLE DIAPERS USED DISPOSABLE DIAPERS WENT IN HOUSE/YARD WENT OUTSIDE THE HOUSE TO THE BUSH HIS/HER CLOTHS OTHERS (SPECIFY	1 2 3 4 5 6 7 8	
1010	The last time (NAME) passed stools, where was the stools disposed of? (IF "WASHED OR RINSED AWAY", PROBE WHERE THE WASTE WATER WAS DISPOSED OF. **IF "DISPOSED", PROBE WHERE IT WAS DISPOSED OFF SPECIFICALLY.**	DROPPED INTO TOILET FACILITY RINSED/WASHED AWAY WATER DISCARDED INTO TOILET FACILITY WATER DISCARDED INTO SINK OR TUB CONNECTED TO DRAINAGE SYSTEM WATER DISCARDED OUTSIDE DISPOSED INTO SOLID WASTE/TRASH SOME WHERE IN YARD OUTSIDE HOUSE BURIED DID NOTHING/LEFT IT THERE OTHER (SPECIFY) DON'T KNOW	1 2 3 4 5 6 7 8 9 10 11 99	

1011	How do you store your drinking water?	IN CONTAINERS (BUCKET, JERRY CAN, BOTTLE, DRUM, POT ETC.) ROOF TANK OR CISTERN NO WATER STORED		
	OBSERVATIONS OF STORAGE CONTAINER, TOILET FACILITY AND PLACE FOR HANDWASHING ARE BEST DONE AT THE END OF THE INTERVIEW. PLACE QUESTIONS AND OBSERVATIONS 12-14 AT THE END OF THE QUESTIONNAIRE.			
1012	IF IN CONTAINERS, may I see the containers, please?	YES NO	1 2	**If NO skip to 1101**
1013	WHAT TYPE OF CONTAINERS ARE THESE? (OBSERVE AND CHECK ALL THAT APPLY) Narrow mouthed: opening is 3 cm or less (interviewers use template)	NARROW MOUTHED WIDE MOUTHED OF BOTH TYPES	1 2 3	
1014	ARE THE CONTAINERS COVERED? (OBSERVE AND CHECK)	ALL ARE SOME ARE NONE ARE	1 2 3	
SECTION 11: ACCESS & UTILIZATION OF HEALTH SERVICES				
1101	What is the name of the health facility that you visit MOST for services in the last 6 months?	**[WRITE DOWN NAME OF FACILITY]** ……..		
1102	What were the reasons why you chose to go to **[NAME OF FACILITY]** and not another place?	Referred there by health provider	1	
		Recommended by partner/ friend/ relative	2	
		Drugs/services are always available	3	
		Providers are always available	4	
		Providers are always friendly	5	
		Services are affordable/ free	6	
		Facility is nearby/ distance is short	7	
		Facility is the only one available	8	
		Did not know any other place	9	
		Other (specify)……..	88	
1103	The last time that you visited Were you satisfied, somewhat satisfied or not satisfied at all with the services you	Satisfied	1	

	received at the facility?	Somewhat satisfied Not satisfied at all	2 3	
1104	Would you recommend a relative or friend to come to this facility for the services you received?	Yes No Don't know/ Not sure	1 2 99	
1105	Are there CHVs in this village?	Yes No Don't know	1 2 99	**If "2" or "99" skip to 1201**
1106	What services do the CHVs provide to residents of this village? **[MULTIPLE ANSWERS POSSIBLE. DON'T READ ANSWER. CIRCLE ALL MENTIONED]**	Health education/counseling Treatment/ caring for the sick Promotion of health services Referral Others (specify)……	1 2 3 4 88	
1107	Has a CHV visited you or your household in the last 3 months?	Yes No Don't know	1 2 99	**IF NO skip to 1201**
1108	During that visit what services did the CHV provide to you/your household?	Health education/counseling Treatment/ caring for the sick Promotion of health services Referral Others (specify)……	1 2 3 4 88	
1109	How would you rate the services you or your household received from the CHV- very poor, poor, good, or excellent?	Very poor Poor Good Excellent	1 2 3 4	
SECTION 12: HEALTH EDUCATION AND INFORMATION				
1201	In the last 3 months, have you heard or read any educative messages about the following? **[READ CHOICES & CIRCLE ANSWERS APPROPRIATELY]**	Family planning Antenatal care Giving birth Postnatal care Child health Immunization Nutrition	**Yes** **No** 1 2 1 2 1 2 1 2 1 2 1 2 1 2	

		HIV	1 2	
		Malaria	1 2	
		WASH	1 2	
		NONE		**If None skip to 1203**
1202	**[ONLY ASK THOSE WHO HAVE HAD AT LEAST ONE MESSAGE]** From what sources did you hear or read about the messages? **MULTIPLE RESPONSES POSSIBLE. PROBE: WHAT OTHER SOURCE?**	Radio	1	
		TV	2	
		Newspaper	3	
		Internet	4	
		Billboard/ posters/wall chart	5	
		Hospital / health center staff	6	
		Community health Volunteer	7	
		Imam/mosque/ religious leader	8	
		NGO/CBO/ women group	9	
		Husband/ relatives	10	
		Friends	11	
		Others (specify)……..	88	
1203	What source/method of passing health messages would be the most effective to reach women like you in this village? **[MULTIPLE RESPONSES POSSIBLE. CIRCLE ALL MENTIONED]**	Radio	1	
		TV	2	
		Newspaper	3	
		Internet	4	
		Billboard/ posters/wall chart	5	
		Hospital / health center staff	6	
		Community health worker	7	
		Imam/mosque/ religious leader	8	
		NGO/CBO/ women group	9	
		Husband/ relatives	10	
		Friends	11	
		Others (specify) ……..	88	
SECTION 13: USE OF LLITNs MOSQUITO NETS				
1301	Do you have any bed nets in your household?	Yes	1	**IF 2 or 99 skip to 1401**
		No	2	
		Don't know	99	
1302	Who slept under a bed net last night?	Children under 5	1	

	[Circle all mentioned]	Husband Wife Baby All Children Other specify……	2 3 4 5 88	
SECTION 14: RESPECT, DIGNITY, EQUITY AND EMOTIONAL SUPPORT				
1401	Are you always treated with appropriate respect by **nurses/doctors at government health facilities** when you or NAME go for any service?	Always Sometimes Not at all I have not attended	1 2 3 4	

Thank you for taking your time to take part in this interview

TOOL 2: HOUSEHOLD INTERVIEW WITH OVC CAREGIVERS

(31 pages)

IDENTIFICATION DATA

001.	QUESTIONNAIRE IDENTIFICATION NUMBER	
002.	COUNTY	
003.	SUB-COUNTY	
004.	WARD	
005.	TYPE OF LOCATION	1=Urban 2=Rural
006.	HOUSEHOLD NUMBER	
007.	CAREGIVER'S SEX	1=Male 2=Female
008.	CAREGIVER'S AGE	1= under 18years 2=18-49years 3=50 years and above

INTERVIEW LOG

INTERVIEWER COMMENTS	Interview Comment Codes
1 = Interview completed 2 = Respondent refused to be interviewed 3 = Respondent started the interview but did not complete it 4 = Multiple attempts made but respondent was not available to be interviewed 5 = Respondent not capable of giving consent to be interviewed (e.g., mentally ill, too sick, drunk, etc.) 6 = Others (specify)	

009.	INTERVIEWER CODE	
010.	DATE INTERVIEW COMPLETED (day/month/year)	
011.	START TIME OF INTERVIEW	[__|__|:[__|__]

CHECKED BY SUB-TEAM LEADER: Signature _____ **Date** _____

Comments

Section 1: OVC Households Status

No.	Questions	Coding Categories	
QUESTIONS 12-14 ARE BASED ON DIRECT OBSERVATION. DO NOT READ THESE QUESTIONS ALOUD TO THE RESPONDENT.			
012.	MAIN MATERIAL OF THE ROOF	1 = No roof 2 = Thatch/palm leaf 3 = Plastic/Polythene sheet 4 = Wood planks 5 = Cardboard 6 = Metal/iron sheets 7 = Asbestos 8 = Cement 66= Other (specify): _____ 99 = NOT OBSERVED	
013.	MAIN MATERIAL OF THE FLOOR	1 = Earth/sand/dung 2 = Wood planks 3 = Parquet or polished wood 4 = Vinyl (PVC) 5 = Ceramic /terrazzo tiles 6 = Concrete cement 66= Other (specify): _____ 99 = NOT OBSERVED	
014.	MAIN MATERIAL OF THE EXTERIOR WALLS	1 = No walls 2 = Cane/palm/trunks 3 = Mud 4 = Bamboo 5 = Stone with mud 6 = Plywood 7 = Cardboard 8 = Cartons/polythene 9 = Wood 10 = Cement 11 = Stone with cement 12= Bricks 13= Iron sheets 66=Other (specify): _____ 99=NOT OBSERVED	

No.	Questions	Coding Categories		
015.	My first set of questions will help us to get a better understanding of your household. To start, how many people **under the age of 18 years** live in this household?	_____ _____ **UNDER 18 YEARS**		
016.	How many people **over the age of 18** live in this household?	_____ _____ **OVER 18 YEARS**		
017.	Does your household have (a)….? **ASK RESPONDENT ABOUT EACH ITEM (A TO J), READING EACH ITEM ALOUD AND RECORDINGA YES OR NO RESPONSE FOR EACH.**		**Yes**	**No**
		a) Electricity	1	2
		b) Solar panel	1	2
		c) Radio	1	2
		d) Television	1	2
		e) Mobile telephone	1	2
		f) Fixed-line telephone	1	2
		g) Refrigerator	1	2
		h) Sewing machine	1	2
		i) Plough	1	2
		j) Grain grinder	1	2
018.	Does your household have a….? **ASK RESPONDENT ABOUT OWNERSHIP OF EACH ITEM (A TO F), READING EACH ITEM ALOUD AND RECORDING A YES OR NO RESPONSE FOR EACH.**		**Yes**	**No**
		a) Bicycle	1	2
		b) Animal-drawn cart	1	2
		c) Motorcycle	1	2
		d) Vehicle	1	2
		e) Boat with a motor	1	2
		f) Canoe	1	2
019.	Does your household own this structure (house, flat, shack), do you pay rent, or do you live here without paying rent?	1 = Owns, 2 = Pays rent/lease, 3 = No rent with consent of owner 4 = no rent, 5 = squatting 98 = I don't know		
020.	Does your household own any land?	1=Yes 2=No→**SKIP TO Q.21**		
021.	Approximately how much land does your household own? **RECORD THE AMOUNT AND SELECT THE MEASUREMENT UNIT MENTIONED BY THE RESPONDENT (I.E., ACRES, HECTARES, FEET).**	_____ acres / hectares /feet*(INDICATE UNITS)*		
022.	What is the **<u>main</u>** source of **drinking** water used by your household?	1 = PIPED INTO DWELLING 2 = PIPED TO COMPOUND/PLOT 3 = PUBLIC TAP/STAND PIPE		

		4 = BOREHOLE 5 = PROTECTED WELL 6 = UNPROTECTED WELL 7 = PROTECTED SPRING 8 = UNPROTECTED SPRING 9 = RAINWATER 10 = TANKER TRUCK 11 = WATER VENDOR 12 = SURFACE WATER **(E.G., RIVER/DAM/LAKE/POND/STREAM/ CANAL/ IRRIGATION CHANNEL)** 13 = OTHER _____ (SPECIFY)	
023.	What do you usually do to make the water safer to drink? **KEEP ASKING** *'Anything else?'* **UNTIL THE RESPONDENT HAS NO MORE RESPONSES FOR THIS QUESTION. RECORD ALL MENTIONED.**	A = DO NOTHING B = BOIL C = ADD BLEACH/CHLORINE D = STRAIN THROUGH A CLOTH E = USE WATER FILTER (CERAMIC/ SAND/COMPOSITE/ETC.) F = SOLAR DISINFECTION G = LET IT STAND AND SETTLE H= OTHER_____ (SPECIFY) Z = DON'T KNOW	
024.	What kind of toilet facility do most members of your household use?	1=FLUSH TO PIPED SEWER SYSTEM 2= FLUSH TO SEPTIC TANK 3 = FLUSH TO PIT LATRINE 4 = FLUSH TO SOMEWHERE ELSE (E.G., RIVER) 5= FLUSH, DON'T KNOW WHERE 6=VENTILATED IMPROVED PIT LATRINE 7 = PIT LATRINE WITH SLAB 8 = PIT LATRINE WITHOUT	

		SLAB/OPENPIT 9 = COMPOSTING TOILET 10 = BUCKET TOILET 11= HANGING TOILET/HANGING LATRINE 12 = NO FACILITY/BUSH/FIELD 96 = OTHER (SPECIFY) _____	
025.	How many of each of the following animals does this household own? **ASK RESPONDENT ABOUT OWNERSHIP OF EACH ITEM (A TO J), READING EACH ITEM ALOUD AND RECORDING A NUMBER FOR EACH ANIMAL.** **IF NONE ENTER '000'.** **IF UNKNOWN ENTER 998.**	a) Traditional cattle	___ ___ ___
		b) Dairy cattle	___ ___ ___
		c) Beef cattle	___ ___ ___
		d) Donkeys or mules	___ ___ ___
		e) Goats	___ ___ ___
		f) Sheep	___ ___ ___
		g) Pigs	___ ___ ___
		h) Chickens	___ ___ ___
		i) Camels	___ ___ ___
		j) Other poultry	___ ___ ___
		k) Other livestock	___ ___ ___

Section 2: OVC Households access to money to meet basic needs

No.	Questions	Coding Categories
026.	I would now like to ask some questions about your household's expenses. Roughly how much is your household's monthly income? **IF RESPONDENT IS UNSURE, ENCOURAGE HER/HIM TO GIVE AN ESTIMATE. IF S/HE STILL DOESN'T KNOW, SELECT DON'T KNOW.**	_____ _____ _____ , _____ _____ _____ KSH ☐ DON'T KNOW
027.	What are the sources of income for this household? **(IF NO INCOME REPORTED IN Q23, SELECT 'A' (NO INCOME REPORTED) AND SKIP TO Q.26.** **IF INCOME WAS REPORTED IN Q23, SELET ALL RESPONSES THAT APPLY. KEEP ASKING 'Anything else?' UNTIL THERE ARE NO MORE SOURCES TO RECORD.)**	A = NO INCOME REPORTED→ **SKIP TO Q.31** B = Agriculture C = Self-employed, not related to agriculture (Describe work (e.g., 'shop owner') in the space provided: _____) D = Informal employment (e.g., domestic work, jua kali, etc.) E = Formal employment F = Government cash transfers G = Money/support from friends or relatives H= OTHER (Specify) _____

		Z = DON'T KNOW
028.	About how much do you spend each month on the following: **READ EACH OF THE FOLLOWING ITEMS ALOUD AND RECORD THE AMOUNT SPENT PER MONTH.** (a) Food? (b) Rent/housing? (c) Health care/medical bills? (d) School fees/education? (e) Clothing? (f) Transport/fares? (g) Entertainment? (h) Other items or issues? **IF RESPONDENT DOESN'T KNOW AMOUNT SPENT FOR A PARTICULAR ITEM, ENCOURAGE HER/HIM TO TRY AND ESTIMATE THE AMOUNT. IF S/HE STILL DOESN'T KNOW, SELECT 'DON'T KNOW' FOR THAT ITEM.**	**(a) Food:** ____ ____ ____ , ____ ____ ____ **KSH** ☐ DON'T KNOW **(b) Rent/housing:** ___ ___ ___ , ___ ___ ___ **KSH** ☐ DON'T KNOW **(c) Health care/medical bills:** __ __ __ , __ __ __**KSH** ☐ DON'T KNOW **(d) School fees/education:** __ __ __ , __ __ __ **KSH** ☐ DON'T KNOW **(e) Clothing:** __ __ __ , __ __ __ **KSH** ☐ DON'T KNOW **(f) Transport/fares:** __ __ __ , __ __ __ **KSH** ☐ DON'T KNOW **(g) Entertainment:** __ __ __ , __ __ __ **KSH** ☐ DON'T KNOW **(h) Other items:** __ __ __ , __ __ __ **KSH**

		(Specify: _____)
029.	Who usually decides how the income you earn will be used	1 = you, 2 = your husband/partner, or 3 = you and your husband/partner jointly 98=I don't Know
030.	Is your household able to save any money?	1=Yes 2=No
031.	Do you or any member of your household participate in any income-generating activities? **(DO NOT PROMPT RESPONDENT. CIRCLE ALL MENTIONED. KEEP ASKING** *'Anything else?'* **UNTIL THE RESPONDENT HAS MENTIONED ALL ACTIVITIES IN WHICH THE HOUSEHOLD PARTICIPATES.)**	A=Food stuff (cooked, raw, grains) B= Second-hand items C= Other petty trading D= Retail /whole sale shop (grocery) E = Unprocessed milk products F = Butchery/Fish selling G = Other animal products H= Phone shop/repair/phone transfer/Mpesa I = Tailoring J= Crafts /carpentry K= Brewing/brewery L= Transport M= Mechanic N = Electronics repair O =Haircutting/salon P =Agricultural processing Q =Restaurant/ bar/lodging/hotel R= NO PARTICIPATION IN INCOME-GENERATING ACTIVITIES S =Other (specify)_____ Z=Don't Know

Section 3: Food Security & Nutrition

032.	I would now like to ask you some questions about your household's food. During the last month (four weeks), was your household able to pay for food expenses?	1=Yes 2=No 98=Don't Know

033.	During the last four weeks, how did your household get food to eat? **DO <u>NOT</u> READ THE LIST OF RESPONSES TO THE RESPONDENT. MULTIPLE RESPONSES ALLOWED. KEEP ASKING** *'Anything else?'*	A=Crops from the farm B=Livestock outputs C=Livestock Sale D=Employed on a Farm E=Employed doing household chores F=Employed in the private sector G=Employed by the government H=Own business/retailing/selling food I=Rental income (house, equipment, animals) J=Money given by friends or family /donors K=Only relied on food donation L=Other (specify):_____ Z=Don't Know
034.	Has the amount your household spends on food changed over the past year?	1=Yes 2=No→ **SKIP TO Q.31** 98=Don't Know→ **SKIP TO Q.31**
035.	Why? **MULTIPLE RESPONSES ALLOWED. RECORD ALL MENTIONED. KEEP ASKING** *'Any other reasons?'* **UNTIL THE RESPONDENT MENTIONS NO OTHER REASONS.**	A=Stopped receiving food donations/food support B=Reduced household food stores C=More disposable income D=Food prices went up E=More people live in household now F=Fewer people live in household now G=Harvest produced food; no need to buy H=Received food support I=Food prices went down J=Other: _____ Z=Don't Know
036.	Are you aware of what foods a household should eat on a daily basis to have a balanced diet? If YES, can you please tell me what those foods are? IF RESPONDENT IS NOT AWARE (ANSWERS 'NO' CIRCLE A (DOES	A=DOES NOT KNOW B= DAIRY PRODUCTS C = FRUITS D = GRAINS (e.g., ugali, maize, rice) E= LEGUMES (e.g., beans, green grams) F = VEGETABLES G = MEAT/CHICKEN/FISH H = OTHER (Specify) _____

	NOT KNOW). MULTIPLE RESPONSES ALLOWED. RECORD ALL MENTIONED. ALL TYPES OF MEAT (SEAFOOD, MUTTON, RED MEAT, CHICKEN, ETC.) ARE CODED IN THE SAME CATEGORY (CATEGORY G)	
037.	Are you aware of any extension services from the Ministry of Agriculture and other ministries such as fisheries and livestock?	1=Yes 2=No→SKIP TO Q54 98=Don't Know→SKIP TO Q54
038.	Has your household received any of those services?	1=Yes 2=No 98=Don't Know
039.	Are there any children from this household who are benefiting from feeding programs in school?	1=Yes 2=No 98=Don't Know

Section 4: Household Management of shocks & Unexpected Financial Occurrences

040.	Did your household incur any unexpected household expenses in the last 12 months? **IF RESPONDENT NEEDS EXAMPLES OF WHAT YOU MEAN BY 'UNEXPECTED HOUSEHOLD EXPENSE,' YOU CAN MENTION 'house repair' or 'urgent medical treatment.'**	1=Yes 2=No→**SKIP TO Q.34** 98=Don't Know →**SKIP TO Q.34**
041.	Was your household able to pay for these expenses?	1=Yes 2=No 98=Don't Know
042.	Thinking about the last time you had an unexpected household expense, how did you cover the costs? **DO NOT READ RESPONSES ALOUD. CIRCLE ALL THAT APPLY. KEEP ASKING** *'Anything else?'*	A=Crops from the farm B=Livestock outputs C=Livestock Sale D=Employed on a Farm E=Employed doing household chores F=Employed in the private sector G=Employed by the government H=Own business/retailing/selling food I=Rental income (house, equipment, animals) J=Money given by friends or family /donors K=Government cash transfer L=Other (specify) _____

		Z=Don't Know
043.	Has the amount your household spends on healthcare changed over the last year (12 months)?	1=Yes 2=No →**SKIP TO Q.39** 3=Don't know→**SKIP TO Q.39**
044.	Why did the amount you spend on healthcare change? **MULTIPLE RESPONSES ALLOWED. RECORD ALL MENTIONED.**	A=Household member was sick B=Household member pregnant/had baby C=Had to buy drugs D=Routine check-ups E=Household member had an accident F=Other_____ Z=Don't Know
045.	Did your household incur any <u>school-related expenses</u> in the last 12 months?	1=Yes 2=No →**SKIP TO Q.46** 98=Don't Know→**SKIP TO Q.46**
046.	Was your household able to pay for these expenses?	1=Yes 2=No 98=Don't Know
047.	What are the main ways that your household pays school-related expenses? **(CIRCLE ALL THAT APPLY. KEEP ASKING 'Anything else?')**	A=Crops from the farm B=Livestock outputs C=Livestock Sale D=School fees support from LIP E =School fee support from Government (CDF, bursaries, etc.) F=Employed on a Farm G=Employed doing household chores H=Employed in the private sector I=Employed by the government J=Own business/retailing/selling food K=Rental income (house, equipment, animals) L=Money given by friends or family /donors M=Other (specify) _____ N=Don't Know
048.	Has the amount your household spends on education changed over the last year (12 months)?	1=Yes 2=No →**SKIP TO Q.47** 98=Don't Know→**SKIP TO Q.47**
049.	Why did the amount you spend on education change? **MULTIPLE RESPONSES ALLOWED. RECORD ALL MENTIONED.** **IF RESPONDENT MENTIONS NUMBER OF SCHOOL-GOING MEMBERS INCREASED (RESPONSE D), PROCEED TO Q46.** **FOR ALL OTHER RESPONSES, PROCEED TO Q47.**	A=School fees increased→**SKIP TO Q.46** B=School requirements, such as: uniforms, school books→**SKIP TO Q.46** C=PTA costs or transportation costs increased→**SKIP TO Q.46** D=Number of school going members in the household increased E=Withdrawal of previous support→**SKIP TO Q.46** F=School fees reduced, add other support received→**SKIP TO Q.46** G=PTA costs or transportation costs reduced→**SKIP TO Q.46** H=Number of school going members in the household reduced→**SKIP TO Q.46** I=Support from government/other agencies →**SKIP TO Q.46** J=Other: _____→**SKIP TO Q.46** Z=Don't Know→**SKIP TO Q.46**
050.	**ONLY ASK IF RESPONSE TO**	1 = Because children living in the household got older (of school-going

	Q45 WAS D: Why did the number of school-going members in your household increase?	age) 2 = Because brought additional children into the household 3 = OTHER (Specify): _____
051.	Approximately how much money did your household spend on making improvements (e.g., home repairs, new furniture) to your home in the last 12 months? **IF THE HOUSEHOLD SPENT MONEY ON IMPROVEMENTS, WRITE THE AMOUNT IN THE SPACE PROVIDED)**	_____[Kshs] ☐**NO MONEY SPENT→Q.48**
052.	How did you pay for those home improvements? **(CIRCLE ALL MENTIONED. KEEP ASKING 'Anything else?')**	A = Household savings/salary B = Government cash transfer C = Loan D = Profits from business E = OTHERS (Specify) _____

Section 5: Health

053.	Where do members of your household usually go for health care? (CIRCLE ONLY ONE) IF RESPONDENT MENTIONS 'PRIVATE HEALTH FACILITY,' PROBE WITH THE FOLLOWING QUESTION: "Do you have to pay fees to receive care at that facility, or do you get the services for free?"). IF FREE, SELECT RESPONSE #3. IF THE HOUSEHOLD HAS TO PAY A FEE, SELECT RESPONSE #4	1= NO WHERE 2=Public health facility: 2a=Name_____ 3=Private health facility—free/waived fees 4=Private health facility—pays fees 5= Chemist/pharmacy 6=Religious leaders 7=Traditional healers 8=Other (Specify) _____ 98=Don't Know
054.	What are the main ways that your household pays for health care? MULTIPLE RESPONSES ALLOWED. CIRCLE ALL MENTIONED. KEEP ASKING 'Anything else?' UNTIL THE RESPONDENTS STOPS MENTIONING WAYS.	A = DOES NOT SEEK HEALTH CARE B= CANNOT PAY FOR HEALTH CARE C = NHIF D = Medical Insurance E = Personal/household funds F = Health fee waivers G = OTHER (Specify) _____
055.	How can a household reduce health care costs? CIRCLE ALL MENTIONED. DO	A=NHIF B=Fee waivers C=Free medical care

	NOT PROMPT. KEEP ASKING 'Anything else?'	D=Private health insurance E=Others (specify) _____ Z=Don't Know
056.	How can a household prevent malaria? **CIRCLE ALL MENTIONED. DO NOT PROMPT. KEEP ASKING 'Anything else?'**	A= Sleep under/use mosquito nets B= Insecticide spray C=Mosquito repellent D=Clearing bushes E=Draining/no standing water F=Other (specify) _____ Z=Don't Know

Section 6: Caregivers involvement in family strengthening activities

No.	Questions	Coding Categories
Household income and property		
057.	I would now like to ask your opinion on a few different topics. What business/income-generating activities Have you been most active with**?** **DO NOT READ RESPONSES ALOUD. CIRCLE ALL THAT APPLY. KEEP ASKING 'Anything else?'** **IF THE RESPONDENT PROVIDES ONE RESPONSE ONLY THEN SKIP TO Q.51**	A=Food stuff (cooked, raw, grains) B= Second-hand items C= Other petty trading D= Retail /whole sale shop (grocery) E= unprocessed Milk products F= Butchery/Fish selling G= Other animal products H= Phone shop/repair/phone transfer/Mpesa I= Tailoring J= Crafts /carpentry K= Brewing/brewery L= Transport M= Mechanic N= Electronics repair O=Haircutting/salon P=Agricultural processing Q=Restaurant/ bar/lodging/hotel R=Other (specify) Z=Don't Know **SKIP TO Q.50**
058.	Which one brings the most income to this household? **SINGLE RESPONSE (CIRCLE ONLY ONE)**	1 =Food stuff (cooked, raw, grains) 2 =Second-hand items 3 = Other petty trading 4 = Retail /whole sale shop (grocery) 5 = Unprocessed Milk products 6 = Butchery/Fish selling 7 = Other animal products 8 = Phone shop/repair/phone transfer/ Mpesa 9 = Tailoring 10 = Crafts /carpentry 11 = Brewing/brewery 12 = Transport 13 = Mechanic

		14 = Electronics repair 15 =Haircutting/salon 16 =Agricultural processing 17 =Restaurant/ bar/lodging/hotel 18 =Other (Specify): _____ _____ 98=Don't Know
059.	Has your small business adopted formal business practices? (Select all that apply)	1=Yes, I have registered my small business with the local authority and government 2=Yes, I have opened a bank account for my small business 3=Yes, I am paying tax for my small business 4=Yes, my small business is using written contracts 5=Yes, my small business is submitting tenders for business opportunities 6=No, my small business has not adopted any formal business practice 98 = Don't know
060.	What are the biggest obstacles facing your business? (Select all that apply)	1 = Low demand for product 2 = Lack of access to market 3 = Strong competition 4 = Stigma issues 5 = Lack of skills / knowledge 6 = Lack of finance 7 = Government interference 8 = Taxation 9 = Corruption 10=Other 98=Don't know
061.	Do you currently belong to any informal business/development/credit/support groups such as SILC, PLHIV, OVC caregiver support group etc.? (Select one)	1=Yes 2=No 98=Don't Know
062.	If yes, which are the support groups,	1 = PLHIV Support Group 2 = OVC caregiver support group 3 = Youth group 4 = Business Development group 5 = Other, specify_____ 98= I Don't know
063.	How long have you been a member of the support group? (Select one)	1 = 1-6 months 2 = 7-12 months 3 = Over one year
064.	Which Household economic strengthening initiatives is your group actively participating in?	1 = Vegetable production 2 = Sale of water 3 = Poultry production and sale of eggs 4 = Fresh milk production 5 = Ghee production

		6 = Harvesting natural grass and selling 7 = Bee keeping 8 = Saving and internal loaning (SILC) 9 = Goat rearing 10=Animal lodge 98=I don't know
065.	Do you think being part of a business/savings/support group is important to your financial stability and future growth? (Select one)	1 = Yes, very important 2 = Yes, somewhat important 3 = No, not very important 4 = I don't know yet
066.	Has this feeling changed over the past year? (Select one)	1 = Yes, the group is more important to me now 2 = No, the group is less important to me now 3 = About the same 4 = I don't know yet
067.	Compared to last year, do you feel more in control of your economic future? (Select one)	1 = Yes, I am a lot more in control of my economic future now 2 = Yes, I am a little more in control of my economic future now 3 = I feel about the same as last year 4 = No, I am a little less in control of my economic future 5 = No, I am a lot less in control of my economic future 6 = I don't know

Section 7: Child Protection

No.	Questions	Coding Categories
068.	Are you aware of any of child rights?	1=Yes 2=No→**SKIP TO Q64** 98=Don't Know→**SKIP TO Q64**
069.	What are those rights? **(DO NOT PROMPT, BUT KEEP ASKING 'Anything else?' CIRCLE ALL MENTIONED.)**	A=Right to protection B=Right to education C=Right to shelter D=Right to health E=Right to participation F=Right to food G=Right to clothing H=Others (Specify_____**)** Z=Don't Know
070.	I just have two more questions. Do you believe that physical punishment is a good way of disciplining or controlling a	1=Yes→**END** 2=No

	child at home or in school?	98=Don't Know
071.	How do you discipline your child?	A = Talk to the child B = Refuse/deny food C = Lock child outside of the house D = OTHERS (specify): _____
072.	Where can household members access legal protection services when needed? **CIRCLE ALL MENTIONED. DO NOT PROMPT. KEEP ASKING 'Anything else?'**	A=Police B=Children's department C=Teacher D=Religious leader E=Relative F=NGO/CBO/FBO G=Paralegals H=Chief I=Lawyer J=Others (specify)_____ Z=Don't Know

The Caregiver is to provide information on the Oldest OVC (5-17yrs) in the Household

No.	Questions	Coding Categories	
010.	**Record / Confirm Child's Name** **"What is the child's name?"**		
011.	**Record / Confirm Child's Sex**	Female Male	1 2
012.	**"In what month and year were NAME born?"**	Month [__|__]	Year [__|__|__|__]
013.	**"How old is {NAME}?"**	[__|__] years	
014.	What kinds of services should a 5-17 year old receive? **(DO NOT READ THE**	A =appropriate family/household based care B =appropriate housing/shelter C =received all immunization as per the schedule	

	RESPONSES ALOUD. HOWEVER, KEEP ASKING 'Anything else?' UNTIL THE RESPONDENT CANNOT NAME ANY MORE SERVICES. RECORD ALL MENTIONED.)	D =health care E =receives proper nutrition/food secure F =has birth certificate G =appropriate clothing H =access to early childhood development I =receives psychosocial support when appropriate J =caregiver receives information on OVC care K=education L =Others (Specify_____) Z =Don't Know

SECTION 3: CHILD EDUCATION

No.	Question		Coding Category	
015.	**"Has NAME ever been to school?"**		Yes No	1 2→**SKIP TO Q23**
016.	Is {NAME} enrolled in school now?		Yes No	1→**SKIP TO Q24** 2
017.	Why does {NAME} NOT go to school? **DO NOT READ RESPONSES ALOUD. MULTIPLE RESPONSES ALLOWED. RECORD ALL MENTIONED. KEEP ASKING 'Any other reason?' UNTIL THE RESPONDENT CAN MENTION NO OTHER REASONS.**	No money for school materials, transport…….. T{NAME} is too sick to attend school ……...……. School is too far away /no school …… {NAME} has to work …… ……. have to care for household members …….. I do not want {NAME} to go to school …… …….. {NAME} doesn't like school …… School was not in session …… Other: …… DON'T KNOW ……	A→**SKIP TO Q29** B→**SKIP TO Q29** C→**SKIP TO Q29** D→**SKIP TO Q29** E→**SKIP TO Q29** F→**SKIP TO Q29** G→**SKIP TO Q29** H→**SKIP TO Q29** I→**SKIP TO Q29** Z→**SKIP TO Q29**	

018.	**What class/form is {NAME} in now?** **FIRST, CIRCLE THE CORRECT CODE NEXT TO THE CURRENT LEVEL OF SCHOOLING (I.E., PRE-PRIMARY=1, PRIMARY=2, SECONDARY=3). THEN,USE THE SPACE PROVIDED NEXT TO THE RESPONSE TO WRITE THE SPECIFIC CLASS/FORM THE CHILD IS CURRENTLY IN.**	1……. PRE-PRIMARY (1-3) [____|____] 2……PRIMARY (Class 1-8) [____|____] 3……SECONDARY (Form 1-4) [____|____] 8…….. DON'T KNOW	
019.	During the last **school week**, did {NAME} miss any school days for any reason?	Yes No	1 2→**SKIP TO Q27**
020.	Why did {NAME} miss school days during the last school week? **DO NOT READ RESPONSES ALOUD. MULTIPLE RESPONSES ALLOWED. KEEP ASKING 'Anything else?' RECORD ALL MENTIONED.**	A = No money for school materials, transport… B = I am too sick to attend school… C = School is too far away / no school… D = I have to work… E = I have to care for household members… F = School was not in session… G = I don't like school… H = Parent/guardian does not want me to go to school… I = Other: _____	
021.	During the **last school term**, how often did you {NAME} miss school? **READ RESPONSES ALOUD TO THE RESPONDENT AND CIRCLE ONLY ONE ANSWER.**	1 = Never…→**SKIP TO Q.2** 2 = Occasionally (Maximum Once A Month)… 3 = Often (Two Or More Times A Month)… 8 = Don't Know…	

022.	What were the main reasons why {NAME} miss school last term? **DO NOT READ RESPONSES ALOUD. MULTIPLE RESPONSES ALLOWED. KEEP ASKING 'Anything else?' RECORD ALL MENTIONED.**	No money for school materials, transport… Was too sick to attend school… School is too far away / no school… I had to work… I had to care for household members… School was not in session… I don't like school… Parent/guardian does not want me to go to school… Other: _____	A B C D E F G H I
023.	IF CHILD HAS NEVER BEEN ENROLLED IN SCHOOL, CIRCLE 3, AND PROCEED TO Q.33. OTHERWISE ASK THE FOLLOWING: Was {NAME} enrolled in school during the **previous school year**?	1 = Yes 2 = No→**SKIP TO Q31** 3 = Never Enrolled In School→**SKIP TO Q32**	
024.	**What class/form was {NAME} in the previous school year?** **FIRST, CIRCLE THE CORRECT CODE NEXT TO THE APPROPRIATE LEVEL OF SCHOOLING (I.E., PRE-PRIMARY=1, PRIMARY=2, SECONDARY=3). THEN, USE THE SPACE PROVIDED NEXT TO THE RESPONSE TO WRITE THE SPECIFIC CLASS/FORM THE CHILD WAS IN LAST YEAR.**	1……. PRE-PRIMARY (1-3) [____|____] 2……PRIMARY (Class 1-8) [____|____] 3……SECONDARY (Form 1-4) [____|____] 8…….. DON'T KNOW	
025.	What is the highest class/form that you {NAME} have completed?	1……. PRE-PRIMARY (1-3) [____|____] 2……PRIMARY (Class 1-8) [____|____] 3……SECONDARY (Form 1-4) [____|____] 8…….. DON'T KNOW	

026.	How many school aged children living in your home go to school currently? (Enter # of each)	*1 = (#) Male Children in School*_____ *2 = (#) Female Children in school*_____ *3 = (#) Male Children not attending School*_____ *4 = (#) Female Children not attending School* _____

073.	Has the number of school aged (5-17) children living in your home going to school changed from a year ago? (Select one)	1 = We don't have child between5-17
		2 = Yes, more children are attending school(#M____ #F____)
		3 = Yes, less children are attending school(#M____ #F____)
		4 = No change

074.	For school aged (5-17) children not receiving education, please note primary reasons for them not attending. (Select all that apply)	1 = Household responsibilities(including child care) 2 = Household labor or farming/IGA 3 = School fees, uniforms, etc., too expensive 4 = No access to formal education 5 = Too ill / sick to attend 6 = Other, specify_____
027.	Have you received any type of educational assistance? (Select all that apply)	1 = Books 2 = Educational Materials (paper, pencils, etc.) 3 = Financial support / School Fees 4 = Food Support 5 = Tutoring 6 = School uniform 7 = Solar lamps 8 = No, we do not receive educational assistance 9 = Other, specify _____
028.	If yes, who provides this assistance? (Select all that apply)	1 = Government 2 = Relatives/friend 3 = NGO/CBO 4 = Religious Organization /Institution 5 = Other, specify _____
029.	Has {NAME} received any life skills training?	1 = Yes 2 = No 8 = Don't know
030.	Has {NAME} been to any vocational institution?	1 = Yes 2 = No
075.	What vocational or technical skills has {NAME} acquired? **MULTIPLE RESPONSES ALLOWED. CIRCLE ALL MENTIONED.KEEP ASKING 'Anything else?' UNTIL NO OTHER SKILLS ARE MENTIONED.**	A = Carpentry B = Masonry C = Mechanics D = Cosmetology E = Tailoring F = Customer care G = Plumbing H = Electrician I = Others specify_____

SECTION 4: FOOD CONSUMPTION

			YES	NO	DK
034.	Now I would like to ask you about liquids or foods {NAME} ate yesterday during the day or at night. Did you drink or eat any of the following? **READ EACH OF THE ITEMS LISTED IN A-Z OUT LOUD TO THE RESPONDENT. RECORD YES OR NO FOR EACH.**	A) Plain Water	1	2	8
		B) Milk	1	2	8
		C) Tea Or Coffee	1	2	8
		D) Other Liquids	1	2	8
		E) Porridge/Gruel	1	2	8
		F) Grains	1	2	8
		G) Red/Yellow Vegetables	1	2	8
		H) Roots, Tubers	1	2	8
		I) Green/Leafy Vegetables	1	2	8
		J) Mango, Pawpaw, Guava	1	2	8
		K) Other Fruits	1	2	8
		L) Meat, Chicken, Fish, Eggs	1	2	8
		M) Beans, Pulses	1	2	8
		N) Sour Milk, Cheese	1	2	8
		O) Other Foods	1	2	8
		Z) Nothing To Eat	1	2	8
035.	Were the foods and liquids that {NAME} ate yesterday the kinds of things that he/she normally eat?	1 = Yes 2 = No 8 = Don't know			
036.	In the past four weeks, did {NAME} have any problems getting enough food to eat?	1 = Yes 2 = No 8 = Don't know			

SECTION 6: LEGAL PROTECTION

No	Questions	Coding Categories
037.	Which of the following apply to {NAME}'s situation?	1 = Mother and Father alive 2 = Mother alive, Father deserted (or survival unknown) 3 = Mother alive, Father deceased 4 = Father alive, Mother deserted (or survival unknown) 5 = Father alive, Mother deceased 6 = Both Mother and Father deceased

038.	what is the relationship between you and this child **Do not read responses. Record one primary response only.**	1 = Biological mother 2 = Biological father 3 = Sister and/or brother 4 = Aunt and/or uncle 5 = Grandmother and/or Grandfather 6 = Other relative 7 = Neighbor 8 = Friend 9 = No one/self 10=Other: _____
039.	Does {NAME} have a birth certificate?	1 = Yes 2 = No **→END** 8 = Don't know **→END**
040.	Could you please show me the birth certificate?	1 = Seen / confirmed 2 = Not seen / not confirmed

I have come to the end of my questions. Is there anything you would like to add or ask us?

Thank you for participating in this interview!

076.	END TIME	[__|__|:[__|__]

CHECKED BY TEAM LEADER: Signature _____ Date _____

Comments

SECTION 1: BACKGROUND INFORMATION

AS A REMINDER: →IF THE CHILD IS AGE 5–9 YEARS, INTERVIEW THE CHILD'S CAREGIVER.

→IF THE CHILD IS AGE 10–17 YEARS, INTERVIEW THE CHILD DIRECTLY, BUT

THE CAREGIVER MUST GIVE CONSENT FOR THE CHILD TO BE INTERVIEWED.

No.	Questions	Coding Categories

033.	**Record / Confirm Child's Name** What is your name?		
034.	**Record / Confirm Child's Sex**	Female Male	1 2
035.	In what month and year were you born?	Month [__|__]	Year [__|__|__|__]
036.	How old were you at your last birthday?	[__|__] years	
037.	What kinds of services should a 5-17 year old receive? **(DO NOT READ THE RESPONSES ALOUD. HOWEVER, KEEP ASKING 'Anything else?' UNTIL THE RESPONDENT CANNOT NAME ANY MORE SERVICES. RECORD ALL MENTIONED.)**	A =appropriate family/household based care B =appropriate housing/shelter C =received all immunization as per the schedule D =health care E =receives proper nutrition/food secure F =has birth certificate G =appropriate clothing H =access to early childhood development I =receives psychosocial support when appropriate J =caregiver receives information on OVC care K=education L =Others (Specify_____) Z =Don't Know	

SECTION 2: HIV TESTING

No.	Question	Coding Categories
038.	I would now like to change the topic again to discuss some other issues. Have you ever heard of HIV, the virus that causes AIDS? **FOR 5-12 YEARS OLD, POSE Qs 17-19 TO THE CAREGIVER**	Yes 1 No 2→**SKIP TO Q.21** Don't know 8→**SKIP TO Q.21**
039.	Do you know your HIV status?	Yes 1 No 2 Don't know 8
040.	*****SKIP THIS QUESTION IF THE CHILD DIRECTLY ANSWERED Q.18*****	Yes 1 No 2 Don't know 8

	Do you know the HIV status of [NAME]?	
041.	Has {NAME} ever been tested for HIV but you did **not** receive his/her test results?	

SECTION 3: CHILD EDUCATION

No.	Question	Coding Category	
042.	Have you ever been enrolled in school?	Yes No	1 2→**SKIP TO Q23**
043.	Are you enrolled in school now?	Yes No	1→**SKIP TO Q24** 2
044.	Why do you NOT go to school? **DO NOT READ RESPONSES ALOUD. MULTIPLE RESPONSES ALLOWED. RECORD ALL MENTIONED. KEEP ASKING 'Any other reason?' UNTIL THE RESPONDENT CAN MENTION NO OTHER REASONS.**	No money for school materials, transport…….. I am too sick to attend school ……...……. School is too far away /no school …… I have to work …… ……. I have to care for household members …….. Parent/guardian does not want me to go to school …… …….. I don't like school …… School was not in session …… Other: …… DON'T KNOW ……	A→**SKIP TO Q29** B→**SKIP TO Q29** C→**SKIP TO Q29** D→**SKIP TO Q29** E→**SKIP TO Q29** F→**SKIP TO Q29** G→**SKIP TO Q29** H→**SKIP TO Q29** I→**SKIP TO Q29** Z→**SKIP TO Q29**

045.	What class/form are you in <u>now</u>? **FIRST, CIRCLE THE CORRECT CODE NEXT TO THE CURRENT LEVEL OF SCHOOLING (I.E., PRE-PRIMARY=1, PRIMARY=2, SECONDARY=3). THEN,USE THE SPACE PROVIDED NEXT TO THE RESPONSE TO WRITE THE SPECIFIC CLASS/FORM THE CHILD IS CURRENTLY IN.**	1……. PRE-PRIMARY (1-3) [____|____] 2……PRIMARY (Class 1-8) [____|____] 3……SECONDARY (Form 1-4) [____|____] 8…….. DON'T KNOW

046.	During the last **<u>school week</u>**, did you miss any school days for any reason?	Yes No	1 2→**SKIP TO Q27**

047.	Why did you miss school days during the last school week? **DO NOT READ RESPONSES ALOUD. MULTIPLE RESPONSES ALLOWED. KEEP ASKING 'Anything else?' RECORD ALL MENTIONED.**	A = No money for school materials, transport… B = I am too sick to attend school… C = School is too far away / no school… D = I have to work… E = I have to care for household members… F = School was not in session… G = I don't like school… H = Parent/guardian does not want me to go to school… I = Other: _____
048.	During the **last <u>school term</u>**, how often did you {NAME} miss school? **READ RESPONSES ALOUD TO THE RESPONDENT AND CIRCLE ONLY ONE ANSWER.**	1 = Never…→**SKIP TO Q.2** 2 = Occasionally (Maximum Once A Month)… 3 = Often (Two Or More Times A Month)… 8 = Don't Know…

049.	What were the main reasons why you missed school last term? **DO NOT READ RESPONSES ALOUD. MULTIPLE RESPONSES ALLOWED. KEEP ASKING 'Anything else?' RECORD ALL MENTIONED.**	No money for school materials, transport… Was too sick to attend school… School is too far away / no school… I had to work… I had to care for household members… School was not in session… I don't like school… Parent/guardian does not want me to go to school… Other: _____	A B C D E F G H I
050.	IF CHILD HAS NEVER BEEN ENROLLED IN SCHOOL, CIRCLE 3, AND PROCEED TO Q.33. OTHERWISE ASK THE FOLLOWING: Were you enrolled in school during the **previous school year**?	1 = Yes 2 = No→**SKIP TO Q31** 3 = Never Enrolled In School→**SKIP TO Q32**	
052.	What is the highest class/form that you {NAME} have <u>completed</u>?	1……. PRE-PRIMARY (1-3) [____|____] 2…….PRIMARY (Class 1-8) [____|____] 3…….SECONDARY (Form 1-4) [____|____] 8…….. DON'T KNOW	
053.	Have you received any type of educational assistance? (Select all that apply)	1 = Books 2 = Educational Materials (paper, pencils, etc.) 3 = Financial support / School Fees 4 = Food Support 5 = Tutoring 6 = School uniform 7 = Solar lamps 8 = No, we do not receive educational assistance 9 = Other, specify _____	
054.	If yes, who provides this assistance? (Select all that apply)	1 = Government 2 = Relatives/friend 3 = NGO/CBO 4 = Religious Organization /Institution 5 = Other, specify _____	
055.	Have you received any life skills training?	1 = Yes 2 = No 8 = Don't know	

056.	Have you been to any vocational institution?	1 = Yes 2 = No
077.	What vocational or technical skills have you acquired? **MULTIPLE RESPONSES ALLOWED. CIRCLE ALL MENTIONED.KEEP ASKING 'Anything else?' UNTIL NO OTHER SKILLS ARE MENTIONED.**	A = Carpentry B = Masonry C = Mechanics D = Cosmetology E = Tailoring F = Customer care G = Plumbing H = Electrician I = Others specify_____

I have come to the end of my questions. Is there anything you would like to add or ask us?

Thank you for participating in this interview!

041.	END TIME	[__|__|:[__|__]

TOOL 3: KEY INFORMANT INTERVIEW QUESTIONNAIRE

- IMPLEMENTING-PARTNER TECHNICAL STAFF -

RECORD NO. ☐☐☐

DATE:				**2018**
		(dd)	(mm)	(yyyy)
ACTIVITY:	I…	Imarisha		
	A…..	APHIAPlus Implementing Partner—PRIME		
	B…..	APHIAPlus Implementing Partner—SUB		
	C….	OTHER (Specify):		

NAME OF KEY INFORMANT	POSITION	AGENCY
1.		
2.		
3.		
4.		
5.		

READ INFORMED CONSENT STATEMENT (see separate sheet)

☐ TICK THIS BOX ONCE YOU HAVE DONE THE FOLLOWING: I read the Informed Consent Statement and have obtained the respondent's informed consent.

RECORD START TIME OF INTERVIEW (HH:MM) _____ _____: _____ _____

NO.	QUESTION	RESPONSES
The Local Context/Local Operating Environment		
1.	Thank you for agreeing to meet with me today. To start, for how long have you been serving in your current position?	RESPONDENT 1 RESPONSE: RESPONDENT 2 RESPONSE: RESPONDENT 3 RESPONSE: RESPONDENT 4 RESPONSE: RESPONDENT 5 RESPONSE:
Evaluation Question One What is the current coverage/improvement status on the priority health outcomes in HIV/AIDS, RMNCAH, Nutrition, Water and Sanitation and institutional/organizational capacity building and to the extent possible, determine the activity's contribution to the observed health outcomes?		
2.	**Based on the activity's theory of change, what have been the actual inputs of the activity at the county, sub-county, health facility and community levels on coverage of high impact interventions** ***More Specifically what did the Imarisha do regarding*** ***i. HIV/AIDS*** ***ii. MARPS*** ***iii. FP/RMNCH*** ***iv. Nutrition*** ***v. WASH*** ***vi. Economic Strengthening*** ***vii. OVC Care***	

NO.	QUESTION	RESPONSES
Contributions of the APHIAPlus Activity		
3.	In your opinion, what was the most important contribution of APHIAPlus to the county's health goals and priorities? **How have these activity inputs led to the observed health outcomes?** **Probe for** ***i. HIV/AIDS*** ***ii. MARPS*** ***iii. FP/RMNCH*** ***iv. Nutrition and food security*** ***v. WASH*** ***vi. Household Economic Strengthening*** ***vii. OVC Support***	
4.	What is the projects contribution to the OVC component Probe for ***a. Supporting Transition to post primary and Secondary education*** b. ***promoting reliance on individual scholarships and provision of supplies to secure educational access*** c. **Probe for roles of livestock and other cooperatives, religious structures, water management committees, schools**	
5.	**How did the Imarisha identify and link eligible children and families to available government social protection initiatives**	
Achievement of expected health outcomes by intermediate results been achieved, if not why		

NO.	QUESTION	RESPONSES
6.	**R3: Increased Use of Quality Health Services, Products and Information**	
7.	**IR 3.1: increased availability of an integrated package of quality high impact interventions at community and health**	
8.	IR3.2 **Increased demand for an integrated package of quality high-impact interventions at community and health facility levels.**	
9.	IR 3.3 **Increased adoption of healthy behaviors**	
10.	IR 3.4: **Increased program effectiveness through innovative approaches**	
11.	R4: **Social Determinants of Health Addressed to Improve the Well-Being of Targeted Communities and Populations**	
12.	IR 4.1**Marginalized, poor and underserved groups have increased access to economic security initiatives through coordination and integration with economic strengthening**	

NO.	QUESTION	RESPONSES
13.	IR 4.2 **Improved food security and nutrition for marginalized, poor and underserved populations**	
14.	IR **4.3: increased access to education, life skills, and literacy initiatives through coordination and integration with education programs**	
15.	IR**4.4: Increased access to safe water, sanitation and improved hygiene**	

NO.	QUESTION	RESPONSES
16.	IR **4.5: Strengthened systems, structures and services for protection of marginalized, poor and underserved populations**	
17.	IR **4.6: Expanded social mobilization for health**	
18.	**How did the APHIAplus integration model work for and/or against the achievement of results in each of the key service delivery program areas** ***(PROBE FOR Contribution of their model to*** ***HIV/AIDS,*** ***RMNCH,*** ***Nutrition,*** ***Water and sanitation, and institutional/organizational capacity building);***	

NO.	QUESTION	RESPONSES
19.	**How did synergies, collaboration or coordination between different program areas and/or between different USG activities contribute if any, to the observed health outcomes?**	
20.	**What other service delivery support systems/structures has the activity initiated and/or strengthened at the county, sub-county, facility, and community levels?** ***Probe for Service delivery systems at*** **a)** ***County*** **b)** ***Sub-County*** **c)** ***Facility*** **d)** ***Community***	
Evaluation Question two: What extent has the activity increased the capability of health community, health facility and county health management teams to sustain the gains in the observed health outcomes?		
21.	**How effective was the capacity building (financial, managerial and technical capacity) to ensure sustainability to provide high quality package of services?** ***Probe for technical, Managerial and Technical capacity of*** *a. county/health facility management teams,* *b. health care workers,* *c. CUs and local* **d.** *CBOs/NGOs*	

NO.	QUESTION	RESPONSES
22.	What are your thoughts on the partnership model adopted by your APHIAPlus Activity? **PROBES:** **WHAT "WORKED?"** **WHAT DIDN'T "WORK?"** **ALSO PROBE ON:** **PROJECT STRUCTURES, E.G., TECHNICAL COMMITTEES, MANAGEMENT MEETINGS—DID THEY OCCUR REGULARLY?** **WERE THEY EFFECTIVE? HOW DID THEY ADVANCE COORDINATION WITHIN THE PARTNERSHIP?** **HOW DID THEY ENSURE QUALITY?**	
23.	(a) What were your experiences with regards to coordination and collaboration with other USG funded projects? (b) What would you recommend regarding rationalization and national mechanisms? (c) What are key considerations for future programming?	

NO.	QUESTION	RESPONSES
24.	**What support did the Imarisha provide to MGCSD to develop policies, protocols and guidance to support quality social services;** ***Explain and Provide evidence***	
25.	What are the established systems for program quality improvement at health facilities? ***Explain and Provide evidence***	
26.	In your opinion, What are the weakest systems/structures at facility, community and administrative levels that might hamper the continuation and sustainability of the achieved health outcomes *Provide examples*	
27.	How did Imarisha Support the development of capacity of functional community units to promote preventive health behaviors, identify, refer cases? *Probe for capacity to* *a. Identify cases* b. *Refer cases*	
	INTEGRATION	
28.	How did APHIAplus contribute to broader integration efforts within the country? **PROBE ON:** • **INTEGRATED SERVICE DELIVERY FOR CLIENTS IN HEALTH FACILITIES** • **SYSTEMS INTEGRATION (E.G., EXTENT TO WHICH DIFFERENT TECHNICAL PROGRAM MANAGERS (E.G., FROM FAMILY PLANNING, HIV) ENGAGED IN JOINT PLANNING AND IMPLEMENTATION.** • **INTER-SECTORAL LINKAGES**	

NO.	QUESTION	RESPONSES
	(E.G., BETWEEN HEALTH AND EDUCATION; LINKAGES TO SOCIAL PROTECTION)	
29.	Have there been any unintended or unexpected consequences from the APHIAPlus integration approach? Please describe. These could be positive or negative.	
30.	(a) Are there particular issues (programs) for which integration was **easy**? Please explain. (b) Are there particular issues (program areas) for which integration was **difficult**? Please explain.	
Evaluation KEY QUESTION 3: What implementation challenges besides security did the activity face during the implementation period?		
IMPLEMENTATION CHALLENGES		
31.	In your opinion, what have been the key **implementation challenges** of APHIAPlus? **PROBE: HOW DID NATIONAL MECHANISMS (E.G., FOR TRAINING, DRUGS) CONTRIBUTE TO THE ABOVE IMPLEMENTATION CHALLENGES?**	

NO.	QUESTION	RESPONSES
32.	Are there any aspects of the APHIAPlus program design that **contributed to** those implementation challenges? Please describe. **PROBE ON:** **-PARTNERSHIP MODEL** **-APPROACH TO CAPACITY BUILDING** **-HOW WELL THE RATIONALIZATION PROCESS WORKED?**	
33.	Are there any aspects of the APHIAPlus program design that **helped to minimize** implementation challenges? Please describe.	
34.	Were there any coordination and collaboration challenges between the activity and its key collaborating institutions did the activity face and how did these challenges affect the achievement of expected outcomes?	
35.	**What suggestions do you have for addressing the design shortfalls if any?**	
	INNOVATION	
36.	Innovations were supposed to be an important aspect of APHIAPlus. Can you please expound on the specific ways innovations were introduced to: (a) overcome known barriers and/or implementation challenges? (b) Accelerate or amplify project achievements?	

NO.	QUESTION	RESPONSES
	Can you share any documentation (e.g., operations research reports, facility performance reviews) on the effectiveness of those innovations?	
37.	Were there any innovations that were part of the original program design but were NOT implemented? Why?	
	Lessons learned	
38.	Are there any lessons learned from APHIAPlus regarding the role of evidence-based innovations in addressing: (a) Social determinants of health? (b) Service integration? (c) Service quality? (d) Sustainability?	
	SUSTAINABILITY	
39.	APHIAPlus had proposed a number of approaches to ensure sustainability of outcomes. Which of those approaches were actually implemented? **PROBE ON:** ☐ ***AMREF ORGANIZATIONAL DEVELOPMENT & STRENGTHENING MODEL,*** ☐ ***LOL AND CRS LIVELIHOODS MODELS,*** ☐ ***PROBLEM SOLVING TOOLS FOR PUBLIC SERVICE PROVIDERS,*** ☐ ***LINKAGE TO NATIONAL MECHANISMS E.G. FANIKISHA*** ☐ ***EMPOWERMENT OF LOCAL HEALTH & DEVELOPMENT:*** ☐ ***STRENGTHENING CAPACITY OF HEALTH SYSTEMS FROM***	

NO.	QUESTION	RESPONSES
	COMMUNITY TO DISTRICT LEVELS TO DELIVER QUALITY SERVICES ☐ ***FOSTERING MULTI-SECTOR INTEGRATION MODELS SUCH AS SILC AND VALUE CHAIN ADDITION TO CREATE POSITIVE CHANGE*** ☐ ***PHASED PROJECT IMPLEMENTATION*:**	
40.	How has the withdrawal of Activity's support to CHWs been addressed	
41.	APHIAPlus is ended in December of this year 2017 **PROBE: PLEASE COMMENT ON WHICH PROGRAM RESULTS ARE LIKELY TO BE SUSTAINED AFTER THE PROGRAM CLOSES. WHY?** **PROBE ON STRUCTURES/MECHANISMS THAT MIGHT HAVE BEEN INTRODUCED VIA APHIAPLUS (E.G., TECHNICAL COMMITTEES, REVIEW MEETINGS). WHAT ARE THE PROSPECTS FOR SUSTAINING THOSE STRUCTURES/MECHANISMS AFTER APHIAPLUS?**	
	SCALE UP	
42.	What strategies or features of APHIAPlus show promise in being scaled up to other parts of the country? Why?	
43.	What implementation models can be replicated in other geographic locations of the country outside NAL region? Give specific Examples	
44.	What are your recommendations for strategic and programmatic design of future activities in the NAL region	
45.	What would you recommend for quality improvement at health facilities as well as use of national guidelines and protocols by Health workers	

TOOL 4: KEY INFORMANTS INTERVIEW, USAID HPN STAFF (MNCH TEAM); USAID SI TEAM

RECORD NO. | | | |

	DATE:			**2018**
		(dd)	(mm)	(yyyy)
TYPE(S) OF RESPONDENT(S) PARTICIPATING IN THE INTERVIEW:	A… …	USAID HPN staff (MNCH Team) USAID –SI Team		

Name of the KII respondent	Designation/Title	Length of service in that designation	Agency
6.			
7.			
8.			
9.			
10.			

READ INFORMED CONSENT STATEMENT (see separate sheet)

Yes ☐ TICK THIS BOX ONCE YOU HAVE DONE THE FOLLOWING: I read the Informed Consent Statement and have obtained the respondent's informed consent.

RECORD START TIME OF INTERVIEW (HH:MM) _____

No.	Question	Targeted Respondent	Responses
The APHIAplus Imarisha Design			
46.	The APHIAplus Imarisha Activity Aimed to achieve sustainable country-led (and now county-led) actions, partnerships with the Ministries of Health, and engaging key stakeholders, the program is addressing ***two results*** of USAID's ***five year Strategic Framework***, what are your opinions about this approach?, (Probe: what are some strengths and weaknesses of this approach)		.
47.	How has the country led approach contributed to the achievement of the observed health outcomes?		
48.	As part of the five year implementation framework, USAID also designed national health system related activities, the APHIAplus activities were to coordinate and collaborate with these national mechanisms to address health systems related challenges at service delivery level. What worked well in this approach, what did not work well? what were the challenges?, how did this contribute to the achievement of the observed health outcomes, how did this hinder achievement of the expected health outcomes, what are your recommendations on how those challenges could be addressed? (Additional probes: Role of each of the national mechanism, when the mechanism started, interventions implemented in collaboration with each APHIAplus Imarisha}		

No.	Question	Targeted Respondent	Responses
49.	In addition to the "health related result areas", APHIAplus Imarisha design included result 4 that focused on *"social determinants of health addressed to improve the well-being of the targeted communities and populations*", in your opinion how has this worked?, do you think this result area has been effectively implemented?, how well did the activities link/integrate this result area with the other result area?, what challenges did the activities experience in the implementation of this result area?, what improvements do you think could be made on the design and implementation of this result area?		
50.	The APHIAplus Imarisha activity focused on technical areas of HIV and AIDS, Malaria, Family Planning and TB, MNCH, WASH, OVC and Social Determinants. In your opinion, how effective has the APHIAplus Imarisha activity been in addressing each of the technical areas?,{*Probe on adequacy of activities that APHIAplus Imarisha implemented in each of the specific technical areas based on the respondent category,*}		
51.	Who are the key development partners/programs supporting the specific technical area?, how well have the activities **synergized with/collaborated** with the other development partners supporting this technical area, how well has this worked?, what has been the challenges in coordinating and synergizing with other development players?, how did this coordination on lack of it affect the implementation of the three activities, what would be your suggestions for improving this? { ***Probe:*** *Activity coordination with other USG and USAID programs/initiatives including CDC,PMI among others, activity coordination with other development partners such as GF for HIV, TB and Malaria, probe for coordination at the facility level* }		

No.	Question	Targeted Respondent	Responses
52.	A key strategic pillar of the APHIAplus Imarisha model was **integration** of the focus technical areas to reduce vertical programming and avoid duplication effect. In your opinion did this work? What worked well and what did not work well and why? How could integration be strengthened? How did integration contribute to the observed health outcomes? **{Probe:** probe on joint planning, integrated service delivery at point of service, referral, data sharing, joint supervision, etc.**}**		
Strategic Shifts			
53.	What were the key strategic shifts that happened during the APHIAplus Imarisha implementation period, how did this affect the APHIAplus Imarisha design and implementation? How did APHIAplus Imarisha adapt into those strategic shifts? What other modifications/adjustments do you the activities should have made given the emerging scenarios? {**Probe for:** policies, technical guidelines, devolution, changes in MoH leadership and management at national and county level, PEPFAR blueprint, budget cuts/ rationalization, new program such as the Beyond Zero Campaign, epidemiological changes}		
Implementation Challenges and Management			
54.	What are some key implementation challenges that affected implementation of the activities? how were those challenges addressed?, how responsive were the implementing partners in addressing the challenges?, How did USAID support the partners in addressing the challenges?, what are your opinions on how those challenges could have been better addressed , how did those challenges impact the on the attained of the expected health outcomes {**Probe:** Partner related challenges, USAID related challenges, Ministry of health and Government/ policy related challenges, health systems related challenges, other challenges)		
Innovation			

No.	Question	Targeted Respondent	Responses
55.	(a) Were there any features of APHIAplus Imarisha that you consider to be particularly innovative? (b) Compared to the strategies implemented by other local actors, how innovative was APHIAplus Imarisha' strategies and approaches?		
56.	The activity proposed to work with government departments (MOPHS, MOMS, MOE, Ministry of Livestock, NDMA, and MOGSD), CSOs, livestock and other cooperatives, schools, water management committees and cultural structures to integrate interventions that were expected to strengthen the health system with those that were to address social health determinants. To what extent was this done		
	Sustainability		
57.	AMREF proposed to deploy a holistic program design that was meant to empower and strengthen health service delivery and social development structures in the region to sustainably fulfill their mandate . To what extent do you think this has been achieved? Probe for *(i) strengthen the capacity of community to county (level 1 to 4) health systems to deliver high quality services, products, and information and create demand for the same;* *(ii) strengthen the ability of local social and* *economic development structures to create positive change in livelihoods, food security, education, and social protection; and* *(iii) Use of proven approaches such as the SILC model by CRS and the value chain approach by Land O'*		.

No.	Question	Targeted Respondent	Responses
	Lakes,		
Recommendations/ Interventions for Scale UP			
58.	What strategies or features of APHIAplus Imarisha show promise in being scaled up to other parts of the country? Why? What is required to accelerate scale up? (PROBE on operations research evidence, costing, etc. Also probe on criteria for determining where (e.g., in which other counties to scale up effective APHIAplus Imarisha interventions)		
59.	Based on lessons learned, policy changes, new priorities and gaps identified during the activity implementation, what would your suggestions for follow on activity? (Probe for new technical areas, new interventions etc.)		

TOOL 5: PANEL DISCUSSION GUIDE WITH ORGANISATIONS WORKING IN TURKANA AND SAMBURU **(2 pages)**

Organisation	Name of the representative and designation

Thematic area	Discussion issues
a. Intervention focus of participating organizations working in the region	a. What are your specific intervention focus in the technical areas of: HIV/AIDS, RMNCAH, WASH, nutrition, food security, HES and institutional capacity building b. Which approaches/strategies do you use to deliver your interventions (through CHWs, mentorship at facility level, etc.)? c. What is your geographical coverage? Do you cover the entire county or some specific counties/sub-counties? d. How long have you worked in the county?
b. Partner organisation's involvement with APHIAplus IMARISHA program	a. Did you collaborate with APHIAplus response? b. What were the areas of collaboration? c. Do you think the collaboration was adequate? d. How do you think the collaboration could have been improved?
c. Opinions on APHIAplus IMARISHA program design	a. What are your views on the effectiveness if of the APHIAplus IMARISHA program design and approaches o County led approach o Working in a consortium o Integrated approach including the multi-sectoral response o Capacity building approaches b. What are your suggestions on how the design of the program could be better addressed?
d. Opinions on whether the APHIAplus IMARISHA addressed the priority needs around HIV/AIDS, RMNCAH, Nutrition, WASH and social determinants	a. What are the priority needs around HIV/AIDS, RMNCAH, nutrition, WASH, food security and institutional strengthening in the county? b. Do you think APHIAplus IMARISHA addressed the priority needs around those technical areas? c. What other priority areas do you think should have been included around the technical areas: HIV/AIDS,

Thematic area	Discussion issues
	RMNCAH, nutrition, WASH, food security and institutional strengthening in the county
e. Impact of APHIAplus IMARISHA in improving health and institutional strengthening outcomes	a. In your opinion how would you rate APHIAplus IMARISHA on achievement of the planned health and institutional outcomes? b. In which areas would rate APHIAplus IMARISHA as having performed the best? c. Which was the weakest area of performance?
f. Recommendations on the what and how for future programming in the technical areas of HIV/AIDS, RMNCAH, Nutrition and social determinants	a. Based on your experience in this county, what innovative strategies do you recommend for sustainable health and institutional strengthening outcomes in each of the technical areas targeted by APHIAplus IMARISHA b. What are you suggestions on the 'how' of implementing the proposed strategies
g. Any other comments	Any other suggestions on what should be done differently to improve health and institutional strengthening outcomes

TOOL 6:KEY INFORMANT INTERVIEW GUIDE—

NATIONAL-LEVEL GOK

(6 pages)

RECORD NO. | | | |

DATE:				
		(dd)	(mm)	(yyyy)
TYPE(S) OF RESPONDENT(S) PARTICIPATING IN THE INTERVIEW:	A… …	National Level GOK		

Name of the KII respondent	Designation/Title	Length of service in that designation	Agency
11.			
12.			
13.			
14.			
15.			

READ INFORMED CONSENT STATEMENT (see separate sheet)

Yes ☐ TICK THIS BOX ONCE YOU HAVE DONE THE FOLLOWING: I read the Informed Consent Statement and have obtained the respondent's informed consent.

RECORD START TIME OF INTERVIEW (HH:MM) ----------: _----------

No.	Question	Targeted Respondent	Responses
The APHIAplus Design			
60.	Are you familiar with the APHIAplus project? *Describe how the project started after March 2012: What type of support was delivered by the APHIA plus project?* ***More Specifically what did the Imarisha do regarding*** ***viii. HIV/AIDS*** ***ix. MARPS*** ***x. FP/RMNCH*** ***xi. Nutrition*** ***xii. WASH*** ***xiii. Economic Strengthening*** ***xiv. OVC Care***		
61.	APHIAplus was supposed to center on "sustainable country led programs and partnerships.", How has this worked?, (Probe: how well APHIAplus involved the Ministry of health at national and county levels in "leading" the implementation of the program?, how well did the program fit in the national priorities and policies,		
62.	APHIAplus Imarisha was to strengthen the capacity of District and later County Health Management Teams; health facility staff and management committees; Community Health Units for **Increased use of quality health services, products and information**. To what extent has this been done?		
63.	The activity was to prioritize the Annual Operating Plan (AOP) cycle and empower sub-county and county health management teams to prepare SMART plans and supervise, document, monitor and review implementation of a multi-sectoral approach to attain health and developmental results? To what extent has this been done?		
64.	In addition to the "health-related result areas," APHIAplus design included result 4 that focused on *"social determinants of health addressed to improve the well-being of the targeted communities and population."* In your		

No.	Question	Targeted Respondent	Responses
	opinion how has this worked? To what extent was this achieved?		
65.	The APHIAplus activity focused on technical areas of HIV and AIDS, Malaria, Family Planning and TB, MNCH, WASH, OVC and Social Determinants. In your opinion, how effective have the three APHIAplus activities been in addressing each of the technical areas?,{Probe on adequacy of activities that APHIAplus implemented in each of the specific technical areas based on the respondent category} USAID, MoH departments, development partners (CDC)		
66.	How has the situation of {mention specific technical area} changed over time since inception of the activities under evaluation in 2012{**Probe for**: national and the regions of focus}, in your opinion what has been the contribution of the activities to the observed health outcomes, what have been the inputs from the activities that have contributed to the observed changes {**Probe for**: inputs of the three activities at national if any and at regional level}		
67.	Who are the key development partners/programs supporting NAL in the technical areas supported by Imarisha?, how well have the activities synergized with/collaborated with the other development partners supporting this technical area		

No.	Question	Targeted Respondent	Responses
68.	A key strategic pillar of the APHIAplus model was integration of the focus technical areas to reduce vertical programming and avoid duplication effect. In your opinion did this work? What worked well and what did not work well and why? How could integration be strengthened? How did integration contribute to the observed health outcomes? **{Probe:** probe on joint planning, integrated service delivery at point of service, referral, data sharing, joint supervision, etc.**}**		
Strategic Shifts			
69.	What were the key strategic shifts that happened during the APHIAplus implementation period, how did this affect the APHIAplus design and implementation?, {**Probe for:** policies, technical guidelines, devolution, changes in MoH leadership and management at national and county level, PEPFAR blueprint, budget cuts/rationalization, new program such as the Beyond Zero Campaign, epidemiological changes}		
Implementation Challenges and Management			
70.	What are some key implementation challenges that affected implementation of the activities? How were those challenges addressed?		
Innovation			
71.	Were there any features of APHIAplus that you consider to be particularly innovative? Probe for a. *Performance Based Financing for DHMTs* b. *Output-based approaches for HCW & CHW* c. *Provider-defined quality approaches* d. *Web-based learning* e. *Institutionalizing data analysis & use* f. *Specialist Clinical Outreaches* g. *Support for equipment maintenance*		

No.	Question	Targeted Respondent	Responses
Sustainability			
72.	The APHIAplus activity designed various strategies for ensuring sustainability		
Interventions for Scale UP			
73.	What strategies or features of APHIAplus show promise in being scaled up to other parts of the country? Why? What is required to accelerate scale up? (PROBE on operations research evidence, costing, etc. Also probe on criteria for determining where (e.g., in which other counties to scale up effective APHIAplus interventions)	USAID, MoH departments, IPs at national level, development partners	As above-I cannot mention any
74.	Based on lessons learned, policy changes, new priorities and gaps identified during the activity implementation, what would your suggestions for follow on activity? (Probe for new technical areas, new interventions etc.)		

TOOL 7: KEY INFORMANT INTERVIEW QUESTIONNAIRE

- CHMT-SCHMT-HW -

(26 pages)

RECORD NO. | | | |

Respondent name	Designation	Length of service in C/SCHT/Facility
16.		
17.		
18.		
19.		
20.		

READ INFORMED CONSENT STATEMENT (see separate sheet)

☐ TICK THIS BOX ONCE YOU HAVE DONE THE FOLLOWING: I read the Informed Consent Statement and have obtained the respondent's informed consent.

RECORD START TIME OF INTERVIEW (HH:MM) _____ _____: _____ _____

NO.	QUESTION	RESPONSES
75.	As part of understanding the local context, we would like to understand the organisations that have been and or are working in this county in the technical areas of HIV/AIDS, RMNCAH, nutrition, food security, household economic strengthening and education. **Probes** Probe on the names of the organisations, the length of time they have been in the county, the type of support they provide specifically on the AI technical areas and the geographical spread of the interventions Probe on whether AI is considered among the main partners/or the leading partner in the AI specific intervention areas, the uniqueness of the AI support in terms of coverage and breadth of the technical intervention areas	

NO.	QUESTION	RESPONSES
76.	What are some changes in health care delivery that have happened since 2013 and how has these impacted on health service delivery? **<u>Probes</u>** How did devolution impact on the delivery of health care services with special focus on the AI intervention areas? How did APHIAplus Imarisha support the health facilities/health workers to adjust to impact of devolution? What are some shifts in strategic direction including changes in policies/guidelines that have happened since March 2012 and how did these impacted on service delivery with special focus on the AI technical areas?, how did AI support the health facilities/health workers to adjust to those changes?	
77.	Please describe to me the changes in coverage /status of the priority health outcomes in HIV/AIDS, RMNCAH, nutrition, WASH and institutional capacity building <u>Probes</u> Probe on changes in by the priority health outcome indicators	

NO.	QUESTION	RESPONSES
78.	Please describe to me the contribution of APHIAplus Imarisha in improving coverage/status on the priority health outcomes in HIV/AIDS, RMNCAH, Nutrition, WASH and capacity building of health workers and health facilities. What has been the contribution by other partners if any? Probe Probe by IRs and identify the specific interventions by APHIAplus IMARISHA for each IR Did the interventions work? How effective were the various interventions implemented	
79.	How is the delivery of health services in this county? Are the services delivered in an integrated manner? What was the contribution of APHIAplus in ensuring that services are provided in an integrated approach? **Probes** How well did the activity integrate the various APHIAplus IMARISHA technical areas? (Extent to which different technical program areas are integrated such as FP and HIV/AIDS, MNCH and PMTCT, engagement in joint planning by different technical areas) Inter-sectoral linkages (e.g., livestock interventions as an entry point for health interventions) What challenges	
80.	(a) Were there any features of APHIAPlus IMARISHA that you consider to be particularly innovative? If not mentioned cite examples of the AI promised innovations by County (b) How well did those innovations work? Were they successful? (c)Were there any mechanisms for ensuring the documentation and dissemination of the innovations? Have the innovations in your opinion been taken up by other partners	

NO.	QUESTION	RESPONSES
	including the county government? If not, why?	
81.	APHIAplus IMARISHA promised to strengthen capacity of community to county health systems to deliver high quality services, products and information, in your opinion do you think this happened? **Probes** Probe on the implementation of the promised capacity building interventions for all the levels: CHMT, SCHMT, Health facilities, CU, health workers, were these implemented? How effective were the approaches used in building at the various levels?	
82.	In your opinion, were the key **implementation successes** of APHIAPlus IMARISHA? **Probes** Probe for successes around the AI design of county led, partnership model, integration, capacity building models, coordination, collaboration and partnership with other institutions, working with national mechanisms	
83.	In your opinion, what were the **implementation challenges** of APHIAPlus IMARISHA? **Probes** Probe for challenges resulting from AI design of county led, partnership model, integration, capacity building models, collaboration and partnership, working with national mechanisms, devolution, shifts in strategic direction including government policies and programs	
84.	What approaches did the program use to address the implementation challenges?	

NO.	QUESTION	RESPONSES
85.	What would you say were the lessons learned in the implementation of APHIAplus program? **Probes** Probe on lessons learned from the implementation of various interventions, capacity building approaches used, the innovations implemented	
86.	What do you think should have been done differently to ensure increased use of quality health services, products and information in this county? **Probes** What should have been done differently in the design of the program In building capacity of the county, CHMT, SCHMT, health facilities, health workers	

TOOL 8: FOCUS GROUP DISCUSSION GUIDE - MNCH CLIENTS

DATE:				**2018**
		(dd)	(mm)	(yyyy)
ACTIVITY:		1…	SAMBURU	
		2…	TURKANA	
COUNTY NAME:				
FACILITY TYPE:		1…		
FACILITY NAME:				
GROUP COMPOSITION:	• Total number of participants**:** • (AGE) Number of FGD participants who are: ○ **Age 15-19 years:** ○ **Age 20-24 years:** ○ **Age 25-49 years:** • (MARITAL STATUS)Number of participants who are: ○ **Currently married:** ○ **Not currently married:** • OTHER GENERAL OBSERVATIONS FROM FACILITATOR:			

Thank you for meeting with me today. I am interested in better understanding the availability and utilization of maternal, new born and child health services in this health facility for the clients like you and I will be asking a few questions about your experiences and about your community. When answering the questions, please be as honest as possible.

Everyone has an opinion. It is okay if someone says something that the other people in the group don't agree with. I am interested in hearing from everyone, so let's be respectful, even if we don't agree with something being said.

Because I don't want to miss anything we discuss, I will be taping our discussion. Also, I will give each of you a nametag with a number written on it. Before you say something, please say the number that I assign you. That will help me keep track of everything everyone say

1. **Changes in FP/MNCH health care services in the community**
   (a) How have the health care services of mothers, new-borns and children **(Antenatal, intrapartum, and postpartum care; FP; PMTCT; neonatal care; child health services)** changed over the last 5 years in this community?

2. **Support provided by APHIAplus Imarisha project**
   - Are you aware of any organizations that have been working in your community to address the health of mothers and children in your community? If yes, name some

(Probe for knowledge on APHIAplus Imarisha project and other organizations working in the locality)

- How has the APHIAplus Imarisha project contributed to improving the health of mothers and children in this community?

3. **Access to FP/MNCH**

- Are FP/MNCH services accessible to women and children in this community? Has the access changed over the last 5 years?

- In Your opinion, what factors made it easier for you to access these services over those years?

- In your opinion, what made it difficult for some women to access these services over these years?

(Probe for: Economic, Geographical and Socio- Cultural barriers)

4. **Availability and utilization of high impact interventions for FP/MNCH/Malaria**

TOOL 9: Focus Group Discussion with OVC Caregivers

(N=10 participants maximum)

(*for: FP services, antenatal care services, postnatal care for mothers, postnatal care for children, malaria prevention and treatment, ort, zinc, ITNs, childhood diseases (pneumonia, diarrhoea, fever, malaria, chest / respiratory diseases, measles etc.), HIV, TB*)

- What role(s) have community health volunteers played in ensuring availability of the above services in your community?
- How has the utilization of these services improved over the last five years? In your opinion, what contributed to the improvement in the utilization of these services?

5. Client treatment at health facilities

I am interested in getting your views on the treatment of women and children when they access health services in this health facility.

- How would you describe the way they are treated at the health facilities in terms of privacy, confidentiality, and consent before receiving a service, dignified care, denial of care, discrimination?)
- How important are those factors when people are deciding whether or not to seek health care?
- Over the past 5 years, have you seen any changes in this health facility in regards to the way health service providers treat? What changes?

DATE:			**2018**
	(dd)	(mm)	(yyyy)
COUNTY NAME:			
NAME OF LIP:			
]]			
GROUP COMPOSITION:	• Total number of participants**:** • (GENDER) Number of FGD participants who are: o **Female:** o **Male:** • {AGE} Number of FGD participants who are: o **Age 15-19 years:** o **Age 20-24 years:** o **Age 25-49 years:** o **Age 50 or older:** • {MARITAL STATUS} Number of FGD participants who are: o **Currently married:** o **Not currently married:** • {RELATION TO CHILD} Number of FGD participants who are: o **Grandparents of OVC:** o **Siblings of OVC:** o **Other relative of OVC:** o **Non-biological custodian of OVC (e.g., "foster parent"):** o **Parent**		

Thank you for meeting with me today. We are interested in better understanding the situation affecting orphans and vulnerable children, as well as their caregivers, and I will be asking a few questions about your experiences.

When answering the questions, please be as honest as possible. Everyone has an opinion. It is okay if someone says something that the other people in the group don't agree with. I am interested in hearing from everyone, so let's be respectful, even if we don't agree with something being said.

Because I don't want to miss anything we discuss, I will be taping our discussion. Also, I will give each of you a piece of paper with a number written on it. Before you say something, please raise your sheet of paper, and I will call on you so that you can share your thoughts with the group.

1. **Please describe the economic status of your household. How does this affect your ability to provide for the orphans and vulnerable children under your care?**

Probes:

a) What HES related support have you received from APHIAplus IMARISHA?
b) Are there other organizations providing HES support.
c) Can you describe the situation before the support and after in terms of the well-being of the OVC.*(how the HES support improved access & utilization of health, education, social protection for the OVC)*
d) Are the benefits to (effects on) your household long lasting or just short-term? Please describe.
e) How will you sustain the benefits of HES? ***(probe for evidence)***
f) What are some of the challenges in accessing and utilizing the HES services?
g) What can be done differently to maximize access and utilization of HES services
h) Transition: linkages to GOK, other organizations.

2. Please describe how the OVC in your care access Education and Life Skills Programs?

Probes:

a) What Education and life skills related services have you received from APHIAplus IMARISHA?
b) Are there other organizations providing similar services.
c) Can you describe the situation before the support and after in terms of school enrollment, retention, progression and ability to cope with life challenges (life skills)
d) Are the benefits to the OVC long lasting or just short-term? Please describe.
e) What are some of the challenges in you and the OVC have experienced in accessing and utilizing these services?
f) What is the extent of reliance on individual scholarships and provision of quickly expended supplies to secure educational access?
g) How will the OVC continue accessing the services provided by APHIAplus IMARISHA after the project ends?
h) What can be done differently to maximize access and utilization of Education and other life skills services*(probe: enrollment, retention, progression)*
i) Transition: linkages to GOK, other organizations.

3. **Please describe the key issues related with social protection of OVC and their families?** *(Violence, abuse, Sexual Assault, Child Maltreatment and Children without Adequate Family Care, FGM, early marriage, Birth Registration, Shelter, Psychosocial support)*

Probes:

a) How do these issues differ between the older and younger OVC.
b) Did APHIAplus IMARISHA address some of these issues? List the issues.
c) Which issues were they not able to address?
a) Are there other organizations supporting the OVC and their families to address these issues? List the Organizations and the support they provide.
b) Can you describe the situation before the support and after in terms of
c) What are some of the challenges you and the OVC have experienced in accessing and utilizing these services?
d) What resources exist at the community level to ensure the protection of OVC and their families? Explain.
e) How will the OVC continue accessing the services provided by APHIAplus IMARISHA after the project ends?
f) What can be done differently to maximize access and utilization of social protection initiatives?
g) Transition: How did the APHIAplus IMARISHA identify and link eligible children and families to available government social protection initiatives through CHWs, CSOs, volunteers and local government representatives?

Tool 10: Guide for FGDs with Community Health Workers (CHWs)

(N=10 participants maximum)

DATE:			**2018**
	(dd)	(mm)	(yyyy)
COUNTY NAME:			
NAME OF COMMUNITY UNIT:			
Total number of CHWs in the CU			
]]			
GROUP COMPOSITION:	• Total number of participants**:** • (GENDER) Number of FGD participants who are: ○ **Female:** ○ **Male:** • {AGE} Number of FGD participants who are: ○ **Age 15-19 years:** ○ **Age 20-24 years:** ○ **Age 25-49 years:** ○ **Age 50 or older:**		

Thank you for meeting with me today. We are evaluating a program called APHIAplus IMARISHA that was implemented in your community by AMREF together with other partners from 2013 up to end of last year. We understand the program worked with you and we are interested in getting your experiences and opinions about the program. We will therefore like to ask you some questions.

When answering the questions, please be as honest as possible. Everyone has an opinion. It is okay if someone says something that the other people in the group don't agree with. I am interested in hearing from everyone, so let's be respectful, even if we don't agree with something being said.

Because I don't want to miss anything we discuss, I will be taping our discussion. Also, I will give each of you a piece of paper with a number written on it. Before you say something, please raise your sheet of paper, and I will call on you so that you can share your thoughts with the group.

1. **Just as a start; let me briefly understand the common health issues in this community? What are your roles as CHWs in addressing those problems?**
   a. *NOTE: THE FIRST PART OF THIS QUESTION IS AN ICE BREAKER QUESTION; PROBE TO UNDERSTAND WHETHER PROBLEMS APHIAPLUS IMARISHA TECHNICAL AREAS ARE MENTIONED*
   b. *IF NOT MENTIONED PROBE TO UNDERSTAND THE ROLE OF CHWS IN THE FOLLOWING AREAS*
      - *HEALTH PROMOTION WITH FOCUS ON THE APHIAPLUS IMARISHA TECHNICAL AREAS*
      - *REFERRALS OF CLIENTS TO THE HEALTH FACILITY FOR HIV, TB, MNCH, MALARIA*
      - *DEFAULTER TRACING FOR HIV AND TB CASES*
      - *EXTEND TO WHICH CHWS SERVE AS A LINK BETWEEN COMMUNITIES AND HEALTH FACILITIES TO ENSURE CONTINUUM OF CARE*
   c. *HOW DO YOU ENSURE DELIVERY OF SERVICES (PROBE FURTHER BY TECHNICAL AREAS) IN AN INTEGRATED APPROACH, WHAT CHALLENGES DO YOU EXPERIENCE IN DELIVERY OF INTEGRATED SERVICES?*

2. I would like to understand the support that APHIAPLUS IMARISHA provided in ensuring that CHWs like you are able to effectively perform their roles?

Probes

- *Have you worked/partnered/received any support from APHIAplus IMARISHA?*
- *What has been the role of APHIAplus in ensuring the CHWs undertake their roles as described earlier- Health promotion, referral of clients, defaulter tracing, serving as a link between communities and health facilities*
- *Probe to get specific role of APHIAPLUS in mobilisation, establishment of the community units and other structures, training of the community health workers, provision of allowances, provision of other materials including reporting tools, supportive supervision*
- *Are there other organisations providing similar support to your community health unit? If yes, which organisations and what support are they providing?*

3. **What approaches/strategies do you use in ensuring access to services at community and facility level? Have any innovative approaches been developed? How have these worked?**

Probes

- *How do the CHWs ensure delivery of services in an integrated manner, how do you integrate the various technical areas (Probe further by the technical areas)*
- *Probe for the promised innovations at community level including: Ngadakarin Bamocha model, Mhealth*
- *What lessons have you learned in the implementation of the various approaches/strategies- probe further by the strategies/approaches that were utilised*

4. **We are now going to discuss the success factors as well the challenges that you have faced in your work as CHWs?,**

What do you think has worked very well in the work in the roles that you undertake as CHWs?

Probes

- *What roles do you think you have done very well and what would you say have been the factors that have contributed to this success*

What challenges do you face in carrying out your work? How have your or AMREF/County Government addressed those challenges?

Probes

- *Probe for challenges related to supportive supervision, training and mentorship, referrals, weak linkage, reporting tools, attrition, motivation including stipends and other allowances*

5. We would like to discuss the ability of your CU to ensure continuity of services that you provide even at the end of the APHIAPLUS program?

Probes

- *How would you rate your ability to continue providing services even after the end of the program? (If no responses probe by type services offered by CHWs), what are/would be the facilitating factors for sustaining the interventions, what would be the constraining factors to ensuring continuity of services?*
- *What are some of the things that you have done as a CU unit to ensure sustainability of interventions even without the support of the program?*
- *What support did APHIAplus provide to ensure that as a CU you can continue to provide services even after the end of the program period?, did that work, if yes why?, if it did not work, what are the reasons why it did not work*
- *Is the CU involved in any economic strengthening interventions for purposes of ensuring sustainability? How has this impacted on the delivery of services by the CU?*
- *What are your suggestions on what should have been done better to ensure sustainability/continuity of services after the end of APHIAplus Imarisha*

TOOL 11 - FGD CCC Beneficiaries

(N=10 participants maximum)

DATE:			**2018**
	(dd)	(mm)	(yyyy)
ACTIVITY:	1…	TURKANA	
	2…	SAMBURU	
COUNTY NAME:			
		Comprehensive Care Clinic (CCC)	
FACILITY NAME:			
GROUP COMPOSITION:	• Total number of participants**:** • (GENDER) Number of FGD participants who are: ○ **Female:** ○ **Male:** • (AGE) Number of FGD participants who are: ○ **Age 15-19 years:** ○ **Age 20-24 years:** ○ **Age 25-49 years:** ○ **Age 50 and older:** • (MARITAL STATUS) Number of participants who are: ○ **Currently married:** ○ **Not currently married:** • OTHER OBSERVATIONS FROM FACILITATOR:		

Facility type	01=HOSPITAL 02=HEALTH CENTRE 03=DISPENSARY 04=CLINIC

	05=NURSING HOME 88=OTHER (SPECIFY)_____
Type of sector (Managing Authority/Ownership)	01=GOVERNMENT/PUBLIC 02=NGO/PRIVATE NOT-FOR-PROFIT 03=PRIVATE -FOR-PROFIT 04=FAITH-BASED/MISSION/CHURCH 88=OTHER (SPECIFY)_____

Thank you for meeting with me today. We are interested in better understanding the situation affecting CCC beneficiaries like you and I will be asking a few questions about your experiences and about your community. When answering the questions, please be as honest as possible.

Everyone has an opinion. It is okay if someone says something that the other people in the group don't agree with. I am interested in hearing from everyone, so let's be respectful, even if we don't agree with something being said.

Because I don't want to miss anything we discuss, I will be taping our discussion. Also, I will give each of you a piece of paper with a number written on it. Before you say something, please raise your sheet of paper, and I will call on you so that you can share your thoughts with the group.

5. WHAT HIV-RELATED SERVICES HAVE YOU RECEIVED IN THE PAST FROM THIS FACILITY?

PROBES:

- *SERVICES: HIV COUNSELING AND TESTING, PMTCT, ADHERENCE COUNSELING, ANTIRETROVIRAL THERAPY (ART), CANCER SCREENING, CD4, CONDOMS/FAMILY PLANNING, COUPLES COUNSELING, GENERAL MEDICAL CARE, NUTRITION COUNSELING/SUPPORT, PEDIATRIC HIV CARE, PRE-EXPOSURE PROPHYLAXIS, POST-EXPOSURE PROPHYLAXIS, PREVENTIVE TREATMENT—SEPTRIN, PREVENTIVE TREATMENT, MALARIA, TUBERCULOSIS (TB) SCREENING, VIRAL LOAD, EID, CHILD IMMUNIZATION, POSTNATAL CARE, GBV, VMMC OTHER (SPECIFY)_____*
- *HOW HAVE THE SERVICES CHANGED OVER THE PAST FIVE YEARS?*
- *OVER THE PAST FIVE YEARS, HAVE YOU SEEN CHANGES IN BEING ABLE TO GET DIFFERENT TYPES OF SERVICES WHEN YOU COME TO A CCC OR HAVE CONTACT WITH A HEALTH WORKER? PLEASE EXPLAIN.*
- *WHAT/WHO WOULD YOU CONTRIBUTE THESE CHANGES TO? HAVE YOU HEARD OF APHIA PLUS IMARISHA? WHAT CONTRIBUTION HAVE THEY PLAYED IN BRINGING ABOUT THESE CHANGES?*

6. WERE YOU REFERRED BY ANYONE TO THIS HEALTH FACILITY FOR THE SERVICES YOU HAVE RECEIVED?

PROBES:

- *ROLE OF CHWS AND LINKAGE VOLUNTEERS*
- *ARE THERE LINK DESKS AND VOLUNTEERS BASED AT THIS HEALTH FACILITY TO REFER PLHIV TO OTHER SERVICES WITHIN THE FACILITY?*
- *HAVE YOU EVER USED THE SERVICES PROVIDED BY THOSE DESKS/VOLUNTEERS?*

7. WHAT COMMUNITY-BASED SERVICES ARE AVAILABLE TO INDIVIDUALS LIKE YOU?

PROBES:

- *HOW HAVE THE TYPES OF SERVICES CHANGED IN RECENT YEARS? HOW OR WHY DID THOSE CHANGES HAPPEN?*
- *WHAT CHANGES HAVE OCCURRED IN ACCESS TO INFORMATION THAT CAN HELP YOU MAKE HEALTH DECISIONS?*
- *WHAT COMMUNITY RESOURCES EXIST TO SUPPORT INDIVIDUALS LIKE YOU IN SEEKING CARE AND LIVING HEALTHY LIVES?*
- *WHAT ROLE(S) DO COMMUNITY HEALTH WORKERS PLAY IN THE ABOVE?*
- *HAVE YOU EVER BEEN LINKED TO RECEIVE THESE SERVICES?*

8. WHAT CHALLENGES HAVE YOU EXPERIENCED IN SEEKING SERVICES AT THIS CCC?

PROBES:

- *NOT EVERYONE COMES TO A HEALTH FACILITY, WHAT FACTORS MAKE IT DIFFICULT FOR SOME PLHIV IN YOUR COMMUNITY TO SEEK SERVICES?*
- *WHAT CHALLENGES DID YOU HAVE TO OVERCOME TO SEEK SERVICES AT THIS CCC?*
- *ARE CERTAIN TYPES OF HIV SERVICES MORE DIFFICULT TO ACCESS THAN OTHERS?*
    - *PROBE ON: PREVENTION (PRIMARY AND SECONDARY), TESTING, TREATMENT, CARE & SUPPORT*

9. I AM INTERESTED IN GETTING YOUR VIEWS ON THE WAY COMMUNITY MEMBERS ARE HANDLED WHEN THEY ACCESS HIV SERVICES. HOW WOULD YOU DESCRIBE THE QUALITY OF HIV SERVICES IN TERMS OF:

PROBES:

- *Privacy (audio and visual)*
- *Confidentiality?*
- *Treating clients and community members with respect when communicating or interacting with them?*
- *HOW DO THE ABOVE VARY FOR DIFFERENT TYPES OF HEALTH SERVICES SUCH AS: HIV/TB? FAMILY PLANNING? MATERNAL, NEWBORN, AND CHILD HEALTH? MALARIA?*
- *HOW IMPORTANT ARE THOSE FACTORS WHEN PEOPLE ARE DECIDING WHETHER OR NOT TO SEEK HEALTH CARE?*

10. WHAT NEEDS TO BE IN PLACE TO ENSURE THAT HIGH-QUALITY SERVICES ARE ALWAYS AVAILABLE?

PROBES:

- *WHAT ARE YOUR VIEWS ON HEALTH WORKERS (AVAILABILITY, SKILLS, ATTITUDES)?*
- *WHAT ARE YOUR VIEWS ON THE AVAILABILITY OF MEDICINES AND SUPPLIES?*
- *WHAT ARE YOUR VIEW ON SERVICE PROVISION TIMES?*
- *WHAT OTHER FACTORS AFFECT QUALITY?*
- *HOW GOOD ARE THE LINKAGES AND REFERRAL BETWEEN DIFFERENT TYPES OF SERVICES AND DIFFERENT TYPES OF SERVICE PROVIDERS? HOW CAN THOSE LINKAGES AND REFERRALS BE IMPROVED?*

Tool 12 Guide for FGDs with Youth served by LIPs

(Target number=7 youth participants [10 is the absolute maximum])

DATE:				**2018**
		(dd)	(mm)	(yyyy)
NAME OF COUNTY		1…	TURKANA	
		2…	SAMBURU	
NAME OF LIP:				
GROUP COMPOSITION:	• Total number of participants**:** • (GENDER) Number of FGD participants who are: ○ **Female:** ○ **Male:** • {AGE} Number of FGD participants who are: ○ **Age 15-19 years:** ○ **Age 20-24 years:** • {MARITAL STATUS} Number of FGD participants who are: ○ **Currently married:** ○ **Not currently married:** • {EDUCATIONAL STATUS} Number of FGD participants who are: ○ **Currently in school:** ○ **Currently out of school:**			

Thank you for meeting with me today. We are interested in better understanding the situation affecting youth like you, and I will be asking a few questions about your experiences and about your community. When answering the questions, please be as honest as possible.

Everyone has an opinion. It is okay if someone says something that the other people in the group don't agree with. I am interested in hearing from everyone, so let's be respectful, even if we don't agree with something being said.

Because I don't want to miss anything we discuss, I will be taping our discussion. Also, I will give each of you a nametag with a number written on it. Before you say something, please say the number that I assign you. That will help me keep track of everything everyone says.

11. How youth friendly are HIV and sexual and reproductive health services in this location?

PROBES:

- *HOW DO YOU DEFINE YOUTH FRIENDLY?*
- *HOW ACCESSIBLE ARE THE SERVICES?*
  - *PROBE FOR FACTORS AFFECTING FEMALES.*
- *HOW SATISFIED ARE YOU WITH SERVICES AVAILABLE AT HEALTH FACILITIES?*
- *HOW SHOULD SERVICES BE PACKAGED (DELIVERED) TO HELP MORE YOUTH ACCESS THE SERVICES?*
- *HOW SHOULD THE SERVICES BE PACKAGED (DELIVERED TO IMPROVE THE QUALITY OF THE SERVICES)?*
  - *ARE THERE ANY SERVICES THAT COULD BE INTEGRATED (JOINED TOGETHER) TO MAKE IT MORE CONVENIENT FOR YOUTH TO ACCESS THOSE SERVICES? WHICH ONES?*
  - *HAVE YOU EVER GONE TO A HEALTH FACILITY OR AN ORGANIZATION TO RECEIVE A SERVICE AND BEEN OFFERED ADDITIONAL SERVICES? DID YOU ACCEPT THE ADDITIONAL SERVICES? HOW DID YOU FEEL ABOUT BEING OFFERED (PROVIDED) THOSE ADDITIONAL SERVICES?*
- *WHAT COULD BE DONE TO INCREASE AVAILABILITY OF THE SERVICES?*

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12. What should be done to specifically encourage young women to access the available sexual and reproductive health services?

PROBES:

- *Who are the key players in helping young women access those services?*
- *What is the best way to deliver those services?*
- *Are there any special circumstances or conditions faced by some young women that need to be taken into account? Which specific types of young women?*
- *What about the attitudes of health workers?*

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13. What should be done to specifically encourage young men to access the available sexual and reproductive health services?

PROBES:

- *Who are the key players in helping young men access those services? (Include access and uptake of VMMC services)*
- *What is the best way to deliver those services?*
- *Are there any special circumstances or conditions faced by some young men that need to be taken into account? Which specific types of young men?*

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14. What innovations exist to address the HIV prevention, testing, treatment, and care needs of youth?

PROBES:

- *HOW DO YOU DEFINE INNOVATIVE?*
- *HOW RELEVANT ARE THE INNOVATIONS TO THE NEEDS OF YOUTH?*
- *HOW USEFUL ARE THEY IN HELPING YOUTH REDUCE HIV RISKS AND ACCESS VARIOUS TYPES OF TESTING, COUNSELING, TREATMENT AND CARE SERVICES?*
- *WHICH INNOVATIONS HAVE BEEN MOST EFFECTIVE? WHY?*
- *WHICH INNOVATIONS HAVE NOT BEEN EFFECTIVE? WHY?*

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15. Please describe the specific APHIAPlus Imarisha activities you have participated in or been exposed to.

PROBES:

- *IN YOUR COMMUNITY, WHAT ARE SOME OF THE APHIAPLUS-SUPPORTED ACTIVITIES INVOLVING YOUTH?*
  - *PROBE FURTHER ON:*
    - *BCC*
    - *PEER EDUCATION*
- *WHAT ARE SOME OF THE CHANGES AMONG YOUTH ASSOCIATED WITH THE ABOVE ACTIVITIES?*
  - *ADDITIONAL PROBES:*
    - *HOW HAVE THOSE ACTIVITIES AFFECTED YOUR KNOWLEDGE OF DIFFERENT HIV-RELATED ISSUES?*
    - *HOW HAVE THOSE ACTIVITIES AFFECTED YOUR ATTITUDES ON HIV AND SEXUAL AND REPRODUCTIVE HEALTH?*
    - *HAVE YOU CHANGED ANY OF YOUR BEHAVIOURS OR PRACTICES AS A RESULT OF THOSE ACTIVITIES? HOW?*
- *THE APHIAPLUS PROJECT CAME TO AN END LATE LAST YEAR. WHAT CAN BE DONE TO CONTINUE ACTIVITIES AND SUSTAIN OUTCOMES IN THE FUTURE?*
  - *WHO ARE THE KEY PLAYERS IN THOSE FUTURE EFFORTS?*
  - *HOW WOULD YOU DESCRIBE THEIR ABILITY TO MEET THE NEEDS OF YOUNG PEOPLE LIKE YOU?*

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16. Describe other legal economic activities that youth are engaged in?

PROBES:

- *ARE YOUTH ABLE TO MAINTAIN EMPLOYMENT OR GENERATE A STEADY INCOME FROM THESE ACTIVITIES?*
- *WHAT ARE THE CHALLENGES THAT YOUTH FACE WHILE SEEKING THESE OPPORTUNITIES?*
- *HOW DO THESE CHALLENGES VARY FOR MALE AND FEMALE YOUTH?*

17. **What have you been able to do differently as a result of support received from APHIAplus Imarisha in this area?**

PROBES:

- *ACCESS TO AVAILABLE SRH SERVICES FOR THE YOUTH*
- *ADOPTION OF HEALTHY BEHAVIOURS*
- *WHICH OTHER LOCAL IMPLEMENTING PARTNERS ARE WORKING ON SIMILAR PROJECTS IN THIS AREA?*

18. **What kinds of services are available for household economic strengthening for the youth?**

PROBES:

- *ARE THE LOCAL IMPLEMENTING PARTNERS TARGETING THE YOUTH WITH THESE SERVICES?*
- *HOW ARE THE YOUTH UTILISING THESE SERVICES?*
- *HOW HAS THIS TRANSLATED TO IMPROVED UTILIZATION OF OTHER SERVICES PROVIDED BY IMARISHA LIKE SRH AND HIV/AIDS?*
- *WHAT CHALLENGES DO YOU FACE AS YOUTH IN ACCESSING THESE SERVICES*

TOOL 13: LIST OF DOCUMENTS TO VERIFY DURING ORGANIZATIONAL CAPACITY ASSESSMENT (OCA)

HF

1. Minutes of the last meeting
2. Strategic plan/ operational plans
3. Policy and guideline documents
4. List of essentials drugs
5. MHFL No
6. Service chatter
7. Financial documents
8. Organizational chart
9. List of trainees by training type
10. List of essential drug
11. Job Aids
12. List of CHV linked to the facility

Local Implementing Partners

1. OVC school enrollment by gender
2. OVC school attendance by gender
3. OVC school progression by gender
4. Proportion of vulnerable OVC households actively participating in community-based household economic strengthening (HES) groups by wards
5. Percentage of functional HES groups by wards
6. Audited accounts report/ Financial report
7. Registration certificate for the LIP

Community Unit

1. Copy of Registers 513, 514, 515, 516
2. Training list by trainees
3. Referral form
4. Drug kit list
5. Minutes of the last meeting
6. List of the CHV

County Health Management Team

1. County Integrated Development plan
2. Health Strategic Plan
3. Implementation plan
4. National documents (policies/guidelines)
5. Communication strategy
6. M&E strategy

7. RH strategy
8. Youth Friendly services
9. Budget
10. Partnership Code of Conduct exists
11. The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health
12. Human Resource Information System
13. Staff appraisal performance
14. Training list by trainees
15. Data quality assessment protocol forms
16. disease surveillance forms
17. Commodity Security Committee's Terms of Reference (TORs)

TOOL 14: ORGANIZATIONAL CAPACITY ASSSESSMENT TOOL FOR COUNTY/SUB-COUNTY HEALTH MANAGEMENT TEAMS

(15 pages)

A. COUNTY NAME	
B. SUB-COUNTY NAME	
C. NAME OF CAPACITY ASSESSOR	
D. DATE(S) CAPACITY ASSESSMENT CONDUCTED	
E. REVIEW/APPROVAL BY SUB-TEAM LEADER (STL):	• SUB-TEAM LEADER'S NAME: • DATE REVIEWED: • SUB-TEAM LEADER'S SIGNATURE:

The objective of this tool will be to assist the evaluation team in assessing the critical elements within the County and Sub-County Health Departments that the activity undertook for effective county health management, and identifying those areas that need further strengthening or further development.

This OCA tool is divided into two sections:

SECTION 1: GENERAL CAPABILITY ASSESSMENT

ITEM	STATUS AT THE TIME OF THE CAPACITY ASSESSMENT				REMARKS
	1 Needs urgent attention	2 Needs improvement	3 Good but require some support	4 No need for additional training	
A. GOVERNANCE AND LEADERSHIP					
1. Has the CHMT demonstrated the capacity to develop health and development strategy in the county from CIDP					
2. Has the CHMT demonstrated the capacity to implement the County Health Strategy?					
3. Has the CHMT demonstrated the capacity to engage with the health and other relevant sector actors sector in the county					
4. Has the CHMT demonstrated the capacity to develop health policies in the county					
5. Has the CHMT demonstrated the capacity for ownership of the health system in the county?					
ADDITIONAL NOTES ON GOVERNANCE:					
B. HUMAN RESOURCE					
6. Has the County/Sub-County health department team shown the ability to recruit, deploy, retain and motivate staff in the					

ITEM	STATUS AT THE TIME OF THE CAPACITY ASSESSMENT				REMARKS
	1 Needs urgent attention	2 Needs improvement	3 Good but require some support	4 No need for additional training	
various departments in the county					
7. Has the County/Sub-County health department team shown the ability to conduct professional development for its staff					
8. Has the County/Sub-County health department team shown the ability to conduct performance appraisal for its staff?					
9. Has the County/Sub-County health department team shown the ability to undertake staff capacity development based on identified need?					
10. Has the County/Sub-County health department team shown the ability to plan for the entire health system?					
11. Has the County/Sub-County health department team demonstrate the ability to equitably distribute staff across the county?					
ADDITIONAL NOTES ON HUMAN RESOURCE					

C. COUNTY HEALTH FINANCING

ITEM	STATUS AT THE TIME OF THE CAPACITY ASSESSMENT				REMARKS
	1 Needs urgent attention	2 Needs improvement	3 Good but require some support	4 No need for additional training	
12. Does the County/Sub-County health department team demonstrate the capacity to develop evidence based budget and allocate it to key departments for the county?					
13. Has the County/Sub-County health department team shown the ability to source for sustainable budget?					
14. Does the County Health Management Department have Financial Policies Procedures and compliance					
15. Has the County/Sub-County health department team shown the ability to monitor and ensure accountability for the county finances?					
ADDITIONAL NOTES ON COUNTY HEALTH FINANCING					
D. ACCESS TO PRODUCTS AND COMMODITIES					
16. Does the CHMT have the capacity to provide oversight for product and commodity management in the county?					
17. Does the CHMT have the capacity to provide oversight					

ITEM	STATUS AT THE TIME OF THE CAPACITY ASSESSMENT				REMARKS
	1 Needs urgent attention	2 Needs improvement	3 Good but require some support	4 No need for additional training	
for the county health supply chain health management					
18. Does the CHMT have the capacity to develop and/or adapt the County owned Logistics information management					
19. Does the CHMT have the oversight ability of the quality of these products?					
ADDITIONAL NOTES ON PRODUCTS AND COMMODITIES					
E. DELIVERY OF HEALTH SERVICES					
20. Has the CHMT demonstrated the capacity to develop and distribute policies, strategies, guidelines on standards of care and services					
21. Has the CHMT/SCHMT demonstrated capacity to effectively implement policies and strategies					
22. Has the CHMT demonstrated the capacity deliver HIV/AIDs, TB, RMNCH, Nutrition WATSAN and Malaria programs?					
23. Has the CHMT demonstrated					

ITEM	STATUS AT THE TIME OF THE CAPACITY ASSESSMENT				REMARKS
	1 Needs urgent attention	2 Needs improvement	3 Good but require some support	4 No need for additional training	
the capacity to supervise the use of health service delivery policies, strategies and guidelines and SOPs?					
24. Has the CHMT demonstrated equity strategies in service provision?					
ADDITIONAL NOTES ON ADMINISTRATION AND HUMAN RESOURCES:					
F. COUNTY HEALTH INFORMATION SYSTEMS					
25. Does the CHMT have the capacity to link and report county data with the DHIS on time?					
26. Does the CHMT have the capacity to provide oversight on data quality assurance?					
27. Does the CHMT have the ability to monitor and evaluate key program performance indicators and use this for planning purposes?					
G. UNIVERSAL HEALTH ACCESS					
28. Has the CHMT demonstrated the capacity to link health (FP/RMNCH/HIV/AIDs/TB, Malaria, Nutrition, water and sanitation) to the other social					

ITEM	STATUS AT THE TIME OF THE CAPACITY ASSESSMENT				REMARKS
	1 Needs urgent attention	2 Needs improvement	3 Good but require some support	4 No need for additional training	
determinants of health					
29. Has the CHMT demonstrated the capacity to and bring the other sectors to dialogue on these social determinants of health?					
H. INNOVATION					
30. Has the CHMT demonstrated to develop/adapt innovations?					
31. Has the CHMT demonstrated to the ability scale innovations in the county?					
32. Has the CHMT demonstrated the ability to harness impacts from these innovations?					
I. Networking, Linkages, collaboration and Partnership building					
33. Has the CHMT demonstrated capacity to hold multi-sectoral stakeholder forum					
34. Has the CHMT demonstrated capacity to coordinate the various sectors aligned to health					
35. Has the CHMT demonstrated capacity to implement the stakeholders resolutions					
Additional notes from Networking, Linkages collaboration and partnership					

ITEM	STATUS AT THE TIME OF THE CAPACITY ASSESSMENT				REMARKS
	1 Needs urgent attention	2 Needs improvement	3 Good but require some support	4 No need for additional training	
J. SUSTAINABILITY					
36. Has the CHMT demonstrated the capacity to sustain their technically competence to deliver the project after its phase out?					
37. Has the CHMT demonstrated the capacity to source for resources to continue finance the programs?					
38. Has the CHMT demonstrated the capacity to continuously create enabling environment to sustain the programs					
Additional notes on sustainability					

SECTION 2: TECHNICAL CAPACITY STATUS ASSESMENT

S/N	DESCRIPTION	RESPONSES (Circle as appropriate)				Remarks
		1 Needs urgent attention	2 Needs improvement	3 Good but require some support	4 No need for additional training	
	A. GOVERNANCE AND LEADERSHIP					
1.	There is a communication plan, and protocols are clearly established to guide the plan.					
	More than 50% of key county staff are aware of the internal communication plan and protocols AND evidence exists of use the plan and protocols more than once a year.					
2.	Evidence of coordination framework that maps out different stakeholders working in the health sector					
	Regular coordination meetings are held between the county and different health actors where key stakeholders have opportunity to present and review health priorities and their contributions toward health goals.					
	All different health actors are fully involved in annual sector performance reviews, county health annual work plan development and in policy development affecting the county					

	population and health services (Partnership Code of Conduct exists).					
d	County health leadership receives regular performance updates in the form of reports from all different health actors.					
3.	The county primary health care system at community level is over 50% funded by county government , with input from the implementing partners					
b	Leadership and ownership of the county primary health care system at community level is held by the county (CHEWs) over 50%, with significant input from development partners for health and implementing partners.					
c	Functionality of community units is over 50% per the reporting rates (MOH515)					
d	Annual accountability platform for reviewing committed funding against results achieved at community level in place.					
Human Resource						
4.	The county develops standard job descriptions for health workers					
b	Harmonized pay system exists (pay structure)					
c	HR policy for staff attraction and recruitment in place.					
d	Incentives for staff retention are in place and effective.					

e	Working conditions attractive and safe, financial and non-financial incentives for rural and hard to reach places are made more attractive and HRH wellness and welfare improved					
5. a	The 2014 National HRH norms, standards and guidelines for conditions of employment, work standards and development of the health work force for staffing of each level of the health system exists.					
b	A system has been developed to track staffing levels and needs,					
c	HRIS monthly updated (upon exit and recruitment).					
d	Staffing data on needs by staffing cadre is being used to advocate for resources to meet staffing gaps.					
6. a	Policies, guidelines or system at the county on staff performance appraisals at all levels of health care management and delivery exists					
b	Staff performance appraisals are conducted as scheduled in the guidelines.					
c	Supervisor performance monitoring is in place					
d	System exists for rewards and sanctions based on performance.					
7. a	System for coordinating in-service training for HRH exists, county					

	coordinates all trainings including those conducted by vertical programs and implementing partners					
b	Training needs assessments conducted and coordinated by the county					
c	Training schedules are fully coordinated/ communicated to all relevant stakeholders					
d	Assessments of the impact of trainings to improve service delivery is conducted annually and feedback used during performance appraisals					
Health information						
8. a	County health department has the national health information system policy and strategy					
	Mentorship program on correct use of HIS forms institutionalized in at least 75% of sub-counties and/or facilities.					
c	Data collection tools systems for all key components are readily available:					
	i source registers					
	ii birth/death registration,					
	iii reporting forms,					
	iv data quality assessment protocol forms,					

	v disease surveillance forms					
d	Sub-counties, facilities and community units have adequate supply					
9. a	County-wide single data collection systems (DHIS2, vital statistics, and disease surveillance) exist; data are routinely collected using standard data collection forms.					
b	County department of health receives timely and complete reports from at least 75% of health facilities (public, private and faith based) i)MOH 731 (HIV)					
	ii)MOH 515 (Community)					
	iii)MOH 710 (Immunization)					
c	County department of health receives accurate reports from more than 75% of health facilities (public, private and faith based)					
d	Health performance data reviewed regularly and regular feedback provided to all health facilities on data accuracy.					
10. a	One Single County preferred Electronic Health Information System platforms (databases) exist at the county for the various components of the HIS,					
b	Data are routinely extracted (at least annually) for use.					
c	Integration of information from other health management systems (i.e., service statistics, financial, human resource, logistics information, and physical assets data systems) is evident.					
d	County Data Management Guidelines exist including policy on health/research data sharing policy.					

11. a	The county analyses available HIS data quarterly and distributes reports containing these analyses to key members of the CHMT, Sub-county HMT, health facilities, county assembly health committee and other state and non-state actors.					
b	Presentations and discussions of data are part of the county health performance review meetings.					
c	The county can identify at least two examples of how data have been integrated into a decision-making process including rational budgeting in the past year.					
	Policy and planning framework (that details national development goals, national health sector priority goals, county health priority goals, county budgetary and donor allocations, and county health development outcomes) exists.					
ACCESS TO PRODUCTS AND COMMODITIES						
12.	A Commodity Security unit/team exists within the county health department representing key service areas and including a community liaison in its membership					
b	Commodity Security Committee's Terms of Reference (TORs) have been documented, are current (within 2 years) and adopted to guide operationalization and implementation of the CS Committee's mandate.					
c	The County Commodity Security Committee structure has been adopted, operationalized and implemented at the sub-county level for all the sub-counties in the county.					
d	Supply chain performance statistics are maintained at county, sub-county and facility levels and reflect improving trends overtime.					
13.a	The county has capacity to estimate commodity needs, and develop a supply plan,					
b	County requires no external technical assistance to estimate commodity needs,					

c	County has capacity to fully procure or source (i.e. buy or secure donations of) essential commodities,					
d	Health commodity procurement done at least once annually					
14.a	The county uses a Health Commodities' LMIS that includes at least two of the four following components: stock keeping record, consumption/usage register, transaction record, and has system for distributing/resupplying these records.					
b	Most staff have been trained in use of the LMIS					
c	Stock on hand within the system and consumption/usage for the past reporting period demonstrates reporting rates of at least 75% from the sub-counties.					
15.a	County has a plan for routine DQA exits, DQA of LMIS data conducted semi annually					
b	Data Quality Improvement Plan for LMIS data developed for every DQA and implemented					
c	The county/sub-county warehouse and health facility store is adequate – meets all four criteria (i.e. large enough, regularly cleaned, dry, well organized) with all special needs storage areas clearly designated with correct signage,					
d	County warehouse has an established re-order and stocking plan, including the use of protocols (such as first expiry, first out), job aides (such as SOP for emergency procurements)					
e	Re-distribution/dispatching/dispensing to sub-counties follows a consistent schedule and/or record maintenance.					

f	Stock-control records such as stock cards and bin cards are well maintained					
COUNTY HEALTH FINANCING						
16. a	The county health budget is developed annually, with input from county health department and other key sectors.					
b	Estimated actual county health expenditures are systematically calculated on an annual basis as part of budget formulation process					
c	Program, surveys and surveillance data used as justification for budget requests					
d	County health budget is at least between 30% - 40% of the overall county government budget.					

Section three

1. What successes/innovations have you experienced in implementing the county health strategic plan with partners in terms of: Governance and leadership 2) Health personnel, 3) Services delivery((HIV/AIDS, TB/HIV, RMNCH, Malaria, Nutrition, Water and Sanitation, 4) Health products and commodities, 5) Health Financing and budgeting, 6, Health information, 7,Social determinants and 8.Networking, linkages collaboration and partnership building
2. Explain the capacity of the county/sub-county is able to sustain the good things/innovation and scale them up after the project IMARISHA by USIAD has ended
3. Describe the training the county teams have gone through since 2012 -2017 and how the trainings have helped the county achieve the planned activities(who went for the training and how many by cadres)
4. What challenges have you experienced in implementing the county health strategic plan with partners in terms of: Governance and leadership 2) Health personnel, 3) Services delivery((HIV/AIDS, TB/HIV, RMNCH, Malaria, Nutrition, Water and Sanitation, 4) Health products and commodities, 5) Health Financing and budgeting, Health information Social determinants and 8.Networking, linkages collaboration and partnership building
5. What must be done different in the new design of the USAID project that will be sustained and transform the health situation in your county

Facility No. N

TOOL 15: HEALTH FACILITY CAPACITY ASSESSMENT TOOL

NAME OF CAPACITY ASSESSOR	
DATE(S) CAPACITY ASSESSMENT CONDUCTED	
REVIEW/APPROVAL BY SUB-TEAM LEADER (STL):	SUB-TEAM LEADER'S NAME: DATE REVIEWED: SUB-TEAM LEADER'S SIGNATURE:

1.0 BACKGROUND

FACILITY IDENTIFICATION		
County	Sub-county	Ward
Facility name: _____ Indicate Codes		
Facility type	01=HOSPITAL 02=HEALTH CENTRE 03=DISPENSARY04=CLINIC 05=NURSING HOME 88=OTHER (SPECIFY)_____	[___|___]
Type of sector (Managing Authority/Ownership)	01=GOVERNMENT/PUBLIC 02=NGO/PRIVATE NOT-FOR-PROFIT 03=PRIVATE -FOR-PROFIT 04=FAITH-BASED/MISSION/CHURCH 88=OTHER (SPECIFY)_____	[___|___]
Urban/Rural	URBAN ……..1 RURAL ……..……2	[___|___]
Facility Services	OUT-PATIENT ……1 IN-PATIENT ……..…….2 BOTH ……..…….3	[___|___]

2.0 GOVERNANCE, MANAGEMENT AND PLANNING

QUESTIONS	**CODING**	**REMARKS**

	CATEGORIES		
2.1 Does the health facility have an organizational chart with all key staff positions?	1=Yes	2=No	
2.2 Does the health facility have a board/health facility management committee?	1=Yes	2=No	
2.4 Does the health facility have a current, written strategic plan?	1=Yes	2=No	
2.5 Does the health facility have a current annual work plan?	1=Yes	2=No	
2.6 Does the health facility have regular Management meetings in this facility?	1=Yes	2=No	
2.7 Does the health facility have minutes from these meetings?	1=Yes	2=No	

3.0 FINANCING

QUESTIONS	CODING CATEGORIES		REMARKS
3.1 Does the health facility have a written finance policy and procedures and applied?	1=Yes	2=No	
3.2 Has the health facility ever received international donor funding (e.g., Global Fund, USAID, DFID, any UN agencies, sub-grants from international NGOs, etc.)?	1=Yes	2=No	LIST ALL DONORS
3.3 Besides the *APHIAplus Imarisha* project, are there other active donor projects?	1=Yes	2=No	
3.4 Does the health facility receive any in-kind support **(**e.g., office space or equipment, materials, supplies)?	1=Yes	2=No	
3.5 Has the health facility undergone annual financial audit?	1=Yes	2=No	
3.6 Does the health facility maintain income/funding and expenditure records?	1=Yes	2=No	
3.7 Does the health facility produce financial reports for donors?	1=Yes	2=No	
	1=Yes	2=No	

4.0 SERVICES

QUESTIONS	CODING CATEGORIES		REMARKS
4.1 Does this facility have the following units?	1=Yes	2=No	
4.1.1 MNCH unit	1=Yes	2=No	
4.1.2 Labour wards	1=Yes	2=No	
4.1.3 TB clinic	1=Yes	2=No	
4.1.4 CCC	1=Yes	2=No	
4.1.5 Lab	1=Yes	2=No	
4.1.6 Malaria unit	1=Yes	2=No	
4.1.7 Nutrition unit	1=Yes	2=No	
4.1.8 Water and Sanitation			
4.2 Does this facility offer the following services?	1=Yes	2=No	
4.2.1 FP	1=Yes	2=No	
4.2.2 ANC	1=Yes	2=No	
4.2.3 PNC	1=Yes	2=No	
4.2.3 Immunization	1=Yes	2=No	
4.2.4 Post Abortion Care (PAC)	1=Yes	2=No	
4.2.5 Maternity	1=Yes	2=No	
4.2.6 TB prevention and treatment	1=Yes	2=No	
4.2.7 EID	1=Yes	2=No	
4.2.8 HIV Testing	1=Yes	2=No	
4.2.9 HIV Care and Treatment	1=Yes	2=No	
4.2.10 VMMC	1=Yes	2=No	
	1=Yes	2=No	
4.2.11 PEP	1=Yes	2=No	
4.2.12 Malaria prevention and treatment			
4.2.13 Nutrition			
4.3 Are there policy and guideline documents for the above service areas?	1=Yes	2=No	
(Confirm physically if the documents listed below are available)	1=Yes	2=No	
	1=Yes	2=No	
4.3.1 FP	1=Yes	2=No	
4.32 ANC	1=Yes	2=No	
4.3.3 PNC	1=Yes	2=No	
4.3.3 Immunization	1=Yes	2=No	
4.3.4 Post Abortion Care (PAC)	1=Yes	2=No	
4.3.5 Maternity	1=Yes	2=No	
4.3.6 TB prevention and treatment	1=Yes	2=No	
4.3.7 EID	1=Yes	2=No	
4.3.8 HIV Testing	1=Yes	2=No	
4.3.9 HIV Care and Treatment	1=Yes	2=No	
4.3.10 VMMC	1=Yes	2=No	
	1=Yes	2=No	
4.3.11 PEP	1=Yes	2=No	
4.3.12 Malaria prevention and treatment			
4.3.13 Nutrition			
4.4 Are there Job aids (Confirm physically			

if the job aids listed below are available (i.e., laminated charts, wall charts, posters, leaflets, etc. appropriately displayed in a visible location) 4.4.1 FP 4.4.2 ANC 4.4.3 PNC 4.4.3 Immunization 4.4.4 Post Abortion Care (PAC) 4.4.5 Maternity 4.4.6 TB prevention and treatment 4.4.7 EID 4.4.8 HIV Testing 4.4.9 HIV Care and Treatment 4.4.10 VMMC 4.4.11 PEP 4.4.12 Malaria prevention and treatment 4.4.13 Nutrition	1=Yes 1=Yes 1=Yes 1=Yes 1=Yes 1=Yes 1=Yes 1=Yes 1=Yes 1=Yes 1=Yes 1=Yes 1=Yes 1=Yes 1=Yes	2=No 2=No 2=No 2=No 2=No 2=No 2=No 2=No 2=No 2=No 2=No 2=No 2=No 2=No 2=No	

5.0 STAFFING

5.1 What is the total number of staff currently working in the MNCH, CCC, VMMC and TB services? (All doctors, nurses and clinical officers including medical officer and clinical officer interns and qualified nurses undergoing post-basic training) [----------]

5.2. Does the Department currently have any unfilled/vacant staff positions? [Y] [N] . If Yes, how many? ----------

5.3 Length the gaps have remained unfilled----------

5.3 Indicate the NUMBER of staff working in the following service delivery points within the Health facility (excluding students)

	STAFF	**FP/MNCH**	**CCC**	**TB**	**MALARIA**
	Medical officers (General practitioners)	[___|___]___]	[___|___]___]	[___|___]___]	[___|___]___]
	Medical officers (Specialists)	[___|___]___]	[___|___]___]	[___|___]___]	[___|___]___]
	Nurse/Midwife	[___|___]___]	[___|___]___]	[___|___]___]	[___|___]___]
	Clinical officers	[___|___]___]	[___|___]___]	[___|___]___]	[___|___]___]
	Counselors	[___|___]___]	[___|___]___]	[___|___]___]	[___|___]___]
	Nutritionists	[___|___]___]	[___|___]___]	[___|___]___]	[___|___]___]
	Pharmacists/ Pharm techs	[___|___]___]	[___|___]___]	[___|___]___]	[___|___]___]

	Lab technicians/ Technologists	[___|___]___]	[___|___]___]	[___|___]___]	[___|___]___]
	Health records officers	[___|___]___]	[___|___]___]	[___|___]___]	[___|___]___]
	Public Health officers/technicians	[___|___]___]	[___|___]___]	[___|___]___]	[___|___]___]
	CHEWs affiliated with facility	[___|___]___]	[___|___]___]	[___|___]___]	[___|___]___]
	CUs affiliated with facility	[___|___]___]	[___|___]___]	[___|___]___]	[___|___]___]

6.0: TRAINING

6.1 Please indicate the total number of staff currently working in the MNCH, CCC and TB units at this facility who have undertaken the relevant training course in the past **12** months? [--------]

	Additional training: Do you have any staff trained on the following areas?	[1] Trained [2] None trained	On job training	Mentorship	Orientation / workshop / seminar	Facility CMEs
		Any trained Staff?	**No. Trained**	**No. Trained**	**No. Trained**	**No. Trained**
	HTS	[1] [2]				
	ART	[1] [2]				
	PMTCT	[1] [2]				
	APOC	[1] [2]				
	TB	[1] [2]				
	VMMC	[1] [2]				
	PEP	[1] [2]				
	Management of puerperal sepsis	[1] [2]				
	Active management of third stage of labor	[1] [2]				
	Management of pre-eclampsia / eclampsia	[1] [2]				
	Manual removal of the placenta	[1] [2]				
	Post abortion care	[1] [2]				
	Assisted vaginal delivery (vacuum extraction)	[1] [2]				
	Newborn resuscitation/ Essential newborn care / Helping Babies Breathe (HBB)	[1] [2]				
	Family planning	[1] [2]				
	Targeted Postpartum Care for the mother	[1] [2]				
	Kangaroo mother care (KMC)	[1] [2]				
	Chlorhexidine cord care	[1] [2]				
	Nutrition	[1] [2]				

7.0 COMMUNITY HEALTH VOLUNTEERS

7.1 Are there any Community Health Volunteers affiliated with this facility? **[Y] [N]**

7.2 What type of services do Community Health Volunteers (CHV) associated with your facility offer? Tick as MENTIONED).

Family Planning,	Immunization,	Well-Baby Care,	TB DOTS,	Health Education,	○
HTS,	Malaria Prevention,	Other (Specify) ----------			

7.3 How many CHVs have been trained to offer the above services? **[All] [Most] [Some] [None**

10.0 INTEGRATION OF SERVICES OFFERRED

10.1 Does this facility offer any of the following client service in any of the location in this facility? **Confirm by checking service provision in each service delivery point. [FOR EACH SERVICE, 'Y' FOR 'YES' OR 'N' FOR 'NO' AS**	**Available at MCH/FP unit**	**Available at Maternity Unit**	**Available in the VCT / CCC/ART clinic**	**Available in the YFC clinic**	**Available in the OPD clinic**
a) Family planning services					
b) Services for the prevention of mother-to-child transmission of HIV (PMTCT)					
c) Adolescent health services					
d) HIV counseling and testing services					
e) HIV & AIDS care and support services, including treatment of opportunistic infections and provisions of palliative care					
f) Nutrition Services					
g) VMMC Services					

11.0. QUALITY IMPROVEMENT

11.1 What quality improvement initiatives have been put in place?	

1. How many times in the last 6 months has a supervisor come to the FP/MNCH, CCC, and TB units for supervisory purposes?	_____ __
2. Is there a Quality improvement team in place	[Y] [N]
3. Are there guidelines for the implementation for the standards	[Y] [N]
4. Has a QI meeting taken place in the quarterly scheduled in the past one year?	
5. What QI topics have been addressed in the past? _____ _____	

12.0 Hygiene and sanitation
Confirm availability of the following through inspections

	MNCH	CCC	TB
Running water	[Y] [N]	[Y] [N]	[Y] [N]
Soap	[Y] [N]	[Y] [N]	[Y] [N]
Disposable Paper Towels	[Y] [N]	[Y] [N]	[Y] [N]
Individual reusable hand towels	[Y] [N]	[Y] [N]	[Y] [N]
Alcohol hand rub/sanitizer	[Y] [N]	[Y] [N]	[Y] [N]
Masks	[Y] [N]	[Y] [N]	[Y] [N]

13.0 How does the facility dispose of waste (Tick all that apply)

Waste Pit	[ ]
Placenta Pit/macerator	[ ]
Functional Incinerator	[ ]
Burning	[ ]
Others (specify)	[ ]

14.0 Sources of power: Indicate the source(s) of power at this facility (Please select **ALL** that are available and FULLY FUNCTIONAL)

a.	Solar power	[ ]
b.	National grid (KPLC)	[ ]
c.	Generator	[ ]
d.	Other (Specify)	[ ]
e.	None	
f.	Is the source of power reliable for use always	[ ]

15.0 Does the Department have a physical office space equipped with office furniture? Related to earlier Equipment

	MNCH	CCC	TB
15.1 Office space	[Y] [N]	[Y] [N]	[Y] [N]
15.2 Furniture	[Y] [N]	[Y] [N]	[Y] [N]

16.0 Communication

16.1 What communication methods are in place in the facility among staff and by departments? (circle all that apply)
[Internet] [Phone] [Social Media Groups] [Others (specify_____)]

17.0 Innovation

17.1 Are the any new innovations that have been generated by the facility? [Y] [N]

17.2 If Yes, list the innovations

_____
_____

17. 3 Have the staff been trained on the new innovations? [Y] [N]

17.4 Have the innovations been used to improve services in the facility? [Y] [N]

17.5 Can these innovations be scaled up? [Y] [N]

17.6 If Yes, please explain

_____
_____
_____

18 Sustainability:

18.1 Does the facility have the relevant technical competency to continue offering the services
[Y] [N]

18.2Is there continuous capacity building
[Y] [N]

18.3 Does the facility have realistic and sustainable budget informed by sound revenue forecasting methods including use of past experience/expenses, development partners for health contributions and projections? [Y] [N]

18.4 All key stakeholders are involved (including county health department, sub-county health administrators, public participation, and as necessary, development partners for health and implementing partners) [Y] [N]

18.5 Is it able to generate financial resources to continue operating beyond the life of the project
[Y] [N]

18.6 The facility has improving financial trends toward sustainability
[Y] [N]

Score: How would you score the facility in the following areas:

Area	Score (%) not 1 to 5 (Best?)
Governance and Planning	
Financing	
Services	
Staffing	
Training	
Community Health Volunteers	

Equipment	
Drugs	
Integration of Services	
Quality Improvement	
Hygiene and Sanitation	
Waste Disposal	
Physical Space	
Communication	
Innovation	
Sustainability	
Overall Score	

Key

- 80% and above = Fully functional (F)
- 50%–79% = Functional (SF)
- 49% and below = Semi-Functional (NF)

TOOL 16: COMMUNITY UNIT CAPACITY ASSESSMENT

- COMMUNITY HEALTH EXTENSION WORKERS (CHEW) QUESTIONNAIRE -

DATE OF ASSESSMENT _____ **Assessors Name** _____

County: _____
Constituency: _____
Ward: _____
Name of the Community Unit: _____
Master Community Unit List Code (MCULCODE) _____
Name of Link Health Facility_____
Number of villages served _____
Estimated number of households in each village: Village 1_____**Village 2**_____ **Village 3**_____
CU Catchment Population _____
CU Supported by USG Yes_____**No**_____

CU FUNCTIONALITY PROFILE-

No.	Parameter	Standard/norm	Scoring instructions	Scores
Process Indicators				
1.	CHEWs recruited and trained	There are two CHEWs attached to the unit and have undergone 5 days orientation on Community Strategy and support supervision	Yes=1 No=0	
2.	CHC recruited and trained	The CHC members (7, 9, 11 or 13 based on population) recruited and have undergone 7 days basic training.(Recruitment and training followed national guidelines)	Yes=1 No=0	
3.	CHVs recruited and trained	CHVS recruited from local community based on population density and have undergone 10 days basic training (Phase 1=5 and Phase 2=5)	Yes=1 No=0	
4.	Technical Updates for CHVs	CHVs provided with technical updates (HIV, TB, Malaria) at least once every 6 months	Yes-1 No=0	
5.	CHVs supplied with CHV kits	A kit per CHV based on content agreed upon by the project and CHMT, guided by the national policy	Yes=1 No=0	
6.	Tools are Available and in use	The MoH 513, 514, 515, community treatment and tracking register, AL RDT register for CHV are available and updated properly.	Yes=1 No=0	
7.	CU supplied with a chalk board (MOH 516)	A chalk board (MOH 516) is available and updated	Yes=1 No=0	
8.	CHVs supplied with referral booklets	A referral booklet per CHVs	Yes=1 No=0	
9.	Reporting CHVs receiving stipend (KES. 2000) or other forms of motivation	CHVs in a CU reporting (using MOH 514)receive 1a monthly stipend of KSHS.2000 based on performance or received seed money and have established an IGA	Yes=1 No=0	

		of their choice		
10.	Means of transport available at the CU for use by CHVs	CU has at least 10 bicycles for use by CHVs as a means of transport.	Yes=1 No=0	
11.	Supervision of CU by CHMT	Supervision of CU by CHMT (at least once every six months)	Yes=1 No=0	
Performance Indictors				
12.	Plan of action available at the CU	CU has a plan of action (check wall or file)	Yes=1 N0=0	
13.	CHCs holding quarterly meetings	CHCs/CHVs holding quarterly meetings to review CU work plan with minutes (check minutes in file)	Yes=2 No=0	
14.	CHVs holding monthly feedback meetings	CHVs holding monthly data review/feedback meetings (check minutes in file)	Yes=1 No=0	
15.	Discuss existence of a sustainability initiative	Discussions held with CHEW, CHC, & CHVs (check reports in the file)	Yes=1 No=0	
16.	Semi Annual Household Mapping	CU conducts household mapping semi-annually (MOH 513 and 516 updated)	Yes-1 No=0	
Cardinal Elements for Basic Functionality				
17.	CHVS Reporting Rate	CHVs reporting rate is over 80% in the CU while the CHEW is reporting at 100%	Yes=1 No=0	
18.	Quarterly community dialogues	Dialogues taking place (check reports from the file)	Yes=1 No=0	
19.	Health Action Days	Takes place each month (check reports from the file)	Yes=1 No=0	
Total Score out of 19				
Percentage (%) Score				
Functionality Categorization				
Rating Score				

Key

- 80% and above = Functional (F)
- 50%–79% = Semi-Functional (SF)
- 49% and below = Non-Functional (NF)

Functionality will be determined by dividing the "yes" totals by the 19 variables*100.

NB: The three (3) cardinal elements (17, 18, 19) MUST all be fulfilled for a for a CU with≥80%

Rates:

4 No need for additional training
3 Good, but requires some support
2 Needs improvement
1 Needs urgent attention

Rating score	Rating Description	Rating %	Comments
4	No need for additional training	**80 and above**	
3	Good, but requires some support	**60–79**	
2	Needs improvement	**50–59**	
1	Needs urgent attention	**1–49**	

TOOL 17: ORGANIZATIONAL CAPACITY ASSSESSMENT

- LOCAL IMPLEMENTING PARTNERS (LIPs) -

F. NAME OF CAPACITY ASSESSOR	
G. DATE(S) CAPACITY ASSESSMENT CONDUCTED	
H. REVIEW/APPROVAL BY SUB-TEAM LEADER (STL):	• SUB-TEAM LEADER'S NAME: • DATE REVIEWED: • SUB-TEAM LEADER'S SIGNATURE:

ABOUT THIS TOOL

This Organizational Capacity Assessment Tool (OCAT) has been adapted for use with community-based organizations (CBOs) and faith-based organizations (FBOs) who have been selected as local implementing partners (LIPs) for the USAID/Kenya East Africa-funded *APHIAplus IMARISHA* Project in Turkana and Samburu.

The tool, which is aligned with the service delivery areas and minimum standards outlined in the Government of Kenya's *Minimum Service Standards for Orphans and Vulnerable Children (OVC) Programs*, provides a rapid assessment of general institutional development issues and in-depth assessment of the program areas outlined in Kenya's minimum service package for OVC.

To elucidate USAID and *APHIAplus Imarisha* implementing partners on key reasons why LIPs have not adopted particular service standards, the OCAT documents the following gaps for each OVC program area:

"Know" =	**Organization is not aware/knowledgeable of the service standard/strategy**
"Staff" =	**Organization has insufficient staff to implement the service/strategy**
"Train" =	**Organization has staff but they are not trained in the service/strategy**
"Fund" =	**Organization has insufficient funds (or suboptimal resource allocation) to implement the service/strategy**

The OCAT will also generate data related to the following *APHIAplus IMARISHA* project performance indicators:

8. OVC school enrollment by gender
9. OVC school attendance by gender
10. OVC school progression by gender
11. Proportion of vulnerable OVC households actively participating in community-based household economic strengthening (HES) groups by wards
12. Percentage of functional HES groups by wards
13. Improved financial, managerial and technical capacity of indigenous organizations serving social and health needs of marginalized, poor and underserved populations

The Annex includes an illustrative list of other indicators that will be gleaned from the *APHIAplus IMARISHA* OCAT and presented in the Evaluation report.

Contents

CHECKLIST, KEY DOCUMENTS TO FACILITATE COMPLETING THE OCAT

The OCAT is not based solely on verbally reported information; it requires verifying evidence. Assessors are advised to request each organization to organize any existing documents such as the following to facilitate the assessment process. Organizing those documents in advance of the assessment visit is strongly encouraged.

- ☐ Vision statement, mission statement
- ☐ Organizational chart or description of the staffing patterns
- ☐ Recent board meeting minutes
- ☐ Strategic plan
- ☐ Work plan/plans
- ☐ Monitoring and Evaluation (M&E) Plan
- ☐ Quarterly budgets for the past one year
- ☐ Recent audit report
- ☐ Organization's financial policies and procedures manual
- ☐ Financial report and financial monitoring tools
- ☐ Procurement policies, plans, and files; payment vouchers; approvals
- ☐ Progress technical reports: quarterly/annual
    1. Evaluation reports
    2. Donor feedback on reports

I. ORGANIZATIONAL PROFILE

1. Name of the organization		
2. Year of registration		
3. County of operation		
4. Type of organization(Circle One)	1.	Non-governmental organization (NGO)
	2.	Community-based organization (CBO)
	3.	Faith-based organization (FBO)
	4.	PLWHA support group
	5.	Self-help group/Association
	6.	Other (specify)_____
5. Total number of sub-counties covered by the organization (including but not limited to those covered by the *APHIAplus Imarisha* project)		
6. Total number of wards covered by the organization (including but not limited to those covered by the *APHIAplus Imarisha* project)		
7. Total number of wards where the organization will be implementing *APHIAplus Imarisha* project activities		
8. Number of vulnerable households served by the organization in the past		

12 months		
9. Number of orphans and vulnerable children (OVC) served by the organization in the past 12 months		
10. Forms of OVC support provided by the organization *(Circle all that apply)*	A.	Food & nutrition
	B.	Health
	C.	Education & vocational training
	D.	Psychosocial support
	E.	Shelter & care
	F.	Child protection
	G.	Household economic strengthening
	H.	Coordination of care
	I.	Capacity building
	J.	OTHER (Specify): _____
11. Total operating budget (in KSH) for the current financial year {*SPECIFY Start and End month for the organization's financial year, e.g., July 2015-June 2016*}		
12. Total number of FULL-TIME staff working for the organization		
13. Total number of PART-TIME staff working for the organization		
14. Total number of VOLUNTEERS working for the organization		
15. Total number of staff whose salaries were supported using *APHIAplus IMARISHA* project funds		
16. **CONTACT DETAILS FOR THE ORGANIZATION**: **a. Name of primary point of contact:**		

b. Position of primary point of contact:

c. Organization's physical address:

d. Organization's mailing address:

e. Telephone number(s):

f. Email address:

g. Website/URL:

II. GENERAL ASSESSMENT OF INSTITUTIONAL DEVELOPMENT

ITEM	STATUS AT THE END-OF-PROJECT CAPACITY ASSESSMENT				REMARKS
	(0) NO (Does not exist)	(1) YES, but not seen/verified	(2) YES, seen/verified	(9) NOT APPLICABLE	
K. GOVERNANCE, LEADERSHIP AND MANAGEMENT					
39. Does the organization have an **organizational chart** with all key staff positions reflecting the mandate for OVC support?					
40. Does the organization have **written** strategy with clear vision and mission statements?					
41. Does the organization have a written **constitution or bylaws**?					
42. Does the organization have an effective management structure in place?					
43. Does the organization have a **board/executive committee**?					

ITEM	STATUS AT THE END-OF-PROJECT CAPACITY ASSESSMENT				REMARKS
	(0) NO (Does not exist)	(1) YES, but not seen/verified	(2) YES, seen/verified	(9) NOT APPLICABLE	
44. Does the organization have clear policies that guide the management and interrelationship between the different internal governance organs i.e. staff, management, Board and target OVCs?					
ADDITIONAL NOTES ON GOVERNANCE, LEADERSHIP AND MANAGEMENT:					
L. PLANNING					
45. Does the organization have a current, written **strategic plan**?					
46. Does the organization have a current **annual work plan**?					
47. Is the annual **work plan costed and effectively implemented?**?					

ITEM	STATUS AT THE END-OF-PROJECT CAPACITY ASSESSMENT				REMARKS
	(0) NO (Does not exist)	(1) YES, but not seen/verified	(2) YES, seen/verified	(9) NOT APPLICABLE	
ADDITIONAL NOTES ON PLANNING:					
M. FINANCE					
48. Does the organization have a full-time **Finance Manager/Officer**?					
49. Does the organization have at least one **bank account** registered in the organization's name?					
50. Does the organization have a written **finance policy and procedures**?					
51. Has the organization ever received **international donor funding** (e.g., Global Fund, USAID, DFID, any UN agencies, sub-grants from international NGOs, etc.)?					
52. Does the organization receive any **in-kind support (**e.g., office space or equipment, materials, supplies)?					
53. Has the organization undergone					

ITEM	STATUS AT THE END-OF-PROJECT CAPACITY ASSESSMENT				REMARKS
	(0) NO (Does not exist)	(1) YES, but not seen/verified	(2) YES, seen/verified	(9) NOT APPLICABLE	
routine **financial audit** in the last two years?					
54. Does the organization maintain **income/funding and expenditure records**?					
55. Does the organization have a **written procurement policy and procedures**?					
56. Is there more than 1 category of signatories with clear authorization and limits?					
ADDITIONAL NOTES ON FINANCE:					
N. GRANTS MANAGEMENT					
57. Does the organization develop and submit **proposals for funding**?					
58. Has the organization received funding for at least one **successful proposal** in the last two years?					

ITEM	STATUS AT THE END-OF-PROJECT CAPACITY ASSESSMENT				REMARKS	
	(0) NO (Does not exist)	(1) YES, but not seen/verified	(2) YES, seen/verified	(9) NOT APPLICABLE		
59. Does the organization **produce financial reports** for donors?						
60. Besides the *APHIAplus Imarisha* project, are there **other active donor projects**?						
61. Record details on all **active projects**, including *APHIAplus Imarisha* in the space provided.	***Project description***			***Donor***	***Project start/ end dates***	***Budget*** *(specify KSH or USD)*

ITEM	STATUS AT THE END-OF-PROJECT CAPACITY ASSESSMENT				REMARKS
	(0) NO (Does not exist)	(1) YES, but not seen/verified	(2) YES, seen/verified	(9) NOT APPLICABLE	
ADDITIONAL NOTES ON GRANTS MANAGEMENT:					
E. ADMINISTRATION AND HUMAN RESOURCES					
62. Does the organization have its **own child protection policy?**					
63. Does the organization have a written **Human Resource (HR) manual/policy**?					
64. Does the organization have **written job descriptions** for all positions?					
65. Does the organization currently have any **unfilled/vacant staff positions** in the organogram?					
66. Does the organization have a **physical office space** equipped with office facilities??					
67. Does the organization have at least one **working computer and printer**?					
68. Does the organization have reliable power supply in any one week?					

ITEM	STATUS AT THE END-OF-PROJECT CAPACITY ASSESSMENT				REMARKS
	(0) NO (Does not exist)	(1) YES, but not seen/verified	(2) YES, seen/verified	(9) NOT APPLICABLE	
69. Do all key positions within the organization have capacity to communicate regularly?					
ADDITIONAL NOTES ON ADMINISTRATION AND HUMAN RESOURCES:					

III. ASSESSMENT OF TECHNICAL CAPACITY

A. Food security and Nutrition

The following are used in the table to highlight key reasons why the LIP is not pursuing particular service standards:

Know = Organization is not aware/knowledgeable of the service/strategy

Staff = Organization has insufficient staff to implement this service/strategy

Train = Organization has staff but they are not trained in this service/strategy

Fund = Organization has insufficient funds (or suboptimal resource allocation) to implement the service/strategy

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
1. Does the organization conduct on-going assessment of the target community's food and nutrition needs?	a. Organizing **forums** to discuss and gauge the **community's food and nutrition needs**							
	b. **Mobilizing and sensitizing the community** on the importance of proper food and nutrition							
	c. Conducting on-going **household needs assessments** from a representative sampling of households							
	d. Establishing **feedback mechanisms** within the community to monitor the community's needs							

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
2. Does the organization conduct mapping and linking of stakeholders and resources available for food and nutrition support?	a. Conducting **mapping**							
3. Does the organization promote knowledge on nutrition for OVC, their households, and the community?	a. Establishing **mechanisms to promote good nutritional practices** among OVC and their families							
	b. Educating and creating community **awareness on nutrition** through use of media, public meetings, and information sessions, etc.							
4. Does the organization provide targeted food and nutrition interventions for OVCs and their households?	a. Providing **food support** for OVC households without access to adequate food supplies							
	b. Enabling OVC households to access **micronutrient supplementation**							
	c. **Creating linkages and referrals systems for OVC requiring specialized** or emergency food and nutrition support							
5. Does the organization aid in increasing access to nutritious food by OVC and their households?	a. Encouraging OVC and their households to **diversify food production**							
	b. Linking OVC and their households to **livelihoods? programs**							
	c. Building OVC and their household capacity on proper **food production, food budgeting, storage, and**							

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
	preservation							

B. Education and Vocational Training

The following are used in the table to highlight key reasons why the LIP is not pursuing particular service standards:

Know = Organization is not aware/knowledgeable of the service/strategy

Staff = Organization has insufficient staff to implement this service/strategy

Train = Organization has staff but they are not trained in this service/strategy

Fund = Organization has insufficient funds (or suboptimal resource allocation) to implement the service/strategy

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
1. Which of the following forms of OVC education support does your organization offer?	a. Ensuring a **safe school** environment and **completion** of primary education							
	b. Promoting access to early childhood development (ECD) programs							
	c. Creating **child-friendly and HIV/AIDS non-discrimination and gender-sensitive** learning spaces							
	d. Strengthening **community-school relationships**							
	e. The transition **for girls from**							

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
	primary to secondary school							
	f. Market-driven vocational training							
2. Does the organization develop and implement appropriate mechanisms that address educational barriers?	a. Holding **community forums** with stakeholders to identify OVC who do not attend school and document reasons for non-attendance/drop out							
	b. Collecting data on household and other barriers to education							
	c. Conducting **site visits** to schools to monitor OVC attendance							
3. Does the organization ensure non-discriminatory, comprehensive education and training to OVCs?	a. Visiting schools to monitor **age- and gender appropriateness** of efforts that promote educational progress of OVC							
	b. Develop **written agreements** with participating schools and institutions creating clear roles and responsibilities in provision of education and training support for OVCs							
	c. **Involving OVCs**, caregivers and other stakeholders in conducting a market assessment to inform vocational training opportunities for OVCs							
	d. Establishing **referral mechanisms** to ensure							

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
	appropriate, comprehensive and continued educational and vocational support to OVC							
4. Does the organization mobilize and sensitize the community, especially key stakeholders, to support age-appropriate education and training for OVCs?	a. Encouraging education and training institutions to enhance their support for **continuity of education for OVC**							
	b. Holding meetings with community members to create awareness of the educational needs and rights of OVC							
	c. **Discuss the importance of education with OVC** and the members of their households, especially caregivers, and emphasis the importance of educating both boys and girls equally							

C. Health

The following are used in the table to highlight key reasons why the LIP is not pursuing particular service standards:

Know = Organization is not aware/knowledgeable of the service/strategy

Staff = Organization has insufficient staff to implement this service/strategy

Train = Organization has staff but they are not trained in this service/strategy

Fund = Organization has insufficient funds (or suboptimal resource allocation) to implement the service/strategy

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
1. Does the organization aid in assessing the health needs, services and costs for OVCs and their households?	a. **Identifying common** health problems in the community							
	b. Developing an assessment tool and using it to identify and assess the health needs of OVC and their households							
2. Does the organization enhance access to HIV prevention, treatment, care and support for OVC through the following?	a. **Training service providers** on HIV prevention, behavior change communication, life skills and adolescent sexual reproductive health							
	b. **Promoting HIV counseling and testing for OVC**, in partnership with the Ministry of Health							
	c. Formation **of age-specific peer clubs**							
	d. **Providing treatment literacy and ART adherence support interventions** to community health workers, caregivers and HIV+ OVCs							

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
	e. Formation of **HIV support groups**							
	f. **Collaborating with other HIV prevention** programs to create age-specific messages							
	g. **Identifying HIV-positive OVCs** and OVC at risk of HIV and linking them to appropriate care and treatment services							
3. Does the organization aid in prevention of childhood illness in OVC, as per the Kenya Essential Package for Health (KEPH)?	a. **Educating and sensitizing parents, caregivers,** and older OVCs on health prevention/promotion needs of OVC							
	b. **Sensitizing CHVs and OVC committee** members on the health prevention/promotion needs of OVCs							
4. Does the organization enhance access to appropriate curative services for OVC and their households through	a. **Training community health workers** and caregivers on addressing curative health needs of OVCs							
	b. **Referring sexually abused children** to the MOH or other appropriate							

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
	service providers for clinical and psychosocial management and follow-up to ensure service is provided							
5. Does the organization promote safe water, hygiene and sanitation practices in their target communities and in OVC households	a. **Conducting household assessments** to determine the current access to safe water and sanitation practices							
	b. **Conducting community** education on use of safe practices, including handwashing with soap, use of latrines, boiling drinking water and proper waste disposal							
	c. **Creating access** points to safe and clean water for OVC and their households							
	d. **Discuss with the girl OVCs** and their caregivers about proper female hygiene during menstruation							

D. Psychosocial Support

The following are used in the table to highlight key reasons why the LIP is not pursuing particular service standards:

Know = Organization is not aware/knowledgeable of the service standard/strategy

Staff = Organization has insufficient staff to implement this service/strategy

Train = Organization has staff but they are not trained in this service/strategy

Fund = Organization has insufficient funds (or suboptimal resource allocation) to implement the service/strategy

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
1. Does the organization conduct community mobilization and sensitization activities to create awareness of psychosocial needs of OVC and their households through the following?	a. Participating in **community forums,** including national and international days, to inform the community on Psychosocial Support Services (PSS) for care on OVC							
	b. Providing **guidance to community health workers, service providers** and caregivers on provision of PSS to OVC							
	c. **Conducting participatory PSS** awareness and education sessions for the community, particularly in schools, clinics and other places frequented by OVC							

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
2. Does the organization build the capacity of OVC to recognize, understand, meet and obtain their PSS needs through the following?	a. Providing **platforms for OVCs** to express their needs and ideas, and documenting their responses in order to find relevant support services							
	b. Distributing **information** and ensuring OVC know where and how to access PSS services							
	c. Formation of **peer PSS** groups through schools or community							
3. Does the organization strengthen community and household capacities to provide PSS to OVC and their caregivers?	a. Conducting **PSS needs** assessments among community PSS providers to identify gaps and determining training needs							
	b. Creating an **inventory** of current PSS providers which could be useful in working with OVC							
	c. Providing **on-going support and mentorship** for caregivers and home visitors engaged in provision of PSS							

E. Child Protection

The following are used in the table to highlight key reasons why the LIP is not pursuing particular service standards:

Know = Organization is not aware/knowledgeable of the service standard/strategy

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Fund = Organization has insufficient funds (or suboptimal resource allocation) to implement the service/strategy

***NOTE TO ASSESSORS: A number of child protection linkages are explored in the HES and Linkages section of this tool. As a result, they are not included in the following table on child protection.

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
1. What is the organization's capacity to educate OVC, caregivers and the target communities on child rights, responsibilities and child protection?	a. **Educating caregivers and stakeholders** on their roles in child protection.							
	b. Holding **forums** to sensitize the community and OVC on **gender-based violence prevention** and what action to take if GBV is observed or suspected.							

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
	c. **Training** children and stakeholders **on child rights**.							
2. What is the organization's capacity to strengthen the capacity of households and local community structures to enhance OVC protection and maximize utilization of available resources?	a. Facilitating **alternative family care for OVC** in need of care and protection (safe places etc.).							
	b. Training caregivers on how to **recognize signs of abuse**.							
	c. Educating the caregivers on their roles in **holding protection services accountable to children**.							
	d. Training members of existing **community structures** such as AAC, Volunteer Children's Officers **in identifying, reporting and investigating** child rights **abuses.**							
	e. **Knowledge of Child Helpline** services for reporting cases of child abuse.							
3. What is the organization's capacity to support the OVC and caregivers to participate in matters affecting them?	a. Ensuring **children know how to report an abuse and find protection** services.							
	b. Establishing **mechanisms**, such as children advisory groups, **to support children's participation** in protection.							
	c. **Disseminating national guidelines on child participation** through forums and community events.							

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
4. What is the organization's capacity to strengthen partnerships and linkages to ensure case management, law enforcement and appropriate referrals and monitoring systems?	a. **Keeping track of existing child protection service** providers at points of service delivery.							
5. What is the organization's capacity to support OVC with special needs e.g. disability?	a. **Link OVCs with special needs** to **social safety nets**.							
	b. Link OVCs with special needs to **rehabilitative/reintegration services**.							
	c. **Provide and linkage for services/support** to address their disability needs.							
6. What is the organization's capacity to support highly vulnerable OVC households to benefit from social support services?								
7. What is the organization's capacity to promote positive	a. Sensitize parents/caregivers on **positive parenting**.							

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
parental/family care and child stimulation?								
	b. Organize **fun/play days** for OVC							

F. Household Economic Strengthening (HES) and Linkages

Name the main household economic strengthening (HES) strategies that are implemented by the organization (can include multiple responses); specify the geographic coverage

Household Economic Strengthening (HES)	☐ No	☐ Yes		**If yes, note the no. of wards**
		Link with other service providers	**Direct support**	
1. **Linkages with Government Service Sector** The organization provides linkage to the following:				
a. To government **OVC Cash Transfer** Program (OVC-CT)				
b. To National Hospital Insurance Fund **(NHIF)** (Share M.O.U, enrolled nos.)				
c. To social safety net programs such as **Local Authorities Trust Fund/CDF**				

d. **Youth Empowerment** Centers				
2. Provide One-time **Asset Transfer** (i.e., pregnant goats for milk, hens for eggs)				
3. **Savings Groups Plus** (SG+) for youth and adults (SILC, VSL, SACCOs, table banking, self-managed financial services including savings and loans, micro-insurance, and Most Vulnerable Children Funds)				
4. Support **Self-help Groups**				
5. OVC Linkages to Health Services a. **Track referrals** of OVCs and/or their household members to health facilities				
b. Monitor/follow up status of those referrals to ensure continuum of care				
6. OVC Linkages to Food and Nutrition a. Training in **agribusiness, value addition, and linkages** to markets				
b. Form producer market groups or link with micro-consignment opportunities				
c. Promote **family-focused approach** to health and nutrition through linkages to ECD and school-based feeding				
7. OVC Linkages to Education &Vocational Training				
a. Community-Based Enterprise Development training—**Basic financial literacy**)				
b. **Collaboration with existing education** and training resources to create opportunities for OVC				
8. OVC Linkages to Child Protection a. Assist with **birth registration and legal identity cards**				
b. Strengthening the **linkage between the formal and the informal** child protection systems				
c. **Networking** with other child protection organizations				

d. **Linking with Department of Children's Services** to ensure grassroots implementation of child safeguarding policies				
e. **Facilitate succession planning**(e.g., inheritance, will writing)				
f. **Are any of the organization's staff members of the local Area Advisory Council** (AAC)?				
g. **Link with the legal protection** mechanisms for OVCs through the provision of legal services				
9. OVC Linkages to Psychosocial Support Services (PSS) a. Connect **child-headed households** with role models/mentors (home visit)				
b. Making **referrals and follow ups on all PSS services**				
c. Others specify: _____				

G. Shelter and Care

The following are used in the table to highlight key reasons why the LIP is not pursuing particular service standards:

Know = Organization is not aware/knowledgeable of the service standard/strategy

Staff = Organization has insufficient staff to implement this service/strategy

Train = Organization has staff but they are not trained in this service/strategy

Fund = Organization has insufficient funds (or suboptimal resource allocation) to implement the service/strategy

KENYAN SERVICE	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT

STANDARD		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
1. What is the organization's capacity to conduct household needs assessments to determine and support appropriate community shelter and care initiatives for OVC households?	a. Identifying **knowledge, skills and attitude gaps related to shelter and care** provision for OVC households							
	b. Periodically **monitoring progress** on improved shelter and care in identified households							
2. What is the organization's capacity to link stakeholders to resources available to support OVC shelter and care?	a. Keeping an **inventory of services and resources** to provide shelter and care support to OVCs and their families							
	b. Hold and participate in **consultative meetings with stakeholders** to determine **mechanisms** and procedures for providing OVC shelter and care							

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
3. What is the organization's capacity to sensitize the community and households on the importance of OVC receiving regular and loving care from adults?	a. Holding community sensitization meetings to **reduce stigmatization** of OVC							
	b. Conducting **regular monitoring of OVC family/living environment** to ensure the OVCs are being properly cared for and protected.							
	c. Facilitating **after-care services t**hat enable OVC to be integrated into the community							
4. What is the organization's capacity to facilitate community and stakeholders implementation of shelter initiatives to support OVC households?	a. Provide training on basic **skills to construct and maintain shelters to child needs standards**							
	b. **Train OVC and**							

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
	caregivers with knowledge and skills on the needs of OVC regarding shelter, including **safe structure, clean toilet facilities**							
	c. Establish **linkages** with income-generating activities, religious organizations and community groups to help maintain shelter for OVC							
	d. Mobilize community members to **commit funds** and/or support for the renovation of needy OVC households							

H. Coordination of Care

The following are used in the table to highlight key reasons why the LIP is not pursuing particular service standards:

Know = Organization is not aware/knowledgeable of the service standard/strategy

Staff = Organization has insufficient staff to implement this service/strategy

Train = Organization has staff but they are not trained in this service/strategy

Fund = Organization has insufficient funds (or suboptimal resource allocation) to implement the service/strategy

KENYAN SERVICE STANDARD	KEY STRATEGIES	STATUS AT TIME OF ASSESSMENT						
		YES	IF YES, verifying evidence	NO	IF NO, why?			
					Know	Staff	Train	Fund
1. What is the organization's capacity to Establish and maintain national directory of service providers for the care of the OVC informed by local level database?	a. Conduct local **mapping** of OVC services and service providers							
	b. Ensure that the **local database** maintained by the organization is **linked with county/national databases** of all OVC services and service providers							
	c. **Update service** and service provider databases as needed d. **Participate in formal key forums for OVC welfare**							
2. What is the organization's capacity to Establish and strengthen new coordination units for the integration and harmonization of OVC service provision at all levels to avoid duplication and encourage								

prudent utilization of resources?								

I. Monitoring, Evaluation and Knowledge Management

KENYAN SERVICE STANDARD	CORE ASPECT OF CAPACITY	YES	NO	COMMENTS
M & E Focal Person 1. Does the organization have human resources for M&E?	a. There is **at least one staff person** responsible for M&E.			
	b. There are **written job descriptions for all M&E staff**.			
	c. M&E staff have **training or formal education in M&E**(or M&E related disciplines such as statistics, information systems)			
	d. The organization has a clear **plan to strengthen the M&E capacity** of its staff.			
	e. There is M&E-related, in-service **training and mentoring** of staff			
M&E Plan **2.** Does the organization have a monitoring and evaluation plan?	a. The organization has a **written M&E plan**.			
	b. The M&E plan is **linked to** the organization's **strategic plan**.			
	c. The M&E plan **includes measurable OVC-related indicators**.			
Data Collection and Data Management **3.** Does the	a. The organization has **data collection tools** to capture OVC data.			
	b. The organization has **standard reporting formats** to summarize and present OVC data.			

KENYAN SERVICE STANDARD	CORE ASPECT OF CAPACITY	YES	NO	COMMENTS
organization collect routine data as stipulated in the M&E plan?	c. The organization has documented **data flow** between implementation level and management level. d. The Organisation has OVC based and led M&E and Learning.			
Evaluation **4.** Does the Organization evaluate its OVC activities?	a. The organization's **OVC program activities have been evaluate**d within the past two years			
	b. Through **linkages/partnerships** with other entities, the organization has access to evaluation expertise, when needed.			
	c. The organization **has presented findings or results from its programs** at meetings of key stakeholders, conferences or forum for dissemination within the past two years.			
Data Quality Assurance 5. Does the organization conduct Supervision data quality assessment or audit?	a. There are mechanisms to check the **accuracy of the organization's OVC data**.			
	b. **Routine supervision** of program activities **includes data review**.			

I. Knowledge Management/Learning

SERVICE STANDARD	CORE ASPECT OF CAPACITY	YES	NO	COMMENT

1. Does the organization use a database to support its implementation and M&E of OVC activities?	a. The organization maintains an OVC Longitudinal Management Information System **(OLMIS)** database.			
	b. IF YES: Does the organization's OLMIS **link to the county/national OLMIS database?**			
	c. The organization maintains a Child Protection Management Information System **(CPMIS**) database.			
	d. IF YES: Does the organization's CPMIS **link to the county/national CPMIS database?**			
2. Does the organization have capacity related to data reporting and use?	a. Does the organization produce **program reports**?			
	b. IF YES: Does the organization produce those reports at least on a quarterly basis?			
	c. Who are the **recipients** of your OVC reports?			
	• Ministry of Labour and Social Services			
	• Ministry of Health			
	• Ministry of Education			
	• Children's Department/MOGSD			
	• Other Government ministries (Specify in remarks column)			
	• Donors (international or local)			
	c. Does the organization **receive feedback** on any of the reports submitted to the above entities?			
3. Does the organization have the capacity to identify and document learning and promising/best practices?	a. Has the organization ever **written a case study** or documented a success story on a particular OVC or OVC caregiver/household (or group of OVCs/OVC households)?			
	b. Does the organization **share its learning or best practices** with other CBOs/FBOs?			

	(Specify forum in remarks column)			
4. How is the organization using its evidence to improve and/or inform its work?	a. What information or data does the organization use to target OVCs and their households in the community?			
	b. How does the organization **use data** to improve its existing work (interventions)?			

- Number/percentage of LIPs with a written M&E plan that includes measurable OVC-related indicators
- Number/percentage of LIPs that produce OVC program reports at least quarterly
- Number/percentage of LIPs with demonstrated use of evidence to inform their OVC targeting, intervention design, and/or program improvement

ANNEX 4: HEALTH FACILITY CAPACITY ASSESSMENT

SERVICE AVAILABILITY			
	Hospital	**Health Centre**	**Dispensary**
Service Availability			
Family Planning	3 (100%)	9 (81.8%)	2 (66.7%)
Antenatal Care	3 (100%)	11 (100%)	2 (66.7%)
Postnatal Care	3 (100%)	11 (100%)	2 (66.7%)
Immunization	3 (100%)	11 (100%)	2 (66.7%)
Post Abortion Care (PAC)	3 (100%)	9 (81.8%)	1 (33.3%)
Maternity	3 (100%)	11 (100%)	1 (33.3%)
TB Prevention & Treatment	3 (100%)	11 (100%)	3 (100%)
EID	3 (100%)	11 (100%)	3 (100%)
HIV Testing	3 (100%)	11 (100%)	3 (100%)
HIV Care & Treatment	3 (100%)	10 (90.9%)	3 (100%)
VMMC	3 (100%)	6 (54.5%)	0 (0.0%)
Post-Exposure Prophylaxis (PEP)	3 (100%)	11 (100%)	3 (100%)
Malaria Prevention & Treatment	3 (100%)	11 (100%)	3 (100%)
Nutrition	3 (100%)	11 (100%)	3 (100%)

AVAILABILITY OF POLICY AND GUIDELINES ON			
	Hospital	**Health Centre**	**Dispensary**
Family Planning	3 (100%)	9 (81.8%)	1 (33.3%)
Antenatal Care	3 (100%)	10 (90.9%)	2 (66.7%)
Postnatal Care	2 (66.7%)	7 (63.6%)	2 (66.7%)
Immunization	3 (100%)	10 (90.9%)	2 (66.7%)
Post Abortion Care (PAC)	2 (66.7%)	7 (63.6%)	1 (33.3%)
Maternity	3 (100%)	10 (90.9%)	1 (33.3%)
TB Prevention & Treatment	3 (100%)	11 (100%)	3 (100%)
EID	3 (100%)	8 (72.7%)	3 (100%)
HIV Testing	3 (100%)	11 (100%)	3 (100%)
HIV Care & Treatment	3 (100%)	9 (81.8%)	3 (100%)
VMMC	2 (66.7%)	5 (45.4%)	0 (0.0%)
Post-Exposure Prophylaxis (PEP)	3 (100%)	10 (90.9%)	2 (66.7%)
Malaria Prevention & Treatment	3 (100%)	10 (90.9%)	3 (100%)
Nutrition	3 (100%)	11 (100%)	3 (100%)

AVAILABILITY OF JOB AIDS ON	Hospital	Health Centre	Dispensary
Family Planning	3 (100%)	10 (90.9%)	1 (33.3%)
Antenatal Care	3 (100%)	10 (90.9%)	1 (33.3%)
Postnatal Care	2 (66.7%)	8 (72.7%)	1 (33.3%)
Immunization	2 (66.7%)	10 (90.9%)	2 (66.7%)
Post Abortion Care (PAC)	2 (66.7%)	8 (72.7%)	0 (0.0%)
Maternity	3 (100%)	10 (90.9%)	0 (0.0%)
TB Prevention & Treatment	3 (100%)	10 (90.9%)	1 (33.3%)
EID	2 (66.7%)	9 (81.8%)	0 (0.0%)
HIV Testing	3 (100%)	10 (90.9%)	2 (66.7%)
HIV Care & Treatment	2 (66.7%)	6 (54.5%)	2 (66.7%)
VMMC	2 (66.7%)	6 (54.5%)	0 (0.0%)
Post-Exposure Prophylaxis (PEP)	2 (66.7%)	9 (81.8%)	2 (66.7%)
Malaria Prevention & Treatment	3 (100%)	11 (100%)	2 (66.7%)
Nutrition	3 (100%)	11 (100%)	3 (100%)

STAFF TRAINING

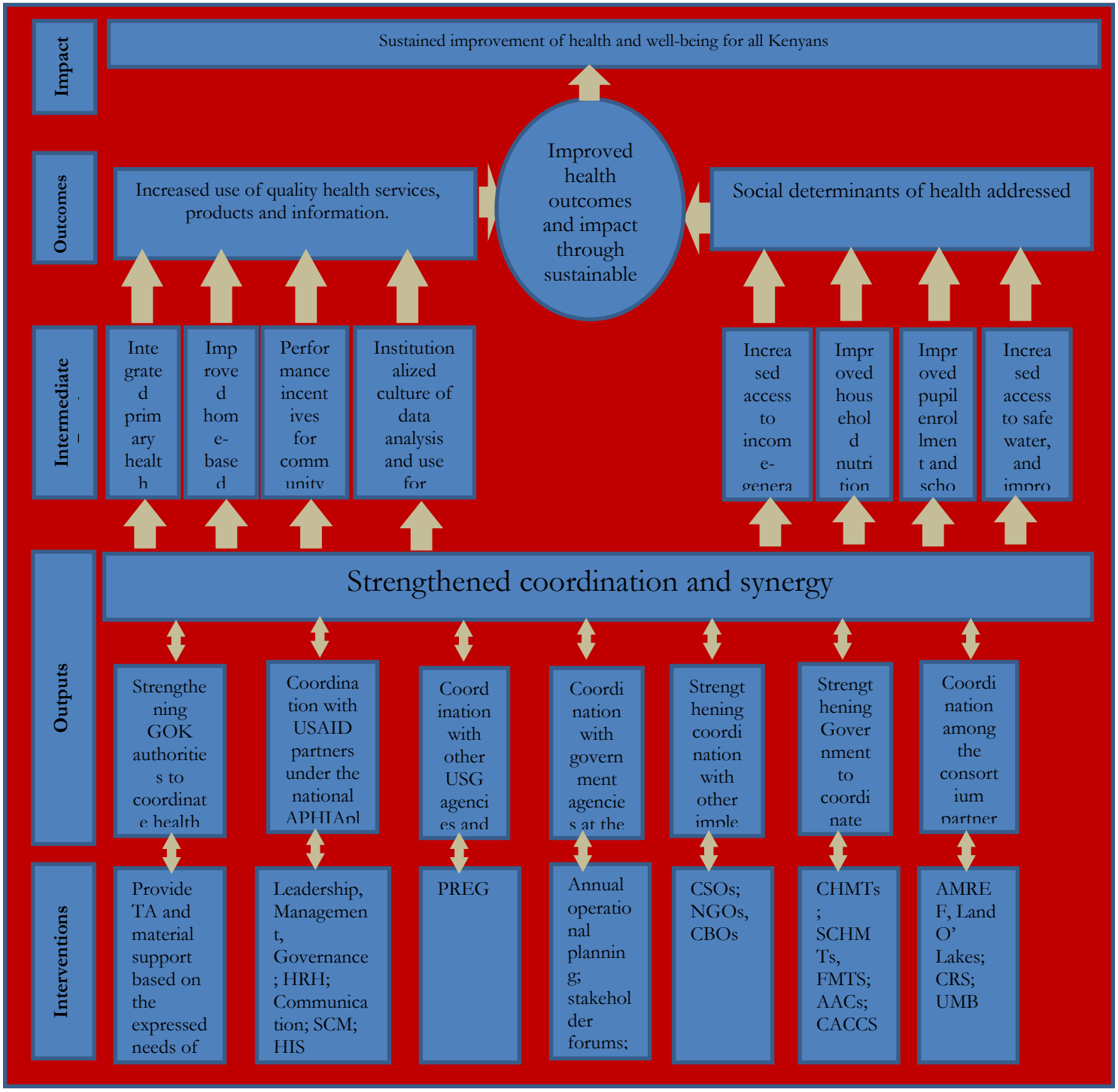
	Hospital	Health Centre	Dispensary
Training			
HTS	3 (100%)	7 (63.6%)	3 (100%)
ART	3 (100%)	6 (54.5%)	3 (100%)
PMTCT	3 (100%)	5 (45.4%)	1 (33.3%)
APOC	2 (66.7%)	1 (9.1%)	0 (0.0%)
TB	3 (100%)	4 (36.4%)	1 (33.3%)
VMMC	2 (66.7%)	2 (18.2%)	0 (0.0%)
PEP	3 (100%)	8 (72.7%)	2 (66.7%)
Management of puerperal sepsis	3 (100%)	7 (63.6%)	1 (33.3%)
Active management of third stage of labor	3 (100%)	7 (63.6%)	1 (33.3%)
Management of pre-eclampsia/eclampsia	3 (100%)	8 (72.7%)	1 (33.3%)
Manual removal of the placenta	3 (100%)	8 (72.7%)	1 (33.3%)
Post abortion care	3 (100%)	7 (63.6%)	1 (33.3%)
Assisted vaginal delivery (vacuum extraction)	3 (100%)	8 (72.7%)	1 (33.3%)
Newborn resuscitation/ Essential newborn care/ Helping Babies Breathe (HBB)	3 (100%)	8 (72.7%)	1 (33.3%)
Family Planning	3 (100%)	8 (72.7%)	1 (33.3%)
Targeted Postpartum Care for the mother	2 (66.7%)	6 (54.5%)	1 (33.3%)
Kangaroo mother care (KMC)	3 (100%)	8 (72.7%)	1 (33.3%)
Chlorhexidine cord care	2 (66.7%)	7 (63.6%)	1 (33.3%)
Nutrition	3 (100%)	8 (72.7%)	3 (100%)

QUALITY IMPROVEMENT

	Hospital	Health Centre	Dispensary
Average number of times (in the last 6 months) a supervisor has come to the FP/MNCH, CCC, and TB units for supervision	1.7	2.3	4
QI team in place	3 (100%)	6 (54.5%)	2 (66.7%)
Availability of guidelines for the implementation of QI standards	3 (100%)	8 (72.7%)	2 (66.7%)
QI meeting taken place in the quarterly scheduled in the last one year	3 (100%)	6 (54.5%)	2 (66.7%)

ANNEX 5: EVALUATION WORKPLAN AND LIST OF KEY INFORMANTS

Theory of change for APHIAplus Imarisha



List of intermediate results for Results 3 and 4 of USAID Kenya Implementation framework

RESULT 3: Increased Use of Quality Health Services, Products and Information
Intermediate Result 3.1: Increased availability of an integrated package of quality high-impact interventions at community and health facility levels

Expected health outcomes:

- Improved capacity of public sector facilities to provide reliable and consistent high quality package of high impact interventions at community, dispensary, health center and district hospital levels
- Increased capacity of the DHMTs to plan and manage service delivery; Strengthened capacity to record, report, and use data for decision making
- Increased capacity of functional community units to promote preventive health behaviors, identify, refer/manage complications
- Increased availability of HIV/AIDS treatment services at points of contact for PLHA with health system, e.g., rural facilities, TB clinics
- Increased availability of malaria prevention and treatment services, including IPT, ITNs, ACTs and rapid diagnostic tests (RDTs); screening and treatment for TB
- Increased availability of FP services in public and private sector facilities and in communities
- Increased availability and capacity of functional skilled birth attendants in public and private sectors and in health facilities and communities
- Increased availability of essential newborn care and resuscitation, nutrition, safe and clean water at point of use, and prevention and management of childhood illnesses
- Expanded coverage of high impact interventions for women and men of reproductive age, youth, vulnerable groups, MARPs, mothers, newborns, and children

Intermediate Result 3.2: Increased demand for an integrated package of quality high-impact interventions at community and health facility levels

Expected health outcomes:

- Reduced social, economic, and geographic barriers to accessing and utilizing services
- Increased capacity of facilities to provide client-centered, humane and dignified care
- Increased capacity of community units to mobilize communities

Intermediate Result 3.3: Increased adoption of healthy behaviors

Expected health outcomes:

- Improved appropriate health care seeking behavior
- Improved home-based healthy practices with a special focus on the high impact interventions
- Improved compliance with preventive and curative protocols

Intermediate Result 3.4: Increased program effectiveness through innovative approaches

Expected health outcomes:

- Innovative approaches developed to increase the use of quality services at community and facility levels, especially among the marginalized, poor, and underserved populations
- Data analysis and of best practices institutionalized

- Increased coverage of services among marginalized, poor, and underserved populations

RESULT 4: Social Determinants of Health Addressed to Improve the Well-Being of Targeted Communities and Populations

Intermediate Result 4.1: Marginalized, poor and underserved groups have increased access to economic security initiatives through coordination and integration with economic strengthening programs

Expected health outcomes:

- Increased economic security among target groups of marginalized, poor and underserved populations
- Established partnership programs with multi-sectoral partners to expand jobs and other sustained economic opportunities for target groups
- Target groups linked to local market potential for revenue and sustainability
- Investments in programs aimed at achieving sustainable livelihoods for the poor are maximized and coordinated

Intermediate Result 4.2: Improved food security and nutrition for marginalized, poor and underserved populations
Expected health outcomes:

- Increased ability to utilize food and increase production of macro and micro nutrients.
- Successful transitioned from therapeutic nutritional interventions to programs that improve long term food security

Intermediate Result 4.3: Marginalized, poor and underserved groups have increased access to education, life skills, and literacy initiatives through coordination and integration with education programs
Expected health outcomes:

- Increased school preparedness; enrollment and retention in quality education marginalized, poor and underserved children and youth
- Increased preparation for primary school achievement through regular participation in quality early childhood development programs
- Increased completion of life skills curriculum offered through primary or secondary levels
- Increased enrollment and retention in primary and secondary schools
- Increased transition to post primary and/or secondary education
- Reduced reliance on individual scholarships and provision of quickly expended supplies to secure educational access

Intermediate Result 4.4: Increased access to safe water, sanitation and improved hygiene
Expected health outcomes:

- Integration of key hygiene practices into HIV and MNCH activities at the community level
- Increased access to improved water sources
- Increased utilization of POU water treatment

Intermediate Result 4.5: Strengthened systems, structures and services for protection of marginalized, poor and underserved populations
Expected health outcomes:

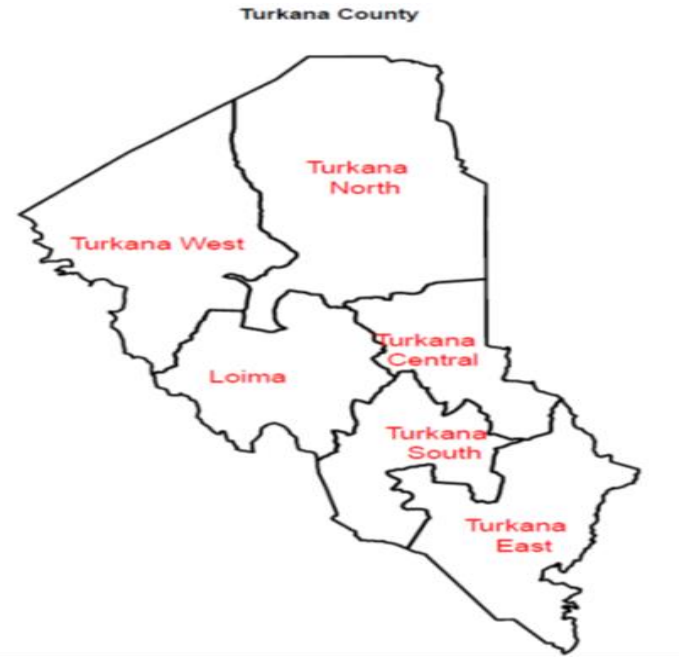
- Quality protective services available to survivors of sexual assault, child maltreatment and children without adequate family care
- MGCSD supported to develop policies, protocols and guidance to support quality social services

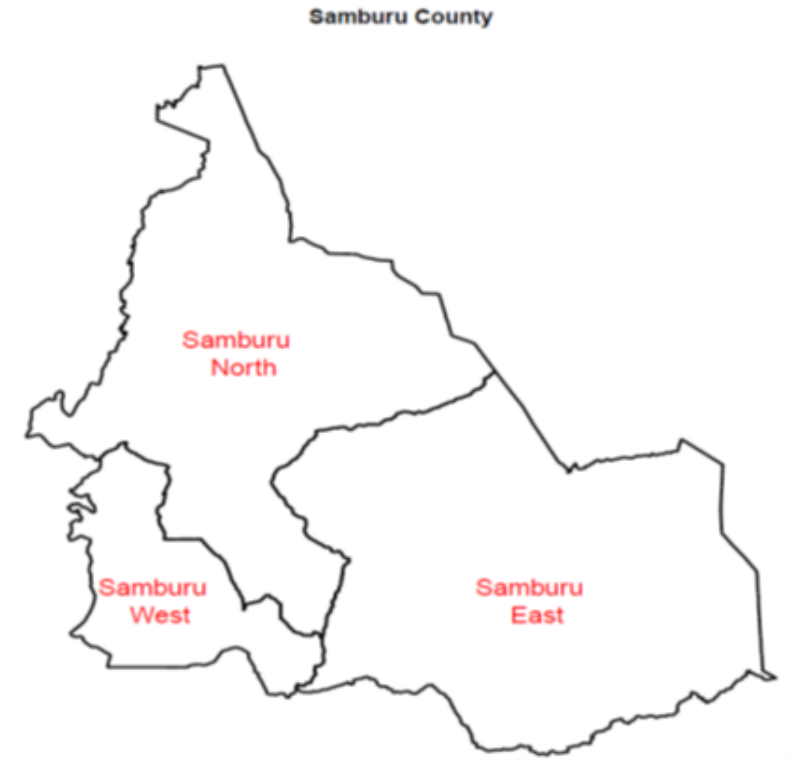
- Eligible children and families are identified and linked to available government social protection initiatives through CHWs, CSOs, volunteers and local government representatives
- Strengthened referrals between police, court, health and social services established

Intermediate Result 4.6: Expanded social mobilization for health
Expected health outcomes:

- Improved financial, managerial and technical capacity of indigenous organizations serving social and health needs of marginalized, poor and underserved populations
- District, sub-district and village health committees plan and coordinate implementation of effective multi-sectoral partnerships for health
- Women, youth, child and MARPs groups meaningfully participate in the design, delivery and monitoring of interventions on their behalf
- Increased social inclusion and reduced stigma and discrimination of MARPs

Map of Evaluation Sites





List of documents included in the program review

1.	RFTOP FINAL Imarisha	SOW for End-of-Activity Evaluation for APHIAplus Imarisha Activity March 14, 2017
2.	AID-623-A-12-00015 signed	Signed Cooperative Agreement No.: AID-623-A-12-00015
3.	MODIFICATION #1	Supplement No. 1 of Grant and Cooperative Agreement No.: AID-623-A-12-00015
4.	EXECUTED MODIFICATION	Modification of Assistance #02
5.	Mod 3 - signed	Modification of Assistance #03
6.	Mod #4. signed	Modification of Assistance #04
7.	Signed Mod 05_AID-623-A-12-00015_APHIAplus NAL	Modification of Assistance #05
8.	Mod 06 doc	Modification of Assistance #06
9.	AID-623-A-12-00015-07-Signed by AO	Modification of Assistance #07
10.	AID-623-A-12-00015-08_Signed by AO	Modification of Assistance #08
11.	Signed Mod #09_APHIA Imarisha	Modification of Assistance #09
12.	Signed APHIA Imarisha Mod #10	Modification of Assistance #10
13.	Modification -AID-623-A-12-00015 - SIGNED	Modification of Assistance #11
14.	AID-623-A-12-00015 - MOD #12	Modification of Assistance #12
15.	Fully Executed Modification #13	Modification of Assistance #13
16.	Signed Mod	Modification of Assistance #14
17.	1. APHIAplus IMARISHA Quarter One Report - 31 07 2012	Quarterly report APRIL - JUNE 2012
18.	2. APHIAplus IMARISHA Quarter 2 Progress Report Jul - Sept 2012 Submitted 31 10	Quarterly report JULY - SEPTEMBER 2012
19.	3. APHIAplus IMARISHA Q 1 (Oct - Dec 2012) report 31 01 2013	Quarterly report OCTOBER - DECEMBER 2012
20.	4. APHIAplus IMARISHA Q 2 (Jan - March 2013) report	Quarterly report JANUARY – MARCH 2013
21.	5. APHIAplus IMARISHA Q 3 (Apr - June 2013) report - July 2013	Quarterly report APRIL - JUNE 2013
22.	6. APHIAplus IMARISHA Q 4 (July - Sept 2013) report	Quarterly report JULY - SEPTEMBER 2013
23.	7. APHIAplus IMARISHA Quarterly Report Oct-Dec 2013 - 15th Feb 2014	Quarterly report OCTOBER - DECEMBER 2013
24.	8. Jan-Mar 2014 Quarterly Report 2 5 2014	Quarterly report JANUARY – MARCH 2014
25.	9. APHIAplus IMARISHA April - Jun 2014 Quarterly Report - 8th July 2014	Quarterly report APRIL - JUNE 2014
26.	10. APHIAplus IMARISHA Quarterly Report July- Sept 2014	Quarterly report JULY - SEPTEMBER 2014
27.	11. APHIAplus IMARISHA Quarterly Report-	Quarterly report
28.	12. APHIAplus IMARISHA Quarterly Report- January to March 2015-updated July 2015	Quarterly report JANUARY – MARCH 2015
29.	13. APHIAplus IMARISHA Quarterly Report-April - June 2015-31st July 2015 - updated	Quarterly report APRIL - JUNE 2015
30.	14. APHIAplus IMARISHA Quarterly Report- July- September 2015	Quarterly report JULY - SEPTEMBER 2015
31.	15. APHIAplus IMARISHA Quarterly Report-Oct-Dec 2015 30_1	Quarterly report OCTOBER - DECEMBER 2015
32.	16. APHIAplus IMARISHA Quarterly Report-Jan-Mar 2016	Quarterly report

		JANUARY – MARCH 2016
33.	17. APHIAplus IMARISHA Quarterly Report-Apr-Jun 2016- 31st July 2016	Quarterly report APRIL - JUNE 2016
34.	18. APHIAplus IMARISHA Quarterly Report- July-Sept 2016	Quarterly report JULY - SEPTEMBER 2016
35.	APHIAplus IMARISHA ME PLAN-11.07.2012	APHIAplus IMARISHA Zone 5 – Northern Arid Lands Monitoring and Evaluation Plan Submitted July 13, 2012
36.	1 APHIAplus IMARISHA Year1 work plan - 18 07 2012	Zone 5 – Northern Arid Lands Year 1 Work Plan March – December 2012
37.	2 APHIAplus IMARISHA - Year 2 Work plan highlighted responses to questions raised 13.3.2013	Year 2 Work Plan January – December 2013
38.	2. APHIAplus IMARISHA - Year 2 Work plan approved - Feb 21 2013	Year 2 Work Plan January – December 2013 SUBMITTED: FEBRUARY 21, 2013
39.	3 APHIAplus IMARISHA- Year 3 Work plan - 9th April 2014	Year 3 Work Plan January – December 2014
40.	4 APHIAplus IMARISHA Year 4 Revised Work plan 16.3.15	FINAL Year 4 Work Plan January – December 2015
41.	5 APHIAplus IMARISHA- Year 5 Work plan - submitted 7th December 2015	Year 5 Work Plan January – March 2017
42.	5. APHIAplus IMARISHA- Year 5 Work plan Revised 2.2.2016	Revised Year 5 Work Plan January – December 2016
43.	6 IMARISHA Cost Extension Work plan 2017_ Revised 27.2.2017	Cost Extension Work-Plan January 1, 2017 – December 31, 2017
44.	APHIAplus IMARISHA MTR Report - Final- August 2015	MID TERM EVALUATION REPORT MAY 2015
45.	APHIAplusIMARISHAAnnualReport2015-updated17thNovember2015	USAID KENYA APHIAPLUS IMARISHA FY 2015 PERFORMANCE REPORT 01 July – 30 September 2015
46.	Evaluation Report Review Checklist _November 30 2016	EVALUATION REPORT AND REVIEW TEMPLATE
47.	KENYA AIDS STRATEGIC FRAMEWORK(KASF)	KENYA AIDS STRATEGIC FRAMEWORK 2014/2015 - 2018/2019
48.	KHSSP Ministry of Health October 2014	KENYA HEALTH SECTOR STRATEGIC AND INVESTMENT PLAN (KHSSP) JULY 2014 – JUNE 2018
49.	POPULATION ACTIVITYIONS_1-3-2012	2009 Kenya Population and Housing Census Analytical Report on Population Activitiess Volume XIV, March 2012
50.	USAID Evaluation Policy Updated October 2016	USAID EVALUATION POLICY Learning from Experience JANUARY 2011 UPDATED OCTOBER 2016
51.	OVC CBO_GARISSA COUNTY	GARISSA INFORMATION FOR THE UPCOMING EVALUATION

52.	OVC CBOs_ Evaluation	2. List of CBOs supporting OVC program in the Community Based Organizations (CBOs) supporting Orphans and Vulnerable Children (OVC) No of OVC supported by Watoto Wazima Initiative in Turkana County per Ward
53.	TX_CURRENT and PMTCT_STAT DATA	PMTCT Statistics

National-Level Key Informants

	Designation	Name	Contact	Location
	Country Director - AMREF Kenya	Dr. Meshack Ndirangu	Phone: 020 699 4623 Meshack.Ndirangu@Amref.org	AMREF HQ, Lang'ata RD. Opposite Wilson Airport
	COP - APHIAplus Imarisha	Dr. Mores Loolpapit	Mores.Loolpapit@Amref.org	AMREF Kenya Country Office Wilson Airport
	M&E - Advisor APHIAplus Imarisha	Emmanuel Musombi	emmanuel.musombi@amref.org	AMREF Kenya Country Office Wilson Airport
	Country Representative Catholic Relief Services (CRS)	Lane F. Bunkers	Phone: 020 4210000 Lbunkers@ke.earo.crs.org	Karuna Close, off Waiyaki behind Lion Place
	Program Manager Catholic Relief Services	Timon Mainga	Cell: 254 735 803021 Timon.Mainga@crs.org	Karuna Close, off Waiyaki behind Lion Place
	Country Director Save the Children Fund	Francis Woods	Tel +254 20 4444006 /1028/ 1032/ 1031 Francis.Woods@savethechildren.org	Matundu Close, Off School Lane, Westlands
	Country Director - FHI360	Dr. Masden Solomon	Cell:+254 722 521361 pmwarogo@fhi360.org;	Chancery building, 2nd floor, Valley Rd
	Chief of Party Population Services Kenya	Anthony S. Okoth	cell: +254 706 161612 aokoth@pskenya.org	Jumuia Place,Wing B, Ground Flr, Lenana Road
	The Principal Secretary State Department of Agriculture Ministry of Agriculture, Livestock & Fisheries	Adija Barasa, Focal Point Person	0727 581013 DIRECT 0722 521 361 E-mail: psagriculture@kilimo.go.ke Telephone: +254-20-2718870/0727581013	KILIMO HOUSE 4TH FLOOR ROOM 3A
	Country Representative BroadReach Healthcare (BRHC)	Joseph Ondigi	Cell: 0715 209802; Phone: +254 20 7603602 Skype: nyamweya.ondigi jondigi@brhc.com	4th Floor, 9 West Building Ring Road Parklands/Lower Kabete Road Westlands
	Catholic Diocese* Kenya Conference of Catholic Bishops	Jacinta Mutegi	Tel: 0722 758249 jmutegi@catholicchurch.or.ke kccb@catholicchurch.or.ke	Waiyaki Way, Westlands Waumini House
	FANIKISHA ACTIVITY	Chistine Kiecha	0723 997328 ckiecha@msh.org cc: Dr. Joseph Mukoko 0722 779337 jmukoko@msh.org	9th Floor, ACK Garden Bishops Road, Community Area Opp. NSSF
	KEMSA	Martin Mwenda	0721 248221	KEMSA

			email;martin.mwenda@kemsa.co.ke	Embakasi,opposite coca cola deport
	Director Strategy National Hospital Insurance Fund (NHIF)	Nicodemus Odongo	Direct: 0712 362911 254 20 2722527 Secretary - 0722 758249	9th Floor NHIF Building Community Area
	Principal Secretary State Department of Public Services Youth Dev. Ministry of Public Service, Youth	Dr. Muinde, Youth Director Rose Mwongera	Tel. 254 20 2227411 Ext 22483 0722 413 773 0722 875 887 rkmwongera@yahoo.com rkmwongera@gmail.com	KENCOM 3RD FLOOR ROOM 313
	Nutrition Specialist	Ann Robins	UNICEF Telephone: +254 20 762 2407 ext 24334 Mobile: 0729659507 Email: arobins@unicef.org	UNICEF office UN Gigiri, UN Complex, UN Avenue
	Chief of Party Land O' Lakes (LOL)	Titianne Donde	Tel: 0722 564563 t.donde@gmail.com titanne.donde@idd.landolakes.com	Land O'Lakes, Inc. International Development Block A, 2nd floor, Peponi Plaza, off Peponi Road, Westlands
	University of Maryland, Baltimore	Prof. Sylvia Ojoo	0735 800040 E-mail: sojoo@mgic.umaryland.edu	Maryland Global Initiatives Corporation – Kenya 6th Floor, K-Rep Centre, Wood Avenue, Kilimani
	The Director of Primary Education Ministry Of Education, Science and Technology	H. S. Abdi	Tel: 0722 931 854 Email: abdihabat@hotmail.com	2nd Floor, Jogoo House Harambee Avenue
	Director of Medical Services Ministry of Health	Dr. Jackson Kioko	707931940; 750803144; 720 908707 kiokojack@yahoo.com dmskenya@gmail.com	Afya House Community Area
	Chief Executive Officer, SUPKEM Kenya	Mr. Latiif Shabaan	Phone: 254-20 243109; 216963; 216965 ncep@supkem.or.ke lanshab@yahoo.com	Njugu lane, Islamia House, 2nd & 3rd Floor

Turkana County Key Informants

INSTITUTION	TARGET	NAME	CONTACT
Ministry of Health	County Health Director (CHD)	Dr. Joseph Epem Esekon	254 729477000 epem.esekon@gmail.com
Ministry of Health	SCMOH	Dr. Ongaki Dominic	728994223
CBO - Watoto Wazima Initiative	Chief Executive Officer Coordinator Reformed Church of East Africa (RCEA)	Josephine Biwott	Tel;0774943900
Elelea Health Centre	NO In-Charge	Vincent	Tel: 0704456023 Email:
Kerio Health Centre	Clinical Officer In-Charge	Alex Natapar	Tel: 0717480485
Kerio Health Centre	In-Charge CCC	John Maluki	Tel: 0729723198
St. Patrick's Kanamkemer Dispensary	Nursing Officer in Charge	Sr. Florence Wafula	Phone: 0721299909 Email:
Kalokol AIC Health Centre	Hospital Administrator In-Charge	Daniel Eripon	Phone: 0722397707
Kalokol AIC Health Centre	In-Charge CCC	Momanyi Alfred	Tel: 0711943679
St. Mary's Kalokol Primary Health Care	in Charge	Sr. Joannina Karega	Tel: 0724 463645
Kalokol Community Unit	CHEW Kalokol AIC HC CHEW i/c, Kalokol CU	Magreat Asuguru	Tel No:07215364812
Lokichar (RCEA) Health Centre	In-Charge	Florence Musumba	Tel: 0727 905240
Lokichar Community Unit	CHEW Lokichar CU	Alice Ekal	Tel: 0714140269
Katilu District Hospital	In-Charge	Dr. Wilson Munai	Tel: 0727 910746
Katilu District Hospital	In-Charge MNCH	James Inyangala	Tel: 0729 792 809
Katilu Community Unit	CHEW i/c Katilu CU	Sarah Cheruto	Tel No: 711211148
Kainuk Health Centre	Nursing Officer in Charge	Lydia Singoe	Tel: 0716 899064
Nakululumaint Community Unit	CHEW i/c/ Nakululumaint CU	Moses Eyanae	Tel No: 0711987649
Kainuk Health Centre	In-Charge MNCH	Lydia Singoe	Tel: 0716 899064
Nakwamoru Health Centre	Nursing Officer in Charge	Elizabeth Wanjoyi	Tel: 0725 903 146
Nakwamoru Health Centre	In-Charge CCC	Jonathan	Tel: 0723 144 613
Nakwamoru Community Unit	CHEW i/c Nakwamoru CU	Alex Lopungurei	Tel: 0705105507
SC-HMT	Sub-County MOH	Dr. David Moru	Tel: 0717 234955
Lokori Primary Health Care Program	In-Charge	Sr. Seline Mbuli	Phone: 0705 639 915 Email:
Lokori Primary Health Care Program	In-Charge CCC	Beatrice Mwale	Tel: 0711257735
Lokori Community Unit	CHEW i/c Lokori CU	Mildred Arot	Tel No: 0713069255
SC-HMT	Sub-County MOH	Ewalan Warrance	Tel: 0712582858
SC-HMT Turkana North/West	Sub-County MOH	Collins Odegi Otima	Collins Odegi Otima Sub-County Health Records Officer 0725 205077 odegicollinsotima@gmail.com
SC-HMT	Sub-County MOH	John Ateyo	Tel: 0706806970

Samburu County Key Informants

INSTITUTION	TARGET	NAME	CONTACT
Ministry of Health	County Health Director (CHD)	Dr. Martin Thuranira	0722 423038 martinthuranira@yahoo.com
Ministry of Health	Sub-County MOH	Dr. Philip Leturuju	0725 056415 pleturuju@gmail.com
County Devolved Government	CEC - Health Chief Officer Health	Peter Jerina Lolmodoni Lydia Letinina	Tel:+254721976627 Tel:0721898333
SAMBURU AID IN AFRICA (SAIDIA) - CBO	Activity Director	Mr. Sammy Lenanyokie	Mobile: 0724 934220.Email: saidia@africaonline.co.ke.Web site: www.saidiakenya.org
Loikas Community Unit	CHW I/C Loikas Community Unit CHW Malaral Dist Hospital	Maria Ntrono Lodokiyia,	+254 720 454 131
Serian Radio Station	Presenter	Nick Lenyakopiro	Tel: 0720145826
Maralal District Hospital	In-Charge Maralal District Hospital	Dr. Nato Robert	Tel: 065-2623; 0708775325 moh@samburu.rvp-moh.go.ke robertnato04@gmail.com
Maralal District Hospital	MNCH Beneficiaries	Evaline Nchalion Lenaigwanai	+254 720 595 777 nchalioneva@gmail.com
Catholic Diocese of Maralal (CBO)	Bishop, Maralal Diocese	Fr. Virgilio Pante	Tel: +254-065-62056; 065062030; +254-065-62056 info@maralaltholic.org
Kisima Dispensary	In-Charge	Jacqueline Lengees	Tel: 0720-096303
Kisima Dispensary	MNCH Beneficiaries	Jacqueline Lengees	Tel: 0720-096304
Kisima Community Unit	CHW Kisima Community Unit CHW Kisima Dispensary	Jennifer Wasenti Letrok Edna Kwamboka	0728 478 043 0721 624423
KIBA Child Development Organization (CBO)	Activity Manager	Mr. Charles Lekaken Lekushula	Mobile no. 0707695872.E-Mail Address: Kibacdo@Yahoo.Com/lekaken7@gmail.com
Suguta Marmar Health Centre	In-Charge	Antonella Leakono	Tel: 0714427390
Suguta Marmar Health Centre	MNCH Beneficiaries	Antonella Leakono	Tel: 0714427391
Suguta Marmar CU	CHW H/Centre	John Lenanyiarra	\ Tel: 0711307198
Suguta Campaign Against AIDs Program (SCAAP) CBO	Activity Coordinator	Mr. Stephen Olesororo	Mobile +254-712277039.E-mail:stephenolesororo@gmail.com/scaap2@gmail.com
Catholic Diocese of Maralal (CBO)	Bishop, Maralal Diocese	Fr. Virgilio Pante	Tel: +254-065-62056; 065062030; +254-065-62056 info@maralaltholic.org
Ministry of Health	Sub-County Health MOH	Peter Zablon Lodokiyiaa	Tel: +254720598220 email: peterlodokiyiaa@yahoo.com
Shepherds of Life (CBO)	Activity Director	Mr. James Wachieni	Tel: +254-720-974311 sherpherdsoflife@yahoo.com,

			info@solkenya.org
Ldergesi Community Unit	CHEW - Community CHEW - Facility	Ngariya Lenayasa Jospine Lolchuraki	Tel: 0700-706566 Tel: 0723-750687
Archers Post Health Centre	In-Charge	Margaret Lekoome	Tel: 0723-427338
Archers Post Health Centre	MNCH Beneficiaries	Margaret Lekoome	Tel: 0723-427339
Sereolip Health Centre	Nursing Officer In-charge	Henry Lantaaya	Tel: 0720 547098
Catholic Hospital - Wamba	In-Charge	Jelisa Leloki	Tel: 0720-284803 Email: chwmanagement@live.com
Catholic Hospital - Wamba	MNCH Beneficiaries	Jeneta Lelesit	Tel: 0720-284803 Email: chwmanagement@live.com
Wamba Health Centre	In-Charge	Bernadetta Lorunguya	Tel: 0720733565
Wamba Health Centre	I/C MNCH	Bernadetta Lorunguya	Tel: 0720733566
Shepherds of Life (CBO)	Activity Director	James Wachieni	Phone: + (254) 720 974 311.Email: info@solkenya.org. Website www.solkenya.org
Ministry of Health	Sub-County Health MOH	Dr. Ezra Lekenit	Tel: +254725149593 email:leruanya@gmail.com
Baragoi Sub-District Hospital	I/C MNCH	Margaret Nabei	Tel: 0723971536 email:margaretnabei@yahoo.com
Bendera Community Unit	CHW I/C	Steve Letipila	Tel: 0723292706 email:letipilas@yahoo.com
Catholic Diocese of Maralal (CBO)	Bishop, Maralal Diocese	Fr. Virgilio Pante	Tel: +254-065-62056; 065062030; +254-065-62056 info@maralaltholic.org
South Horr Dispensary	In-Charge	Micheal Lenkaak	Tel: 0726-017364 OR RADIOCALL email: michaellenkak@gmail.com
South Horr Community Unit	CHEW	Michael Lekarato	Tel: 0718371908
Lesirikan Health Centre	In-Charge	Mathew Lekeren	Tel: 0726-310623 OR RADIOCALL. Email: lekerenmathew@gmail.com
Lesirikan Community Unit	CHEW	Stephen Lealmusia	Tel: 0716142147
Catholic Diocese of Maralal (CBO)	Bishop, Maralal Diocese	Fr. Virgilio Pante	Tel: +254-065-62056; 065062030; +254-065-62056 info@maralaltholic.org

List of USAID priority indicators for APHIAplus Imarisha activity

DATA FROM DQA /DHIS

VMMC (limited to Turkana County only)
% positivity yield in VMMC
Improvement in institutional capacity to conduct VMMC

HIV Testing (limited to Turkana County only)
Positivity yield disaggregated by adults, pregnant women and pediatrics
% positivity yield initiated into HIV treatment disaggregated by adults, pregnant women and pediatrics

eMTCT (limited to Turkana county only)
% PCR results at 8 weeks;
Proportion +ve;
% PCR +ve initiated on Treatment;
% patients on treatment with viral load suppression;

DATA FROM HOUSEHOLD SURVEY

OVC program: Turkana, Samburu and Garissa
% enrollment, attendance and progression disaggregated by gender
% proportion of vulnerable OVC households actively participating in community-based household economic strengthening groups disaggregated by wards within each county
% functional household economic strengthening groups disaggregated by wards within each county

MNCH and FP: (Turkana, Samburu and Garissa)
% of births attended by skilled health care worker
Proportion of pregnant women with 4+ ANC visits
Proportion of children under 1 year fully immunized
DPT1 coverage;
DPT3 Coverage;
Measles Coverage

Existence of established systems for program quality improvement at health facility (Turkana, Samburu and
Garissa)
Existence of Quality Improvement Multi-Disciplinary Committee
Use of performance measurement data to improve quality of services
Use of national guidelines/protocols by health care workers
Use of program data for developing work plans, plan supportive supervision by health managers

Complete List of Evaluation Team Members

	Name	Designation
1.	Dr. John Paul Oyore	Team leader
2.	Dr. Nelly Yatich	M & E expert
3.	Phillip Wambua	Public health expert
4.	Angela Nguku	RMNCH Expert
5.	Grace Jowi Jobita	Social Scientist
6	Njoroge Kimani	Capacity Assessor – Turkana
7.	Salmon Owii	Capacity Assessor – Samburu
8.	Jackson Musembi	Sub-Team Leader – Turkana
9.	Peter Sangoro	Sub-Team Leader – Samburu

IMARISHA EVALUATION WORK PLAN

DATE	ACTIVITY	TEAMS
PRE-FIELDWORK IN NAIROBI AND COUNTIES		
Tues Jan 2 – Fri Jan 5, 2018	Document Review	All key personnel
Mon Jan 8 – Sat Jan 13	Team Planning Meeting, Nairobi	TL, KP, STL, CA
Thu Jan 11, 2018	**Submit In-Brief PPT with Work Plan**	TL, KP, STL, CA
Fri Jan 12, 2018	**In-Brief at USAID**	**TL, KP, M&E and ESPS Team**
Sat Jan 13, 2017	Travel to Turkana for training	TL, KP, STL(Turkana), M&E, CA (Turkana)
Mon Jan 15 – Wed Jan 17	Training in Turkana - mobile data collection	TL, KP, STL(Turkana), M&E, CA (Turkana)
Thu Jan 18	Travel to Samburu for training	TL, KP(RMNCH), STL(Samburu), M&E, CA (Samburu)
Fri Jan 19 – Mon Jan 22	Training in Samburu - mobile data collection	TL, KP(RMNCH), STL(Samburu), M&E, CA (Samburu)
FIELDWORK IN TURKANA AND SAMBURU (simultaneously)		
Tue Jan 23	Travel to assigned counties (TL to Nairobi)	PHE, SS, RMNCH, STLs and CAs
Wed Jan 24 – Tue Feb 13	Field work in Samburu/travel	PHE, STL and CA
Wed Jan 24 – Tue Feb 13	Field work in Turkana/travel	RMNCH, STL and CA
FIELDWORK IN NAIROBI (simultaneously)		
Wed Jan 24 – Tue Feb 13	Conduct, KIIs, Panel discussions and FGD	TL
ANALYSIS		
Wed Feb 14 – Mon Feb 26	Data Analysis (Home & together in Nairobi)	M&E PHE, SS, RMNCH and STLs
Tues Feb 27	Preparation USAID/IBTCI Mid-brief meeting	ESPS, TL, M&E, PHE, SS, RMNCH,CA
Wed Feb 28	**Submit Mid-Brief PPT to USAID**	ESPS, TL, M&E, PHE, SS, RMNCH
Thu Mar 1	**USAID/IBTCI Mid-Brief meeting**	**ESPS, TL, KP, M&E**
Fri Feb 23 – Thu Mar 15	Case Study – Analysis of work plans & project documents & Validation Workshop preparation – 18 days over period at IBTCI offices	TL, M&E PHE, SS, RMNCH,
Feb 27-Mar 10th	Evaluation Team work together at IBTCI offices	TL, M&E, PHE, SS, RMNCH,CA

VALIDATION WORKSHOPS		
Fri-Sat Mar 16-17, 2018	Travel to Maralal, Samburu	TL, M&E PHE, SS, RMNCH, , WF
Mon Mar 19, 2018	**Validation Workshop: Samburu**	**TL and all**
Tues Mar 20, 2018	Travel to Lodwar, Turkana	TL, M&E PHE, SS, RMNCH, , WF
Wed Mar 21, 2018	**Validation Workshop: Turkana**	**TL and all**
Thu Mar 22, 2018	Team travel to home counties – TL to Nairobi for Out-Brief	TL, M&E PHE, SS, RMNCH, , WF
POST FIELDWORK		
Fri Mar 23, 2018	**Out-Brief at USAID**	**TL, KP, M&E, ESPS**
Mon Mar 26 – Tues Apr 10	Report Writing – 12 days over this period	TL, Key Personnel and M&E
Tues Apr 10	Submit draft report to IBTCI	TL
Wed Apr 11 – Mon Apr16	IBTCI Review	IBTCI/ESPS
Tue Apr 17	**Submit draft report to USAID**	**IBTCI**
Tue Apr 17 – Fri Apr 27	USAID review	USAID
Mon Apr 30 – Thu May 3	Respond to comments & finalise report	Team
Fri May 4	**Submit FINAL report to USAID**	**IBTCI**

TABLE 2: DELIVERABLE DATES

PHASE	DELIVERABLE	DATE
Pre-Fieldwork	In-Brief to USAID	FridayJanuary12, 2018
Analysis	Mid-Brief to USAID	Thursday February 22, 2018
Validation Workshop	Validation Workshop: Samburu	Monday March 19, 2018
Validation Workshop	Validation Workshop: Turkana	Wednesday March 21, 2018
Post Fieldwork	Out-Brief with USAID	Friday March 23, 2018
Post Fieldwork	IBTCI submits draft report to USAID	Tuesday April 17, 2018
Post Fieldwork	IBTCI submits FINAL report to USAID	Friday May 4, 2018

QUALITY ASSURANCE PLAN

The aim of the APHIAplus IMARISHA End of activity evaluation was to;

- Determine the extent to which the activities have met the expected health outcomes
- Look at aspects of the activity that have direct and indirect bearing on anticipated health outcomes.
- Inform future direction in activity design, development, implementation and management strategies

The following steps were taken in each stage of the evaluation process for quality assurance.

PRE-FIELD WORK

Recruitment – Experienced and seasoned Research Assistants (coming from Samburu and Turkana counties) were recruited from KNBS.

- **Document review -** An evaluation matrix was developed and each evaluation team member focused on their area of expertise and responded to the evaluation questions and centered on the priority indicators.
- **TPM –** Team planning meeting was held to review the methodology and the review/finalize data collection tools
    - **Tools development -** The household survey tools used in data collection borrowed heavily from the KNBS household survey tool to ensure comparability and also because these questions have been pretested and proven before.
- **Training –** RAs were trained in Turkana and Samburu counties before the data collection process commenced. This was a 5-day training.

FIELDWORK

- *Use of CHWs* to guide the RAs to the households – this ensured the correct households were sampled and visited by the RAs during data collection process.
- *Use of tablets for quantitative data collection* – Hand-held devices (Android-enabled mobile phones) were used to collect the survey data. The survey questionnaire was programmed/administered electronically using Survey ToGo Dooblo Software. The database had data entry screens with skip patterns and data/value ranges programmed into it. This ensured that the data is consistent at the point of interview. At the end of each day, the Evaluation Team came together to debrief on key issues related to the tools/instruments, review completed surveys and upload the day's surveys onto a remote server. There was very close supervision of enumerators during data collection.
    - **Qualitative Data -** Paper-based tools were used as both FGDs and KII/Panel discussion interview guides. The evaluation team used audio recorders in each interview/discussion session that were submitted to ESPS on a daily basis for transcription. The transcripts were then sent back to the evaluation team member who conducted the interview/discussion for review. Transcripts were further cross-referenced with field notes and areas of digression highlighted and discussed.
- *Sub-Team Leaders* – overseeing the research assistants
    - The Sub-Team Leaders held daily field team meetings – to assess data collection progress towards target, review compliance to the protocol/methodology, identify and address emerging challenges
        - They also did random checks on the data collection process
- *Central QA* – this was managed by the ICT Programmer, Data Manager, and M/E Expert
    - The ICT Programmer did daily checks on data streaming in from the field – checking for anomalies and flagging back to the field team on a daily basis
- **Validation of findings -** To validate the findings, two validation workshops - one in Maralal (Samburu County), the other in Lodwar (Turkana county) - were held to discuss the findings and also capture stakeholders' views on implementation strategies adopted in the implementation of APHIAplus IMARISHA project. The County health authorities and the IPs were invited and participated

Post-field work

- Data analysis by the M/E expert
- Data analysis by the ESPS Snr M/E Advisor, and Public Health Specialist

CHALLENGES EXPERIENCED AND MITIGATION MEASURES TAKEN.

Despite the steps taken by the evaluation team for quality assurance, the following challenges were experienced and mitigation measures taken as noted for each challenge.

Challenges/Limitations	Mitigation Measures
Pockets of Insecurity in data collection sites	▪ Liaising with the locals and mapping out the movement timings in some areas ▪ Moving with Security personnel in some areas
Uncooperative respondents mainly due to overdependence of beneficiaries on stipends from CSOs hence refusal to cooperate during interviews	▪ Taking comprehensive notes to those who refused to be tape recorded ▪ Paying stipends to respondents ▪ Working within their proposed schedules even when they postpone several times
Language Barrier (Some Research Assistants not locals)	▪ Distributing the RAs to areas where they can be of maximum use e.g. near market centres where Swahili is spoken ▪ Pairing of RAs with local RAs
Vastness of project area	▪ Moving to different sites as different times
Listing of non-beneficiaries in the evaluation	▪ Concentrating on project beneficiary sites
Lack of data in some health facilities	▪ Use OF DHIS data
Delay in getting subscribers	▪ Outside Scope of evaluators
Transport delays hence delaying data collection	▪ Outside scope of evaluation team. Liaised with the office for quick fixes

End Notes

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[ii] IMARISHA Quarterly Report, Oct–Dec 2013, QR Apr–Jun 2014, QR Jul–Sep 2015, Annual Report 2015, QR Apr–Jul 2016; KII – AMREF, SCHMT–Turkana West (2018), HF–In-charge Nakwamoru (2018); FGD – LIP, Youth Kalokol RCEA (2018); LIP–Youth Turkana Central (2018), CCC – Nakwamuru HC.

[iii] KII – Turkana West SCHMT, KII – Turkana East SCHMT, KII – Kerio Delta HC.

[iv] Quarterly Report April–June 2014, Quarterly Report July–Sept 2015, Annual Report 2015, KII – AMREF, KII – Turkana West SCHMT, FGD CCC–Nakwamuru HC

[v] Annual Report 2016, Annual Report 2015, KII – SCHMT Turkana North and KII – SCHMT Turkana West.

[vi] KII – St. Mary's HC, KII – Kainuk HC, KII – AIC Kalokol HC, KII – Turkana South SCHMT, Annual Report 2016.

[vii] Annual Report 2016, Annual Report 2015, Quarterly Report July–Sept 2015, Quarterly Report July–Sept 2014, KII – Turkana East SCHMT, KII – Turkana South SCHMT, KII – Nakwamoru HC, KII – St. Patrick Dispensary, KII – St. Mary's HC, KII – Kainuk HC, KII – AIC Kalokol HC

[viii]Annual Report 2015, Quarterly Report July–Sept 2015

[ix] Annual Report 2015, Quarterly Report April–June 2014, KII – AIC Kalokol HC,

[x] Annual Report 2016, Annual Report 2015, KII – Turkana South SCHMT, KII – CHMT Turkana, KII – St. Mary's HC.

[xi] Annual Report 2016, Quarterly Report July–Sept 2015, Quarterly Report April–June 2014, Quarterly Report July–Sept 2014, KII – Turkana South SCHMT, KII – St. Patrick Dispensary, KII – St. Mary's HC, FGD CCC Katilu Hospital, FGD CCC AIC Kalokol, FGD CCC Kainuk HC, FGD CCC Nakwamoru HC.

[xii] Quarterly Report July–Sept 2015, FGD CCC AIC Kalokol, FGD CCC Katilu Hospital, FGD Nakwamoru HC, FGD CCC St. Patrick Dispensary, FGD CCC St. Mary's Dispensary, FGD CCC Kainuk HC, KII – CHMT Turkana.

[xiii] Annual Report 2015, Quarterly Report July–Sept 2015, KII – St. Mary's HC, KII – Turkana South SCHMT, KII – St. Patrick Dispensary, KII – St. Mary's HC, FGD – CCC Katilu Hospital, FGD – CCC AIC Kalokol, FGD – CCC Kainuk HC, FGD – CCC Nakwamoru HC.

[xiv] Annual Report 2016, Quarterly Report July–Sept 2015, KII – AIC Kalokol HC, KII – St. Patrick Dispensary, FGD – CCC Kainuk HC, FGD – CCC St. Patrick Dispensary, FGD – CCC Nakwamoru HC, FGD – CCC Katilu HC, FGD – CCC AIC Kalokol HC.

[xv] Quarterly Report July–Sept 2015, Annual Report 2015, Annual Report 2016, Quarterly Report April–June 2014, KII – Turkana East SCHMT, KII – Turkana South SCHMT, KII – CHMT Turkana, KII – Nakwamoru HC, KII – Kerio Delta HC, KII – St. Patrick Dispensary, KII – Kainuk HC, KII – AMREF.

[xvi] Quarterly Report Jan–March 2014, Quarterly Report July–Sept 2014, KII – Turkana East SCHMT, KII – AIC Kalokol HC, KII – Kainuk HC, KII – St. Mary's Dispensary.

[xvii] Annual Report 2016, Annual Report 2015, Quarterly Report July–Sept 2015.

[xviii] Quarterly Report April–June 2014, Quarterly Report Jan–March 2014, Quarterly Report July–Sept 2015, Annual Report 2016, KII – St. Mary's Dispensary, KII – Kainuk HC.

[xix] Annual Report 2015, Annual Report 2016, Quarterly Report April–June 2014, Quarterly Report July–Sept 2014, Quarterly Report Jan–March 2014, Quarterly Report Oct–Dec 2013, KII – AMREF, KII – Nakwamoru HC, KII – Kerio Delta HC, KII – St. Patrick Dispensary, KII – AIC Kalokol HC.

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[xxi] Annual Report 2016, Annual Report 2015, Quarterly Report April–June 2014, KII – AMREF.

[xxii] KII – AMREF, KII – CHMT Turkana, KII – Turkana West, KII – Turkana South SCHMT, KII – Turkana North SCHMT, KII – Nakwamoru HF, KII – Kerio Delta HF, KII – Kainuk HF.

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[xxiv] KII – Maralal SCHMT, KII – AMREF, Annual Report–2016, Annual Report 2015, Quarterly Report Jan–March 2014.

[xxv] KII – Samburu Central CHMT, KII – Baragoi SCHMT, Quarterly Report July–Sept 2014.

[xxvi] KII – SCHMT Baragoi, Quarterly Report July–Sept 2014, Quarterly Report April–June 2014, Annual Report 2015, Quarterly Report July–Sept 2015.

[xxvii] FGD MNCH – Maralal, FGD MNCH – Wamba HC.

[xxviii] Annual Report 2016, Quarterly Report July–Sept 2014, FGD MNCH – Maralal, FGD MNCH – Sereolepi, FGD MNCH – Wamba HC, FGD MNCH – Wamba Mission Hospital, FGD MNCH – Lesirikan Samburu West, FGD MNCH – Baragoi SDH, FGD MNCH – Kisima HC

[xxix] FGD MNCH – Wamba HC, FGD MNCH – Wamba Mission Hospital, FGD MNCH – Baragoi SDH.

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[xxxiii] KII – SCHMT Turkana South, KII – AIC Kalokol HC.

[xxxiv] Quarterly Report July–Sept 2015, KII – FHI360, KIIs – BroadReach, KII – AMREF.

[xxxv] KII – Turkana North SCHMT, KII – Turkana West SCHMT.

[xxxvi] Annual Report 2016, Quarterly Report July–Dec 2013, KII – St. Patrick Dispensary, Turkana Central.

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[xxxviii] Annual Report 2016, Quarterly Report Jan–March 2014, Quarterly Report July–Sept 2014, Quarterly Report Oct–Dec 2013, FGD MNCH – Kainuk HC Turkana South, FGD MNCH – Nakwamoru HC, Turkana South, FGD MNCH – Katilu HC, Turkana South.

[xxxix] Annual Report 2015, Quarterly Report July–Sept 2015.

[xl] Annual Report 2016, Annual Report 2015, Quarterly Report July–Sept 2015, Quarterly Report Jan–March 2014, Quarterly Report July–Sept 2014, Quarterly Report April–June 2014.

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[xlii] Annual Report 2016, Quarterly Report April–June 2014, FGD – MNCH Katilu HC Turkana South,

[xliii] Annual Report 2016, Quarterly Report Jan–March 2014, Quarterly Report July–Sept 2014, Quarterly Report Oct–Dec 2013.

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[xlv] Annual Report 2016, Quarterly Report April–June 2014, FGD MNCH – Lesirikan Samburu West, FGD MNCH – Baragoi SDH.

[xlvi] Annual Report 2015; FGD – OVC Caregivers, LIP-RCEA Watoto Wazima Initiative, Turkana.

[xlvii] FGD – OVC Caregivers, LIP-RCEA Watoto Wazima Initiative, Turkana.

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[xlix] Annual Report 2015; FGD – OVC Caregivers, SAIDIA Samburu; FGD – OVC Caregivers, Shepherds of Life, Samburu; KII – KIBA, LIP Samburu.

[l] KII – SAIDIA, LIP, Samburu.

[li] Annual Report 2015; FGD – CHV Nakwamoru CU, Kaptir HC, Kaptir Ward, Turkana; FGD – CHV Kanamkemer CU St. Patrick Dispensary, Lodwar Township Ward, Turkana.

[lii] Annual Report 2015; FGD – CHV Nakwamoru CU, Kaptir HC, Kaptir Ward, Turkana; FGD – CHV Kanamkemer CU St. Patrick Dispensary, Lodwar Township Ward, Turkana.

[liii] Annual Report 2015.

[liv] KII – SAIDIA LIP, Samburu; FGD – OVC CARITAS, Samburu, Annual Report 2015.

[lv]Annual Report 2015; Annual Report 2016; KII – SAIDIA LIP, Samburu; KII – CRS; CRS Kenya Program 2017: Improving Access to Health Services for OVC: Success stories from APHIAplus Project in Rift Valley and Northern Arid Land of Kenya.

[lvi] FGD Caregivers – CARITAS, Samburu; Annual Report 2015; KII – CRS.

[lvii] Community Health Extension Worker (CHEW) Questionnaire.

[lviii] Annex 4: Health Facility Capacity Assessment.

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[lx] KII – CHMT Turkana; KII – AIC Kalokol; Quarterly Report Oct–Dec 2013; KII – AMREF.

[lxi] KII – Nakwamoru HC; KII – Kainuk HC; Quarterly Report July–Sept 2015; Quarterly Report Oct–Dec 2013; Quarterly Report Oct–Dec 2012; FGD MNCH Kainuk HC; KII – AMREF.

[lxii] Quarterly Report Oct–Dec 2012.

[lxiii] Quarterly Report Oct–Dec 2012.

[lxiv] KII – Turkana East SCHMT.

[lxv] KII – Turkana South SCHMT, KII – Kainuk HC, KII – St. Patrick Dispensary, KII – AMREF.

[lxvi] KII – Turkana West SCHMT, KII – Turkana East SCHMT, KII – Kerio Delta HC.

[lxvii] Annual Report 2015, Annual Report 2016, KII – AMREF.

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[lxix] Kenya HIV County Profiles 2016.

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[lxxi] Quarterly Report July–Sept 2015, page 74.

[lxxii] KII with AMREF.

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[lxxiv] Ibid.

[lxxv]APHIAplus IMARISHA Monitoring & Evaluation Plan 2012, page 16.

[lxxvi] US PEPFAR Guidelines for Orphans and Vulnerable Children Programming 2012, page 16.

[lxxvii]APHIAplus IMARISHA Quarter 1, Year 1 Progress Report, page 10, 23, 24.

[lxxviii]APHIAplus IMARISHA Cost Extension Work Plan 2017, page 46.

[lxxix] KII with SAIDIA LIP in Samburu.

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[lxxxvi] APR 2016, page 101.

[lxxxvii] APR 2016, page 85.