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

Kisumu Integrated Family Health Project
DCI-NSAPVD/2014/333-130

FIRST INTERIM NARRATIVE REPORT

Reporting period:
1st November 2014 – 30th October 2015

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Project implemented by CARE, FHOK and KRCS
FIRST INTERIM NARRATIVE REPORT

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List of acronyms used in the report

ANC  Antenatal Care
ARV  Anti-retroviral
CARE Cooperative for Assistance and Relief Everywhere
CBDs Community-Based Distributors
CHCs Community Health Committees
CHEWs Community Health Extension Workers
CHMT County Health Management Team
CUs Community Units
CHVs Community Health Volunteers¹
DHIS District Health Information System
ECD Early Child Development
EU European Union
FANC Focused Antenatal Care
FHOK Family Health Options Kenya
FP Family Planning
FP/SRH Family Planning, Sexual and Reproductive Health
HCW Health Care Workers
HiNi High Impact Nutrition Interventions
HIV Human Immunodeficiency Virus
HMIS Health Management Information System
IEC Information, Education and Communication
IYCF Integrated Young Child Feeding
JOOTRH Jaramogi Oginga Odinga Teaching and Referral Hospital
KRCs Kenya Red Cross Society
M&E Monitoring and Evaluation
MCA Member of County Assembly
MCH Maternal and Child Health
MNCH Maternal, Newborn and Child Health
MOH Ministry of Health
MoU Memorandum of Understanding
MUAC Mid-Upper Arm Circumference
NGOs Non-Governmental Organizations
PE Peer Educators
PET Participatory Edutainment Theatre
PMTCT Prevention of Mother to Child Transmission
RH Reproductive Health
SAA Social Analysis and Action
SAAFs Social Analysis and Action Facilitators
SCHMT Sub County Health Management Team
SMOH Sub-County Medical Officer of Health
SRH Sexual and Reproductive Health
SRMNH Sexual, Reproductive, Maternal and Newborn Health
STIs Sexually Transmitted Infections
TBAs Traditional Birth Attendants
UNFPA United Nations Population Fund
WHO World Health Organisation

¹ This expression replaces “Community Health Workers” (CHW) used in the project proposal.
1. Description

1.1. Name of Coordinator of the grant contract: CARE Austria

1.2. Name and title of the Contact person: Marion Ehalt, Programme Officer

1.3. Name of Beneficiary(ies) and affiliated entity(ies) in the Action: CARE; Kenya Red Cross Society (KRCS) and Family Health Options Kenya (FHOK)

1.4. Title of the Action: Kisumu Integrated Family Health Project

1.5. Contract number: DCI-NSAPVD/2014/333-130

1.6. Start date and end date of the reporting period: 1st November 2014 to 30th October 2015.

1.7. Target country(ies) or region(s): Kenya, Kisumu urban slums (Manyatta and Nyalenda)

1.8. Final beneficiaries &/or target groups (if different) (including numbers of women and men): 68,000 direct and 125,000 indirect beneficiaries (family planning and sexual and reproductive health interventions: 14,000 women in reproductive age and 15,000 men and boys; nutrition interventions: 18,000 children under 5 years and 4,000 pregnant and lactating women; maternal, neonatal and child health interventions: 25,000 women in reproductive age and 15,000 men and boys; interventions aimed at counteracting harmful cultural practices: 60,000 people).

1.9. Country(ies) in which the activities take place (if different from 1.7): N/A
2. Assessment of implementation of Action activities

2.1. Executive summary of the Action

Please give a global overview of the Action’s implementation for the reporting period (no more than ½ page)

Kenya’s maternal mortality remains unacceptably high, far above the WHO rating, and Kisumu County is ranked among the top ten counties with high maternal mortality ratio, contributing to the worse indicators nationally as compared to other Counties of similar wealth quintile (UNFPA, 2014 report). 495/100,000 mothers are dying from child birth and the under-five mortality still stands at 79/1000 children. CARE Kenya in partnership with the Kenya Red Cross Society and Family Health Options Kenya were awarded a grant by the European Union, with co-funding from the Austrian Development Corporation and CARE, to improve maternal and child health, sexual reproductive health, family planning and the nutritional status of communities living within Manyatta and Nyalenda in Kisumu County for a period of three years (November 2014-October 2017).

As planned, most of the project trainings have been completed in year one to accelerate the achievement of the project expected results in years two and three. The coordination between the County health teams and project teams has worked efficiently, with both parties following a joint work plan and implementing it in synergy.

From November 2014 to October 2015, thanks to the Action 10,630 patients accessed maternal, newborn and child health (MNCH) services, 657 pregnant and lactating mothers were reached, 6,742 people accessed family planning and sexual and reproductive health (FP/SRH) services, 9,621 final beneficiaries were screened for nutritional assessment and 20,741 were sensitised on harmful socio-cultural barriers limiting access to quality MNCH, FP/SRH and nutritional services.

Please list the indicators of the Specific Objective, and provide level of achievement if available at this stage:

**Specific Objective 1:** Strengthened capacity of non-state and state health actors to provide quality maternal and child health, sexual reproductive health, family planning and nutrition services to communities in Manyatta and Nyalenda slums, and to integrate vulnerable groups in decision making processes

**Indicator 1:** Increase the proportion of children under one fully immunized in Kisumu slums from 83% to 87% by 2017.

**Baseline value:** 83%

**Level of achievement:** This indicator was not measured at the end of year 1 since it requires a survey methodology to measure it. As such, it will be measured during mid-term and end line evaluations. In year 1, the project immunized a total of 7,682 children; out of these, 1,166 children under 1 year were fully immunized within Manyatta and Nyalenda by the end of October 2015.
Indicator 2: Decrease the proportion of under-five who are stunted or underweight in Kisumu slums from 23% to 18%

Baseline value: 23%

Level of achievement: This indicator was not measured at the end of year 1 since it requires a survey methodology to measure it. As such, it will be measured during mid-term and end line surveys. In year 1, the project screened a total of 9,621 people within the target population, out of whom 250 children were stunted and 88 were severely underweight. These were referred for further management to Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH).

Indicator 3: Ensure quarterly consultation and collaboration working group meetings held between non-state and state health actors on MNCH, FP/SRH and nutrition.

Baseline value: 0 quarterly consultation and collaboration working group meetings reported.

Level of achievement: The trained state and non-state actors now have regular consultations and collaboration meetings to assess progress and areas needing improvements. For example, 80 Community Health Volunteers (CHVs), 70 Community Health Committee (CHC) members, 4 Community Health Extension Workers (CHEWs) and 4 Sub-County Health Management Team (SCHMT) members meet on a monthly basis to hand in reports and draw the next work plans. 31 mother-to-mother support groups also meet monthly for information sharing and health education. The 15 Social Analysis and Action Facilitators (SAAFs) meet monthly to review progress and draw the next months’ work plans, while Mentor Mothers meet quarterly to review their quarterly performance and hand in reports. Health Care Workers (HCWs) and the SCHMT meet quarterly to review progress and share their support and supervision findings as well as challenges identified during the joint mentorship visits conducted by project staff and SCHMT. Peer educators meet quarterly to review progress and submit reports on the number of education sessions conducted to peers and share challenges. Finally, the County and Sub-County management teams continue to positively support and work closely with the project team to reverse the negative indicators within the County. Consultative meetings have regularly taken place to jointly plan all the trainings and the support supervision activities. The project has also supported joint activities spearheaded by the County, such as the “Beyond Zero Campaign”, the world contraceptive days and the Malezi Bora weeks. The project is well represented within the County reproductive health (RH) technical working group and the MNCH technical working groups at both County and national level.

Indicator 4: Ensure that interests of vulnerable population groups are voiced in at least 25% of all County public resource allocation forums by 2017.

Baseline value: 0 (no such forums were reported).

Level of achievement: During the first project year, three County forums took place in which the interests of vulnerable population groups were voiced. The first was held at Nyalenda with the project team, the Sub-County reproductive health coordinator, a community focal person

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2 These include people with disabilities, orphans and widows within the reproductive age, women living with HIV and adolescents.
and 18 women with disabilities. They highlighted some of the SRH challenges they face, for example in hospital delivery facilities. They emphasized their constitutional rights to be offered adequate services. Staff attitude was another example cited by the clients as an obstacle faced while seeking services. The SCHMT agreed to invite the chairperson Ms. Benta Oloo to the next quarterly meeting of HCWs and in-charges in order to shed more light on the constitutional rights of people with disabilities. During the subsequent quarterly meeting, the project facilitated interactions with and sensitization of HCWs on the rights of these vulnerable groups when seeking SRH services in the facilities and during outreach activities.

The second forum was held in conjunction with the County Health Management Team (CHMT) and Members of the County Assembly (MCAs) to voice challenges faced by vulnerable groups and lobby for additional resource allocation. The forum attended by several County Assembly health budget committee members was chaired by the MCA budget committee chair and co-chaired by the disability representative in Kisumu County Assembly. The third forum brought together facility in-charges and maternal and child health (MCH) implementers (nurses working in MCH clinics). The chairperson and secretary of the group of women with disabilities highlighted the challenges they face while seeking SRH services in the health facilities, mentioning for example the case of deaf women. They sensitized the HCWs on the needs of women with disabilities and their right to be served first as per the current Kenya constitution (the HCWs confessed they did not know it). The RH coordinator Ms. Elizabeth Onyango agreed to work closely with the project and to create more forums to sensitize HCWs on the rights of vulnerable groups. The project will follow up and continue to advocate for the representation of vulnerable population groups’ interests in at least 25% of all County public resource allocation forums in years 2 and 3.

**Specific Objective 2:** Targeted communities are aware and empowered to demand, access and utilise quality maternal & child health, nutrition, sexual reproductive health and family planning services

**Indicator 1:** Increase the proportion of pregnant women attending 4 or more ante-natal care visits from 65% to 70% in Kisumu slums.

**Baseline value:** 65%

**Level of achievement:** This indicator was not measured at the end of year 1 since it requires a survey methodology to measure it. As such, it will be measured during the mid-term and end line evaluations. In the first project year, 4,277 pregnant women attended antenatal care (ANC) visits, with 1,249 attending all the 4 comprehensive ANC visits. It is important to note that several pregnant women went to JOOTRH for ANC visits. These women are not included in the above data since the hospital is a referral facility that receives a wide range of clients from even the neighbouring counties and the hospital does not segregate the data to be able to capture those referred from the two slums supported by this Action. In the future, the project will work with the hospital administration to ensure that all ANC visits attributable to the Action are captured.
**Indicator 2:** Increase the proportion of skilled care deliveries from 62% to 65% in Kisumu slums.

**Baseline value:** 62%

**Level of achievement:** The total numbers of skilled care deliveries continued to rise across quarters. By September 2015, the proportion of skilled care deliveries was 73.4% (Quarterly County MNCH indicator tracking report from July to September 2015). The project supported activities fostering skilled care deliveries and there were 1,045 skilled care deliveries conducted from January 2015 to October 2015 in the facilities supported by the project. The increase in numbers is probably a result of the door-to-door mobilization technique used by the CHVs and the improved attitude of health facility staff.

**Indicator 3:** Increase the percentage of WRA using long-acting family planning methods from 22% to 26% in Manyatta and Nyalenda slums, Kisumu County.

**Baseline value:** 22%

**Level of achievement:** This indicator was not measured at the end of year 1 since it requires a survey methodology to measure it. As such, it will be measured during the mid-term and end line evaluations. In the first project year, 2,057 women of reproductive age received long-acting and permanent family planning methods and 6,186 people received a modern family planning method from the facility or during the Action’s outreach activities.
2.2. Results and Activities

What is your assessment of the results of the Action so far? Include observations on the performance and the achievement of outputs, outcomes and impact in relation to specific and overall objectives, and whether the Action has had any unforeseen positive or negative results. Following Annex 1, please list all the results with progress of the related indicators and all the related activities implemented during the reporting period.

Non-result specific activities / Inception phase activities

Memorandum of Understanding (MoU) with Kisumu County Heath team: A MoU with Kisumu County and Kisumu East SCHMT was signed. It outlines the roles and responsibilities of each partner within the partnership agreement; for example the CHMT and SHMT shall provide technical support to the project, support in training state actors as well as support in providing services as organised by the project team. They shall also periodically carry out support supervision visits to project-supported health facilities to monitor the progress and quality of care provided.

Partnership between CARE, KRCS and FHOK: The project beneficiaries signed a partnership agreement outlining the roles and responsibilities of CARE, KRCS and FHOK. CARE has a leadership role and coordinates the Action. CARE also coordinates the technical component on MNCH and social change, while KRCS coordinates the technical component on nutrition and community strategy, and FHOK coordinates the FP/SRH component. All the project beneficiaries follow a common activity plan and closely collaborate in delivering services to the final beneficiaries, in liaison with the Ministry of Health (MOH) technical teams. Key project staff (one officer per organization and the project manager) work in the same office. The partnership has functioned efficiently and created fruitful synergies thanks to joint planning, good coordination of activities and the unified office.

Staff recruitment: The project staff was competitively recruited through open advertisement by the respective project beneficiary organisations. Five persons were recruited: one CARE project manager, one CARE project officer, one KRCS project officer, one FHOK project officer and one CARE project driver.

Baseline survey: After the receipt of seven expressions of interest, and based on the terms of reference and a rigorous selection criteria list, 4 consultants were selected for interviews. The Policy Research and Management Consultants Ltd emerged as the top candidates to conduct the baseline survey, based on the relevance of similar assignments, the team composition and their costs. Subsequently, 19 research enumerators were recruited for a contractual period of 7 days to provide support in collecting data. They underwent a two-day training on the 29th and 30th of March 2015. Data collection tools were pre-tested at Nyawita Village which was outside the sample population. The data was then collected in the field from 31st March to 4th April 2015. Respondents were women of reproductive age (15-49), pregnant and lactating women, adolescent girls, men, children under 5 years as well as vulnerable groups such as women living with HIV-AIDS and women living with disabilities in the two slums of Manyatta and Nyalenda.
Expected Result 1: "Capacity Building" - Non-state and state health actors have greater capacity and improved skills to respond and meet needs on maternal, newborn & child health, family planning, sexual & reproductive health and nutrition in Kisumu slums, and adequately include affected population in health decision making.

Indicator 1: Increase the number of health facilities providing both essential MNCH services and full High Impact Nutrition Interventions (HiNi) package from 2 to 5 in Kisumu slums (R1)

Baseline value: 2

Level of achievement: 8 facilities were mapped to provide quality MNCH, FP/SRH and nutritional services within Manyatta and Nyalenda under this project. Out of the 8 facilities identified, 1 is a faith-based (mission facility), 3 are MOH facilities and 4 are private health facilities. The capacity of the health care providers has been improved through various training sessions and sensitizations (see below the description of activities). All the 8 facilities are now offering essential MNCH services except the conducting of deliveries on a 24 hour basis (due to a lack of some basic equipments and staff shortages). The project, in conjunction with the County government, is in the process to equip the Nyalenda health centre so that it can offer 24 hour delivery services, in additional to Migosi health centre and Nightingale hospital. 4 health facilities are now delivering the full HiNi package while the rest of the facilities offer nutritional assessment only and not the full HiNi package. The main reason is a lack of fulltime nutritionists stationed at the facilities. The nurses working in the facilities carry out nutritional assessments and appropriately refer the clients needing further services.

Indicator 2: Increase the number of health facilities offering comprehensive long-term FP/SRH services from 4 to 8 in Kisumu slums (R1)

Baseline value: 4

Level of achievement: All the 8 health facilities supported by the project are now offering comprehensive long-term FP/SRH methods (their capacities and competences were improved through continuous mentorship and competency-based learning during outreaches).

Indicator 3: Increase the number of community health units offering comprehensive level 1 Sexual, Reproductive, Maternal and Newborn Health (SRMNH) and nutrition services in Kisumu slums from 0 to 4 units by 2017.

Baseline value: 0

Level of achievement: During the first year, the project supported the establishment of 8 functional Community Units (CUs) offering comprehensive level 1 SRMNH and nutrition services in Kisumu slums. The newly established CUs were trained on technical modules on MNCH, FP/SRH and nutrition as well as on the basic module concerning the functioning of CUs. Currently all the CUs are working well and regular reports are being submitted to the CHEWs and the County Health Management Information System (HMIS).
**Indicator 4:** At least 75% of clients report that targeted health actors demonstrate improved attitude towards clients (women, adolescents)

**Baseline value:** 25%

**Level of achievement:** This indicator was not measured at the end of year 1 since it requires a survey methodology to measure it. As such, it will be measured during the mid-term and end line evaluations. However, it has already been noted that in all the 8 health care facilities supported by the project, more clients continue to access the targeted services. In the reporting period, 10,630 final beneficiaries accessed MNCH services, 6,742 received FP/SRH services and 9,621 benefitted from nutritional interventions. This increase in the number of final beneficiaries accessing services suggests an increased level of confidence towards health providers and an improved attitude of health workers towards clients. Exit interviews also show that people have confidence in the facilities supported by the project and their staff. Most health facility staff is willing to efficiently work with the project team, even during prolonged hours of outreaches.

**Activities**

**1.1: Organise a sensitisation forum and continuous review sessions with County leadership and County Assembly members**

**1.1.1: Sensitisation forum with County leadership and County assembly members on resource allocation and accountability**

First, from 19th to 30th January 2015, the project team held a series of meetings with the CHMT and SCHMT members to present the project activities. Then, a project inception meeting took place on 4th February 2015. It brought together the CHMTs and SHMTs to discuss the implementation of the project. The meeting was chaired by Dr. Otieno, the Sub-County Medical Officer of Health (SMOH), who pointed out that the County strategic plan indicators were linked to various project activities. He encouraged his team and the project team to work together. Kisumu East Sub-County contains almost half of the entire Kisumu population; the majority having settled in the Nyalenda and Manyatta slums. Therefore, the project shall create a meaningful impact in Kisumu County. Dr. Otieno further promised full support to the Action and appreciated that the project team had met with the County and Sub-County teams before starting working with the communities.

An advocacy session also took place on 19th May 2015 at the governor’s office. He was briefed on the project funded by the EU, ADA and CARE and promised his total support to the Action. He also emphasised its commitment to ensure the County achieves its health-related strategic objectives.

20 Kisumu MCAs were engaged in another forum on the 2nd of October focusing on resource allocation. Other stakeholders implementing MNCH, SRH and nutrition interventions were also invited, e.g. the NAYA organisation supporting youth and adolescents. The MCA budget committee chair brought together the MCAs in a round table forum to discuss the progress made on MNCH, SRH and nutrition within the County and to share some of the challenges and improvements needed. Various issues discussed showed that the majority of the MCAs in the health budget committee did not understand some of the challenges faced by facilities in delivering services. They had always attributed facility challenges to a lack of human resources. The project manager explained the barriers limiting access to quality care, including lack of supplies, inadequate staff capacities as well as harmful socio-cultural
practices and beliefs. The project team was able to convince the health budget committee to apportion more resources to address MNCH and FP/SRH challenges hindering service provision such as the lack of equipment or the erratic supply of commodities. The MCAs also agreed to organise a stakeholders’ forum to bring on board more members. This will help get the needed majority to push for the allocation of more budget to address the gaps discussed. It will also contribute to raising awareness among all stakeholders including members of parliament (they could equip some of the health facilities with basic equipments through the constituency development fund). The targeted MCAs further promised to present a paper to the Minister and Governor to prioritize and allocate additional human and financial resources for MNCH, FP/SRH and nutrition in the County.

1.1.2: Quarterly reviews and planning sessions with CHMTs and SCHMTs

The project teams held two review and planning sessions with CHMT and SHMTs. The first review meeting took place on 26th February 2015 at MOH Sub-County office. 8 key members from the CHMTs and SHMTs as well as project team members attended it. The main agenda was to discuss the joint implementation of the project activities. The participants also reviewed existing tools to conduct capacity assessments and mapping of state and non-state actors that will support the project. The mapping and selection tools were harmonised and the UNICEF community functionality score card assessment tools were adopted to select the CUs. The second meeting was held on 14th August 2015 with 24 members from the CHMTs and SCHMTs. The main agenda was to share the joint support supervision findings with the facility in-charges and service providers stationed at MNCH clinics. Some of the findings showed that several facilities had not fully integrated the nutrition component as a service package for under five and pregnant mothers. Indeed, most of the health care providers never did the comprehensive anthropometric measurements for full nutritional assessment (they only used weight). The participants also discussed the project progress based on data collected at the supported facilities. The findings indicated that the project needed to develop an accelerated work plan for the next quarter in order to increase the uptake of long-term family planning methods. The team developed a joint work plan and set timelines with clear responsibilities for the project team, the County leadership and the facility in-charges.

1.2: Carry out mapping of outreach sites, community units (CUs), health facilities, existing partners and structures for collaboration and conduct organisational capacity assessment

This activity was important to map all state and non-state actors to support the project, to identify collaborators and drivers of community mobilization activities and to brand service outlets. The project team held a series of planning meetings with key Kisumu East Sub-County Teams and the mapping activity started in the week of 5th March (it lasted until 18th March). The team used already developed mapping and selection tools. The mapping and selection teams were comprised of SCHMT members, the project staff and key contacts from the communities of Nyalenda and Manyatta. The mapping and selection exercise was conducted in all the health facilities within Nyalenda and Manyatta. In Nyalenda, 5 facilities were identified: God’s Will Medical Centre, Pand Peiri Health Centre, Kowino dispensary, Nyalenda Health Centre and the Jones and Ring Road Community Health Centre. In Manyatta, the facilities identified were JOOTRH, Migosi Health Centre, YOEF Medical Centre and Nightingale Hospital. The following conclusions were drawn from the mapping and selection exercise:

- Not all the visited facilities offered integrated MNCH/FP/SRH services;
- Some of the facilities’ staff lack knowledge and skills in these thematic areas;
- Referral systems are good and in place but data storage is manual, so most of the data is never captured. The reception of the facilities’ chiefs and assistant chiefs was very positive. They all appreciated the coming of the project since this was going to improve the health indicators.

1.3: Support the establishment of 8 functional community units

The project has fully established 8 functional CUs as per the project work plan. The Manyatta and Nyalenda informal settlements now have 15 CUs in total.

1.3.1: Community entry meeting

First, the project team engaged with the Sub-County MOH teams in a round table planning session on 27th February. The deliberations centred on how they would jointly support the community. Subsequently, the team met all chiefs both from Manyatta and Nyalenda together with their assistant chiefs in their respective offices on 18th March 2015. The aim was to sensitise them on the project, discuss with them the mapping activity, the recruitment of community health workers and the establishment of community units. On April 7th, the project team met with the CHEWs from both Manyatta and Nyalanda slums. All agreed that the new 8 CUs should be established in Nyalanda slum since it had no proper functional CUs unlike those in Manyatta which were fully functional.

1.3.2: Recruitment of health workers

The project recruited 80 CHVs in Nyalenda on 9th and 13th April 2015 (since Manyatta already had CHVs in its functional CUs). The tools used for the recruitment were adopted from the existing MOH guidelines.

1.3.3: Community health workers basic training

The CHV basic training was done in two phases because of the number of participants. As per the MOH guidelines, the basic training must be done in 10 days. The classes were divided into two clusters of 40 people. The first basic training was conducted between 11th and 23rd May at Nyalenda community hall and the second group was trained from 28th September to 9th October 2015 at KUAP Pandipieri Catholic community hall. The training was facilitated by MOH teams from Kisumu East Sub-County. The training content covered following topics: overview of community health strategy; health and development in the community; community governance and leadership; community advocacy and social mobilization; management and use of health information systems; Kenya essential package for health; basic counselling skills; health promotion and disease prevention; immunization for children; maternal and infant child nutrition; basic health care and live saving skills.

1.3.4: Community health workers technical training (MNCH, RH/FP & Nutrition)

The technical training for all the 80 CHVs was also done in two phases due to the number of participants. The first session was held from 15th to 26th June at Magadi centre in Manyatta and the second was from 12th to 29th October 2015 at KUAP Pandipieri Catholic community hall. The training was facilitated by MOH teams and coordinated by the project team. It covered the following topics: roles and responsibilities of CHVs; home visit timings; counselling skills; focused antenatal care; promoting antenatal care; importance of nutrition in the community; food and personal hygiene; family planning and birth spacing; record keeping.
1.3.5: Community health workers refresher training on technical training (MNCH, FP/SRH & Nutrition)
This training has not yet been conducted since the newly recruited CHVs have just had the technical training. It will take place in year two. This will give adequate time to evaluate the performance of CHVs following the first technical training and to prepare the refresher training.

1.3.6: Community health committee (CHC) training
39 CHC members from the newly established 8 functional units in Nyalenda and the existing CUs in Manyatta were trained from 20th to 29th July 2015. The facilitation was led by the County teams. The training content entailed following topics: governance in community health services; personnel management issues; resource mobilization and financial management; community health information systems; monitoring and evaluation; development of work plans; role of CHC in effective mobilization and networking; advocacy and application of leadership in the community health context.

1.3.7: Community health workers monthly review meetings
Five review meetings took place on 28th July, 25th August, 10th September, 15th October and 12th November 2015. They started in July because we needed to train CHVs before starting to conduct monthly review meetings. The review meetings are attended by the 80 CHVs, 70 CHC members and 4 CHEWs, facility in-charges and County MOH support teams. During the review meetings, the CHVs present the monthly data to the MOH and project teams, get updates from the project team, MOH and community leaders, evaluate challenges and find solutions to them, share the following months’ work plan and receive a stipend. Mother-to- mother support groups’ progress is also discussed and the schedule for their next talks and follow-up activities are agreed upon.

1.4: Design and support capacity-building interventions for non-state and selected state actors
The selected non-state actors who have been trained by the project include SAAFs, religious leaders and Traditional Birth Attendants (TBAs). Participatory Edutainment Theatre (PET) teams, peer educators, male champions and mentors mothers were also recruited and trained (see activities under Result 2). State actors who were trained were mainly HCWs, CHVs and County leadership teams.

1.4.1: Training of social analysis and action facilitators on SAA for FP/SRH and MNCH
The project has recruited 15 community members as SAAFs and trained them on the social change approach to engage the community through dialogues on the social and cultural barriers affecting the uptake of FP/SRH and MNCH. The training took place on 15th-19th June 2015 at Manyatta Bio Centre Hall. Topics covered included the introduction and understanding of the Social Analysis and Action model, community mobilisation and SAA model and process, SAA approach, basic technical knowledge on the project thematic areas, facilitation skills, and the application of selected community dialogue tools. The trained SAAFs have remained active in engaging the community throughout the year through community-organised forums and open dialogues. To date, they have conducted 60 community dialogues reaching out to an average population of 20,741 final beneficiaries. Due to increased demand, the project team also integrated the SAAFs as part of the mobilization strategy into community and facility-organised outreaches. They engage the crowd on harmful
socio-cultural norms before they are offered health care services. This has improved the turnout during the outreaches and created synergy with the health talks provided by health care providers.

1.4.2: Social analysis and action facilitators’ (SAAFs) review meeting
The trained SAAFs conduct monthly review meetings in which they share experiences, report on the previous month, review the SAAF dialogue tool, identify challenges and discuss solutions. Four review meetings have been conducted on 5th August, 28th August, 30th September and 2nd November. 15 SAAFs, 4 CHEWs and the project team attended them.

1.4.3: Sensitisation of religious leaders, chiefs and sub chiefs on FP/SRH & MCH, mobilisation, advocacy, rights, and law enforcement
The project identified and sensitised 20 religious leaders, chiefs and sub-chiefs on the project thematic areas, advocacy, mobilisation, rights and law enforcement. The current indicators on MNCH, FP, SRH and nutrition were presented to them in a meeting on 18th September 2015 at St. Ann guesthouse. The aim was to sensitise them on the project thematic areas, to explore the roles of community and religious leaders in the project and to develop an action plan. The religious leaders have also been linked with other non-state actors like SAAFs, PET teams and CHVs so that they can collaborate in creating forums for youth and religious groups on good health practices, especially on MNCH, FP/SRH and nutrition. They agreed to share the dates and venues of their meetings in advance and to work with them (giving them a time slot in the agenda) to engage the crowd on the project thematic targets.

1.4.4: Sensitization of TBAs on referral and importance of skilled care delivery
The activity was conducted on 5th November 2015 at Nyalenda community hall. 35 TBAs were identified by CHEWs and CHVs and the session was co-facilitated by both the project team and County MOH teams. The main agenda of the meeting was to identify all TBAs within Manyatta and Nyalenda, understand their experiences and challenges as TBAs and discuss the referral mechanisms to health facilities for pregnant and lactating mothers including those in need of family planning. Key issues discussed included the danger signs during pregnancy, safe feeding practices and the importance of an individual birth plan and of hospital delivery (or skilled care delivery). TBAs were encouraged by the RH coordinator to actually physically escort their clients to health facilities during delivery to build confidence vis-à-vis health care workers in the facilities. All phone numbers for the available ambulances were circulated so that TBAs can call them if needed.

1.4.5: Sensitisation of private health care providers on FANC, child health, male friendly services and FP
The activity was not done in the first year; it will be conducted in year two.

1.4.6: Sensitisation of community leaders on rights (health, gender, disability, nutrition and education)
The activity was not done in year one and is scheduled in year two.

1.4.7: Undertake cross-learning visits for staff and implementers
In year one, the project managed to support two cross-learning visits. First, 22 SAAFs went on the 25th of August 2015 to Siaya County to share experiences with mature SAAFs who were previously involved in similar activities related to a family planning project. Second, the project officer Cynthia Muhambe visited on the 28th of August 2015 a Kisii program (‘Chagua Maisha’) implemented by CARE to understand how the mentor mother component works.
She visited the health facilities implementing the program and had a one-on-one interaction with mentor mothers attending to clients.

1.4.8: Steering committee meetings
The steering committee is composed of 10 staff members from CARE, FHOK and KRCS who discuss the project implementation progress and make adjustments if needed. In year one, the project held two steering committee meetings. The first meeting was held on 5th February 2015 in Nairobi and the main agenda was to review coordination mechanisms. The second meeting was held on 19th May 2015 in Kisumu to discuss the efficiency of the partnership and to assess the project progress to date.

1.4.9: Sub-County planning and review sessions
These planning and review sessions bring together 16 members from the SCHMT and CHMT, as well as project staff and 1 member from each organisation from the steering committee. The first meeting was held at the MOH Kisumu Sub-County office on 22nd August 2015 with 13 participants. The main agenda was to discuss the project activities and to clearly identify the roles of both parties in executing the work plan. The discussions were centred on the implementation of the outreach activities, the support supervision reports, mentorship and on-the-job training for HCWs at the facilities.

1.5: Train and update regularly different cadres of health workers on relevant technical skills
The state actors were trained on technical relevant skills to empower them and provide them with updates on the current guidelines for each of the project thematic areas. The main targets were HCWs in the facilities.

1.5.1: Train health care workers on contraceptive and male services
The technical training of HCWs on MNCH, FP/SRH and nutrition was prepared by the project team and Kisumu East Sub-County management team. They agreed on the choice of participants to be invited, ie. those who actively offer MNCH, FP/SRH and nutrition services at the facilities. The training was held at the Good Samaritan Hotel in Kisumu from 25th to 29th May with a total number of 25 health care providers from Manyatta and Nyalenda health facilities. The topics covered in the technical module included an overview of family planning, current FP guidelines and policy documents, current fertility trends and unmet needs in Kisumu County, long acting and permanent methods, infection prevention, counselling in FP/SRH, reproductive health anatomy and physiology, medical eligibility criteria, data and records management, nutritional interventions and essential obstetric care. The course was facilitated by the MOH County and Sub-County technical expert teams in close collaboration with the project teams. All the sessions were evaluated on a daily basis. The training days also included a two-day practicum session to selected health centres within the catchment areas (Migosi health centre, Manyatta outreach sites and Nyalenda health centre). Different methodologies were used to deliver the technical training, such as lecture methods, group discussions, role plays and demonstrations.

1.5.2: Training health care workers on IYCF
The main purpose of this training was to improve the child health outcomes throughout the pregnancy and nursing periods. The Infant and Young Child Feeding (IYCF) training was conducted at Jumuiya hotel from 5th to 10th October 2015. A total of 20 HCWs selected from the 8 healthcare facilities in Manyatta and Nyalenda attended the training. The cadres included
nurses, clinical officers, nutritionists and social workers. The training content covered the following topics: introduction to IYCF; infant feeding beliefs and myths; importance of breastfeeding; breastfeeding positioning and attachment; lactation amenorrhea; common breastfeeding challenges; importance of cup feeding and breastfeeding; nutrition for the mother during breastfeeding; nutrition before pregnancy and complimentary feeding. The facilitators for the training were selected from the County MOH teams.

All these trainings of state and non-state actors have increased their capacities to deliver quality services to the final beneficiaries. For example, the health care providers trained on modern contraceptive technology updates are now able to insert the contraceptive implant NXT which was recently introduced into the market to replace Implanon, thereby increasing the uptake of long-term contraception. Thanks to the trainings, nutritional screening at community, outreach and facility levels is now properly done. Integrating both state and non-state actors in offering services has further boosted the numbers of people reached. For example, introducing PET during community outreaches has really changed community mobilisation and more people are accessing health services.

1.6: Provide basic renovation of existing structures, equipment and basic supplies for MNCH, nutrition and family planning

The project procured all the listed basic equipments to facilitate service delivery during the outreach activities. Moreover, as identified during the capacity assessment, some facilities that lacked basic equipments received supplies to help them deliver essential services, especially long-acting family planning methods. Some of the equipments procured included IUCD insertion kits, implant insertion kits, screening equipment (BP machines and stethoscope), coaches autoclaves and nutritional screening equipments.

1.7: Mentoring and support supervision for health care workers

CHMTs and SCHMTs offer mentorship and support supervision to the HCWs in the 8 facilities supported by the project in order to improve the quality of the services provided to the communities of Manyatta and Nyalenda.

1.7.1: Joint mentorship and support supervision of health care workers

In 2015, the project conducted one joint support supervision visit in all the 8 health facilities from 10th to 12th August, followed by a debrief on 13th August 2015 and a feedback meeting to share the mentorship findings with facility in-charges on 14th August. The MOH and the project team had preliminary preparatory meetings to harmonise the mentorship tool to be used during support supervision and agreed on the areas to be assessed. 24 participants (facility in-charges, MNCH implementers and Sub-County teams) attended the feedback meeting. Some of the gaps identified related to nutritional assessments (no full anthropometric measurements), the lack of reporting tools (especially on nutritional services), the lack of basic equipments to provide long-acting family planning methods (e.g. IUCD kits) as well as the heavy workload at Migosi health centre. This facility needs additional staff and the SMOH promised to post students as a temporary measure as well as to engage with the County government to recruit more personnel and reduce the workload. The project budget revision also includes a nutritional intern to be posted in Migosi and Nyalenda health centres. Moreover, the MOH will initiate job trainings to improve the competency of some of the HCWs and the project will procure basic equipments and supplies to the identified health facilities.
1.7.2: Quarterly programme coordination, review and planning meetings
The project conducted in 2015 four programme coordination, review and planning meetings with all the project beneficiaries (CARE, KRCS and FHOK). The first took place on 24th February 2015 and focused on the development of a detailed project work plan. The second meeting was held at the Kisumu office on 18th May 2015. Its aim was to discuss partnership and project progress, each partner presenting a review on its thematic component. The third review meeting was conducted at Bondo Pride Hotel from 31st August to 2nd September 2015. Project progress based on the accelerated work plan was assessed. The last meeting was done in Nairobi on 9th and 10th October 2015. The annual budget burn rates were discussed and a revised budget based on activity implementation in year one was agreed upon.

Expected Result 2: “Awareness & Demand” - Awareness and knowledge empowered targeted men, women and adolescents in Kisumu slums to take part in health decision making, and to demand accountability and quality health services on maternal & child health, family planning, sexual & reproductive health and nutrition.

The targeted communities are increasingly aware of and demanding services on MNCH, FP/SRH and nutrition, as shown by the increase in the number of clients accessing integrated services. The demand and mobilisation are resulting from a combined effort of HCWs through morning health talks and the provision of high quality services measured through client exit interviews, CHVs already trained on community mobilization, PET teams who mobilize through participatory theatre as well as SAAF who open community dialogues to address some of the barriers limiting access to MNCH, FP/SRH and nutrition services.

Indicator 1: Increase in the percentage of Women of the Reproductive Age (WRA) who are aware of at least 3 HiNi interventions from 16% to 30% (R2)

Baseline value: 16%

Level of achievement: This indicator was not measured at the end of year 1 since it requires a survey methodology to measure it. As such, it will be measured during the mid-term and end line evaluations. In year 1, the project reached 9,621 women of reproductive age with nutrition information focusing on HiNi interventions. In addition, 657 pregnant and lactating women were sensitised on HiNi packages, including good nutritional practices during the antenatal and post-natal periods.

Indicator 2: Increase the percentage of WRA knowledgeable about at least 5 pregnancy danger signs from 28% to 40%.

Baseline value: 28%

Level of achievement: This indicator was not measured at the end of year 1 since it requires a survey methodology to measure it. As such, it will be measured during the mid-term and end line evaluations. During year 1, the project reached out to 4,277 ANC clients who were educated on the pregnancy danger signs and encouraged to go to a hospital in case they notice any of the danger signs.
**Indicator 3**: Maintain the percentage of targeted population aged 15-49 who know at least one modern contraceptive method at 97% through to 2017.

**Baseline value**: 97%

**Level of achievement**: This indicator was not measured at the end of year 1 since it requires a survey methodology to measure it. As such, it will be measured during the mid-term and end line evaluations. During year one, 6,186 clients were at least aware of one modern contraceptive method.

**Activities**

**2.1: Quarterly joint community leaders, health managers and health providers’ forum**

This activity will start in year two.

**2.2: Plan and conduct behaviour change and participatory discussions and education sessions on health rights, health services uptake and knowledge**

The project has used the identified community agents to mobilise clients through behaviour change and participatory discussions as well as education sessions. Various community agents were trained in this regard, including peer educators (PE), PET teams, male champions and model couples. SAAF and Malezi Bora support groups were also trained (see activities under expected results 1 and 3 respectively) and played an important role in mobilising communities on behaviour change.

**2.2.1: PE training for adolescent, peer educators in and out of school**

The project trained 30 peer educators in and out of school from 15th to 18th September 2015 at Polyview hotel in Kisumu. The peer educators were identified/recruited using a tool developed by the project team soliciting specific information like previous experience on SRH, ability to mobilize or public confidence. They were selected by CHEWs from Manyatta and Nyalenda slums based on the analysis of the tool summary. All peer educators were trained on the following areas: sexuality, anatomy and physiology of reproductive organs, family planning, prevention of STIs and HIV, growth and development, drug abuse, personal hygiene, relationship, communication and youth friendly services. They were also sensitised on project thematic areas. The training was facilitated by reproductive health trainers from FHOK and the project team. The peer educators now mobilise and sensitise other youth on reproductive health issues and refer cases to youth friendly centres.

**2.2.2: Quarterly planning and review forums for peer educators**

In 2015, we have only had one review forum for peer educators because of delays encountered in recruiting them. The FHOK program officer coordinating this activity resigned and it took time to recruit another officer. The review forum took place at Manyatta youth centre on the 30th of October 2015. It was attended by all 30 peer educators. The agenda was to review the activities of peer educators and compare them with their action plan. The peer educators shared monthly reports, work plans, experiences, and challenges they faced in the field. They also developed a joint work plan for the following quarter.
2.2.3: Form and train Participatory Educational Theatre (PET) teams
The PET groups mobilise community members through plays encouraging access to health services, promoting health-conducive practices and addressing harmful socio-cultural barriers concerning reproductive health and nutrition. Two PET groups were selected in the slums of Manyatta and Nyalenda. The Manyatta group is a registered theatre group called Amazon and the Nyalenda group is called Vuka Vuka youth group. They were trained from 7th to 11th September 2015 on topics such as basic skills of drama, basic concepts of FP, MNCH and nutrition, community entry and mobilisations, and the use of PET tools. The PET groups usually present plays during outreaches and community dialogues. Each group comprises ten members and has signed a MoU on the number of dramas they must perform each month to the targeted audience. The teams have worked well with SAAFs and CHVs and have reached a total of 20,741 final beneficiaries in year 1.

2.2.4: Sensitization of male champions in decision-making, role modelling and social cultural barriers impeding access to MNCH, FP/SRH and nutrition services
The male champions were recruited by SAAFs in conjunction with CHVs, CHEWs and facility staff. They were selected based on their experience in influencing others, their active participation on RH issues, their role modelling as a father figure and their recognition by MOH health facilities. In total, the project recruited and trained 27 male champions at St. Ann guest house on 9th November 2015. The key topics covered included basic family planning services, basic RH issues in regard to pregnancy and nutrition, the role of men in RH issues, social cultural myths and misconceptions regarding household decision-making as well as sharing of roles as family members. The trained champions were linked to community social agents (SAAF and PET teams) for championing male involvement in community forums and dialogues. Furthermore, model couples were selected from among the male champions and their spouses/partners who demonstrated behaviour change and had overcome socio-cultural barriers to support their families on issues relating to MNCH, FP/SRH and nutrition. The main role of model couples is to raise awareness and explore with other couples, and especially men, the socio-cultural obstacles limiting access to MNCH, FP/SRH and nutrition services. The male champions and model couples are collaborating well with CHVs and other community agents and they take advantage of organised community forums like chiefs’ barazzas or church forums to sensitise the communities on behaviour change.

2.2.5: Development of media and communication content
The development of media and communication content is expected to start immediately after the award of a tender contract in December 2015.

2.3: Organize targeted health education on family planning, SRH, FP and nutrition at facility level for different target groups

2.3.1: Training of mentor mothers on Kenya mentor mother programme
Mentor mothers are HIV-positive mothers who were recruited as per the Kenya mentor mother programme guidelines to support the project in the prevention of mother-to-child transmission (PMTCT) and in linking pregnant women to facilities for ANC, Focused Antenatal Care (FANC), skilled care delivery, postnatal care and nutrition for under five children. The training was conducted from 13th to 16th July 2015 at KUAP Pandpieri Community Hall. 12 mentor mothers from Nyalenda and Manyatta attended it. The facilitator was a trainer of trainees from Kenya mentor mothers’ programme. The content covered included an introduction to KMMP, HIV/AIDS basics, opportunistic infections and other HIV-related illnesses, HIV testing, addressing stigma and supporting disclosure, prevention of
PMTCT, anti-retroviral (ARV) drugs, SRH, safe motherhood and early infant care, infant feeding, healthy mothers and healthy families, responsibilities, standards and codes of practice, communication skills, behaviour change as well as leadership and management. After the training, the mentor mothers were placed at Migosi, Nyalenda, Kowino and Nightingale hospitals. They have done a tremendous work in tracking all clients screened at the health facilities and in linking them to PMTCT programmes for follow-up.

2.3.2: Quarterly review and planning meetings for mentor mothers
Their first quarterly review and planning meeting was held at Royal City Hotel on 15th October with all the 12 mentor mothers as well as facility in-charges whom they report to in the attached health facilities and the SCHMT (making a total of 21 participants). They shared field experiences based on the work they have implemented for the last months, submitted reports and discussed challenges. The project team also responded to some of the logistical obstacles they encountered. The participants finally planned and shared targets for the next quarter review meeting scheduled in January 2016.

2.4: Adopt a mobile phone platform (Jamii Smart Initiative e-Health solutions), registration of clients and dissemination of information on MCH, FP/SRH and nutrition to impact group members
The mobile application currently has some technical challenges related to the notification messages sent to clients. The application operator has been working on the fault and the project team is waiting for the confirmation of its rectification before it starts using the application.

Expected Result 3: “Utilization & Practices MNCH, FP/SRH, Nutrition” - Targeted men, women, adolescents, children and vulnerable groups in Kisumu slums are empowered to increase utilization of quality maternal and child health services, family planning and sexual reproductive health services, nutritional health services, and to take up health conducive practices in these fields

Indicator 1: Increase the proportion of infants exclusively breastfed for first six months of life from 37% to 45% (R3)

Baseline value: 37%

Level of achievement: This indicator was not measured at the end of year 1 since it requires a survey methodology to measure it. As such, it will be measured during the mid-term and end line evaluations. During year 1, the project mobilised 2,258 children who were exclusive breastfed for the first six months of life. The project team and trained health care providers continue to advocate for exclusive breastfeeding, but some women report challenges when they have to go back to work (they then start to introduce mixed feeding instead of exclusive breastfeeding).

Indicator 2: Increase the proportion of children who receive Vitamin A supplementation from 36% to 47% (R3)

Baseline value: 36%
Level of achievement: This indicator was not measured at the end of year 1 since it requires a survey methodology to measure it. As such, it will be measured during the mid-term and end line evaluations. In year 1, 825 children received Vitamin A supplementation.

Activities

3.1: Plan and conduct targeted participatory education on health-conducive behaviour to counter retrogressive cultural practices regarding maternal and child health, SRH and nutrition

As mentioned above (2.2.3) the project has recruited and trained 20 PET members who work in groups of 10 to conduct participatory educational theatre, as well as 15 SAAFs, 30 PE and 80 CHVs who all engage and dialogue with final beneficiaries on health-conducive behaviours and the dangers of harmful socio-cultural practices. The PET members have also been incorporated into the outreach programme. To date, they have conducted 34 performances.

3.2: Facilitate the provision of family planning services incl. counselling by trained community health care workers at household level

3.2.1: Train community health workers as community based distributors

The activity was not implemented in year one because the recruitment of CHVs and the related technical training took more time than anticipated (some of the CHVs recruited are planned to be part of the community distributors of contraceptives). Therefore, the training will be done in year two to accelerate access to contraceptives.

3.2.2: Quarterly community based distributors’ (CBD) reflection and review forums

They will take place in year two.

3.3: Orient teachers, patrons and education officials for FP/SRH in school health clubs on FP and sexual health

This will be done in year two.

3.4: Conduct effective screening of vulnerable groups for malnutrition at health facility and community level and treatment

3.4.1: Monthly outreach session with integrated FP/SRH, MNCH & nutrition services for men and women of reproductive age, children, youths and adolescents

In year 1, the project conducted 21 outreaches within Manyatta and Nyalenda slums. 1,560 clients accessed FP services and 847 cervical cancer screening. 261 pregnant and lactating mothers as well as 655 children under five (333 males and 322 females) were offered a nutritional assessment. During these outreach sessions, it was measured that 43 children were moderately mal-nourished and 14 were severely mal-nourished. All the children were referred for further nutrition management to JOOTRH and Kisumu Sub-County Hospital. Out of the 261 pregnant and lactating mothers, one was moderately mal-nourished. Moreover, 294 children under five were fully immunised during outreaches, as well as 138 pregnant mothers (antenatal with tetanus toxoid). 123 lactating mothers received targeted postnatal care.
Offering outreach activities in collaboration with health facilities and community members increased the access to FP/SRH, MNCH and nutrition services in the targeted areas.

3.5: Targeted mobilisation of pregnant and lactating women for nutrition educational sessions on HiNi package and establish link to malaria control and prevention

3.5.1: Formation of Malezi Bora support groups
In year one, the project established 31 support groups for pregnant and lactating mothers commonly referred to ‘mother-to-mother support groups’ (or “Malezi Bora” groups) within Manyatta and Nyalenda. 31 CHVs (among the 80 already recruited, see activity 1.3.2) were trained as mother-to-mother facilitators from 7th to 10th September 2015 at KUAP Pandi Pieri community hall in Nyalenda. The training included a full module on IYCF, mother-to-mother group objectives, roles and responsibilities of facilitators as well as training on saving for births under the group savings and loan model. Creating Malezi Bora support groups for pregnant and lactating mothers created synergies and encouraged fellow mothers to prepare individual birth plans and get support during the nursing period.
2.3. Revised logframe (approved by Mita Manek on December 21st, 2015)

|整体目标 | 改进母子健康、性健康、计划生育和营养状况，肯尼亚基苏木县社区内
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<tr>
<td>干预逻辑</td>
<td>主观可验证的成就指标</td>
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</table>
| 每个具体目标 | SO 1: 提高非政府和政府健康工作者提供母子健康、性健康、计划生育和营养服务的能力，设基苏木县Manyatta和Nyalenda难民营的非政府和政府健康工作者，以及参与决策过程的脆弱群体。 | 指标 1: 提高基苏木县难民营儿童一岁以下全免疫比例从83%到87%（SO1）
 指标 2: 减少基苏木县难民营5岁以下儿童生长迟缓或营养不良的比例从23%到18%（SO1）
 指标 3: 确保每季度举行至少25%的MNCH、FP/SRH和营养专家会议。
 指标 4: 确保利益相关者群体的影响能在至少25%的基苏木县多重指标群组调查和项目活动报告中反映。
 | 肯尼亚人口和健康调查、项目评估报告、基苏木县多重指标群组调查和项目活动报告。
 | 国家战略和政策得到有效实施。关键的政府部门和健康工作者有兴趣和能力促进政策和实施标准。
 | 基础设施和脆弱群体的参与。
 | 食物不安全问题被政府和其他干预措施解决。 |

注: 这些包括残疾人、孤儿和与HIV有关的妇女，以及处于生育年龄的青少年。
**SO 2:** Targeted communities are aware and empowered to demand, access and utilise quality maternal & child health, nutrition, sexual reproductive health and family planning services

| Indicator 1: | Increase the proportion of pregnant women attending 4 or more ante-natal care visits from 65% to 70% in Kisumu slums. |
| Indicator 2: | Increase the proportion of skilled care deliveries from 62% to 65% in Kisumu slums. |
| Indicator 3: | Increase the percentage of WRA using long acting family planning methods from 22% to 26% in Manyatta and Nyalenda slums, Kisumu County. |

**Expected results**

| R1 – “Capacity building” | Non-state and state health actors have greater capacity and improved skills to respond and meet needs on maternal & child health, family planning, sexual & reproductive health and nutrition in Manyatta and Nyalenda slums, and adequately include affected population in health decision making |
| Indicator 1: | Increase the number of health facilities providing both essential MNCH services and full HiNi package from 2 to 5 in Kisumu slums (R1) |
| Indicator 2: | Increase the number of health facilities offering comprehensive long-term FP/SRH services from 4 to 8 in Kisumu slums (R1) |
| Indicator 3: | Increase the number of community health units offering comprehensive level 1 SRMNH and nutrition services in Kisumu slums from 0 to 4 units by 2017. |

Local non-state and state actors are willing to engage and collaborate and are sufficiently equipped and financed. Key health actors are willing to improve their professional skills and attitudes. Means of communication and transportation of health extension workers are ensured.
## Indicator 4
At least 75% of clients report that targeted health actors demonstrate improved attitude towards clients (women, adolescents)

### R 2 – “Awareness & Demand”
Awareness and knowledge empowered targeted men, women and adolescents in Manyatta and Nyalenda slums to take part in health decision making, and to demand accountability and quality health services on maternal & child health, family planning, sexual & reproductive health and nutrition

<table>
<thead>
<tr>
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<td>Increase the percentage of WRA knowledgeable about at least 5 pregnancy danger signs from 28% to 40%.</td>
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<td>Indicator 3</td>
<td>Maintain the percentage of targeted population aged 15-49 who know at least one modern contraceptive method at 97% through to 2017.</td>
</tr>
</tbody>
</table>

**Project evaluation reports, project activity reports.**

Vulnerable groups are willing to actively participate in project activities.

Local non-state and state actors are willing to engage and collaborate with vulnerable groups.

### R3 – “Utilisation & Practices MNCH, FP/SRH, nutrition”
Targeted men, women, adolescents, children and vulnerable groups in Manyatta and Nyalanda slums are empowered to increase utilisation of quality maternal and child health services, family planning and sexual reproductive health services, nutritional health services, and to take up health conducive practices in these fields

<table>
<thead>
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</table>

**Project evaluation reports, project activity reports, DHIS**

Community members and opinion leaders willing to actively participate in project activities.
<table>
<thead>
<tr>
<th>Activities</th>
<th>Means:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Organise sensitisation forum, review sessions with county</td>
<td>1.1: Transport, Venue Hire, Conference Package</td>
</tr>
<tr>
<td>1.2 Carry out mapping of outreach sites, conduct organisational capacity assessment</td>
<td>1.2: Transport, lunch, stationary</td>
</tr>
<tr>
<td>1.3 Support the establishment of 8 functional Community Units (CUs)</td>
<td>1.4, 1.5: Transport, Venue Hire, Conference Package; Facilitation Fee, Radio airing; dinner allowance</td>
</tr>
<tr>
<td>1.4 Design, carry out capacity building interventions for non-state and selected state-actors</td>
<td>1.6: Injectables, Implants, IUDs, FP Consumables, Gloves, Cotton Wool, Spirit, Gauze; FP basic equipment: IUD Insertion Kits, Norplant Insertion Kits, Kidney dishes, Sponge forceps, Teneculum, Uterine Sound Assorted forceps, Examination couch, BP Machines, Autoclaves, Stethoscopes, Weighing scales, Lockable metal Cabinets</td>
</tr>
<tr>
<td>1.5 Train, update regularly health workers on technical skills</td>
<td>1.7: Transport costs, Lunch, Supervision Tools (Check Lists &amp; Stationary)</td>
</tr>
<tr>
<td>1.6 Provide basic renovation, equipment, basic supplies</td>
<td>2.1: Transport, Lunch, Tents, Chairs, PA system</td>
</tr>
<tr>
<td>1.7 Mentoring, supervision for health care workers</td>
<td>2.2, 2.3: Transport, stationery, materials</td>
</tr>
<tr>
<td>2.1 Quarterly joint community leaders, health managers and health providers’ forum</td>
<td>3.1: Transport, Venue Hire, Conference Package, Facilitation Fee, Accommodation; youth: Stipend for PETs, Tents, Chairs, PA System, Transport, Mobilization Fee; Model couples: Transport, Lunch</td>
</tr>
<tr>
<td>2.2 Plan, conduct participatory discussion &amp; education sessions for information, knowledge</td>
<td>3.2, 3.3: Transport, Lunch</td>
</tr>
<tr>
<td>2.3 Organise health education forums at facility level</td>
<td>3.4, 3.5: Stipends, Commodity Bags, Reporting Tools (Hand cover books, pens)</td>
</tr>
<tr>
<td>2.4 Adopt a mobile phone platform (Jamii Smart Initiative /e-Health solutions) for registration of clients and information dissemination</td>
<td>Project office: Rental Costs, Furniture &amp; Fittings, Office Equipment, Personnel Costs, Travel Costs</td>
</tr>
<tr>
<td>3.1 Plan, conduct participatory education on health conducive behaviour to counter retrogressive cultural practices</td>
<td>Monthly, quarterly, annual project reports (incl. financial reports); mid-term evaluation; independent reports, surveys from partners and stakeholders;</td>
</tr>
<tr>
<td>3.2 Facilitate provision of family planning by trained Community Health Workers at household level</td>
<td>Costs in EURO</td>
</tr>
<tr>
<td></td>
<td>Human Resources (incl. Per diems): € 308.897.18</td>
</tr>
<tr>
<td></td>
<td>Travel: € 41.188</td>
</tr>
<tr>
<td></td>
<td>Equipment &amp; Supplies: € 5.163.39</td>
</tr>
<tr>
<td></td>
<td>Local office: € 71.536.05</td>
</tr>
<tr>
<td></td>
<td>Other Costs/ Services: € 415.517,55</td>
</tr>
<tr>
<td></td>
<td>Others: € 245.368,82</td>
</tr>
<tr>
<td></td>
<td>Total direct costs: € 1,087,671</td>
</tr>
</tbody>
</table>

Stock outs of MCH related drugs can be avoided by all supply chain actors being prepared to be better coordinated. Other interventions such as economic empowerment in the Kisumu slums support the project’s effort to improve gender equality. Strong project management system precludes fraudulent and corrupt practices of all involved stakeholders, also outside of the project’s reporting system. Communities and target groups prepared to participate in the project.
<table>
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<tr>
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<th>3.3 Orient teachers, patrons and education officials for SHR/FP in school health clubs</th>
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<tr>
<td></td>
<td>3.4 Conduct screening of vulnerable groups for malnutrition and treatment</td>
</tr>
<tr>
<td></td>
<td>3.5 Mobilise pregnant and lactating women on HiNi, link to malaria control</td>
</tr>
</tbody>
</table>
Please list all contracts (works, supplies, services) above €60,000 awarded for the implementation of the action during the reporting period, giving for each contract the amount, the award procedure followed and the name of the contractor.

No contracts above 60,000 EUR have been awarded.

### 2.4. Updated action plan

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Activity</th>
<th>Months</th>
<th>Implementing body</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>D</td>
</tr>
<tr>
<td>1.1. Organise a sensitisation forum and continuous review sessions with County leadership and County Assembly members</td>
<td>Sensitisation forum with County leadership and County assembly members on resource allocation and accountability</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quarterly reviews and planning sessions with CHMTs and SCHMT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3. Support the establishment of 8 functional Community Units (CUs)</td>
<td>Community health workers refresher training on technical training (MNCH/FP &amp; nutrition)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community health workers monthly review meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4. Design and support capacity-building interventions for non-state and selected state actors</td>
<td>Social Analysis and Action Facilitators review meetings</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Sensitisation of religious leaders, chiefs and sub-chiefs on FP/SRH &amp; MNCH, mobilisation, advocacy, rights and law enforcement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sensitisation of TBAs on referral and importance of skilled hospital delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sensitization of private health providers on FANC, child health, male friendly services &amp; FP</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Sensitisation of community leaders on rights (health, gender, disability, nutrition and education)</th>
<th>X</th>
<th>X</th>
<th>X</th>
<th>CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undertake cross-learning visits for staff and implementers</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>CARE</td>
</tr>
<tr>
<td>Steering committee meetings</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sub-County planning and review sessions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

1.5. Train and update regularly different cadres of health workers on relevant technical skills

| Train and coach MOH staff in strengthening the supply chain, management systems and commodity management | X | | | KRCs and CARE |
| Training health care workers on integrated management of childhood illnesses (IMCI) | X | | | CARE |
| Staff training on gender diversity and mainstreaming | X | | | CARE |

1.6. Provide basic renovation of existing structures, equipment and basic supplies for MNCH, nutrition and family planning

| X | X | X | X | ALL |

1.7. Mentoring and support supervision for health care workers

| Joint mentorship and support supervision of health care workers | X | X | X | X | X | CARE |
| Quarterly programme coordination, review and planning meetings | X | X | X | X | X | CARE |

2.1 Quarterly joint community leaders, health managers and health providers’ forum

| X | X | X | X | X | CARE |

2.2. Plan and conduct behaviour change and participatory discussions and education sessions on health rights, health services uptake and knowledge

| Quarterly planning and review forums for peer educators | X | X | X | X | X | CARE |

| Development of media and communication content | X | | | | | FHOK |

2.3. Organise targeted health education on family planning, SRH, FP and nutrition at facility level for different target groups

<p>| Quarterly review and planning meetings for mentor mothers | X | X | X | X | X | CARE |</p>
<table>
<thead>
<tr>
<th>2.4 Adopt a mobile phone platform (Jamii Smart Initiative e-Health solutions), registration of clients and dissemination of information on MCH, FP/SRH and nutrition to impact group members</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant mothers notification through mobile phone messages</td>
<td>X X X X X X X X X</td>
</tr>
<tr>
<td>3.1. Plan and conduct targeted participatory education on health conducive behaviour to counter retrogressive cultural practices regarding maternal and child health, nutrition and SRH</td>
<td>X X X X X X X X X</td>
</tr>
<tr>
<td>3.2. Facilitate the provision of family planning services incl. counselling by trained community health care workers at household level</td>
<td></td>
</tr>
<tr>
<td>Train community health workers as community based distributors (CBD)</td>
<td>X</td>
</tr>
<tr>
<td>Quarterly CBDs’ reflection and review forums</td>
<td>X X X X X X</td>
</tr>
<tr>
<td>3.3. Orient teachers, patrons and education officials for FP/SRH in school health clubs on FP and sexual health</td>
<td></td>
</tr>
<tr>
<td>Sensitisation of ECD providers and teachers on child health education, immunisation and hygiene</td>
<td>X</td>
</tr>
<tr>
<td>Quarterly review with teachers and ECD (primary and secondary)</td>
<td>X X X X X X</td>
</tr>
<tr>
<td>3.4. Conduct effective screening of vulnerable groups for malnutrition at health facility and community level and treatment</td>
<td></td>
</tr>
<tr>
<td>Mapping and conducting outreach sessions with integrated FP/SRH, MNCH &amp; nutrition services for men and women of reproductive age, children, youths and adolescents</td>
<td>X X X X X X X X X X</td>
</tr>
<tr>
<td>3.5. Targeted mobilisation of pregnant and lactating women for nutrition education sessions on HiNi package and establish link to malaria control and prevention</td>
<td>X X X X X X X X X</td>
</tr>
<tr>
<td>Mid-term evaluation</td>
<td>X</td>
</tr>
</tbody>
</table>
3. Beneficiaries/affiliated entities and other Cooperation

3.1. How do you assess the relationship between the Beneficiaries/affiliated entities of this grant contract (i.e. those having signed the mandate for the Coordinator)? Please provide specific information for each Beneficiary/affiliated entity

The partnership between CARE, KRCS and FHOK functions efficiently. CARE coordinates the Action and the MNCH component, while KRCS focuses on nutrition and FHOK on FP/SRH activities. As mentioned above, the key project officers work in the same office (in CARE premises) under the coordination of the project manager. All activities are jointly planned and no major challenge has been encountered.

3.2. How would you assess the relationship between your organisation and State authorities in the Action countries? How has this relationship affected the Action?

The MOH and County Government of Kisumu have given full support to the project, especially through its Kisumu East SCHMT. Their participation is particularly important during joint support supervision, trainings and mentorship visits. They also provide logistical support and commodities for several activities (for example contraceptives during outreaches).

3.3. Where applicable, describe your relationship with any other organisations involved in implementing the Action:

Final Beneficiaries and Target groups
Final beneficiaries expressed their appreciation to participate in project activities including outreaches, facility-based initiatives and other community-organised events. Some of them are actively taking part in project activities, as role models or members of various support groups. Community and religious leaders are supporting the project and their involvement is important to mobilise the populations.

Other third parties involved (including other donors, other government agencies or local government units, NGOs, etc.)
The project has not encountered any challenges in its relationships with other donors that have funded the project (CARE and ADA). The CARE USA President and CARE Regional Director accompanied by CARE Kenya’s Assistant Director of Programs visited the project on 25th June 2015. They attended a project activity with young and breastfeeding mothers in Manyatta. The dialogue focusing on sexual reproductive health and family planning was conducted by trained SAAF groups and PET teams.
Andrea Schmid, Head of the “Civil Society International Unit” at the Austrian Development Agency (ADA), visited the project on November 9th. After meeting with the project team, she participated in a facility-organised integrated outreach in Nyalenda and in a meeting of nursing mothers challenging harmful socio-cultural barriers limited access to skilled health care.
3.4. Where applicable, outline any links and synergies you have developed with other actions

Not applicable.

3.5. If your organisation has received previous EU grants in view of strengthening the same target group, in how far has this Action been able to build upon/complement the previous one(s)? (List all previous relevant EU grants)

Not applicable.
4. Visibility

How is the visibility of the EU contribution being ensured in the Action?

A project communication and visibility plan was developed and submitted to the EU on 14th April 2015. Its two overall objectives are:

- Ensure that key target groups/populations including County leaderships are aware of the work that the EU, CARE and the co-beneficiaries (FHOK & KRCS) are doing in this particular Action to improve MNCH, FP/SRH and nutrition indicators in Manyatta and Nyalenda slums of Kisumu: All communication materials produced and the supported health facilities will be branded as per EU guidelines including all Information Education Communications (IEC). We commit to seek prior EU approvals of all brand identity productions. In addition, the project will hold targeted forums both at County level and community levels as part of the project activities to encourage the communities to demand and utilise health services. In such forums, the EU support will be displayed and communicated to the beneficiaries and County leadership teams and the training materials will bear the EU logo.

- Raise awareness within Kenya and in Europe on how the EU and the project’s beneficiaries are working together to support activities on MNCH, FP/SRH as well as nutrition in the Kisumu County: This objective targets among others policy-makers and activities will include participation and inclusion in national technical working groups per each thematic area under the relevant Ministry’s division of family health as well as participation in national and international SRH conferences (e.g. presenting good practices from the project activities).

The target groups of our communication and visibility plan are as follows:

- Local population in Kisumu County, with a specific focus on youth as well as women and men of reproductive age;
- County government and other local authorities;
- Local vernacular media channels;
- Community opinion leaders (religious leaders, community elders);
- Local NGOs and CBOs;
- National policy-makers;
- International NGOs, UN agencies, international delegations and embassies;
- National and international journalists / mass media to report and cover open public events;
- Specific media and interested public in Austria and the European Union.

As planned, the project launch ensured donor visibility and several IEC materials bearing all donors’ logos were distributed. The project has further produced official project banners and brochures which we use on a daily basis to communicate and increase donor visibility during various forums. The County and Sub-County health management teams know that the EU is the main donor of the Action. EU-approved T-shirts, banners and IEC materials are currently displayed in all the community events and training sessions to ensure project and donor visibility. Some examples are visible in the pictures below.
Official project launch in Kisumu with representatives from the EU delegation and H.E Jack Ranguma

Nutritional screening during an outreach
Training of SAAFs

We were informed that a number of facilities supported by the project need painting. We would like to use this opportunity to design large IEC murals/drawings/strong messages that we can paint on the walls of these facilities (including EU logo). It would also contribute to increased visibility at community and facility level. This proposal has been included in our revised budget.

The project also took part in Kenya’s First Lady “Beyond Zero Campaign” since its activities are well aligned towards the goals of the “Beyond Zero Campaign”, namely averting maternal deaths, improving maternal health, child health and ensuring zero new HIV infections. The project was selected because of its unique integration of three core components (MNCH, FP/SRH and nutrition) and the incorporation of a social change aspect into RH-related activities. The project was well represented and the First Lady acknowledged that integrating deep rooted socio-cultural norms limiting the access (especially women’s access) to health care into the project was a major step towards the “Beyond Zero Campaign” objectives.
Presentation of the project to the First Lady
The European Commission may wish to publicise the results of Actions. Do you have any objection to this report being published on the EuropeAid website? If so, please state your objections here.

We do not have any objections.

Name of the contact person for the Action: Marion EHALT

Signature: ..........................................

Location: Vienna

Date report due: 31st January 2016

Date report sent: 1st February 2016