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USAID KENYA EVALUATION SERVICES AND PROGRAM SUPPORT

APHIAPLUS END-OF-ACTIVITY PERFORMANCE EVALUATION

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DISCLAIMER

The authors' views expressed in this report do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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ACRONYMS

ACT	Artemisinin-Based Combination Therapies
ADT	Antiretroviral Dispensing Tool
AIDS	Acquired Immune Deficiency Syndrome
AMPATH	Academic Model for Prevention and Treatment of HIV
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
AOR	USAID Agreement Officer's Representative
APHIA	AIDS, Population, and Health Integrated Assistance
ASSIST	USAID's Applying Science to Strengthen and Improve Systems Project
BEmONC	Basic Emergency Obstetric and Neonatal Care
CABDA	Community Asset Building and Development Action
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
CHW	Community Health Worker
CINCO	County Integration Coordinator
CME	Continuing Medical Education
CoP	Chief of Party
COP	USAID Country Operational Plan
CRS	Catholic Relief Services
CSI	Child Status Index
CYP	Couple years of protection
DBS	Dried Blood Spot
DH	District Hospital
DHIS	District Health Information System (Kenya's National Health Information System)
DHS	Demographic and Health Survey
DIC	Drop-in Center
EBI	Evidence-Based Intervention
EID	Early Infant Diagnosis
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EmONC	Emergency Obstetric and Neonatal Care
EPI	Expanded Program on Immunization
ESPS	Evaluation Services and Program Support
ET	Evaluation team
FBO	Faith-based organization
FGD	Focus group discussion
FGM/C	Female genital mutilation/cutting
FHI360	Family Health International
FHOK	Family Health Options Kenya
FP	Family planning
FSW	Female sex workers
FUNZO	Kiswahili word for "Training"
GoK	Government of Kenya

HC	Health centre
HCSM	USAID's Health Commodities and Services Management Project
HES	Household Economic Strengthening
HEI	HIV-exposed infants
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HSSF	Health Sector Services Fund
HTC	HIV Testing and Counseling
IBTCI	International Business and Technical Consultants, Inc.
ICAP	International Center for AIDS Care and Treatment Programs
ICCM	Integrated community case management
IGA	Income-generating activity
IMCI	Integrated management of childhood illnesses
Jhpiego	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KAP	Knowledge, Attitudes, and Practices
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Supplies Authority
KEPHS	Kenya Essential Package of Health Services
KePMS	Kenya HIV/AIDS Program Management System
KII	Key informant interviews
KIR	Key Indicators Report (KDHS 2014)
KES	Kenyan shilling
LAPM	Long-acting permanent methods of family planning
LIP	Local implementing partner
LLIN	Long-lasting insecticide-treated bed net
LMS	USAID's Leadership, Management, and Sustainability Project
LVCT	Liverpool Voluntary Counseling and Testing
MARPs	Most-at-risk populations
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MCHIP	Maternal and Child Health Integrated Program
MMR	Maternal mortality ratio
MNCH	Maternal, newborn, and child health
MoH	Ministry of Health
MSH	Management Sciences for Health
MSM	Men who have sex with men
NOPE	National Organization of Peer Educators
OBA	Output-based aid
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
PATH	Program for Appropriate Technology in Health
PBC	Performance-based contracting
PCR	Polymerase chain reaction
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PGH	Provincial General Hospital
PITC	Provider-initiated testing and counseling

PMI	U.S. President's Malaria Initiative
PMP	Performance Management Plan
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PwP	Prevention with Positives
QIT	Quality Improvement Teams
RA	Research assistant
RDT	Malaria rapid diagnostic test
REC/REC	Reaching Every District/Reaching Every Child
RH	Reproductive health
RMNCH	Reproductive, Maternal, Newborn and Child Health
SCHMT	Sub-County Health Management Team
SGBV	Sexual and gender-based violence
SILC	Savings and Internal Lending Communities
SIMS	PEPFAR's Site Improvement through Monitoring System
SME	Subject matter expert
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TRH	Teaching and Referral Hospital
UNDP	United Nations Development Program
USAID	United States Agency for International Development
USG	United States Government
VMMC	Voluntary Medical Male Circumcision
WASH	Water, Sanitation, and Hygiene

GLOSSARY OF TERMS

Activity: USAID-funded program; referred to in this report as Western, KAMILI and Rift.
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.
Best practice: Methods, approaches, and tools that have been demonstrated to be effective, useful, and replicable.
Boda boda: Swahili term for motorcycle or bicycle taxis.
Burden of disease: Impact of a health problem as measured by financial cost, morbidity, mortality, or other indicators; in other words, the magnitude to which a disease affects a population.
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, through 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 Worker (CHW): 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; generally regarded as a volunteer 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.
Continuity of Care: Service provision that is coordinated across multiple levels of care (e.g., community to primary care facility to referral facility) or across time (e.g., at least four antenatal care visits during a given pregnancy)
Core areas: For the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), core areas are strategies and interventions that are grounded in science and deemed critical to saving lives and preventing new HIV infections. Examples of core areas include: HIV treatment and care, combination prevention for key populations, and orphans and vulnerable children (OVC) support.
Cost-benefit analysis: A comparison of costs and achieved benefits with both expressed in monetary terms.
Cost-effectiveness analysis: A comparison of costs (in monetary terms) and outcomes/results (expressed in physical units, such as clients screened for TB, or bed nets distributed).
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.
Couple years of protection (CYP): An indicator that represents the estimated protection of family planning (contraception) for every one year of use; tabulation of the indicator is based on the number of family planning/contraceptive methods sold or distributed.
Demand: A willingness and/or ability to seek or use particular services.
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.

District Health Management Team (DHMT): In Kenya, a defunct management structure that existed prior to devolution; now replaced by the Sub-County Health Management Team.

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.

Drop-in center (DIC): A "one-stop shop" approach used to increase the access of specific sub-populations (e.g., female sex workers) to various services related to HIV and other issues.

Equity: No differences in access across population groups and between segments of society, however those groups are defined (e.g., socially, economically, demographically, geographically, behaviorally, etc.)

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

Magnet theater: A form of community-based theater entertainment used to engage communities in dialogue and action around health-related beliefs, norms, and practices.

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 advisers and SCHMTs.

Most-at-risk populations (MARPs): Segments of a population that, based on epidemiological evidence, are deemed to have elevated risks of HIV transmission and/or acquisition.

Moonlight HTC: Provision of HIV testing and counseling (HTC) services via outreach sessions that usually take place at night and in locations that are known access points for key populations such as female sex workers and their clients.

Non-core areas: For the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), non-core areas are strategies and interventions that do not directly contribute to PEPFAR HIV/AIDS goals, and/or can be undertaken by the host government or its other development partners.

OLMIS: Stands for OVC Longitudinal Management Information System; developed by APHIAPlus Rift Valley to support case management and decision making related to support to orphans and vulnerable children; rolled out to the other two APHIAPlus activities in Western Kenya and Central/Eastern Kenya.

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.

Operations research: Application of scientific principles to test programmatic solutions (tools, strategies) to implementation challenges and/or service delivery problems.

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.

Performance-based contracting (PBC): Approach adopted by the Government of Kenya for its Health Sector Services Fund to establish a direct correlation between performance/outcomes achieved and compensation/funding received; applied to both public-sector and private-sector health facilities.

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.

Reaching Every District/Reaching Every Child (RED/REC): A strategy developed by WHO and UNICEF to increase immunization coverage in low-performing geographic locations; it centers on outreach, supportive supervision, and M&E.

Routine data: Defined by the MoH as ongoing data collection of health status, health interventions, and health resources.

Social determinants of health: Contextual factors that impact health, for example, socio-cultural norms, poverty, and education.

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, 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 communities and has established a reputation within the community 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.

Twinning: A method of institutional capacity building whereby two organizational entities are paired in a form of cooperation to transfer competencies from a "mature" entity to a "less-mature" entity; a common model adopted by some international and local non-governmental organizations.

Value for money: A development concept used to refer to maximizing the impact of inputs/investments to improve the lives of poor people.

Youth-friendly services: Packaging and providing services based upon what young people want and need; an empowerment approach that places high value on ensuring respect for the experiences and rights of young people when they come in contact with the formal health system.

Whole market approach (WMA): Also referred to as "total market approach" in other contexts; a set of strategies intended to sustainably increase access to priority health products and/or services in a sustainable manner; for APHIAPlus, it involved the engagement of the public, private, and faith-based sectors.

TABLE OF CONTENTS

List of Tables

List of Figures

EXECUTIVE SUMMARY

The United States Agency for International Development (USAID) has a solid track record of supporting health and development initiatives in Kenya. AIDS, Population, and Health Integrated Assistance (APHIA) is the agency's flagship health initiative in the country. APHIA is currently in its third iteration, APHIAPlus, which began in January 2011 and is slated to end in December 2015. APHIAPlus was designed to contribute to Result 3 ("Increased use of quality health services, products, and information") and Result 4 ("Social determinants of health") of USAID/Kenya's implementation framework. The main technical areas of focus are HIV/AIDS; malaria; family planning (FP); tuberculosis (TB); maternal, newborn, and child health (MNCH); and water, sanitation, and hygiene (WASH).

Three independent consortia implement APHIAPlus in three regions of Kenya:

1. **APHIAPlus Rift Valley** (also known as "Nuru ya Bonde") is implemented by Family Health International (FHI 360) in collaboration with the African Medical and Research Foundation (AMREF) Health Africa, Liverpool Voluntary Counseling and Testing (LVCT), Gold Star Kenya, National Organization of Peer Educators (NOPE), Catholic Relief Services (CRS), and a number of local implementing partners (LIPs).
2. **APHIAPlus Western Kenya** is implemented by the Program for Appropriate Technology in Health (PATH) in collaboration with Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Jhpiego, World Vision, and various LIPs.
3. **APHIAPlus Central/Eastern** (also known as "KAMILI") is implemented by Jhpiego in collaboration with AMREF, LVCT, Kenya Red Cross, NOPE, PATH, and various LIPs.

Evaluation Methods:

This summary highlights features of the methodology, as well as key conclusions and recommendations emerging from the evidence. Both the body of the report and the annexes provide extensive detail on both the methodology and evaluation findings.

The reference period for the evaluation is January 2011 through December 2014. There are two key purposes for conducting this evaluation:

1. To learn to what extent the activities' objectives and expected health outcomes have been achieved at the county, sub-county, health facility, and community levels.
2. To inform the design of follow-on service delivery activities.

To obtain the evidence to address these stated purposes, a set of evaluation questions have been posed and will be the focus of the data collection. The following four main Evaluation Questions were posed (additional sub-questions can be found in Annex 4):

1. For each APHIAPlus activity, what is the status of the expected health outcomes and, to the extent possible, what is the activity's contribution to the observed health outcomes?
2. For each APHIAPlus activity, what are the prospects for the sustainability of the implemented strategies and/or systems and structures that contributed to the observed health outcomes produced by this activity?
3. For each APHIAPlus activity, what implementation challenges did the activity face during the implementation period? What are the key programmatic and management lessons learned?
4. Based on the analysis of the evidence generated by this evaluation, what activity implementation strategies/approaches, with particular focus on integration and coordination with national-level mechanisms, are most effective? How can they be scaled up in similar activities in the future?

A 27-person evaluation team employed a mixed-methods approach. It consisted of

- Document review

- Key informant interviews (KIIs) with national-level, county-level, sub-county-level, and community stakeholders
- Focus group discussions (FGDs) with clients of maternal, newborn, child health, (MNCH) and comprehensive care clinic (CCC) services; caregivers of orphans, vulnerable children (OVC), and youth aged 15–24 years; and community health workers (CHWs)
- Small-sample knowledge, attitudes, and practices (KAP) surveys with MNCH clients and CCC clients, OVC caregivers, youth aged 15–24 years, and CHWs
- Abstracted data from HIV-exposed infant (HEI) registers, tuberculosis registers, and other site-based records and registers
- Data/databases managed by the Government of Kenya and non-governmental entities

The ESPS team worked closely with USAID's technical team in designing a sampling strategy that weighed methodological rigor against implementation costs. In consultation with USAID, the evaluation team employed a multi-stage sampling process that entailed purposive selection of health facilities and LIPs from rural and urban areas before sampling respondents to meet sampling quotas. Further details on the methodology appear in both the body of the report and Annexes 5–9.

Thirteen health facilities (seven urban and six rural) were selected for APHIAPlus Central/Eastern, 13 health facilities (seven urban and six rural) were selected for APHIAPlus Western Kenya, and 12 health facilities (six urban and six rural) were selected for APHIAPlus Rift Valley. The team also purposely selected local partners implementing youth and OVC interventions in the same vicinities.

Key Conclusions drawn from the evaluation evidence:

The body of the report provides a detailed presentation of findings, along with data, organized according to APHIAPlus activity and program area (e.g., HIV treatment and care, MNCH and FP, malaria, youth, MARPs, OVC support). In general, major increases in the coverage of HIV care and treatment interventions were observed in all three APHIAPlus regions. There is some evidence of integration between HIV services and other services such as TB and family planning, however, this practice is far from universal. Second to HIV-related services, MNCH has been a program area for which positive trends are observed, with carryover benefits to PMTCT efforts. The level of effort for MNCH and FP was particularly high for APHIAPlus Central/Eastern. Traditional birth assistants continue to play a very prominent role in delivery assistance, particularly in Western Kenya and Rift Valley. Rift Valley also highlighted issues of quality (e.g., mistreatment of clients by health workers). Progress in child immunization coverage is less impressive than for other MNCH-related intervention areas. Malaria was not a prominent feature of APHIAPlus programming, although the three projects have supported CHWs (and the Community Health Strategy in general), in the area of community-based promotion of malaria prevention and treatment, particularly in the malaria-endemic region of Western Kenya. Large numbers of youth and other key populations have been reached by evidence-based interventions, although there remain shortfalls in comprehensive HIV knowledge and consistent condom use. OVC support and, more broadly, household economic strengthening, have been the flagship achievements under Result 4. Achievements are observed in mitigating economic vulnerability, linking OVC and their families to a constellation of support mechanisms, and fostering a culture of evidence-informed action through innovations such as OVC Longitudinal Management Information System (OLMIS).

The following are the evaluation's key conclusions (described in the body of the report):

Evaluation Question 1: *For each APHIAPlus activity, what is the status of the expected health outcomes and, to the extent possible, what is the activity's contribution to the observed health outcomes?*

1. Despite the broad spectrum of technical issues APHIAPlus addressed, APHIAPlus is widely regarded as an "HIV initiative."

2. APHIAPlus has made direct contributions to the frequency of HIV testing and HIV treatment and care outcomes (including, but not limited to, TB-HIV integration).
3. Given the nature and level of APHIAPlus' inputs, relative to others working in the same target geographies, malaria-related outcomes cannot be directly attributed to APHIAPlus. But in Western Kenya, APHIAPlus activity was directly responsible for providing grassroots 'infrastructure' – in the form of support for CHWs and community health units (CHUs) – that other players have used to roll out their own community-based malaria programming.
4. APHIAPlus has directly contributed to strengthening MNCH service delivery, as a platform for the prevention of mother-to-child transmission of HIV (PMTCT). It has also contributed to access to family planning in communities, and has promoted MNCH care-seeking from CHWs. It has also helped improve health-sector readiness for delivering emergency obstetric and neonatal care.
5. Because of the APHIAPlus emphasis on improving service availability and quality, socio-cultural norms and male involvement did not receive extensive attention, though they are significant drivers of inequities and shortfalls in high-impact health interventions.
6. The absence of clear milestones, rules of engagement, and dedicated resources to support functional linkages impeded maximizing the impact of national mechanisms in APHIAPlus' target geographies. Support needs were so vast that APHIAPlus' own efforts – related to training, human resources for health, quality improvement, and supply-chain management – appear to have more successfully met local needs than national mechanisms were able to.
7. Despite investments in creating a culture of data use, critical gaps in the collection, recording, and reporting of routine data limit the ability to make definitive, objectively verifiable statements regarding achievements of key health outcomes. This is particularly salient for prevention of mother-to-child transmission of HIV.
8. In Western Kenya, structural causes of shortfalls in skilled birth attendance persist, and the role of TBAs for some segments of the population warrants further attention.
9. With respect to PMTCT, follow up and retention of mother-baby pairs still warrants vigilance to maximize outcomes for HIV-exposed infants.
10. In Rift Valley, the softer side of quality of care, such as the treatment of clients in maternity wards, still needs improvement.
11. Wholesale adoption of certain strategies (e.g., kitchen gardening) employed under the Result 4 component did not always account for the uniqueness of particular sub-populations within Rift Valley (e.g., pastoralists), resulting in a misalignment between some implemented strategies and the circumstances of the populations being targeted.
12. In Central/Eastern (KAMILI), youth have high comprehensive HIV/AIDS knowledge. However, there are gaps in youths seeking medical treatment for other sexually transmitted infections (STIs).
13. APHIAPlus made direct contributions to generating demand and improving the quality of maternal, newborn, and child health care and family planning in KAMILI's area of operation.

Evaluation Question 2: *For each APHIAPlus activity, what are the prospects for the sustainability of the implemented strategies and/or systems and structures that contributed to the observed health outcomes produced by this activity?*

1. APHIAPlus' capacity-building approach addressed gaps within units of the county health system: County and Sub-County Health Management Teams, health facilities, and Community Health Units. However, it did not sufficiently take into account that a high-functioning health system centers on working relationships between those units.
2. APHIAPlus provides County and Sub-County Health Management Teams, health facilities, and CHUs equipment, commodities, and staff in varying degrees. The Ministry of Health (MoH) has not factored these costs, of essential services, into its budget allocations. The result is an underfunding of essential services that will effect sustainability in the short- and medium-term after activities conclude.

3. Strategic shifts prompted transitioning, involving handing over certain program components (e.g., CHU support), before sustainable change could take hold.
4. Because of continued dependence on APHIAPlus for HIV service delivery, prospects for sustaining HIV-related strategies and outcomes are low.
5. In contrast, the MNCH platform as it is, particularly in Central/Eastern Kenya, is sufficient to ensure that integrated service delivery will be sustainable beyond APHIAPlus.
6. Local implementing partners (LIPs) have mobilized additional funds from county governments and other sources, which bodes well for sustainability.

Evaluation Question 3: *For each APHIAPlus activity, what implementation challenges did the activity face during the implementation period? What are the key programmatic and management lessons learned?*

1. Geographic parameters established at APHIAPlus' inception are no longer appropriate or relevant given Kenya's newly devolved system of governance.
2. Most implementation challenges APHIAPlus encountered originated from strategic decisions taken by USAID/USG during the first four years of implementing the flagship activities.
3. The rationalization that occurred under the direction of USAID in 2012 was, in essence, a reset of capacity building and other forms of Health Systems Strengthening (HSS) support.
4. Strategic shifts had a bearing on both implementation and performance measurement/program evaluation because the standards against which APHIAPlus' performance would be evaluated were not completely aligned with the strategies being executed or the indicators being routinely reported.
5. Changes in the local operating environment, such as devolution, created a mismatch between the technical support provided by the national mechanisms and sub-national support needs.

Evaluation Question 4: *Based on the analysis of the evidence generated by this evaluation, what activity implementation strategies/approaches, with particular focus on integration and coordination with national-level mechanisms, are most effective? How can they be scaled up in similar activities in the future?*

1. A number of promising practices are being introduced on a small scale (e.g., "Mama Pack" in Western Kenya, and community-based FP distribution by CHWs in Tharaka Nithi in Eastern Kenya). However, the paucity of evidence about their effectiveness, even the lack of simply testing proof of concept, keeps these strategies from being considered in national scale-up discussions.
2. Strategic shifts, such as rationalization, suppressed innovation in all three geographic areas.
3. There are no replicable models for linking IPs and national mechanisms. The mandates and foci of field IPs and how they might complement national-level mechanisms require a complete rethink in light of changes in the local operating environment.

Cross-cutting Key Recommendations:

1. In designing future activities, narrow the technical scope for Result 3 ("increased use of quality health services, products and information") and Result 4 ("social determinants of health") to concentrate on maximizing synergies between the two work streams.
2. For sustainability purposes, give strong consideration to positioning OVC efforts within the framework of "child protection" or "child-friendly social welfare."
3. Position future USAID-funded efforts addressing the social determinants of health as a platform that integrates health and social protection.
4. Strengthen community capacity to sustain health strategies and outcomes, e.g., through community financing, or other self-sustaining mechanisms to maintain the functionality of community health units and/or by engaging critical household and community gatekeepers such as husbands/partners or religious and community leaders, to promote positive behavior change, service uptake, and service use.
5. Redouble efforts to improve the quality of routine information collected (e.g., District Health Information System, HEI data).

6. Enhance documentation and analysis of what works.
7. Support a more comprehensive approach to sexual and reproductive health (HIV prevention, testing, treatment, and care; family planning; STI prevention, diagnosis, and treatment; cervical cancer screening; voluntary male medical circumcision (VMMC) designed specifically for youth and most-at-risk populations (MARPs).

Illustrative Evaluation Question Specific Recommendations

1. ***Evaluation Question 1:*** A silo/vertical program mentality was an early impediment that had to be overcome before APHIAPlus could promote integrated service delivery among the existing cadre of health workers. To curb this problem (a) make integrated service delivery part of pre-service training for doctors, nurses, and midwives; and (b) incorporate integration (e.g., TB-HIV, FP-HIV) into the national clinical protocols and standards to which health providers must adhere.

2. ***Evaluation Question 2:*** In the short term, provide (a) evidence-based advocacy support to county health directors, County and Sub-County Health Management Teams when they are lobbying county assemblies for budget allocations necessary for HIV service delivery; and (b) health planning support, on issues such as human resources for health, lab networking, and logistics to counties with an emphasis on HIV and RMNCH.

3. ***Evaluation Question 3:*** Establish an accountability framework for collaboration in health systems strengthening (HSS) between field implementers and national-level mechanisms. The framework for collaboration should include key milestones and indicators, and a plan with budget allocations that reflects the resources required for effective collaboration.

4. ***Evaluation Question 4*****:** In light of the paucity of evidence that innovative strategies implemented under APHIAPlus were effective, include a learning and policy influence component in future iterations of APHIAPlus, with budget allocations for operational research to inform the national scale-up of innovations and strategies with demonstrated effectiveness.

The full set of recommendations appears in the body of this report.

1. INTRODUCTION

1.1 Evaluation Purpose

The evaluation described in this report serves two overarching purposes: (1) to learn to what extent the activities' objectives and expected health outcomes have been achieved at county, sub-county, health facility, and community levels; and (2) to inform the design of followup service delivery activities.

As presented in USAID's scope of work for the evaluation, the evaluation results will be used to help USAID's Office of Health Population and Nutrition (HPN) reach decisions related to (1) the effectiveness of the APHIAPlus model (as envisioned in the Five-Year Implementation Framework) in strengthening the capacity of Kenya's Ministry of Health (MoH) to deliver an integrated package of high-quality and high-impact interventions within the Kenya Essential Package of Health Services (KEPHS); (2) the model for integrating service delivery and health systems strengthening when future health sector activities are designed; and (3) the nature and scope of possible future interventions in the health sector, based on the challenges experienced and lessons learned when implementing the current APHIAPlus flagships activities.

The primary audience for this evaluation is USAID/Kenya and East Africa, USAID's Office of Health Popoulation and Nutrition leadership and its technical team. The implementing partners–PATH, Jhpiego and FHI360--and USAID's Office of Agriculture Business and Energy, Office of Education and Youth, and Office of Democracy and Governance are the next primary audience for the evaluation findings. Secondary users of the evaluation findings will include national and county governments, 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, and others. Civil society organizations and researchers from local and international universities are second-line users of the findings. Finally, the donor community supporting health programs will be consumers of the evaluation findings.

1.2 Key Evaluation Questions

(Sub-questions can be found in Annex 4)

1. For each APHIAPlus activity, what is the status of the expected health outcomes and, to the extent possible, what is the activity's contribution to the observed health outcomes?
2. For each APHIAPlus activity, what are the prospects for the sustainability of the implemented strategies and/or systems and structures that contributed to the observed health outcomes produced by this activity?
3. For each APHIAPlus activity, what implementation challenges did the activity face during the implementation period? What are the key programmatic and management lessons learned?
4. Based on the analysis of the evidence generated by this evaluation, which activity implementation strategies/approaches, with particular focus on integration and coordination with national level mechanisms, are most effective and how can they be scaled up in similar activities in the future?

2. THE CONTEXT IN WHICH APHIAPlus WAS DESIGNED AND IMPLEMENTED

2.1. Development Problem and USAID Kenya Response

In general, HIV/AIDS prevalence has been in decline, globally, for the past two decades. Kenya has seen its HIV prevalence drop from a high of 14 percent to nearly 5 percent. Even so, sub-Saharan Africa has the highest HIV/AIDS infection rate in the world. In 2012, roughly 25 million people were living with HIV, accounting for nearly 70 percent of the global total. In 2013, the total number of people living with HIV stood at 1,592,342 in Kenya. Total new HIV infections are estimated to have declined by 15 percent in the last five years, from about 116,000 in 2009 to around 100,000 in 2013. Annual AIDS-related deaths have been on a declining trend, from about 85,000 in 2009 to 58,000 in 2013. Despite this progress, the

epidemic has had widespread social and economic consequences, not only in the health sector but also in education, industry, and the wider economy.

Kenya showed a 44 percent decline in new infections among children from 2009 to 2012, although 5 out of 10 pregnant women living with HIV did not receive antiretroviral medicines to prevent mother-to-child transmission of HIV. The annual need for PMTCT decreased slightly from 98,000 in 2009 to 79,000 in 2013.[1]

It is estimated that 7,700 Kenyan women die each year due to pregnancy-related causes. This translates to approximately 21 women each day, or almost one Kenyan woman every hour. The Kenya Demographic Health Survey (2008–09) indicates that maternal mortality levels in Kenya have remained unacceptably high, at 488 per 100,000 live births. In 2014, the maternal mortality ratio stood at 495 per 100,000 live births. Kenya is not making progress towards Millennium Development Goal (MDG) 5 (Reduce maternal death to 147 per 100,000 by 2015) and will not achieve that target. Limited access to contraceptives, skilled birth attendants, and antenatal care, and high adolescent birth rates all contribute to the high maternal mortality ratio (MMRs) in Africa. Global progress in reducing child deaths since 1990 has been significant. Even so, in 2012, Kenya's under-five mortality rate was 73/1000 live births, ranked by United Nations Development Program (UNDP) as 33rd out of 46 nations in Sub-Saharan Africa – one of the worst.

USAID has a solid track record of supporting health and development initiatives in Kenya. AIDS, Population, and Health Integrated Assistance (APHIA) is the agency's flagship health initiative in the country. APHIA is currently in its third iteration, APHIAPlus, which began in January 2011 and is slated to end in December 2015.

As originally conceived, three APHIAPlus service delivery activities, implemented in Western Kenya, Rift Valley, and Central/Eastern Kenya, known as KAMILI,[2] were aligned with the five-year USAID/Kenya Implementation Framework (2010–2015). The three flagship activities support a broader strategic objective to "reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services," with specific contributions to Result 3 ("Increased use of quality health services, products and information") and Result 4 ("Social determinants of health addressed to improve well-being of targeted communities and populations") of USAID Kenya's Results Framework for its Kenya Health Program.

The promulgation of the constitution of Kenya on August 27, 2010, was a major milestone in improving health standards. It provides a legal framework for ensuring more comprehensive and community-driven health services and for adopting and applying a rights-based approach to health. To improve the lives of Kenyans overall, the country aims to provide an efficient, integrated, high-quality, and affordable health care system. It has given priority to preventative care at the community and household levels, through a decentralized national health-care system.

The development hypothesis for APHIAPlus is as follows: If the APHIAPlus activity strengthens the Ministry of Health's capacity at the county and sub-county levels to make the Kenya Essential Package of Health Services (KEPHS) more available;[3] its ability to create and increase demand for a high-quality KEPHS package at the facility and community levels; its ability to increase the adoption of health behaviors and effectiveness through innovative approaches, strengthen coordination and collaboration among key

[1] 2013 Progress Report on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.
[2] Hereafter referred to as Western, Rift and KAMILI.
[3] KEPHS: Kenya Essential Package of Health Services.

stakeholders, and address social determinants of health to improve the well-being of marginalized communities and the population, the result will be improved health outcomes, achieved through sustainable country-led programs and partnerships. (See Annex 1: Theory of Change for the Three APHIAPlus Activities.)

2.2. Activity Design

The three APHIAPlus flagship activities' designed their service delivery to have an integrated approach to improve health service access, coverage, and quality.[4] The three flagships are expected to address the social determinants of health in the areas of HIV/AIDS; malaria; reproductive health and family planning (RH/FP); tuberculosis; maternal, newborn and child health; nutrition; and water, sanitation, and hygiene (WASH).[5] There is a broad array of expected intermediate results (IRs) that all three flagship activities in the three geographical areas support. (See Annex 2: List of Intermediate Results for Results 3 and 4 of USAID/Kenya's Implementation Framework.) Subtle differences, however, distinguish how each area achieves those intermediate results.

An important pillar of APHIAPlus' efforts to maximize effectiveness and impact has been the creation of programs, with consortia, that build functional links with existing efforts to improve the national-level health system (health system strengthening, HSS), commonly referred to as "national mechanisms." These national mechanisms include:

- FUNZO/Kenya, Capacity Kenya to strengthen human resources for health (HRH)
- Kenya Pharma, Kenya Medical Supplies Authority (KEMSA) Support, Health Commodities and Supply Management (HCSM) to strengthen supply-chain management
- MEASURE Evaluation-PIMA Community of Practice, AfyaInfo to strengthen health information collection and use

APHIAPlus centers on consortium-based implementation that (1) targets regional/county and sub-county institutions, (2) integrates services that have historically been implemented in a very vertical manner, and (3) strengthens the continuum of care from community to health facility. Three distinct consortia, each comprised of a mix of international and local organizations, implement the three APHIAPlus flagship activities.

2.2.1. APHIAPlus Rift Valley Program Strategy

APHIAPlus Rift Valley (also known as "Nuru ya Bonde") is led by FHI 360. Its USAID funding is $70,980,677 with cost sharing of non-federal funding of $4,73,222.[6] APHIAPlus Rift Valley is implemented in collaboration with AMREF Health Africa, Liverpool Voluntary Counseling and Testing (LVCT), National Organization of Peer Educators (NOPE), Catholic Relief Services (CRS), and a broad array of local implementing partners (LIPs).[7] Under Kenya's devolved government structure, APHIAPlus Rift spans five counties: Baringo, Kajiado, Laikipia, Nakuru, and Narok. (See Annex 3: Maps of APHIAPlus Catchment areas.)

APHIAPlus Rift Valley emphasizes strengthening sub-national Kenyan health structures and entities along the continuum of care and decisionmaking, from health management teams to community health units (CHUs).[8] Integrated service delivery and practical, evidence-based approaches are prominent features of the APHIAPlus Rift design.

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[4] As stated in the following three cooperative agreements: USAID Cooperative Agreement AID-623-A-11-00007 (APHIAPlus Health Service Delivery Project, Rift Valley Province—Zone 3); USAID Cooperative Agreement AID-623-A-11-00002 (APHIAPlus Health Service Delivery Project—Zone 1, Western and Nyanza Provinces); USAID Cooperative Agreement AID-623-A-11-00008 (APHIAPlus Health Service Delivery Project—Zone 4, Central and Eastern Provinces).
[5] Ibid.
[6] USAID Cooperative Agreement No. AID-623-A-11-0000623-A-11-00007, page 3
[7] USAID Cooperative Agreement AID-623-A-11-00007 (APHIAPlus Health Service Delivery Project, Rift Valley Province—Zone 3).
[8] Ibid.

2.2.2. APHIAPlus Western Program Strategy

APHIAPlus Western is led by PATH, with total USAID funding of $142,691,684 and non-federal funding cost share of $2,425,619.[9] Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Jhpiego, World Vision, and a broad array of local partners collaborate on implementation.[10] Originally, this Western Kenya-focused activity covered the now-defunct "provinces" of Nyanza and Western. Under the current devolved government structure, APHIAPlus Western spans seven counties: Bungoma, Busia, Kakamega, Migori, Nyamira, Homa Bay, and Vihiga.[11] (See Annex 3: Maps of APHIAPlus Catchment areas.)

APHIAPlus Western positions the community as the fulcrum for all its efforts. Community-facility linkages aim to enhance economic and social capital gains at the household level and through mentorship, supportive supervision, and quality improvement, enhance the quality of service delivery during high-impact interventions.[12] There is an explicit focus on marginalized, poor, and underserved populations. In addition, given the burden and dynamics of HIV in western Kenya, most-at-risk populations are a key population targeted by the activity's HIV interventions.

2.2.3. APHIAPlus Central/Eastern (KAMILI) Program Strategy

KAMILI is led by Jhpiego and implemented in collaboration with AMREF, LVCT, Kenya Red Cross, NOPE, PATH, and various LIPs.[13] The total USAID funding is $91,408,901 and the cost-sharing (non-federal) is $4,350,999.[14] Under Kenya's devolved government structure, APHIAPlus Central/Eastern spans 11 counties: Embu, Kiambu, Kirinyaga, Kitui, Machakos, Makueni, Muranga, Meru, Nyandarua, Nyeri, and Tharaka Nithi. (See Annex 3: Maps of APHIAPlus Catchment areas.)

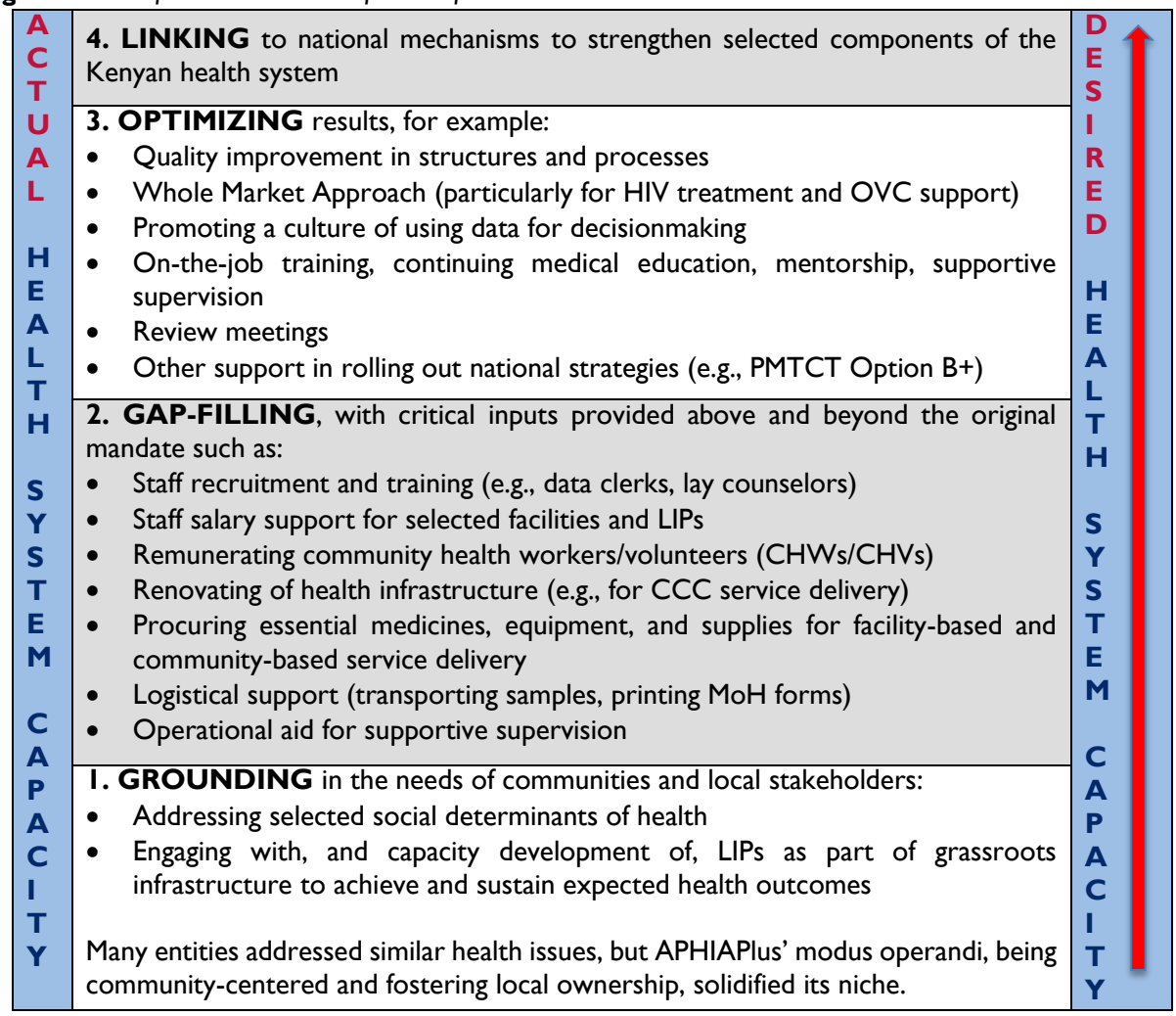
KAMILI's strategies are client-centered, high-impact, and demand-driven. KAMLI, like Rift Valley and Western, emphasizes integrating services at all levels, to eliminate missed opportunities to link clients with the full complement of high-impact interventions, whether they come in contact with public, private, or faith-based health providers. Through its use of evidence-based innovations, KAMLI aims to empower all actors along the continuum of care.[15]

The three APHIAPlus flagship activities direct their attention to distinct geographies and have varying areas of emphasis. It is notable that there is overlap in the agencies involved across the three flagship activities. AMREF and NOPE are sub-contractors for both Rift and KAMILI, and Jhpiego is a sub-contractor to PATH.

All three flagship activities pursued a multitude of strategies to address different technical issues, all of which can be distilled down to four major functions or streams of work: (1) grounding, (2) gap-filling, (3) optimizing, and (4) linking (see Figure 1).

[9] Cooperative Agreement No AID-623-A-11-00002, page 3
[10] USAID Cooperative Agreement AID-623-A-11-00002 (APHIAPlus Health Service Delivery Project—Zone 1, Western and Nyanza Provinces).
[11] USAID Cooperative Agreement AID-623-A-11-00002 (APHIAPlus Health Service Delivery Project—Zone 1, Western and Nyanza Provinces).
[12] Ibid.
[13] USAID Cooperative Agreement AID-623-A-11-00008 (APHIAPlus Health Service Delivery Project—Zone 4, Central and Eastern Provinces).
[14] USAID Cooperative Agreement No. AID-623-A-11-0000623-A-11-00008, page 3
[15] Ibid.

Figure 1: *Core functions/streams of work of APHIAPlus*[16]



3. METHODS AND LIMITATIONS

Evaluation Services and Program Support (ESPS) received a Task Order (TO) from USAID on June 10, 2015, to conduct an end-term evaluation of three of the health flagship activities noted above. The reference period for the evaluation is January 1, 2011 through December 31, 2014.

In addressing the four key evaluation questions (See Annex 4: Evaluation Question Matrix), the evaluation team employed a mixed-methods approach that used both quantitative and qualitative elements as described below.

3.1. Sources of Data

Qualitative Evidence

- **Document Review:** This component of the evaluation involved systematic review of APHIAPlus program design documents, annual work plans, quarterly reports, and other relevant documentation (e.g., national documents such as reports from Demographic and Health Surveys (DHS), policy guidelines, etc.) produced during the reference period. Some quantitative evidence (e.g., program

[16] Data Sources for Figure: Key informant interviews with IPs, county health officials, and health facility informants; corroborating evidence from quarterly reports and Cooperative Agreements for the three activities

statistics included in quarterly reports) were also gleaned from the document review. (See Annex 5: List of Documents Included in Document Review)

- **Key Informant Interview (KIIs):** Interviews were an opportunity to elicit in-depth information from national-level stakeholders (including personnel at USAID-funded national level mechanisms, USAID, and the MoH) and a broad array of local stakeholders (e.g., county government officials, APHIAPlus implementing partners (IPs), heads of LIPs, and in-charges/department heads at selected health facilities). (See Annex 5: List of Key Informants)
- **Focus Group Discussions (FGDs):** Focus group discussion with five stakeholder groups that directly benefitted from APHIAPlus' interventions offered critical perspectives, experiences, and dynamics. Evaluators conducted discussions with MNCH clients and clients of comprehensive care clinics at sampled health facilities. Two types of FGDs took place with local implementing partners: with caregivers of orphans and vulnerable children supported by the local implementing partners, and with youth age 15–24 years reached by evidence-based interventions implemented by the local partners. Focus groups were also held with community health workers at sampled Community Health Units. The number of participants in the groups ranged from seven to ten.

Sources of Quantitative Data

- **Mini knowledge, attitudes, and practices (KAP) surveys** were given at sampled facilities to (1) maternal, newborn and child health clients; (2) clients of comprehensive care clinics; (3) caregivers of orphans and vulnerable children supported by local implementing partners; (4) youth (aged 15–24 years) being served by local implementing partners; and (5) community health workers at Community Health Units established and/or supported by APHIAPlus. Although the same respondent categories were targeted for both KAP interviews and FGDs, a single respondent could not participate in both (non-overlapping samples).
- The field teams **abstracted data** from HIV-exposed infant (HEI) MoH registers, and other health facilities' MoH registers (including TB, ANC, ART, training records, and visitors' sign-in registers). Information related to indicators was culled during data collection site visits.
- The evaluation team also secured limited access to **other routine data/databases** managed by national mechanisms (e.g., FUNZO/K) and/or programs/departments within the central MoH (e.g., National TB Program data on TB-HIV integration issues).

The team developed 11 tools for primary data collection and two data abstraction tools, as described below (See Annex 7: Data Collection Tools). Tools were pretested with selected respondent groups at two locations in Nairobi before being finalized for use in the field. In addition to English versions, the FGD and KAP tools were translated and back-translated into Kiswahili and Dholuo (the latter for use in Western Kenya). The field teams deployed to the three regions (Central/Eastern, Rift Valley, and Western Kenya) consisted of individuals who were fluent in other languages/dialects indigenous to the region where data were being gathered. There was only one instance in Central/Eastern Kenya in which an entire FGD had to be conducted in a language other than Kiswahlii or Dholuo, it was conducted in Kiembu. For that FGD, a Research Assistant who was a native Kiembu speaker conducted the FGD in the local language. The FGD, which was audio recorded, was later translated into English by an independent Kiembu translator, as well as back-translated by Kiembu speakers to confirm accuracy of the translation before inclusion in the analysis.

3.2. Modifications to the Original Evaluation Approach

Deviations from the original evaluation design (See Annex 8: Evaluation Scope of Work), were minimal. Instead of conducting FGDs with devolved county government officials, the team felt it prudent to structure consultations using key informant interviews. This was appropriate as high-level officials had limited availability. Conducting interviews allowed the evaluators to obtain detailed evidence and clarification during time-limited interactions with county officials.

3.3. Sampling Approach

The ESPS team worked closely with USAID's technical team in designing the sample and weighed methodological rigor against implementation costs. The evaluation team employed a multi-stage sampling process as suggested by USAID. For a complete description of the sampling approach, see Annex 9: List of Sites Selected for the Evaluation.

Table 1: *Sample sizes achieved for each data collection method*

Type Of Data	Activity			Total
	Rift Valley	Western	KAMILI	
MNCH KAP	60	65	65	190
CCC KAP	60	65	60	185
Youth KAP	41	39	31	121
CHW KAP	60	65	64	189
OVC Caregiver KAP	60	65	65	190
FGDs	53	56	43	152
Field-based KIIs	32	39	23	94
National-Level KIIs	--	--	--	28
Abstracted Clinic Data	12	13	13	38

Sampling for qualitative data gathering was purposive. The standard approach for sampling MNCH and CCC clients for KAP data collection entailed systematic random sampling of clients who were present on the day evaluation team members visited the site for data collection. However, there were instances when the evaluation team encountered far fewer clients than expected on a given day, rendering systematic random sampling infeasible. In those instances, team members adopted a "catch-all" approach in an effort to achieve the target sample size (quota) for the respondent category at the site. Sampling of OVC caregivers from selected LIPs, youth reached by selected LIPs implementing evidence-based interventions, and CHWs operating from selected CHUs, was largely dependent on the sampling frame provided by LIPs, as well as their mobilization efforts to recruit individuals for data gathering, based on inclusion criteria communicated by ESPS and evaluation team members. When multiple forms of data gathering occurred at a given site, the evaluation team maintained independent samples (e.g., an MNCH or CCC client could be selected for a KAP interview or an FGD, but not both).

3.4. Data Management

Quantitative Evidence: A Microsoft Access (2013) database was designed for KAP data entry. Data were double-entered by teams of research assistants during the week of July 27, 2015, and range and error checks, with requisite error correction using hard copy completed questionnaires, were then completed.

Databases containing data extracted from routine health information (e.g., from DHIS, National TB Program, FUNZO/K training databases) were built in Microsoft Excel (2013).

Qualitative Evidence: Data were translated into English and imported into ATLAS.ti[17] for analysis. Audio recordings and verbatim transcripts are warehoused for the FGDs. KIIs, the majority of which were audio recorded, have typed interview notes that follow the structure of the KII tool.

3.5. Data Analysis

For quantitative analysis, priority was given to assessing the 33 priority indicators (See Annex 9: List of USAID Priority Indicators). The team used SPSS (version 22 for Windows)[18] to conduct the quantitative data analysis, and ATLAS.ti (version 7.5 for Windows) to conduct the qualitative analysis. Most parameters

[17] ATLAS/ti. Version 7.5. [Computer software] (1999) Berlin, Scientific Software Development
[18] IBM Corp. Released 2013. IBM SPSS Statistics for Windows, Version 22.0. Armonk, NY: IBM Corp.

of interest were either proportions or absolute numbers. The main comparison was between the baseline (or, for some parameters, Year 1) estimate and the 2014 estimate. When feasible, the team examined trends in parameters which required comparing at least three different estimates from three points in time. In light of the small sample sizes for each activity, tests of statistical significance are not presented in this report. For the qualitative data, the team employed thematic analysis, identifying patterns and common themes emerging in the responses from different respondents within the same geography or within a particular respondent group (e.g., MNCH caregivers) across different geographies (e.g., all counties covered by an APHIAPlus activity). (See Annex 11: Additional Data Tables)

3.6. Approach to Fieldwork

IBTCI established a Central Team comprised of a Team Leader, a Senior Evaluation Specialist, and a Data Manager to support the evaluation process. In addition, for each APHIAPlus activity, IBTCI assembled multidisciplinary, eight-person field teams made up of: three senior-level subject matter experts (SMEs), one of whom served as the sub-team leader for the field team; three research assistants (RAs); and two transcribers (See Annex 11: Complete List of Evaluation Team Members and Contributors; and Annex 13: Key Personnel CVs). Fieldwork for this evaluation was carried out between June 15, 2015, and August 31, 2014, (see Annex 14: Data Collection Schedule) by 27 consultants.

SMEs conducted both KIIs and FGDs, whereas RAs conducted KAP interviews and abstracted data from facility-based data sites selected for the evaluation. In addition to producing verbatim transcripts of all FGDs, the transcribers assisted in translating some of the FGD transcripts into English. IBTCI's ESPS Kenya staff supported all phases of the evaluation process.

Prior to field work, during a three-week planning phase (June 15 to July 4) the majority of the document review was conducted. That time was also used to train field teams; develop, pretest, and translate tools; finalize mobilization of target respondents; and other field logistics. Fieldwork was originally scheduled to last 18 days between July 6 and July 25, 2015. However, with approval from USAID, an additional six days were dedicated to telephone and in-person interviews with critical stakeholders (e.g., CHMT members and selected individuals from USG-supported national mechanisms) who were not reached during the original allotted time frame.

3.7. Ethical Considerations

All persons consulted gave their Informed consent, regardless of the interview technique. The evaluation team devised an informed consent statement available in English, Kiswahili, and Dholuo. Both respondent and interviewer were required to indicate (via signature or thumbprint, as necessary) that the informed consent statement was read to the respondent and that s/he provided consent before the interviewer initiated any data gathering. As part of the informed consent process, target respondents were oriented on why data were being gathered, confidentiality, the minimal risks and inconveniences associated with participation, and the voluntary nature of their participation in the interview or discussion. All team members certified that they had no conflict of interest in undertaking this evaluation. Each member signed a Conflict of Interest statement which is stored at ESPS/IBTCI in Nairobi.

3.8. Limitations

The ET used multiple mechanisms to minimize respondent and interviewer bias:

1. **Forced Answers:** KIIs were implemented using standardized guides rather than a detailed interview guide that might have seemed to force respondents to provide answers to questions about aspects of the projects about which they might not have had knowledge.
2. **Recall bias:** Key evaluation questions focused on the review period. Respondents could have some difficulty recalling events from the start of the activities.
3. **Interviewer bias** was mitigated to the extent possible by training the team in the use of all instruments as well as pilot testing the instruments prior to the start of field work. Additionally,

daily team briefs were held at the field level and the ESPS team reviewed instruments as they were completed.

4. **Selection bias:** The proposed methodology adopted a purposeful selection criteria for KII respondents to have the most informed stakeholders in the sample and a multistage sampling procedure for the KAP and FGD respondents. In light of several factors, however, caution should be exercised in generalizing findings to an entire sub-population of interest (e.g., all MNCH caregivers, all PLHIV, all youth, all OVC caregivers). Those factors include: small sample sizes, a sampling approach that allowed the team to reach the target sample sizes within the time frame for data collection, rather than ensuring purely random selection, and the sampling of individuals who had come in contact with sites rather than the community at large (as outlined by USAID). Consequently, findings pertaining to the aforementioned sub-populations should not be regarded as population-based.

As described later in this report, there were strategic shifts during the life of the project. Some of those shifts had a bearing on field work and the evaluation design. Evaluation teams, particularly the two teams gathering data for Rift Valley and KAMILI, encountered far fewer active LIPs than they anticipated. This was particularly true for LIPs targeting youth. Final sample sizes were close to target sample sizes for all respondent categories except for youth. For APHIAPlus Rift Valley, only two LIPs (both of which are Nakuru based) were active and could be engaged for the evaluation. One of the implementing partners, NOPE, worked in other sub-counties, however, their youth-focused strategies in those locations ended two years prior, leaving no pool of active beneficiaries to sample. Similarly, some KAMILI LIPs originally selected for data collection had not been serving youth for some time. Youth mobilized for data collection did not consistently meet the inclusion criteria (that is, age 15–24).

Table 2: *Additional limitations*

Description of limitation	Mitigation Measure
The number of people in some FGDs was smaller than anticipated due to difficulties mobilizing participants. For example, on several occasions, days designated for data collection at certain sites, client volume was low.	The proposed evaluation design called for many more FGDs and KIIs than were actually required to establish a robust body of evidence on which to base the analysis. In fact, the evaluation team observed convergence of thinking and findings with a small number of FGDs and KIIs. Because data are available for all target respondent groups and all targeted geographic locations, the quality of the evidence base has not been compromised. The available data reflect perspectives and experiences from diverse, relevant stakeholder groups.
There was a paucity of data on training, supportive supervision, mentoring, and quality improvement at the local level.	The evaluation team triangulated primary and secondary sources of data (including but not limited to information contained in quarterly reports and data managed by selected national mechanisms).
Assessing trends for all 33 priority outcome indicators was challenging due to the absence of bona fide baseline assessments and strategic shifts and reprogramming decisions that affected what IPs were implementing and what they were monitoring/measuring. It is noteworthy that the IPs have been reporting on a different set of indicators, not completely aligned with the set of priority indicators.	The evaluation team identified a range of measures that can be derived from either the data collected by the field teams or culled from routine information systems such as DHIS and KePMS. Those proxy measures are presented, along with estimates of priority indicators when available, in the body of this report and the annexes. In addition, as outlined in the evaluation scope of work, the team also reconstructed 'baseline' data using 2010 data from the DHIS data.
APHIAPlus' design did not allow for rigorous assessment of attribution or impact.	In documenting APHIAPlus' story through the four main evaluation questions, the evaluation team was deliberate in determining the specific niche and relative contributions of APHIAPlus versus other actors and/or external factors. This information provides insight on possible confounders in our assessment of expected health outcomes. The team also documented the nature and extent of APHIAPlus program exposure among KAP respondents.
The extremely small KAP sample sizes limited our ability to calculate particular indicators for subsets of respondents. For example, the sampling approach USAID advised yielded sample sizes that were too small to tabulate full immunization coverage before the first birthday.	The evaluation team has relied on DHIS data to shed light on priority indicators when KAP sample sizes were too small and prone to data volatility.

4. KEY FINDINGS AND CONCLUSIONS

Evaluation Question 1: For each APHIAPlus activity, what is the status of the expected health outcomes, and to the extent possible, what is the activity's contribution to the observed health outcomes?

4.1. Evaluation Question 1

4.1.1. Crosscutting Issues

Notable changes in the operating environment are important confounders in analyzing trends in outcomes in all three activities and across the three geographic areas. They included policy changes such as the Beyond Zero Campaign (2014) to reduce maternal and child mortality and the Free Maternity Care Policy (2013). Another change was the proliferation of updated health guidelines, protocols, and strategies (e.g., new ART guidelines, PMTCT Option B+ Strategy, and new HIV Testing and Counseling [HTC] protocols).

As originally conceived, all three activities were expected to contribute to health outcomes related to HIV/AIDS, malaria, MNCH/FP, and TB and to the extent that funds were available, nutrition, food security, WASH, and selected social determinants of health. In all of the geographic regions, APHIAPlus has been positioned first and foremost as an HIV/AIDS project and then as a contributor to reproductive, maternal, newborn, and child health (RMNCH). [19, 20]

National-level stakeholders do not perceive malaria to be a core issue addressed by APHIAPlus, particularly since there are other entities and initiatives with malaria-specific mandates.[21]

Result 4 addresses social determinants of health including the economic strengthening of households, improving access to education, food security and nutrition, and community WASH. But the three flagship activities primarily addressed support to orphans and vulnerable children (e.g., education and WASH) under the rubric of Result 4.[22, 23]

4.1.2. Rift Valley

Rift/ Result 3: Increased use of Quality Health Services, Products and Information

Rift/ Contributions to Community Health Strategy

The activity's support scaled up from 23 Community Health Units (CHUs) in 2011 to 140 CHUs by 2014.[24] Inputs included training and provision of basic drugs and commodities (e.g., job aids such as flip charts, first aid kits, reporting tools, CHW badges, bicycles).[25] The consortium also provided supportive supervision to CHWs/CHVs and performance-based stipends (in the amount of KES 2000 per month) to CHWs.[26] The activity also provided training and 42 percent of CHWs interviewed for the purposes of this evaluation reported that they had undergone training by Rift.[27]

There is evidence of diffusion of the activity's approach to CHW/CHU support and the Community Health Strategy (CHS) in particular. The activity's CHS Implementation model informed the development of

[19] KII with USAID AORs, MNCH teams and MoH departments- TB, DFH, Malaria, July – August 2015.
[20] Corroborating evidence based on multiple KIIs with county government officials: high-level county health official in Bungoma County (Western Kenya); high-level county health official in Kakamega County (Western Kenya); high-level county health official in Nyamira (Western Kenya); KII with high-level Baringo county government focal points (Rift Valley); high-level Meru County health official and SCHMT members (Central/Eastern Kenya); high-level county MOH key informants in Tharaka County (Central/Eastern Kenya) July, 2015.
[21] Separate KIIs with national-level Malaria key informants (MOH, USAID), as well as with the MoH Director of Medical Services August, 2015.
[22] FGDs with MNCH beneficiaries in Western Kenya (Busia, Bungoma); Central/Eastern and Rift July, 2015.
[23] Interviews with CRS and USAID OVC team August, 2015.
[24] 2014 4th Quarterly report.
[25] Based on KIIs with APHIAPlus Rift Valley IPs, July 2015; Quarter reports 2011 – 2014.
[26] Quarter reports 2013, 2014.
[27] Data source: Mini-KAP survey with Rift Valley CHWs (N=60), July 2015.

Kenya's CHS Manual.[28] It should be noted, however, that with the reduction in USG resources available to support CHUs, there was a decline in the number of CHUs supported starting in quarter one of Year 4 (2014). Integrated health outreaches, a joint effort by CHWs and health-facility staff, with support from Rift, did not occur routinely thereafter.[29]

Rift/ Conclusions related to Community Health Strategy

APHIAPlus Rift Valley increased CHU coverage during the four years of its implementation by providing technical and material support. Withdrawal of USG support posed a challenge to the continuation of these services and support.

Rift/ Contributions to HIV Care and Treatment

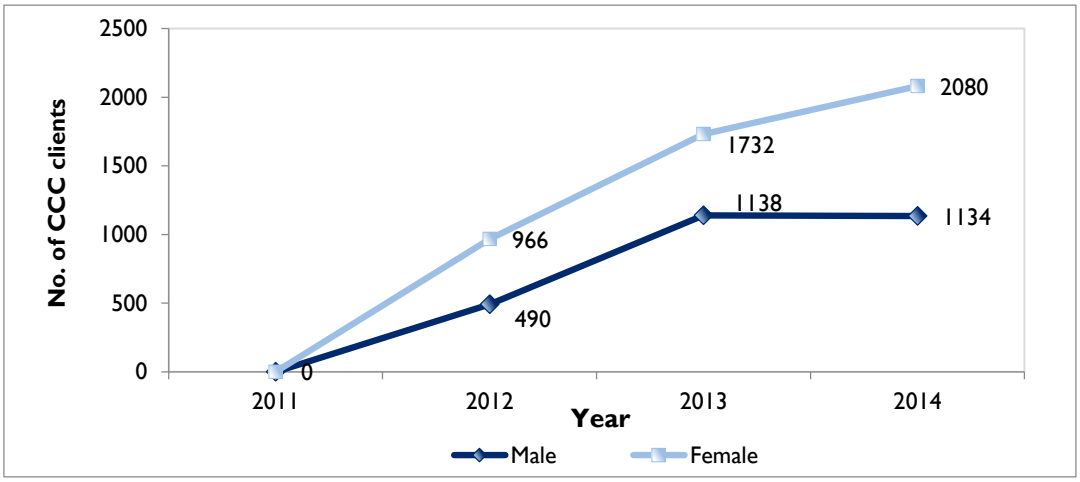
Advancing HIV care and treatment have entailed capacity-building efforts as well as operational support, such as facilitating transport of samples for CD4, viral-load testing, and dried blood spot (DBS) commodities, saving rural clients from having to be referred to the largest regional city Nakuru, and thus mitigating loss-to-follow-up.[30] This has been achieved through the use of a courier service paid for with activity funds, and Internet-based dissemination of laboratory results.[31] By Year 4, the project supported 113 ART sites in the five counties.[32] Through linkages with KEMSA, APHIAPlus was able to facilitate procurement of HIV test kits, antiretrovirals, and family planning.[33] This effort was complemented by a Whole Market Approach that engaged faith-based organizations and the private sector in quality service delivery and reporting of performance.[34]

Rift/ Status of Expected Health Outcomes for HIV Care and Treatment

CCC enrollment was much higher in 2014 than in 2011 (see Figure 2), although evidence suggests a leveling off of the upward trend.[35] The gender gap in CCC enrollment is also increasing, with females enrolling in much higher absolute numbers than men. CCC coverage in Rift is estimated at 86 percent among women and 81 percent among men.

[28] Ibid.
[29] 2014 Quarterly report, 4th quarter.
[30] This finding was corroborated by information gleaned from CCC FGDs in Rift Valley and KIIs with an In-charges of supported health facilities, July 2015.
[31] This finding was corroborated by information gleaned from CCC FGDs in Rift Valley and KIIs with an In-charges of supported health facilities, July 2015.
[32] 2014 Jan-March and April-June quarterly reports.
[33] KII with APHIAPlus Rift Valley IPs, July 2015; Whole Market Approach also described by SCHMT key informant from Nakuru Central.
[34] Ibid.
[35] Data source: DHIS.

Figure 2: *Trends in the number of enrolled CCC clients, according to sex of the client; APHIAPlus Rift, 2012-2014*[36]



According to mini-KAP surveys of CCC clients, 13 percent of respondents had forgotten to take ARVs in the past 30 days.[37] Service integration is not occurring to the extent that it should: only four out of ten CCC respondents reported that they were screened for TB (40 percent) or received FP commodities or counseling (43 percent). The precise reasons for this lack of integration are not known. The CCC mini-KAP did not assess the specific FP commodities received. However, FGDs with CCC clients indicate that access to family planning services has improved in recent years, although the full choice of methods is not always available in the CCC clinic.[38] Male condoms are often available on site; but pills and injectables require referrals to other units (e.g., FP, maternity) or contacts with CHWs at the community level.[39]

Ten percent of CCC clients interviewed reported ever having received an SMS or mobile phone reminder to attend the clinic, with only two percent reporting that they received a reminder the day they were interviewed. Linkages and referrals to other services or interventions that addressed their holistic needs were also low; for example, only 47 percent of interviewed CCC clients had been referred to PLHIV support groups.[40]

Rift/ Conclusions related to HIV Care and Treatment

There has been significant increase in the enrollment of clients into HIV care and treatment over the evaluation period. Integration of FP and TB screening was sub-optimal. The precise bottlenecks that limit service integration warrant further investigation. The activity's logistical, material and technical support contributed to the increased enrollment. Despite strides in linking PLHIV to a spectrum of treatment and care, stigma and fear of stigma persists, even within families.

Rift/ Contributions to Prevention of Mother-to-Child Transmission of HIV (PMTCT)

In Year 1, the activity focused its inputs on improving the knowledge and technical capacity of health workers, orienting them on the new PMTCT guidelines.[41] However, from the onset, the project also invested in mentoring health workers and health managers on PMTCT M&E, data quality, and data- use

[36] Data Source for Figure: DHIS. Data from DHIS did not exist until 2012 for these indicators; therefore the starting point is zero.
[37] Data collected by the evaluation team at 12 sampled CCC sites in July 2015.
[38] Corroborated by multiple FGDs with CCC clients in Rift Valley: Elburgon CCC; Esageri CCC; Subukia CCC; Kabazi CCC; Sogoo CCC; Ngong SCH CCC; Narok CCC July 2015.
[39] Ibid.
[40] Based on multiple FGDs with OVC caregivers: LIP FAIR; LIP in Nanyuki; LIP MAAP Kajiado July, 2015.
[41] 2011 APHIAPlus Nuru ya Bonde Quarter 1 Report.

issues, and assisted health management teams (pre-devolution) in conducting a verification of the status of infant and maternal prophylaxis in 22 facilities.[42] By Year 4 (2014), it supported 420 PMTCT and 242 early-infant diagnosis sites on a range of issues such as male partner testing and infant and young child feeding in compliance with PMTCT guidelines.[43] As part of the Whole Market Approach, the activity worked with the GoldStar network to extend PMTCT—as well as HIV testing and counseling, antiretroviral therapy, and reproductive, maternal, newborn, and child health services—to the private sector. The project also mainstreamed HIV testing in the context of ANC and supported trained CHWs to follow up mother-baby pairs.[44] In 2013, Rift recruited and deployed Mentor Mothers to selected sites in Nakuru as part of its approach to reduce loss-to-followup of HIV-infected mothers and HIV-exposed infants, as well as to promote optimal health practices for HIV-infected mothers and HEI.[45, 46]

Rift/ Status of Expected Health Outcomes for PMTCT

The proportion of HIV-positive women newly enrolled in HIV care and support has increased substantially over the past three years (from 47 percent in 2012, to 74 percent in 2013 and 83 percent and 2014).[47] By the third quarter of 2014, the activity had exceeded its 2014 target for the percentage of HIV-positive women receiving antiretrovirals (actual estimate: 91 percent; target: 90 percent).[48] Data abstracted from HEI registers indicated that the percentage of HEI who underwent PCR testing at eight weeks to assess HIV status increased from 37.5 percent in 2010 to 92.2 percent in 2013.[49] Retention at nine months tripled between 2011 and 2013 (from 23.4 percent to 64.2 percent), and retention at 18 months also increased substantially in the same period (from 15.6 percent to 39.4 percent).[50] Exclusive breastfeeding rates among HEI increased from 76 percent in 2011 to 82 percent in 2013. The mother-to-child transmission rate at 18–24 months is 3.3 percent.[51]

Rift/ Conclusions related to PMTCT

1. Through its bifurcated approach that covered both community-based and facility-based (public and private) service delivery and demand generation, Rift has contributed to increased PMTCT access to more women in Rift Valley.
2. The activity's inputs improved health system readiness for PMTCT. Although some indicators (e.g., retention indicators) serve as proxies for quality, there are limited data on the precise impact of health system strengthening work on the quality of PMTCT service provision.
3. Although HEI retention has increased substantially, there is still tremendous attrition of mother-baby pairs. In light of gains observed for other parts of the PMTCT cascade, improvements in retention would further optimize PMTCT impact.

Rift/ Contributions to Maternal, Newborn, and Child Health and Family Planning

Integration was a core theme of Rift Valley's approach to achieve MNCH-related outcomes. From Year 1, it rolled out cervical cancer screening under the rubric of integrated FP services.[52] It also collaborated with the MoH and UNICEF to launch a 100-day Rapid Results Initiative[53] focused on integrated MNCH, providing both technical and operational support (e.g., transport) to the MoH to implement the initiative.[54]

[42] Ibid.
[43] Ibid.
[44] KII with facility-in-charge Eldama Ravine Hospital July, 2015.
[45] Based on Group KII with APHIAPlus Rift Valley IPs July, 2015.
[46] FGD with MNCH beneficiaries from: Eldama Ravine and Esageri HCs-Baringo County July, 2015.
[47] APHIAPlus Nuru ya Bonde 2014 Report, July-September.
[48] APHIAPlus Nuru ya Bonde Quarter 4 Report, FY2014.
[49] Data source: Abstracted data from HEI registers in 12 health facilities sampled from Rift Valley.
[50] Ibid.
[51] Ibid.
[52] APHIAPlus Nuru ya Bonde Quarterly Report, October-December 2011.
[53] A management tool through which small components of larger projects can be geared to achieve set results in 100 days.
[54] APHIAPlus Nuru ya Bonde Quarterly Report, October-December 2011.

Promoting long-acting permanent methods (LAPM) of FP was also a prominent feature of the activity's work over the past four years. Rift collaborated with FUNZO/Kenya (FUNZO/K) to train health workers on both BEmONC and LAPM, as well as orienting and mentoring larger cohorts of health workers on basic emergency obstetric and neonatal care (BEmONC), MNCH, and commodity management issues in 2014.[55]

With the passage of the Free Maternity Care policy (2013), and new policy guidelines related to PMTCT/Option B+, Rift adapted its efforts. It moved to help CHMTs in the area of supportive supervision and to offer site-based capacity-building and quality-assurance support (e.g., via job aids) to health workers to respond to surging MNCH demand.[56, 57] Mentorship also addressed child survival issues such as child immunization and the integrated management of childhood illnesses.[58] Integrated outreach sessions also included immunization, and nutrition services such as deworming and vitamin A supplements for children.[59]

Rift/ Status of Expected Health Outcomes for FP and MNCH

Family planning and couple-years of protection (CYP) use have both increased. APHIAPlus Rift Valley served more than 300,000 FP clients in 2014, with 30.2 percent of them new users of FP.[60] Results are variable for LAPM use. In some counties, such as Nakuru, it accounts for 66 percent of CYP. In counties such as Baringo, it only accounts for 7 percent of CYP.[61] In 2014, the project exceeded its annual target for child immunization by 21 percent: 146,099 children received DPT3 before their first birthday.[62] Examining KDHS data for former Rift Valley Province as a whole, the percentage of 12–23 month olds who had all basic vaccinations dropped substantially from 85.0 percent in 2008–9 to 68.6 percent in 2014.[63] The DHIS provides further corroborating evidence of this trend: in 2011, full immunization coverage across the Rift Valley facilities fell from 63.0 percent in 2011 to 59.2 percent in 2012, 57.8 percent in 2013, and 48.4 percent in 2014.

The cumulative number of pregnant women receiving at least four ANC visits increased since project inception, from 36,374 in 2011 to 48,552 in 2014.[64] Based on the mini-KAP survey of MNCH beneficiaries at 12 sampled health facilities in Rift Valley (N=60), ANC-1[65] coverage was universal, and nine out of every ten respondents, whether urban or rural, had delivered their youngest child with the assistance of a skilled birth attendant. Only 68 percent of respondents reported receiving at least four ANC visits during their last pregnancy. The 2008 Kenya Demographic and Health Survey (KDHS) and the 2014 KDHS Key Indicators Report (KIR) document a modest increase in ANC-1 coverage between 2008 and 2014 in former Rift Valley Province (88.4 percent and 93.9 percent, respectively).[66] Although population-based survey estimates of skilled birth attendance coverage are not as high as the coverage noted in the mini-KAP with MNCH clients, the KDHS documented a substantial increase in skilled birth attendance coverage 2008-2014 in former Rift Valley Province (33.7 percent and 51.3 percent, respectively).[67]

In an era when the Government of Kenya has introduced measures to mitigate some barriers to care seeking (e.g., free maternity care), other barriers persist. For example, husbands and partners remain an

[55] APHIAPlus Nuru ya Bonde Quarter 4 Report, FY2014.
[56] Group KIIs with APHIAPlus Rift Prime and Subs; Baringo CHMT key informants July, 2015.
[57] APHIAPlus Nuru ya Bonde Quarter 4, FY 2014 report; Year 3, Quarter 4 Report.
[58] Ibid.
[59] Ibid.
[60] Ibid.
[61] Ibid.
[62] DPT=Diphtheria, pertussis and tetanus vaccine; Data source: APHIAPlus Nuru ya Bonda Quarter 3, Year 4 report.
[63] Data sources: 2008/9 KDHS, Table 10.3, page 131; 2014 KDHS Key Indicator Report (KIR): Table 3.17, pages 30-31.
[64] APHIAPlus Nuru ya Bonde Quarter 4, FY2014 report.
[65] ANC-1 refers to first ANC visit
[66] Data sources: 2008 KDHS, Table 9.1, page 114; 2014 KDHS Key Indicator Report (KIR): Table 3.14, page 25.
[67] Data sources: 2008 KDHS, Table 9.8, page 122; 2014 KDHS Key Indicator Report (KIR): Table 3.14, page 25.

impediment to optimal health practices such as FP use, HIV testing, and institutional delivery.[68] The evaluation's qualitative component highlighted shortcomings on the softer aspects of service quality, such as respectful treatment of clients in maternity wards. Some MNCH clients noted instances of verbal and physical abuse of pregnant women by health workers in maternity wards.[69]

Rift/ Conclusions related to MNCH and FP

1. APHIAPlus has contributed to gains in overall FP use; however, given its emphasis on promoting the use of long-acting permanent methods (LAPM), the variable results across counties in LAPM use warrant further investigation to ascertain reasons why LAPM account for a much lower couple years protection (CYP) in some counties (e.g., Baringo) than in others (e.g., Nakuru).
2. There is scope to improve the client-centered aspects of service delivery (in particular, the treatment of clients by health workers) in addition to technical/clinical elements.
3. The role of men in MNCH/FP care seeking warrants attention.
4. Child immunization warrants increased vigilance.
5. Although the coverage of high-impact maternal health interventions has increased, coverage levels are still suboptimal. This points up the need to address persistent barriers and bottlenecks.

Rift/ Contributions to Youth Interventions

Rift's youth-focused strategies did not cover the entire project catchment area; they were limited primarily to Nakuru and Narok counties. Rift did, however, support the extension of youth-friendly services to more youth in Nakuru County.[70] In addition, moonlight HTC services extended access to testing services to more individuals in the community.[71] Rift also supported interventions to enhance the adoption of healthy behaviors by supporting Magnet Theaters, youth- friendly services, and other evidence-based interventions (EBIs), primarily in Nakuru.[72, 73] Concentrating on EBIs, Rift implemented approaches such as Sister to Sister, meant to reduce HIV and pregnancy risk in young women.[74] By the end of 2014, it had reached 65,157 females aged 15–24 years, primarily through post-secondary educational institutions, exceeding its fiscal year (FY) 2015 target of reaching 48,000 young women.[75] The project relied on a mix of peer education and EBIs such as "Shuga," a television drama serial about young people, to cover issues such as alcohol abuse, multiple concurrent sexual partnerships, and sexual and gender-based violence.[76]

Rift/ Status of Expected Health Outcomes for Youths

Forty-one per cent of the respondents from the youth mini-KAP in Rift (N=41) had comprehensive HIV knowledge. Coverage of HIV testing in the past 12 months is extremely high (94 percent). Seven out of ten Rift youth with multiple sexual partners over the past year had used a condom at last sex.[77] Fifteen percent of youth reported experiencing signs of an STI over the past year, though less than half sought treatment.[78] Some of the focus group discussions with youth documented how fear and fear of stigma acted as a deterrent to health care seeking for some youth.[79]

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[68] Based on FGDs with MNCH beneficiaries at Subukia SCH (Nakuru County); Sogoo HC (Narok County); Narok SCH (Narok County) July, 2015); Bisil HC (Kajiado County), Ngong SCH (Kajiado County) July, 2015.
[69] Based on multiple FGDs with MNCH clients: Eldama Ravine and Esageri HCs (Baringo County); Subukia SCH (Nakuru County); Ngong SCH (Kajiado County); Nanyuki CH (Laikipia County) July, 2015.
[70] Based on KIIs with LIP NOPE in Naivasha, as well as Nakuru East SCHMT, July, 2015.
[71] Based on KIIs with In-charges from Eldama Ravine (Baringo County) and Kajiado (Kajiado County) HCs; SCHMT from Nakuru East, and CHMT Narok (Nakuru County).
[72] Based on KIIs with Nakuru CHMT, and In-charge at Nakuru PGH, July, 2015.
[73] Corroborated by APHIAPlus Nuru ya Bonde Quarterly Report, October-December 2011, page 28.
[74] APHIAPlus Nuru ya Bonde Quarterly Report, July-September 2014, page 49.
[75] Ibid.
[76] APHIAPlus Nuru ya Bonde Quarterly Report, October-December 2013, page 49
[77] Mini-KAP with youth aged 15-24 years, Rift Valley, July, 2015.
[78] Ibid.
[79] FGDs with youth in Narok (NOPE LIP), Nakuru (NOPE) and Naivasha (K-NOTE) July, 2015.

Rift/ Conclusions related to Youths
HIV knowledge levels, and uptake of optimal risk-reduction practices, are lower in youth. This suggest there is a need for continued efforts to implement HIV combination prevention interventions for youth.

Rift/ Contributions to Most-at-Risk Populations
The primary targets for MARP interventions are currently female sex workers (FSWs), male sex workers (MSWs), and men who have sex with men (MSM), with specific geographic targeting: nine urban areas and three truck stops.[80] However, the number of priority target groups was larger at the project's inception, when it included additional MARPs such as public transportation conductors and traders, PLHIV, males and females in formal and informal workplaces,[81] and clients at Rift supported drop-in centers (DIC) in Salgaa, Nakuru, Narok, Nanyuki, and Naivasha. Program efforts included HTC, HIV post-exposure prophylaxis, STI treatment, SGBV trauma counseling, and other services.[82]

Rift/ Status of Expected Health Outcomes for MARPS
An estimated 15,000 members of the aforementioned MARP groups were reached with individual or small-group evidence-based interventions, which falls short of the intended target (40,000).[83] It should be noted, however, that the 2012 NASCOP size estimates for female and male sex workers are closer to the numbers reached by APHIAPlus, than to the target numbers for the project.[84] MARPs were linked with a constellation of services. For example, in Quarter 4 of Fiscal Year 2014, drop-in centers reached 544 female and 147 male sex workers. The evidence-based Sister-to-Sister intervention reached 5,507. Of those, 940 FSW were tested for HIV, 1415 FSW received HIV screening and 488 individuals received FP.[85]

Rift/ Conclusion related to MARPs
While Rift has extended interventions to a laudable number of MARPs, the reach of its interventions are far below what was expected, suggesting that the means used to reach MARPs in this region were not effective.

Rift/ Contributions to Malaria Control
Malaria intervention was not a key focus for Rift Valley.[86] CHWs were involved in limited distribution of long-lasting insecticide-treated bed nets (LLIN) to women and households with whom they came in contact, community-based mobilization around malaria prevention, and referral/linkages to health facilities for malaria diagnosis and treatment.[87, 88, 89] Rift also supported counties in their monitoring of the use of rapid diagnostic tests (RDTs).[90]

Rift/ Status of Expected Outcomes for Malaria Control
Annual DHIS data indicate that distribution of (LLINs) has doubled, from 26,236 in 2011 to 53,176 in 2014).[91] This increased access to LLINs is corroborated by population-based KDHS estimates of household LLIN/insecticide-treated bednet (ITN) coverage. In former Rift Valley Province as a whole,

[80] APHIAPlus Nuru ya Bonde Quarterly Report, Jul-Sep 2014, page 50.
[81] APHIAPlus Nuru ya Bonde Quarterly Report, Jan-Mar 2011, page 15.
[82] APHIAPlus Nuru ya Bonde Quarterly Report, Jan-Mar 2014, page 51.
[83] APHIAPlus Nuru ya Bonde Quarterly Report, Jul-Sep 2014, page. ix.
[84] Additional information provided by USAID, October 2015.
[85] APHIAPlus Nuru ya Bonde Quarterly Report, Jul-Sep 2014, page. ix.
[86] As evidenced by all Quarterly Reports between 2011 and 2014.
[87] Based on FGDs with MNCH beneficiaries at Esageri HC (Baringo County), July, 2015.
[88] Based on KIIs with Nakuru CHMT and Nakuru East SCHMT, July, 2015.
[89] APHIAPlus Nuru ya Bonde, Jul-Sep 2014 Quarterly Report, page 39.
[90] APHIAPlus Nuru ya Bonde October-December 2013 Quarterly Report, page 38.
[91] SOURCE: DHIS data for Rift Valley.

household LLIN/ITN ownership increased from 41.4 percent in 2008 to 55.6 percent in 2014.[92] Available evidence does not allow for the direct attribution of LLIN gains specifically to CHWs, however.

Rift/ Conclusions related to Malaria Control

Malaria was not a focus for Rift, but the activity directly contributed to training that provided CHWs with critical skills related to community health-promotion efforts against malaria.

Rift/ Result 4: The Social Determinants of Health

Rift's inputs related to the social determinants of health centered on capacity development of grassroots entities. These included local partners (LIPs) implementing evidence-based interventions (EBIs) targeting youth, and LIPs supporting orphans and vulnerable children (OVCs) and their households. Those inputs are further described in the section on Evaluation Question 2.

The activity, through LIPs, worked to stimulate demand, such as demand for birth registration. The LIPs linked clients to GoK entities, but did more, addressing gaps in caregivers' awareness about the importance of possessing a birth certificate.[93]

Rift/ Contributions to supporting Orphans and Vulnerable Children

Through its LIPs, Rift worked with 30,210 households, of which 78 percent were deemed high vulnerability.[94] The activity's emphasis in Year 4 was moving as many households as possible along the vulnerability curve, with a view toward graduating households with low vulnerability from project support, with minimal monitoring for six months before their final exit. The activity created Savings and Internal Lending Communities (SILCs) as part of its approach to household economic strengthening in Kajiado, Laikipia, and Nakuru counties.[95] The SILC project provided school fees to 8,614 OVC (69 percent females) during the quarter of 2012. A total of 19,989 OVC (51 percent boys) received school fees support directly from the project through Equity Bank's Wings to Fly, Kenya Commercial Bank (KCB), and other stakeholders.[96] Through its LIPs, the project assisted households with OVCs to address other barriers to school attendance, such as the lack of uniforms or the inability to purchase textbooks.[97]

Other discrete streams of work have been implemented in specific sub-counties. For example, a girls' empowerment program called "Four Pillars" in Loitokitok sub-county, [98] which seeks to engage communities, school management, and local leadership in creating a safe environment for girls' education through girls' mentorship, teacher professional development, community engagement, and providing scholarships to OVCs. As of 2014, 1,922 girls from 20 schools were mentored on various life skills. Community meetings were held to discuss the importance of girls' education, the importance of staying in school, and the need to eliminate early marriages.[99]

[92] Data sources: 2008/9 KDHS, Table 12.1, page 163; 2014 KDHS Key Indicator Report (KIR): Table 3.24, page 41.
[93] Ibid.
[94] APHIAPlus Nuru ya Bonde Quarter 1, Year 4 Report, page 20.
[95] APHIAPlus Nuru ya Bonde Quarterly Report, Oct-Dec 2012, pp. 32, 34, 36.
[96] Q1, progress report page 48.
[97] Based on FGDs with OVC caregivers: MAAP Kajiado; LIP Kabazi July, 2015.
[98] APHIAPlus Rift Apr-June 2014, page 61.
[99] Ibid.

As a foundational aspect of ensuring the legal protection of children, Rift sensitized communities to the importance of birth registration, supported OVC caregivers in filing the necessary paperwork to secure birth certificates for OVCs in their care, and paid the required processing fees.[100, 101, 102, 103]

Working collaboratively with police, Rift also pursued community-based strategies to foment social intolerance of child threats, such as child marriage, sexual abuse, and sexual molestation, particularly of young female OVCs.[104] Extensive grassroots capacity building (e.g., of CHWs, LIP personnel, persons involved in M&E) related to OLMIS ensured greater availability, quality, and use of evidence on OVCs for programmatic and reporting purposes.[105,106]

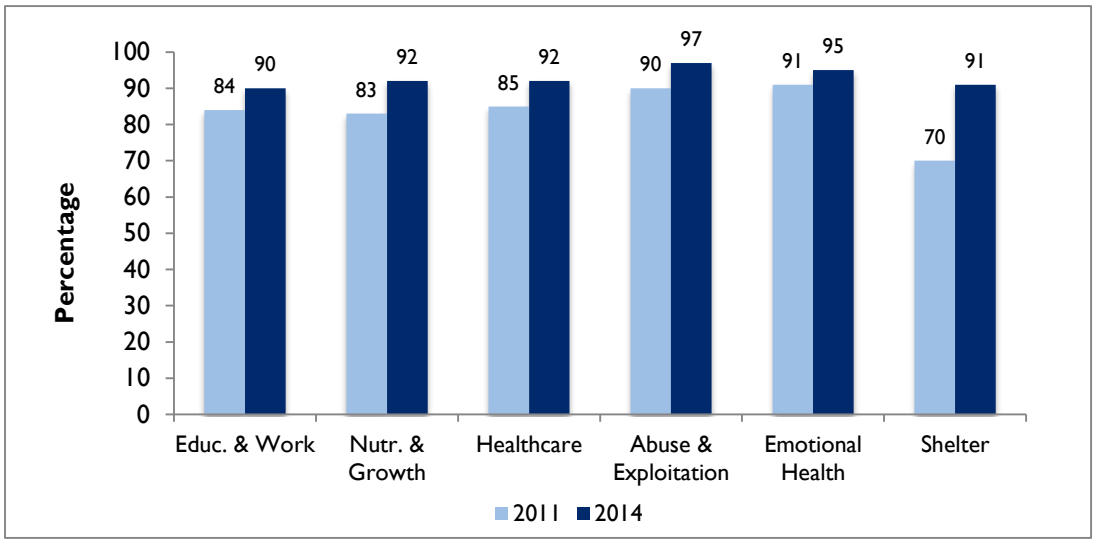
Rift/ Status of Expected Outcomes for Orphans and Vulnerable Children

In the mini-KAP survey with OVC caregivers (N=60), virtually all (98 percent) of school-aged OVCs were currently attending school, with an equal proportion receiving educational support. When asked about the service or form of OVC support that helped them the most, nine out of every ten OVC caregivers who were interviewed said OVC educational support was the most important. Other frequently mentioned supports were medical support (70 percent), psychosocial support (68 percent), food and nutrition support (65 percent), and child protection support (63 percent).[107] Approximately 8 out of every 10 respondents noted that they had participated in some form of household economic strengthening; for example, 81 percent were members of Savings and Internal Lending Communities (SILC). At the end of Fiscal Year 2014, there were 619 active SILC groups (exceeding the annual target of 604), with cumulative savings of KES 33,639,332.[108]

Child Status Index (CSI) scores for various dimensions of child-wellbeing were already fairly high in 2011. As shown in Figure 3, there have been improvements in all key domains of the CSI in Rift Valley.[109] The greatest improvement is in legal protection, for which 58 percent of OVC were assessed with fair/good status in 2011, compared with 90 percent in 2014 (data not shown in the figure).[110]

[100] Based on KIIs with LIP AJAM (Kajiado County); the Laikipia Sub-County Children's Officer; LIP CDoN Ngong (Kajiado County), and LIP WOFAK Bahati (Nakuru County), July, 2015.
[101] Corroborating evidence from KII with Kajiado County Children's Department key informant, July, 2015.
[102]Additional corroborating evidence from multiple FGDs with OVC caregivers: LIP FAIR; Elburgon FAIR; LIP NADINEF in Narok; in Nanyuki, LIP WOFAK July, 2015.
[103] Further corroborating evidence cited in APHIAPlus Nuru ya Bonde Quarterly Progress Report, January-March 2014, page 59; Quarterly Report, October-December 2013, page 68; Quarterly Progress Report, April-June 2012, pp. 48-49 Quarterly Progress Report, April-June 2011, page 32.
[104] Based on FGDs with OVC caregivers: MAAP Kajiado July, 2015.
[105] APHIAPlus Nuru ya Bonde Jul-Sep Quarterly Report, pages 15-16, 22, and 77.
[106] Unlike in the other two regions, OLMIS was not mentioned extensively by Rift Valley's LIP key informants; however, improved data for decision making was mentioned by selected LIPs supporting OVCs in Nakuru and Narok.
[107] Data source: Mini-KAP with OVC caregivers, July, 2015.
[108] APHIAPlus Nuru ya Bonde Quarter 4, Fiscal Year 2014 Quarterly Report, page 58.
[109] APHIAPlus Nuru ya Bonde Child Status Index (CSI) Report 2015.
[110] APHIAPlus Nuru ya Bonde Child Status Index (CSI) Report 2015.

Figure 3: *Percentage of OVCs with "Good" or "Fair" status for selected domains of the Child Status Index (CSI), APHIAPlus Rift Valley, 2011 and 2014*[111]



APHIAPlus' family-centered approach, coupling household economic strengthening with linking households to formal support mechanisms, was cited favorably by LIPs and OVC caregivers, forcontributing to the economic viability of vulnerable households and improving OVC outcomes (e.g., educational access).[112, 113] The evaluation did, however, also document some shortcomings in the approach. For example, the promotion of kitchen gardening among pastoralists (in places such as Laikipia, Kajiado, Narok and Baringo), who typically live nomadic lifestyles, is an example of misalignment between implemented strategies and the circumstances of the populations being targeted.[114]

Rift/ Conclusions regarding Result 4

1. Improvements in child status results cannot be attributed solely to Rift's interventions, because of targeting inefficiencies that had multiple entities/projects target the same OVC beneficiariesHowever, forging clear linkages to government support services—such as OVC scholarships and assistance with obtaining birth certificates—as well as various forms of household strengthening (such as the use of home gardens) can be attributed to the activity.
2. Household economic strengthening was an effective complement to APHIAPlus' facilitating linkages to various other forms of OVC and household support.
3. Optimizing impact is a function of access and the appropriateness/quality of the interventions being offered. For the OVC component, there were shortcomings when general strategies were not adapted to the local context.
4. Wholesale adoption of certain strategies employed under the Result 4 component did not account for the uniqueness of particular sub-populations within Rift Valley (e.g., pastoralists), limiting the strategies' effectiveness.

[111] Data Source for Figure: APHIAPlus Nuru ya Bonde Child Status Index (CSI) Report 2015.
[112] KII data sources: Nakuru and Narok LIPs (e.g., WOFAK Bahati, Catholic Diocese of Ngong), July 2015
[113] Mentioned in multiple FGDs with OVC caregivers (LIP NADINEF in Narok, Catholic Diocese of Ngong, CG Nanyuki, Elburgon FAIR), July 2015
[114] Corroborated by various KIIs with LIPs supporting OVCs and their households July, 2015.

4.1.3. Western

Western/ Result 3: Increased use of Quality Health Services, Products and Information

Western increased the number of Community Health Units (CHUs) from 100 to 379 and bolstered CHU capacity to carry out functions such as verbal autopsies, routine reporting, and community WASH.[115] Ninety-one percent of community health workers (CHWs) interviewed reported that they had undergone training provided by the activity.[116] Western also supported Rescue Centers for victims of sexual and gender-based violence (SGBV), liaising with both communities and the police. Western addressed harmful traditional practices such as female genital mutilation/cutting (FGM/C) and other forms of SGBV through community-based interventions such as community dialogue days.[117, 118] The number of Rescue Centers grew from one in Year I of implementation to three by Year 3. They served as mechanisms for reporting and responding to cases of SGBV (reported cases in Year 1, 2 and 3 were 419 and 1,209, and 4,765 respectively).[119]

Western/ Contributions to HIV Care and Treatment

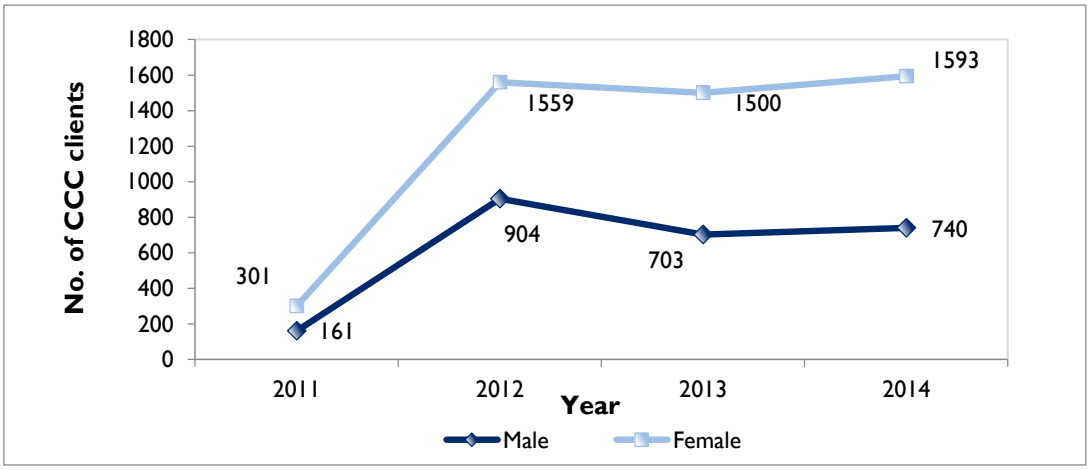
Interviews with implementing partners, in-charges, and Sub-County Health Management Teams shed light on the operational issues vital to correct to ensure service availability, quality, and use. Issues included, for example, laboratory networking, transporting CD4 and dried blood spot samples to Bungoma and follow-up health facilities, supplying HIV test kits and testing supplies, and strengthening routine documentation and reporting.[120, 121, 122, 123] A glut of health players operate in Western Kenya and the constellation of local players has not changed substantially over the last four years.[124] However, the activity was instrumental in introducing community HIV testing and also made capital investments such as renovations of comprehensive care clinics (CCCs).[125] The project also supported 477 sites in implementing different models for TB-HIV integration (143 sites offered complete integration, 109 sites offered partial integration, and 225 utilized a cross-referral model of care).[126]

Western/ Status of Expected Health Outcomes

CCC enrollment figures in Western Kenya have generally been on an upward trajectory over the past four years, though more than twice as many women are enrolled as men (Figure 4). The gender gap in CCC enrollment has actually increased over time (161 males and 301 females in 2011, compared with 740 males and 1593 females in 2014). Although enrollment rates are higher in 2014 than they were in 2011, the available data suggest a leveling off of the upward trend.[127]

[115] Based on KII with informants from APHIAPlus Western Kenya IP, July, 2015.
[116] Data source: Mini-KAP survey with Western Kenya CHWs (N=65), July, 2015.
[117] APHIAPlus Western Kenya Quarter 4, 2014 Report 2014, page 54.
[118] Also corroborated via KII with SCHMT in Migori July, 2015.
[119] APHIAPlus Western Kenya Quarter 4, Report 2014, page 38.
[120] Group KII with Result 3 Technical Leads July, 2015.
[121] KIIs with HF in Charges in Western July 2015.
[122] FGDs with Youth Groups of LIPs ICL; KANCO & YWCA July, 2015.
[123] KII with Health Facility In-charge, Bumula Health Center July, 2015.
[124] According to high-level county health key informants in Homa Bay and Kakamega, as well as APHIAPlus Western Kenya Result 3 key informant: key health players include AMREF (DFID-funded community-level MNCH initiative), AMPATH, Tupange (Kenya Urban Reproductive Health initiative funded by the Bill and Melinda Gates Foundation), ICAP, Jhpiego, UNICEF, CABDA, Great Lakes University, and the Clinton Foundation, Nyanza Reproductive Health Society July, 2015.
[125] KII with SCHMT information, Iguhu (Kakamega) July, 2015.
[126] APHIAPlus Western Kenya Quarter 4, 2014 Report, page 27.
[127] DATA SOURCE: DHIS, 2014.

Figure 4: *Trends in the number of enrolled CCC Clients, by sex of client, APHIAPlus Western Kenya, 2012-2014*[128]



There is evidence of successful service integration which, anecdotally, has contributed to retention gains in HIV treatment and care.[129] The integration of FP in HIV treatment service delivery is corroborated by the mini-KAP conducted with CCC clients in July 2015. Almost two-thirds of CCC respondents reported receiving FP counseling and/or commodities. Respondents noted seamless integration with TB service delivery. TB patients are routinely screened for HIV and those individuals who are diagnosed as being HIV-positive are referred to comprehensive care to CCC services. [130, 131] According to the mini-KAP, almost six of every ten CCC respondents included in the mini-KAP reported undergoing TB screening. Program data yields a much higher proportion of PLHIV who are screened for TB in Year 4 of implementation (85 percent), with an even higher percent of TB clients counseled and screened for HIV (92 percent).[132] In addition, almost seven out of ten respondents had undergone STI screening and 82 percent of the respondents' partners were tested for HIV.

According to the mini-KAP sample with CCC clients (N=65), one-fourth of CCC clients interviewed for the mini-KAP survey reported receiving SMS or mobile phone reminders to attend the clinic and 15 percent had received a reminder to attend clinic the day they were interviewed. Virtually all (98 percent) interviewed CCC clients were on antiretroviral therapy (ART); however, more than one out of every five CCC respondents reported that they had forgotten to take their ARV medicine at least once in the past 30 days.

Western/ Conclusions related to HIV Care and Treatment

1. Western's inputs, coupled with the capacity-building activites described in the Evaluation Question 2 discussion, imply that Western as directly contributing to gains in HIV treatment and care over the past four years.
2. The gender gap between the number of males vs. females enrolled in CCCs has widened over time and there is no evidence that explains this gap. One possible explanation could be a widening gap between males and females who have been diagnosed with HIV/AIDS.
3. The extent of TB screening within the context of CCC service delivery is moderate, although there is a system in place to screen CCC patients for TB. This is a missed opportunity.

[128] Data Source for Figure: DHIS data aggregated across facilities targeted for the evaluation; estimates exclude data from Amakura and Nyamira DH facilities due to data volatility likely attributed to poor data quality and reporting.
[129] Ibid.
[130] KIIs with health center staff July, 2015.
[131] KII with SCHMT informant, Butere (Bungoma) July, 2015.
[132] APHIAPlus Western Kenya Progress Report, Quarter 4 Year 4, Table 11, page 27

Western/ Contributions to PMTCT

Starting in Year 1, Western laid the foundation for its future prevention of mother-to-child transmission of HIV **(**PMTCT) efforts by orienting 312 health workers on the PMTCT guidelines, and providing continuing medical education on early infant diagnosis (EID) and MCH-HIV integration.[133] It also addressed deficiencies within the health system response, such as laboratory networking, supportive supervision, and linkages to psychosocial support.[134] Over the past four years, the activity has continued to provide inputs to maintain demand for, and support for, PMTCT services through peer educators and Mentor Mothers.[135] By the end of Year 4, the project covered 606 sites offering comprehensive PMTCT services and continued to mentor health facility staff along all phases of the PMTCT cascade.[136] EID laboratory support, including distribution of testing commodities, continued to be an important component of its work in 2014.[137] From the start, Western paid attention to integration issues, particularly between MCH and HIV, to reduce missed opportunities for PMTCT.[138] The activity also invested in strengthening MCH-HIV integration. As will be discussed in the MNCH section, it introduced elements to drive demand for antenatal care (ANC) and safe delivery, to thereby increase access to PMTCT services. [139] From Year 1, there was acknowledgement that numerous actors were addressing PMTCT in Nyanza Province. However, Western's efforts addressed other actors' deficiencies that limited PMTCT impact.[140]

Western/ Status of Expected Health Outcomes for PMTCT

In Year 4, Western reported that 179,083 women accessed PMTCT testing services, exceeding the Performance Monitoting plan (PMP) target of 176,012, with 8,331 of these testing HIV positive[141]. While there have been achievements in access to testing, only 75 percent of the PMP targets for maternal prophylaxis for PMTCT was met. However, among pregnant women identified as HIV positive, the uptake of maternal prophylaxis was high (92 percent).[142] This uptake rate is much higher than the national average in 2013 when 70.6 percent of HIV-positive pregnant women nationwide were given ARVs.[143] According to data abstracted from HEI Registers in 13 Western Kenya health facilities supported by the activity, the reported MTCT rate at 18–24 months ranged between 7.1 percent and 9.6 percent between 2010 and 2013. There have been notable gains in PCR testing for HEI at eight weeks; increasing from 64.7 percent in 2010 to 94.3 percent in 2013.[144] HEI retention at 9 months more than tripled between 2011 and 2013 (from 29.4 percent to 67.7 percent, respectively). However, a less-encouraging picture emerges with respect to retention at 18 months which started at 32.4 percent in 2010, peaked at 40.7 percent in 2012, and then dropping to 27.1 percent in 2013.[145] Exclusive breastfeeding rates among HEI increased from 76 percent to 82 percent between 2011 and 2013.[146]

Western/ Conclusions related to PMTCT

1. Western's inputs have directly contributed to health system readiness to link more pregnant women with HTC and link HIV-positive pregnant women with services to reduce MTCT risk and live healthier lives.

[133] APHIAPlus Western Kenya Progress Report, Quarter 4 Year 1, pp. 33 and 34.
[134] Ibid.
[135] APHIAPlus Western Kenya Progress Report, Quarter 4, FY2014, page 12.
[136] APHIAPlus Western Kenya Progress Report, Quarter 4, FY2014, pp. 7, 10, and 12.
[137] Ibid.
[138] APHIAPlus Western Kenya Progress Report, Quarter 4 Year 1, page 40.
[139] APHIAPlus Western Kenya Progress Report for Oct-Dec 2012, page 26.
[140] APHIAPlus Western Kenya Progress Report, Quarter 4 Year 1, page 41.
[141] APHIAPlus Western Kenya Progress Report for Quarter 4, FY 2014, page 7.
[142] Ibid.
[143] Data source: Kenya AIDS Response Progress Report 2014: Progress towards Zero, page 20 (http://www.unaids.org/sites/default/files/country/documents/KEN_narrative_report_2014.pdf)
[144] Data source: Abstracted data from HEI registers in 12 health facilities sampled from Western Kenya.
[145] Ibid.
[146] Ibid.

2. Strides are being made in the reduction of PMTCT by linking more women with PMTCT services. However, there are bottlenecks along the cascade that limit the retention of mother-baby pairs and ultimately compromise PMTCT impact. Follow up and retention of mother-baby pairs still warrant vigilance to maximize outcomes for HEI.
3. It is unclear whether observed rates are due to improved reporting versus bona fide shortcomings in HEI retention and quality of PMTCT follow up.

Western/ Contributions to MNCH and FP

Policy developments such as Free Maternity Care drove more mothers to health facilities; yet access barriers such as physical distance persisted for some segments of the population.[147] Western conducted integrated outreach sessions to link hard-to-reach women with MNCH and FP services, including cervical cancer screening.[148] Peer education networks such as Mentor Mothers facilitated continued contact between pregnant women and the formal health system.[149, 150] The project's efforts to engage community health workers (CHWs) in MNCH started in 2011with the training of 501 CHWs on a range of MNCH and FP issues.[151] Over the past four years, these health workers and volunteers have identified pregnant women, promoted care seeking for the minimum four ANC visits, referred pregnant women to health facilities for delivery, and provided followup for ANC defaulters.[152] The activity supported CHWs in FP promotion to change community perceptions related to FP/child spacing, as well as to provide women with access to condoms, oral contraceptives, injectables, and implants.[153, 154]

Spurring MNCH Demand in the Era of Free Maternity Care

The year Western introduced "Mama Packs" as a demand driver for facility-based delivery care, it witnessed a dramatic increase in institutional deliveries: from 36 to over 100 per month, on average, at Kehancha District Hospital in 2013. The "Mama Packs" included soap, baby diapers, a sanitary pack, a baby shawl, and a baby vest. Unfortunately, this was discontinued after one year. It is noteworthy thatthe introduction of the Government of Kenya Free Maternity Care Policy, while it lifted the number of institutional deliveries, did not match the surge observed when Western implemented the "Mama Pack" intervention (e.g., at Kehancha DH there are currently an estimated 70 institutional deliveries per month).

There are plans to reintroduce the innovation, with support from other development partners and, hopefully, county government.

KII with a health facility In-charge in Migori County.

Western also addressed service delivery gaps in health facilities by, for example, helping facilities meet requirements for both basic and comprehensive emergency obstetric and neonatal care. It also trained and supported health workers in Maternal and Perinatal Death Audits.[155] The introduction of *boda boda* ambulances to ferry pregnant mothers to health facilities addressed noted transport and distance bottlenecks in the MNCH referral system.[156] In Kakamega County, the activity also supported Oparanya Care, a formal re-purposing of TBAs as birth companions

[147] KII with SCHMT key informants in Bungoma County, July, 2015.
[148] APHIAPlus Western Kenya Progress Report, Quarter 4 Year 1, page 45.
[149] KIIs with Result 3 and Result 4 Technical Leads, as well as the BCC Lead for APHIAPlus Western, July, 2015.
[150] KII with health facility In-charge from Bungoma County, July, 2015.
[151] APHIAPlus Western Kenya Progress Report, Quarter 4 Year 1, page 44.
[152] FGDs with: Emia/Kopsiro CHWs in Bungoma County; Kivaywa/Matete HC CHWs in Kakamega county; Muanda/Bumula HC CHWs in Bungoma county; Chango/Mbale RHDC CHWs in Vihiga county July, 2015.
[153] KII with high-level key informant on CHUs/CHWs in Homa Bay, July, 2015.
[154] Corroborated by evidence from FGDs with CHWs from Emia/Kopsiro CHWs; Muanda/Bumula CHWs on July, 2015.
[155] APHIAPlus Western Kenya Progress Report, Quarter 4 Year 1, page 42.
[156] KII with health facility In-charge from Bungoma County, July, 2015.

who accompany women to health facilities for delivery by skilled birth attendants. [157, 158]

On the issue of child health, Western supported immunization service delivery through Reaching Every District/Reaching Every Child (RED/REC). The approach included facilitating support supervision by County and Sub-County Expanded Program on Immunization (EPI) focal persons, quarterly county and sub-county EPI performance review meetings, and integrated outreach services targeting the relatively hard-to-reach areas. Western also facilitated repair of cold chain equipment in a number of health facilities, based on identified need.[159] As a result of continued project engagement with County Health Management Teams (CHMTs), Busia County provided KES250,000 during the quarter towards cold chain maintenance. This was a best practice that the project will help showcase to other county governments in the region.[160]

Western/ Status of Expected Health Outcomes for MNCH and FP

The rate of skilled birth attendance in the Western Kenya sample was 71 percent, with a marked urban-rural differential (urban respondents: 78 percent; rural respondents: 64 percent), according to the facility-based MNCH mini-KAP survey (N=65). TBA-assisted deliveries accounted for 16 percent of all deliveries. These facility-based figures are not drastically different from Lot Quality Assurance Sample Survey estimates among mothers of children aged 0-5 months in Q4 of 2014 (81 percent in former Nyanza province, 75 percent in former Western province).[161] However, the coverage estimates are higher than population-based estimates derived from the 2008 KDHS and 2014 KDHS KIR, even though those data sources noted substantial increases in skilled birth attendance coverage between 2008 and 2014 in former Western Province (25.8 percent and 47.8 percent, respectively) and in former Nyanza Province (45.5 percent and 65.0 percent, respectively).[162] DHIS data since project inception indicate an upward trend; however, some annual skilled birth attendance rates exceed 100 percent, suggesting issues with the population estimates used for the denominator of the indicator.

ANC-1 coverage is universal according to the mini-KAP, which is fairly consistent with near-universal population-based ANC-1 coverage estimates from the 2008 KDHS and 2014 KDHS KIR, according to which there were modest increases in ANC-1 coverage between 2008 and 2014 in former Western Province (91.5 percent and 97.2 percent, respectively) and in former Nyanza Province (93.6 percent and 96.6 percent, respectively).[163] The 2014 mini-KAP for the evaluation also documented a chasm between urban and rural areas in ANC-4 coverage (70 percent and 45 percent, respectively). In Year 4, MoH data from Western's catchment area show ANC-4 coverage was only 58 percent in the former Western Province and 54 percent in the former Nyanza Province.[164]

KDHS coverage estimates on child immunization indicate that, in former Western Province, the percentage of 12-23 month olds who had all basic vaccinations only increased slightly, from 73.1 percent in 2008–9 to 74.2 percent in 2014; corresponding values for former Nyanza Province are 64.6 percent (2008–9) and 67.0 percent (2014).[165] According to routine data housed within the DHIS, there is no clear annual pattern in child immunization across the facilities covered in Western Kenya; full immunization coverage was 79.5 percent in 2011, peaked at 85.8 percent in 2012, dropped to 70.8 percent in 2013, and stood at 77.3 percent in 2014.

[157] Multiple KIIs with Kakamega County health key informant: senior level county health official, SCHMT key informants in Butere; health facility in-charge in Makunga July, 2015.
[158] Corroborated by FGDs with CHWs in Butere (Kakamega County) who described shifting TBAs away from their old roles in home deliveries July, 2015.
[159] APHIAPlus Western Quarter 4 Report, page 39.
[160] Ibid.
[161] APHIAPlus Western Quarterly 4 Report 2014 Table 34, page 69.
[162] Data sources: 2008 KDHS, Table 9.8, page 122; 2014 KDHS Key Indicator Report (KIR): Table 3.14, page 25.
[163] Data sources: 2008/9 KDHS, Table 9.1, page 114; 2014 KDHS Key Indicator Report (KIR): Table 3.14, page 25.
[164] APHIAPlus Western Quarterly Report, Quarter 4, Year 4; Table 13, page 34.
[165] Data sources: 2008/9 KDHS, Table 10.3, page 131; 2014 KDHS Key Indicator Report (KIR): Table 3.17, pages 30-31.

Western/ Conclusions related to MNCH and FP

1. Western has directly contributed to service integration via its inputs related to HIV and MNCH as well as MNCH and FP. The activity has contributed to strengthening the platform through which PMTCT can be addressed.
2. Shortfalls in skilled birth attendance persist, and the role of TBAs warrants further attention.
3. Pregnant women come in contact with the formal health system; however, barriers and bottlenecks persist and prevent them from achieving the minimum four antenatal visits required for focused ANC.
4. Child immunization needs to be prioritized, in light of poor progress in increasing coverage.

Western/ Contributions to Malaria Control

Inputs focused on the community aspects of malaria control in Western Kenya. The activity trained CHWs on rapid diagnostic tests (RDTs), provided community-level support related to malaria case management, and supported county and sub-county structures on supply-chain issues related to RDTs and ACTs.[166, 167, 168, 169, 170] Western partnered with the Clinton Health Access Initiative to roll out new guidelines on the treatment of severe malaria, and also filled training gaps by orienting health staff who had not undergone CHAI training.[171]

There was support for long-lasting insecticide-treated bed net (LLIN) efforts, with CHWs supporting community behavior change related to malaria prevention and diagnosis (e.g., promotion of LLIN use and RDT use at the community level).[172, 173, 174,175] The activity also supported CHMTs with coordination and malaria surveillance.[176]

Western/ Status of Expected Health Outcomes for Malaria Control

According to DHIS data, the number of LLINs distributed to children under the age of five in 2014 was 209,727 compared to 700 in 2010. Increased LLIN coverage is borne out in population-based KDHS data as well. In former Western Province, LLIN/insecticide-treated bednet (ITN) ownership (percent of households with at least one ITN) increased slightly between 2008 and 2014 (from 71.4 percent to 81.5 percent). Slight increases were observed in former Nyanza Province (from 76.5% in 2008 to 81.1% in 2014).[177]

In 2013, CHWs began supporting integrated community case management (iCCM). Trained CHWs identified and referred a total 107,527 cases in that year alone.[178] Between 2011 and 2013, the number of malaria cases identified and referred by CHWs more than doubled in all five counties covered by Western. The most marked increase was in Kakamega County.[179]

[166]KIIs with an In-charge in Bungoma County and a CHEW in Homa Bay, July, 2015.
[167] KIIs with SCHMT informants in Kakamega County and a CHMT informant in Nyamira County Director of Health, July, 2015.
[168] KIIs with APHIAPlus Western IPs, health facility In-charges from Kopsiro HC (Bungoma County) and Kehancha DH (Migori County), as well as Homa Bay CHEWs (Kendu Bay sub-county), and informants from Kakamega CHMT, selected Kakamega SCHMTs (Butere DH, Iguhu DH), and SCHMT Amukura in Busia County July, 2015.
[169] Corroborated with evidence from KIIs with high-level county health key informants in Kakamega County and Homa Bay County, July, 2015.
[170] Corroborated with evidence from FGDs with Obisa/Rachuonyo CHWs; Muanda/Bumula CHWs; Emia/Kopsiro CHWs July, 2015.
[171] APHIAPlus Western Kenya Quarter 4, Year 4 report, page 44.
[172] Based on KIIs with Homa Bay CHMT senior official and a CHU key informant from Kendu Bay sub-county; KII with County Director of Health in Homa Bay County, Western) July, 2015.
[173] KII with high-level informant on Homa Bay CHUs/CHW July, 2015.
[174] FGD with Bumula CHWs (Bungoma County), July, 2015.
[175] Based on KII with a health facility In-charge in Bungoma County, July, 2015.
[176] APHIAPlus Western Kenya Quarterly Report, Quarter 4, Year 4, page 45.
[177] Data sources: 2008/9 KDHS, Table 12.1, page 163; 2014 KDHS Key Indicator Report (KIR): Table 3.24, page 41.
[178] APHIAPlus Western Kenya Quarter 4, Year 3 (2013) report, page 22.
[179] APHIAPlus Western Kenya Quarter 4, Year 3 (2013) report, Table 19 page 22.

Western/ Conclusions related to Malaria Control

1. Quantifying Western's contribution to achievements in malaria control is difficult due to the proliferation of players addressing malaria issues. However, the activity has likely made direct contributions to the marked improvement in community detection of malaria.
2. Through its support to CHWs and CHUs, Western is directly responsible for providing grassroots infrastructure that other players (e.g., President's Malaria Initiative) have used to roll out their own community-based malaria programming (for both prevention and management of identified malaria cases).
3. Further attention is required to make sense of trends in malaria case reporting in light of intensified community-based efforts aimed at prevention.

Western/ Contributions to Youth

In 2011, Western introduced a variety of strategies to reach both in-school and out-of-school youth, such as festivals and Magnet Theater to promote the adoption of healthy behaviors (e.g., FP, HTC, voluntary medical male circumcision, malaria prevention). Life Skills Education (LSE) training was provided for teachers and students in primary and secondary schools.[180] By 2014, there were still substantial inputs in LSE. Western also targeted very young adolescents (10-14 years) with abstinence and faithfulness promotion through its Families Matter EBI, which was incorporated into LSE and Health Clubs.[181] In 2014, the project achieved 125 percent of its PMP target, reaching 125,934 with that EBI.[182]

Western/ Status of Expected Health Outcomes for Youth

Almost nine out of ten (87 percent) youth respondents in the mini-KAP (N=39) demonstrated comprehensive knowledge of HIV. The youths' knowledge of where they can be tested for HIV is also extremely high (95 percent). More than one-third (36 percent) of interviewed youth in Western's catchment area reported having multiple sexual partners in the 12 months preceding the evaluation, with 71 percent of those youth using a condom at last higher-risk sex. There is a stark urban-rural disparity in youth condom use (82 percent urban and 33 percent rural).[183] All youth interviewed had been tested for HIV at least once, and 82 percent had been tested in the past 12 months and reported receiving the test results. Ten percent reported experiencing signs of an STI in the past 12 months, and half had sought medical treatment for the STI(s).

Western/ Conclusions related to Youth

1. While the methodology for the evaluation precludes attributing gains in outcomes seen in the youth population, the activity has undoubtedly contributed to these gains.
2. The urban-rural disparity in condom use among youth warrants further attention, in particular to the deterrents to condom use among rural youth.

[180] APHIAPlus Western Kenya Quarter 4 Report 2011, pp. 90-91.
[181] APHIAPlus Western Kenya, Quarter 4 2014 Report, page 52.
[182] Ibid.
[183] Mini-KAP survey with youth aged 15-24, Western Kenya, July, 2015.

Western/ Most-at-Risk Populations

The dynamics of the HIV epidemic in Western Kenya necessitated strategic targeting of high-burden areas and subpopulations deemed most at risk for HIV transmission and/or acquisition (MARPs). Female sex workers (FSWs), men who have sex with men (MSM), and fisherfolk were key populations targeted via small-group and one-on-one sessions for Splash Inside Out and Sister to Sister.[184, 185, 186] Peer educators and LIPs engaged these groups to distribute condoms and refer them to sexual and reproductive health services. In fact, the activity exceeded its PMP targets for each of these key populations. Western distinguished itself with an increased level of effort related to HIV combination prevention. This orientation is a by-product of the strategic shift that occurred in 2012 when Western transitioned from general BCC approaches to EBIs tailored to MARPs and key populations. Communities in locations such as Busia and Homa Bay, widely known hotspots for the HIV epidemic, were targeted with interventions such as voluntary medical male circumcision (VMMC) to reduce risks.[187]

Western/ Status of Expected Health Outcomes for MARPs:

Western exceeded its Year 4 PMP targets for key populations reached. Female sex workers represented 74.5 percent of all key populations reached (36,491) in 2014, followed by fisherfolk (22.6 percent), and men who have sex with men (2.9 percent).[188] In terms of service uptake, 12,036 were referred for various high-impact, HIV-related services.[189] FSWs were most frequently referred to HTC, STI, FP/emergency contraception, and TB services. Men who have sex with men were most commonly referred to HTC and STI services; and fisherfolk were most commonly referred to HTC, FP/emergency contraception, and STI services in 2014.[190] In 2011, only female sex workers (3,800) and their clients (2,384) were targeted, with 67,659 male condoms distributed and 534 service referrals made.[191]

Western/ Conclusion related to MARP Interventions for Western:

Western did an excellent job designing activities specific to MARPs and as a result, was able to meet or exceed targets.

Western/ Result 4: Social determinants of health addressed to improve the well-being of targeted communities and populations

Western/ Contributions to OVC Support

Economic strengthening was a major thrust of the activity's Result 4 efforts. LIPs consulted during the evaluation reported strengthened capacity for community care and support of OVC, with increased rates of birth registration.[192] However, bottlenecks related to the child protection system are impediments. In Western Kenya, LIP key informants noted that despite submitting the requisite paperwork and payments for OVC caregivers to obtain birth certificates for the children under their care, lost payment by county governments, and other delays in processing paperwork abounded. Western linked with other USG-supported efforts; for example, the Kenya Horticultural Competitiveness Project (KHCP), which facilitated smallholder OVC caregivers with their home gardens and access to local markets. The introduction of OLMIS, which is largely regarded as an innovation, enabled LIPs to better support OVCs

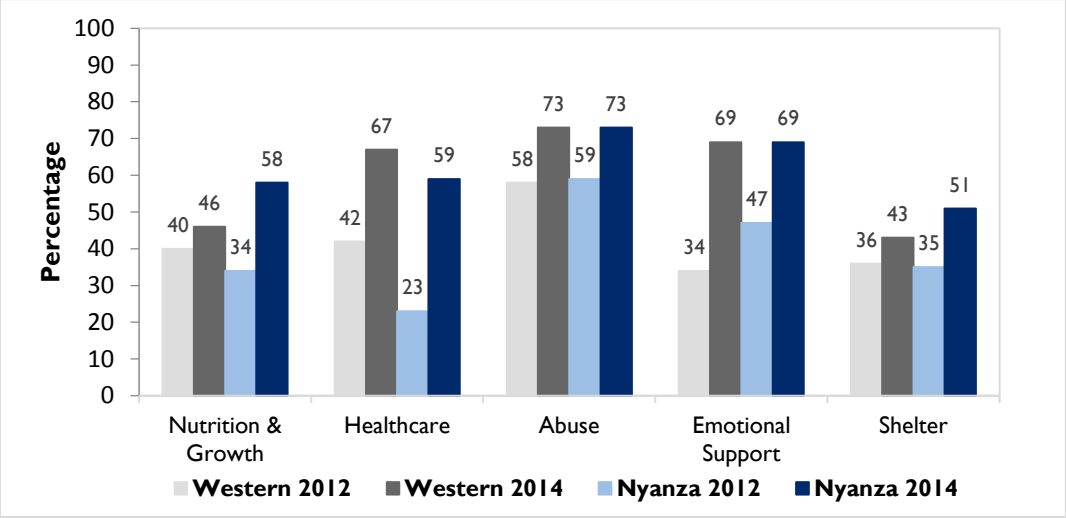
[184] Western Kenya Q4 2014 Report, Oct-Dec 2015, page 50.
[185] APHIAPlus Western Kenya Quarter 4 Report 2014, page 50.
[186] APHIAPlus Western Kenya Quarter 4 Report 2011, page 93.
[187] KIIs with SCMOH Busia; CDH Homa Bay & Former PMO Nyanza/CDH Kisumu July 2015; APHIAPlus Western Kenya Quarterly Report 4, 2013 page 48.
[188] ibid
[189] APHIAPlus Western Kenya Q4 2014 Report, Oct-Dec 2015, Table 18, page 51.
[190] APHIAPlus Western Kenya Q4 2014 Report, Oct-Dec 2015, Table 18, page 51.
[191] APHIAPlus Western Kenya Quarter 4 report 2011, page 9.
[192] Based on KIIs with LIP KDDN (Migori County), LIP Shirere (Kakamega County), LIP CABDA (Kakamega County), LIP Gagi Gagi (Vihiga County), LIP Malakisi CIC (Bungoma County), and LIP Kagwa (in Homa Bay), July, 2015.

and their households, linking them with a range of services to address their holistic needs (e.g., cash transfers via the County Children's Department).[193]

Western/ Status of Expected Health Outcomes for OVC Support

By the end of Year 4 (2014), Western had achieved 100 percent of the 2015 Country Operational Plan target for OVCs supported by the program (180,000).[194] Prior to 2012, the activity focused on providing direct support to OVCs, but USAID advised it adopt a household-strengthening approach. The OVC program approach has evolved in former Nyanza and Western provinces. While the child is used as the entry point to household support, there has been variation across the two provinces in the extent to which all vulnerable children within a household are supported.[195] Despite changing perceptions, there are still community practices that create special vulnerabilities for girls, for example, child marriage, rape/SGBV, and early pregnancy.[196]

Figure 5: *Percentage of OVCs with "Good" status for selected domains of the Child Status Index, acccording to former province (Western and Nyanza), APHIAPlus Western Kenya, 2012 and 2014*[197]



Western was the only activity that provided gender-disaggregated statistics on the Child Status Index. The mini-KAP with OVC caregivers (N=65) showed that 93 percent of OVCs under the care of the respondents were of primary or secondary-school age, and that school attendance among those children was near universal (98 percent), with an equal proportion receiving financial support to attend school. Other frequently cited forms of support are medical support (70 percent), psychosocial support (68 percent), food and nutritional support (65 percent), and child protection support (63 percent).

Numerous community-level stakeholders (MNCH and CCC beneficiaries, OVC caregivers and CHWs) cited the contributions of the activity's community WASH interventions, such as LifeStraw, construction of homestead latrines, and improved hygiene practices such as the use of dish drying racks and hand washing at critical times.[198, 199] CHWs have been important players in this regard.[200] The activity has trained

[193] Ibid
[194] APHIAPlus Western Kenya Fiscal Year 2014 Quarter 4 Progress Report, Table 31, page 64.
[195] Based on KII with Western Result 4 Lead, July, 2015.
[196] Based on multiple FGDs with OVC caregivers: from LIP Kenya Council of Imams; LIP NADINEF; LIP FAIR July, 2015.
[197] Data Source for Figure: APHIAPlus Western Kenya Child Status Index Assessment (CSI) Report, October, 2014.
[198] Corroborating evidence from FGDs with MNCH beneficiaries in: Kopsiro (Bungoma County) July, 2015.
[199] Corroborating evidence from FGDs with CHWs in: Bumula (Bungoma County) July, 2015.
[200] FGD with Bumula CHWs (Bungoma County), July, 2015.

CHWs in Positive Deviance Hearth model to address malnutrition issues in children via their health outreach sessions.[201]

In addition to the above, the activity supported the establishment of 384 Village Savings and Loan Associations, covering a total of 6,893 OVC households (34,000 OVCs).[202] In addition, 1,308 highly vulnerable households were supplied with local chickens, providing a source of extra income through the sale of eggs.[203] Through training of OVC household members as artisans in energy-saving technology (e.g., 'rocket stove'), the activity also assisted OVC households in generating a grand total of KES23,637,800 in labor income from installation of that technology.[204]

Western/ Conclusions related to Result 4

1. Given the lack of uniformity in HIV burden and the dynamics of the epidemic, nuanced approaches related to targeting for OVC support and targeted combination prevention are justified.
2. Optimizing impact is a function of access and the appropriateness/quality of the interventions being offered. CHWs have been important players in this regard.
3. Socio-cultural norms still contribute to child vulnerability, particularly for girls.

4.1.4. KAMILI

At its inception, KAMILI had a much more pronounced focus on MNCH and gender-based violence, which continued through late 2012.[205] However, 2013 ushered in substantial reprogramming.

KAMILI/ Result 3: Increased use of Quality Health Services, Products and Information

KAMILI/ Contributions to Community Health Strategy

During the period under review, the activity supported 134 facilities in Central/Eastern region.[206] Through the community health strategy, the activity increased the capacity of community units (CUs) in service delivery, linking the community and the facility.[207] This strategy saw the success of household mapping and registration in 193 CU, for which each CHW was responsible for an average 80-100 households.[208] By Quarter 4 of 2014, the activity transitioned the Community Health Strategy to county governments, but continued to support 27 sites with targeted community mobilization related to MNCH, nutrition and HIV care and treatment. [209]

KAMILI/ Status of Expected Health Outcomes Related to the Community Health Strategy

The Community Health Strategy has contributed to achieving the outcomes described in subsequent sections (e.g., related to MNCH). Available data do not allow for attribution of high-level health outcomes solely to the Community Health Strategy.

KAMILI/ Conclusion related to Community Health Strategy:

The Community Health Strategy provided a foundation for community mobilization and community-facility linkages, in support of broader health objectives.

[201] KII with high-level informant on Homa Bay CHUs/CHW July, 2015.
[202] APHIAPlus Western Kenya Fiscal Year 2014 Quarter 4 Progress Report, page 58 and Figure 35.
[203] Ibid., page 59.
[204] Ibid.
[205] APHIAPlus KAMILI Program Quarterly Narrative Report October to December 2012 page 9.
[206] Quarterly Report July-Sep 2014 page 6.
[207] Quarterly reports 2011-2014; FGD with CHW, KIIs with Facility in-charges in Central/Eastern July, 2015.
[208] Quarterly Report 2012, 2013, 2014; FGD CHWs in Central/Eastern Region; KII-Prime, SCHMT-Tharaka South, Imenti South.
[209] APHIAPlus KAMILI Program Quarterly Narrative Report October to December 2014, page 3.

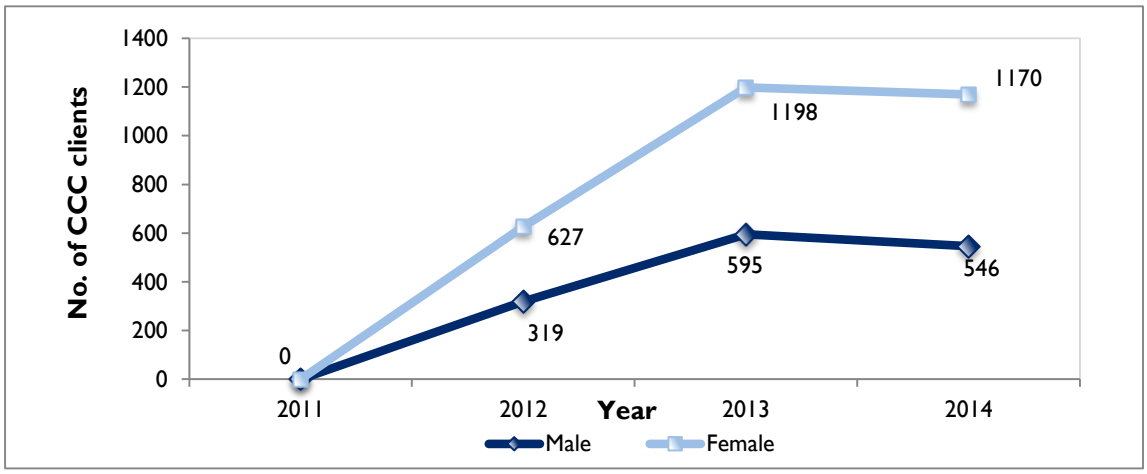
KAMILI/ Contribution to the HIV Care and Treatment:

The activity established satellite CD4 and HIV viral-load testing laboratories under the guidance of Provincial Health Management Teams (PHMTs)/District Health Management Teams **(**DHMTs) in locations such as Thika, Meru, Kiambu, and Nyeri.[210] Adoption of the Whole Market Approach enabled the activity to work collaboratively with private-sector providers on general HIV treatment and care issues and TB-HIV integration.[211] The activity also supported efforts to expand client- and provider-initiated HIV testing and counseling (CITC and PITC, respectively).[212] The activity established referrals of HIV Testing and Counseling (HTC) clients to HIV care and treatment.[213] The activity's collaboration with KEMSA also facilitated and strengthened supply and management of essential commodities at the supported health facilities.[214]

KAMILI/ Status of Expected Health Outcomes in HIV Care and Treatment

CCC enrollment in KAMILI is much higher in 2014 than it was in 2011 (see Figure 6), although evidence suggests a leveling off of the upward trend.[215] The gender gap in CCC enrollment is also increasing, with females being enrolled in much higher absolute numbers than men. The DHIS yields data on CCC coverage in Central/Eastern, which is estimated at 62 percent among females and 51 percent among males (percentages are not shown in the figure).[216]

Figure 6: *Trends in the number of enrolled CCC clients, according to sex of the client, KAMILI, 2012-2014*[217]



Analysis of the mini-KAP survey with CCC clients (N=65) shows the median duration of CCC enrollment was six years, much longer than the median enrollment observed for the other activities. Ninety-five percent of respondents are on ARVs; however, almost one-fourth reported to forgetting to take their ARVs at least once in the past 30 days.[218] Only nine percent of all interviewed CCC clients in Central/Eastern reported ever receiving CCC appointment reminders. SMS/mobile phones were the most frequently cited (by five percent of all interviewed CCC clients). Only three percent had received some form of reminder to attend clinic on the day they were interviewed. According to the mini-KAP survey,

[210] APHIAPlus KAMILI Program Quarterly Narrative Report January to March 2011, 2013, 2014. CD4 Transport Mechanisms consultations; KII-Prime, Facility in-charge-Ngoliba Health Centre, Lari SDH, Kihara SDH; County Nursing Officer/CHMT-Meru County July, 2015.
[211] KII with Technical Leads from APHIAPlus Central/Eastern IP, July, 2015.
[212] APHIAPlus KAMILI Program Quarterly Narrative Report, Project Year 1, Quarter 4.
[213] Quarterly reports 2013, 2014; KII with Prime, Facility in-charges-Central/Eastern, County Nursing Officer/CHMT-Meru County July, 2015.
[214] Quarterly reports 2011-2014, KII-Prime July, 2015.
[215] Data source: DHIS.
[216] Ibid.
[217] Data Source for Figure: DHIS; data from DHIS for these indicators were not collected until 2012.
[218] Data collected by the evaluation team at 12 sampled CCC sites in July, 2015.

seven out of every ten interviewed CCC clients were screened for TB. STI screening among CCC clients was at 67 percent. More than three-fourths of Central/Eastern CCC respondents reported receiving FP commodities and/or counseling.

Focus group discussions with CCC participants offered the insight that when service delivery times are limited to conventional clinic hours, it might limit access for fully employed CCC clients who fear disclosure at their workplace or loss of employment due regular absenteeism (to visit the CCC during working hours).[219] The issue of stigma further complicates the issue of access to HIV treatment and care. Out of fear of stigma, some CCC clients travel to distant clinics rather than to clinics in their communities. Stigma/fear of stigma, coupled with transport costs, compounds access barriers and creates an impediment to clinic attendance. It also makes tracing defaulters more difficult for CHWs and peer educators.[220]

KAMILI/ Conclusions related to HIV treatment and care

1. The activity's efforts in service delivery—CD4 laboratory networks, commodity management, effective linkage to care and treatment, and HIV/TB integration—enabled the availability of and demand for key interventions in the region.
2. HIV/AIDS patients may still be stigmatized in the region and this acts as a barrier to HIV care and treatment.

KAMILI/ Contributions to PMTCT

During the period under review, the activity supported 486 facilities in Central/Eastern. The activity integrated MNCH with PMTCT. It also introduced the Mentor Mothers approach in high-volume facilities as a form of psychosocial support to HIV-positive mothers, with the aim of reducing loss-to-follow-up of HIV-infected mothers and HIV-exposed infants.[221] Peer Mentor Mothers currently work in eight counties at the MNCH departments where they integrate psychosocial support for PMTCT and act as the link between PMTCT and CCC.[222] The mentor mothers were instrumental in the rollout of Option B+ in PMTCT sites, ANC follow up, infant and young child feeding education, HEI defaulter tracing, and linkages to care and prevention for positives support.[223]

KAMILI/ Status of Expected Health Outcomes for PMTCT

There have been laudable gains on various dimensions of PMTCT, although data quality issues persist. The problems may pertain to HIV-exposed Infant (HEI) MoH registers housed within health facilities or aggregate data housed within the DHIS; these limit the quality and rigor of analysis that can be conducted. The number of HIV-infected pregnant women who received ARVs to reduce PMTCT risk has increased slightly (from 2,187 in FY2012 to 2,311 in FY2014).[224] However, this achievement has fallen short of the intended targets. For example, in FY2014, the activity achieved 70 percent of its target of 3,316 HIV-infected pregnant women receiving ARVs.[225] Nevertheless, by Quarter 4 of 2014, 89 percent of identified HIV-positive mothers received ARV prophylaxis, with the same proportion (89 percent) receiving Nevirapine prophylaxis for their infants.[226] Data from Chuka District Hospital provides insight on the

[219] Based on insights gleaned from FGDs in Kiambu County with CCC clients in Kihara and Youth Group members in Kingeero.
[220] Based on FGDs with CCC clients in Nyandarua, Kiambu, Kitui, Tharaka, Meru, and Embu counties; FGD CHW Tharaka DH, Tharaka County; Chuka DH, Tharaka County; Ngoliba HC, Thika Sub County, Kiambu County; Kithimu CHU, Embu County FGD CCC Chuka DH, Tharaka County; Kihara SDH, Kiambu County; Ngoliba HC, Thika Sub County, Kiambu County July, 2015.
[221] Based on Group KII with APHIAPlus Central/Eastern IPs; County Nursing Officer/CHMT, Facility in-charge Akachiu SDH, Chuka DH, Tharaka SDH –Meru County; Ngoliba HC- Kiambu County July, 2015; Quarterly Reports 2012-2014.
[222] APHIAPlus Quarterly Report, October-December 2013 page 8.
[223] Based on FGD with CCC clients at Mutuati SDH (Meru County) and a KII with the In-charge at Tharaka DH (Tharaka County), County Nursing Officer/CHMT-Meru County July, 2015, Quarterly Reports 2013, 2014.
[224] APHIAPlus KAMILI Quarterly Report, Jul-Sep 2014 page 56.
[225] APHIAPlus KAMILI Quarterly Report, Jul-Sep 2014 page 56.
[226] APHIAPlus KAMILI Quarterly Report, Oct-Dec 2014, page 5.

impact and quality of the mentor mothers approach. In Quarter 4 of Year 4, the rate of HIV-disclosure to partners was 88 percent, partner testing stood at 68 percent, maternal highly active ART coverage was 96 percent, infant prophylaxis was universal, hospital delivery by HIV-infected mothers was near-universal (95 percent), and the rate of exclusive breastfeeding was 84 percent.[227]

Data from abstracted HEI registers in KAMILI's catchment area indicate that the percentage of HEI who underwent PCR testing at eight weeks to assess HIV status increased from 72.1 percent in 2010 to 92.3 percent in 2013.[228] There was a modest increase in retention at nine months between 2010 and 2013 (from 67.4 percent to 74.6 percent, respectively), and a stark improvement in retention at 18 months (from 27.9 percent to 51.4 percent, respectively).[229] Exclusive breastfeeding rates among HEI increased from 65 percent to 83 percent between 2012 and 2013.[230] The MTCT rate at 18–24 months is 4.2 percent.[231] (See Annex 11 for additional data.)

KAMILI/ Conclusions related to PMTCT

1. Challenges were noted in introducing the concept of integration during in-service capacity building. This signals a need to mainstream the concept, as part of pre-service training, as well as via any vertical trainings (e.g., PMTCT training, HIV clinical care training).
2. Despite PMTCT-related gains, KAMILI has not reached its targets. However, the activity contributed to observed achievements along the PMTCT cascade, such as PCR testing at 8 weeks and retention at nine months.
3. KAMILI contributed to strides in PMTCT-MNCH-CCC integration.

KAMILI/ Contributions to Youth

The activity directly contributed to adoption of healthy behaviors and to service integration via youth-friendly services. For example, aEmbu Level 5 and Meru Teaching and Referral Hospitals integrate service delivery of youth-friendly services (YFS), family planning, TB-HIV and cervical cancer screening. Although youth groups preceded KAMILI, the activity directly contributed to peer educator efforts, training large numbers of youth peer educators, supporting monthly review and reporting, and establishing youth-friendly desks at health centers.[232] In 2014, USAID requested that the activity prioritize implementation of evidence-based interventions (EBIs) for demand creation and behavior change, quality improvement, and acceleration of key HIV-infected individuals for HIV, MNCH, and OVC services.[233, 234] There is a strong sentiment that the EBI replaced a package of locally developed HIV-prevention interventions that were more context-specific and responsive to local dynamics.[235] Other strategies included use of Magnet Theater to educate peers on issues of sexual and reproductive health, SGBV, and drug abuse. [236, 237] The activity also supported Mobile VCT sessions extend HTC access to youth.[238]

[227] APHIAPlus KAMILI Quarterly Report, Oct-Dec 2014, page 6.
[228] Data source: Abstracted data from HEI registers in 13 health facilities sampled from Central/Eastern.
[229] Ibid.
[230] Ibid. Zero data are available prior to 2012 on this indicator. As a result the comparison is made between 2011 and 2013.
[231] Ibid.
[232] Based on information shared during an FGD with youth from Dallas Tubidii (Embu County), July, 2015.
[233] APHIAPlus KAMILI Program Quarterly Narrative Report January to March 2014, page 6.
[234] APHIAPlus KAMILI Program Quarterly Narrative Report April to June 2014, page 6.
[235] Group KII with APHIAPlus Central/Eastern IPs July, 2015.
[236] APHIAPlus KAMILI Program Quarterly Narrative Report, Oct – Dec 2011 (Project Year 1, Quarter 4); FGD-Youth –Ambassadors of Change, Meru Youth ART Program-Meru County July, 2015.
[237] Corroborated through FGDs Kisima Youth Group (Kiambu County); Based on Youth FGDs: Dallas Youth Group (Embu County); Nkabune Technical School (Meru County), July, 2015.
[238]Based on Youth FGDs: Kisima Youth Group (Kiambu County), July, 2015.

For the youths in school, the activity supported the implementation of the comprehensive school health program (CSHP) in 405 schools across 26 counties.[239] Notably, the activity contributions were not limited to HIV. Through school-based interventions, IPs also worked with county education officials and other stakeholders to train teachers and establish Health Clubs that addressed first aid and other issues such as WASH.[240, 241] In the training-of-trainers approach, county officials were trained; they trained teachers; then teachers worked with students.[242] In September, 2014, KAMILI concluded with the handing over of the CSHP to the Ministry of Education and to school teachers in the region.

In addition to the above, KAMILI was engaged in effective workplace-based HIV prevention interventions. These interventions were eventually abandoned per the request of USAID to focus on PEPFAR "core areas."

KAMILI/ Status of Expected Health Outcomes for Youth

According to the mini-KAP among youth (N=31), among almost nine out of every ten youth respondents (87 percent) have comprehensive knowledge of HIV. Nineteen percent of youth in Central/Eastern Kenya reported having multiple sexual partners in the 12 months preceding the evaluation, with no differences between urban and rural youth. Condom use at last higher-risk sex was universal. The rate of condom use among youth with multiple partners was 71 percent. Knowledge of where youth can be tested for HIV is extremely high (95 percent), and all youth interviewed had been tested at least once for HIV, with 82 percent being tested in the past 12 months and received their test results.[243] Only eight percent of Central/Eastern youth reported experiencing signs of an STI in the past 12 months. Half of these youth sought medical treatment for the STI(s).

KAMILI/ Conclusions related to Youth

1. It's plausible that KAMILI's efforts to ensure increase the adoption of healthy behaviors among the youth led to high levels of comprehensive HIV knowledge and appropriate health care seeking behavior in the region.
2. The scaling down of youth-focused strategies was justified given the lower HIV burden in that region of Kenya. However, targeted combination prevention interventions for youth are still required in the future to address shortfalls in HIV-related knowledge and practices.

KAMILI/ Contributions to Most-at-Risk Populations

The activity supported direct service delivery as well as technical assistance in providing a combination prevention for 4,063 key populations through three DICs in Thika, Limuru and Kyumbi, and two MARPs-friendly facilities that integrated key population services (i.e. at Dallas dispensary in Embu and Brothers of St. Joseph's health center in Nyeri). [244] In Machakos, the activity is also running a drop-in center with the support of the county, which providesservices and donates space).

KAMILI/ Status of Expected Health Outcomes

The evaluation did not entail primary data collection on MARPs, nor is there routine data on MARP outcomes (whether data managed by IPs or housed within routine data sources such as DHIS). However, the evaluation did include one FGD with youth MARPs (Dallas Tubidii in Embu). That group noted improved access to integrated HIV-sexual and reproductive health (SRH) services (e.g., HTC, FP, ART for HIV-infected individuals), but raised the need for greater decentralization of services (e.g., at lower-level

[239] Quarterly reports 2013, 2014.
[240] KII with County Government officials in Kitui County, July, 2015.
[241] Based on Group KII with Muranga County Government officials, July, 2015.
[242] Ibid.
[243] Mini KAP with youth in Central/Eastern Kenya, July, 2015.
[244] Quarterly Report 2013, 2014; KII-Result 3 Technical Lead July, 2015.

health facilities). They also raised the need for access to counseling and services at unconventional times (e.g., on weekends).[245]

KAMILI/ Conclusions related to MARPS

1. There is a need to bolster the evidence base on outcomes related to MARPs.
2. While inputs to date have extended access of sexual and reproductive health services to young MARPs, access barriers persist.

KAMILI/ Contributions to MNCH and FP

KAMILI scaled up MNCH/FP sites from 679 facilities in 2011 to 1067 facilities in 2014.[246] In Year 1, the activity established a foundation to address newborn health by facilitating four health worker orientations on newborn resuscitation.[247] It also sensitized local administrators and personnel involved in health service delivery at all levels to maternal and perinatal death audits, and initiated on-the-job training on long-acting permanent methods of family planning (LAPM).[248, 249]

KAMILI scaled up basic emergency obstetric and neonatal care (BEmONC) services, and capacity building of health facilities to provide all FP methods, especially LAPM. As of September, 2014, a total of 50 facilities were certified as BEmONC sites.[250]

KAMILI has been very proactive in bringing FP closer to women in areas where the unmet need is greatest. Some distribution of FP at the community level proved challenging due to difficulties in accessing FP commodities from facilities and local resistance to allowing CHWs to administer Depo Provera injections (despite being sanctioned to do so by the CHS). Nevertheless, the work that KAMILI pursued in Tharaka Nithi (see text box above), as well as its work related to cervical cancer screening, is acknowledged at the national level as an "innovation."[251] The MoH has noted that this input from APHIAPlus in promoting community-based access to FP has contributed to increased contraceptive prevalence; and, because of the integration of MNCH messages into that community FP program, the effort has also contributed to increased MNCH demand.[252] In 2010, the number of persons receiving FP services in Central/Eastern region was 509,747. By the end of 2014, it had increased to 947,741 persons.[253]

Tharaka Nithi—An Illustration of How APHIAPlus linked marginalized women with family planning (FP)

Tharaka Nithi, a county in former Eastern province, is known to contain marginalized areas and sub-populations. It is also a hotspot for harmful traditional practices such as female genital mutilation and gender inequality. KAMILI utilized CHWs—who are major targets for capacity building—and other support provided by the activity, to offer community-based family planning distribution. With the introduction of FP via this contextually appropriate approach for reaching underserved women, contraceptive prevalence rose from 42% to 76%—the highest in the country.

--Primary sources of information: KIIs with Tharaka Nithi CHMT; APHIAPlus Central/Eastern Result 3 Technical Leads; 2014 KDHS; FIGO (http://www.figo.org/news/fgm-cases-widespread-kenyan-county-0014799)

As part of its gap-filling role, KAMILI improved facilities' capacity to provide reliable services by supporting renovations of administrative offices and MNCH departments, and by providing equipment to various

[245] FGD with Dallas Tubidii Youth (Embu County), July 11, 2015
[246] Quarterly Reports 2011-2014.
[247] APHIAPlus KAMILI Quarter 1, Year 1 Report page 43.
[248] APHIAPlus KAMILI Quarter 1, Year 1 Report pp. 43 and 45.
[249] Based on KII with SCHMT key informants in Muranga, July, 2015.
[250] Quarterly Report Jul-Sep 2014; KII with County Nursing Officer/CHMT-Meru County July, 2015.
[251] Based on KII with Central-level MOH key informant from the Division of Family Health, July, 2015.
[252] Ibid. Also based on KIIs with APHIAPlus KAMILI IP Technical Leads, July, 2015.
[253] APHIAPlus KAMILI FY2014 Quarter Jul-Sep 2014 page 67.

health facilities.[254, 255] The activity supported exchange visits to model sites for learning best practices—for instance, HCW from Gatundu undertook an exchange visit to Thika hospital and HCW from Meru Teaching and Referral Hospital went to Kitui hospital's newborn unit.[256] Theactivity also supported childhood immunization inputs, immunization data audits, EPI orientations, and outreach sessions for rotavirus vaccination.[257]

Over the course of implementation, the project also embarked on strategies to link marginalized communities with specific services. In Tharaka, CHWs were involved in community-based distribution of condoms.[258, 259] The activity's whole market approach saw the involvement of/collaboration with Deutsche Gesellschaft für Internationale (GIZ) on an output-based aid (OBA) initiative in Kitui and Kiambu counties, which served as a demand-generating endeavor (through health promotion work conducted by CHWs) to drive more MNCH clients to the health system.[260, 261]

KAMILI/ Status of Expected Health Outcomes for MNCH and FP

The number of pregnant women receiving at least four antenatal visits increased from 36,002 in 2012 to 105,834 by September, 2014. The number of children delivered by skilled birth attendants increased from 131,663 in 2012 to 173,259 in September, 2014. Analysis of the mini-KAP with MNCH clients (N=65) showed that the rate of skilled delivery is extremely high: nine out of every ten rural respondents in the Central/Eastern sample had delivered with the aid of a health professional. The above estimates, which are based on MNCH clients and thus are not reflective of the population as a whole, are much higher than population-based estimates derived from the 2008 KDHS and 2014 KDHS KIR. Nevertheless, according to the 2008 and 2015 KDHS data, there were substantial increases in skilled birth attendance coverage between 2008 and 2014 in former Central Province (73.8 percent and 89.7 percent, respectively) and Eastern Province (43.1 percent and 63.3 percent, respectively).[262]

Based on the mini-KAP, ANC-1 coverage is similarly high (100 percent among urban respondents; 97 percent among rural respondents). In fact, 42 percent of respondents had received ANC on the day in which they were interviewed for the mini-KAP. The high level of ANC-1 coverage is consistent with population-based findings from the 2008 KDHS and 2014 KDHS KIR. More specifically, there were modest increases in ANC-1 coverage between 2008 and 2014 in former Central Province (from 92.7 percent to 97.3 percent) and in former Eastern Province (from 93.4 percent to 97.2 percent).[263]

With respect to childhood immunization, there have been shortfalls in achieving intended targets, despite increases in the annual number of children who are fully immunized by 12 months of age (i.e. from 95,783 in 2010 to 153,429 by September, 2014).[264] Notably, however, population-based coverage estimates from the 2008 KDHS and 2014 KDHS KIR indicate that in former Central Province, the percentage of 12–23 month olds who had all basic vaccinations actually decreased from 85.8 percent in 2008–9 to 79.6 percent in 2014; corresponding values for former Eastern Province are 84.2 percent (2008–9) and 81.8 percent (2014).[265] Routine DHIS data across APHIAPlus Central/Eastern facilities indicate that full immunization

[254] KII with Kitui CHMT, Facility in-charges at Ngoliba HC; IKII INC Akachiu HC, Meru County, Kihara SDH, Kiambu County and Chuka DH, Tharaka County; GKII INC Tharaka County and Bamboo HC, Nyandarua County; GKII INC Bamboo Health Centre, Nyandarua County July, 2015.
[255] Group KII with Nyandarua County Government Officials (Health, Education, and Agriculture) July, 2015.
[256] Quarterly 2014; KII-County Nursing Officer/CHMT Meru County July, 2015.
[257] APHIAPlus KAMILI Q1 Report July – September 2014 page 64.
[258] Based on FGD with CHWs from Tharaka, July, 2015.
[259] Based on Group KII with County MOH officials in Tharaka County, July, 2015.
[260] APHIA KAMILI Quarterly Report, October to December 2013 page 3.
[261] APHIA KAMILI Quarterly Report, January - March 2014 page 4.
[262] Data sources: 2008 KDHS, Table 9.8, page 122; 2014 KDHS Key Indicator Report (KIR): Table 3.14, page 25.
[263] Data sources: 2008 KDHS, Table 9.1, page 114; 2014 KDHS Key Indicator Report (KIR): Table 3.14, page 25.
[264]APHIAPlus Quarterly Report October – December 2013 page 13, QR July –September 2014 page 64.
[265] Data sources: 2008/9 KDHS, Table 10.3, page 131; 2014 KDHS Key Indicator Report (KIR): Table 3.17, pages 30-31.

coverage hovered between 53 and 57 percent from 2011 to 2013; however, it was as high as 68.2 percent in 2014. The reason for this stark contrast in 2014 versus earlier years is unclear.

KAMILI/ Conclusions related to MNCH and FP

1. National-level policy shifts such as Free Maternity Care (2013) are major confounders in determining the activity's contributions. The multiplicity of players involved in MNCH also makes it difficult to make definitive statements about KAMILI's contributions to key MNCH outcomes such as ANC coverage and skilled delivery coverage. However, KAMILI has contributed to strengthening MNCH service delivery as a platform for PMTCT, as well as improving quality of care to accommodate surging numbers of clients accessing MNCH services. Through support to CHWs/CHUs who are tasked, among their other responsibilities, with referring pregnant women to ANC and delivery care, KAMILI has increased skilled birth attendance.
2. Continued vigilance is required to address shortfalls in full immunization.

KAMILI/ Malaria Control

Malaria did not receive a significant amount of attention, although KAMILI-supported CHWs have been involved in community LLIN distribution.[266] KAMILI has also supported malaria case management in targeted communities.[267]

KAMILI/ Status of Expected Health Outcomes for Malaria Control

The geographic locations covered by KAMILI are not malaria-prone areas. Using fever in children as a proxy for malaria and malaria care seeking (survey-based estimates), counties such as Tharaka-Nithi, Meru, and Kirinyaga have higher rates of childhood fever than other counties in Central/Eastern.[268] The DHIS does track confirmed cases. However, there is a preponderance of zero reporting across sites and across all 12 months of the year, suggestive of data-quality issues that indicate the need for caution in using the DHIS as a reliable source of malaria incidence in non-malaria-prone Central/Eastern region. Household LLIN coverage data from the KDHS does, however, indicate a slight increase in household LLIN coverage in Central and a slight decrease of LLIN coverage in Eastern (Central—between 2008 and 2014: 32.7 percent and 37.7 percent, respectively; Eastern—between 2008 and 2014: 60.4 percent and 56.2 percent, respectively).[269]

KAMILI/ Conclusions related to Malaria Control

Given the nature and level of inputs of KAMILI, compared to other implementers working in the same target geographies, malaria-related outcomes cannot be directly attributed to the activity.

KAMILI/ Result 4: Social determinants of health addressed to improve the well-being of targeted communities and populations

KAMILI/ Contributions to OVC Support

In pursuit of Result 4, KAMILI worked in collaboration with 34 LIPs across the Central/Eastern region. During the period under review, the activity scaled up household economic strengthening (HES) interventions and continued to support HES in OVC households and among other vulnerable groups by implementing income-generating activities.[270] "*We make assessment on household vulnerability and are able to determine through the scores which household is most vulnerable and from these we make recommendations for the assistance of the caregivers in terms of IGAs.*"(KII-OVC LIP AMURT). The activity facilitated linkages

[266] Based on FGD with CCC clients in Chuka DH July, 2015.
[267] Based on KII with Tharaka Nithi MoH officials, July, 2015.
[268] Kenya Demographic and Health Survey, Table 3.30, page 48). APHIAPlus distributed between 22,000 and 30,000 LLINs per quarter via MNCH services. APHIAPlus KAMILI Oct-December 2013, page 45; APHIAPlus KAMILI Jan-Mar Quarterly Report 2012, page 62.
[269] Data sources: 2008/9 KDHS, Table 12.1, page 163; 2014 KDHS Key Indicator Report (KIR): Table 3.24, page 41.
[270] Quarterly reports 2012-2014; KII with OVC-LIPs Central/Eastern.

to formal support mechanisms that addressed unmet educational and clothing needs of OVCs and their elderly caregivers.[271] These linkages, which identify vulnerable children and households, facilitate their access to central mechanisms such as the Cash Transfer Program; however, a major constraint is that not all authorities are devolved, for example, the Kenyan Department of Children is still centrally managed.[272, 273]

KAMILI supported household food security and nutrition by promoting income-generating activities and food/nutrition production, food banking, and storage of high nutrient foods in the region.[274] The activity also supported increased access to education within the region through OVC scholarships and school uniforms.[275] "*So through APHIAPlus Project, the education sponsorship went beyond primary, to secondary and even for some, tertiary level*"-KII OVC-LIP Catholic Diocese of Kitui.

Working through the LIPs, the activity addressed a multiplicity of OVC support needs such as household WASH improvement, as well.[276] Efforts such as improved sanitation and hygiene promotion also extended to the community at large.[277]

The activity also oversaw the introduction of OLMIS to facilitate the work of LIPs supporting OVCs and their households, linking them with a range of services to address their holistic needs (e.g., cash transfers via the County Children's Department).[278]

KAMILI/ Status of Expected Health Outcomes for OVCs

By the end of 2014, APHIAPlus KAMILI had achieved its end-of-project target of 140,000 OVCs reached by the program, with a virtually 50-50 split of males and females being served.[279] Through its LIPs, APHIAPlus has reached a cumulative total of 4,288 households and 464 community groups with household economic strengthening interventions.[280] According to the mini-KAP with OVC caregivers (N=64), 84 percent of those OVCs were of primary- or secondary-school age, with nine out of every ten school-aged OVCs (93 percent) currently attending school. When asked about the service or form of support that helped them the most, 52 percent of OVC caregivers mentioned educational support and 39 percent mentioned IGA support, which is quite different from what was observed for the other two APHIAPlus activities (for which almost nine out of every ten respondents cited educational support as the most important form of support). Of KAMILI OVC caregivers who were interviewed, 98 percent mentioned that they had received educational support for the OVC(s) under their care. The inability to pay school fees has been cited as a major challenge for OVC caregivers.[281]

In the Central/Eastern region the "good" CSI scores decreased between 2011 and 2014. It should be noted, however, that CSI scores were on an upward trajectory from 2011-2013, after which there was a stark decline (data, which are based on raw data provided by the IPs, not shown).

[271] Based on separate Group KIIs with Embu County Government officials (Gender and Children's Department) and Kitui County Government Officials (Education, Children's Services, and Agriculture), and Meru County officials (Children's Department, Youth Department, and Social Services), July, 2015.
[272] Ibid.
[273] Based on Group KII with Kitui County Government officials (Education, Children's Services, Agriculture), July, 2015.
[274] Quarterly reports – 2013, 2014; KIIs with OVC-LIPs in Central/Eastern; FGDs with OVC Caregivers in Central/Eastern July, 2015.
[275] Quarterly reports 2013, 2014; KII-Lead SDH/OVC-AMREF, Devolved Government Department-Embu County, KIIs with OVC-LIP in Central/Eastern region July, 2015.
[276] Based on Group KII with Tharaka County MOH officials, July, 2015.
[277] Corroborated by FGDs with CHWs July, 2015.
[278] Based on multiple KIIs: LIPs COMEHA (Kiambu County), Cheer Up (Kiambu County), and CDM (Muranga County) July, 2015.
[279] APHIAPlus KAMILI Quarterly Report Jul -Sep 2014 page 68.
[280] APHIAPlus KAMILI Quarterly Report Jul -Sep 2014 pp. 58, 68.
[281] FGD with ACK-supported OVC caregivers, Embu County, July, 2015.

Another focus was psychosocial support groups that linked HIV-positive mothers to sources of support. The groups were also used as vehicles for economic empowerment through the project's household economic strengthening efforts, including linkages to the agriculture sector.[282] More broadly, APHIAPlus supported the rollout of income-generating activities targeting vulnerable households, routinely monitoring household vulnerability status to identify and assist less-vulnerable households tograduate from APHIAPlus support. For example, in Quarter 4 of 2014, APHIAPlus' post-vulnerability assessment of 1,117 households documented that 26 percent of supported households were deemed less vulnerable with monthly earnings of KES 2,000 or higher (and thus eligible for 'graduation'), with an additional 54 percent of households rising from very vulnerable to moderately vulnerable status (monthly household earnings of KES 1000-2,000).[283]

KAMILI/ Conclusions related to Result 4

1. The HES initiative successfully linked households to central support mechanisms; it also promoted income-generating ventures that improved the well-being of the households, including the food security of its members.
2. The activity's linking of OVCs to sources of educational support, and OVC caregivers internalizing the idea that education is a social equalizer, regardless of the child's circumstances, led to improved access to education.
3. The post-2013 decline of CSI scores likely reflects the imposed modifications in the approach in OVC support, per the PEPFAR OVC Guidelines, which were released in 2012.

4.2. Evaluation Question 2

Question 2: For each APHIAPlus activity, what are the prospects for the sustainability of the implemented strategies and/or systems and structures that contributed to the observed health outcomes produced by this activity?

4.2.1. Crosscutting Issues

Capacity building was an underlying theme of APHIAPlus' strategies, and the main modality adopted by all three APHIAPlus activities to achieve expected health outcomes.[284, 285] As will be described separately for each activity, IPs addressed discrete functions of various entities such as CHMTs, SCHMTs, health facilities, LIPs, and CHUs. The evidence and insights presented for each activity all point to how the dynamics between the entities, and other critical players such as County Assemblies, impact the functionality of the health system and, ultimately, sustainability.

Sustainability at the health facility-level was a concern voiced by KII respondents in all three regions. Essential services are underfunded due to the provision of equipment, commodities, and staff by all three implementers. When health facility managers and county health officials become aware of these inputs, they decrease budget allocations to the facilities by a corresponding amount. Respondents noted that since little to no budgetary allocations have been made in the past for these essential services, when funding for the APHIAPlus activities stops, the missing funding will have a major negative effect on sustainability. Further complicating the issue of budgetary allocations, according to Sub-County Health Management Teams (SCHMTs) interviewed across all regions: since devolution, control of budgets is held

[282] APHIAPlus KAMILI Quarterly Progress Report, October-December 2013, page 25.
[283] APHIAPlus KAMILI Quarterly Report, October-December 2014, page 21.
[284] As described in the USAID Cooperative Agreement for each activity: AID-623-A-11-00007 (APHIAPlus Health Service Delivery Project, Rift Valley Province—Zone 3); AID-623-A-11-00002 (APHIAPlus Health Service Delivery Project—Zone 1, Western and Nyanza Provinces); AID-623-A-11-00008 (APHIAPlus Health Service Delivery Project—Zone 4, Central and Eastern Provinces).
[285] Further corroborating evidence appears in the Year 1 Quarterly Reports for all three APHIAPlus activities.

at the county level. This limits the SCHMTs ability to provide resources at the sub-county level. KIIs conducted with the CHMTs corroborated these concerns.

4.2.2. Rift Valley

In 2013, Rift aligned its program support with newly devolved government structures, and developed joint work plans with the new county governments.[286, 287]

Rift's approach to strengthening capacity within the health sector was a departure from conventional, didactic training approaches. Capacity development was done at two levels: (1) with health management teams and (2) with health workers involved in direct service delivery. Through the Whole Market Approach, mentorship, on-the-job-training, and supervision was extended to private providers.[288] Rift engaged CHMTs and SCHMTs in mentorship, coaching, and on-the-job training for health workers, as well as joint work-plan development.[289, 290, 291] The activity also provided operational support for the above in the form of stipends, transport, and other essential inputs for executing tasks.[292] Rift was also the conduit between SCHMTs and the USAID-funded national mechanism, Capacity Kenya, which addresses staffing needs.[293]

Rift's facility graduation plan, which is embedded in its broader Quality Assurance/Quality Improvement approach, was to transition the MoH off of the activity's support and to greater self-sufficiency due to the MoH's increased capacity.[294] The "graduation approach" was not as successful as envisioned. Pressure, whether perceived, self-imposed or real, to produce results leads to a reluctance to "graduate" facilities and hand over responsibility to local authorities, particularly in light of local capacity gaps in leadership and governance, as well as limited budget allocations.[295,296] Graduation to higher levels of self-sufficiency is, however, evident in households supported by the household economic strengthening component of Rift. [297, 298, 299]

Rift/ CHW Capacity Development, Multiplicative Effect

Rift addressed core issues among CHWs in Year 1, training male and female Lead CHWs on reporting, communication, leadership, and best practices.[300] Early investments led to engaging CHWs and peer educators in higher-level functions such as defaulter tracing and hygiene promotion, and combating jiggers. [301] There was a cascade-like effect as Rift-supported community resources (CHWs, peer

[286] KII with APHIAPlus Rift Prime & Subs July, 2015.
[287] APHIAPlus Nuru ya Bonde Quarterly Report, October-December 2013, page vii.
[288] APHIAPlus Nuru ya Bonde Quarterly Progress Report, April-June 2011, page11; APHIAPlus Nuru ya Bonde Quarterly Progress Report, October-December 2012, page15; APHIAPlus Nuru ya Bonde Quarterly Progress Report, October-December 2013, page 21.
[289] APHIAPlus Nuru ya Bonde Quarterly Progress Report, October-December 2013, pp. 15 and 38; APHIAPlus Nuru ya Bonde Quarterly Progress Report, October-December 2014, page13.
[290] Based on KIIs with CHMTs and SCHMTs in Baringo, Kajiado, Narok, and Nakuru as well as KII with a non-health county government official in Laikipia, July, 2015.
[291] Based on KII with In-charge in, Baringo County July, 2015.
[292] APHIAPlus Nuru ya Bonde Quarterly Progress Report, October-December 2014, page13
[293] APHIAPlus Nuru ya Bonde Quarterly Progress Report, October-December 2013, page 14.
[294] USAID Cooperative Agreement: AID-623-A-11-00007 (APHIAPlus Health Service Delivery Project, Rift Valley Province-Zone 3), page 20.
[295] KII with health facility In-charge in Nakuru July, 2015.
[296] KIIs with CHMTs and SCHMTs (e.g., in Nakuru East, Nakuru Central, Kajiado) provide corroborating evidence on concerns regarding local technical and governance capacity.
[297] APHIAPlus Nuru ya Bonde Quarterly Progress Report, October-December 2013, page 62.
[298] Corroborating evidence from FGDs with OVC Caregivers from: NADINEF Narok County; AJAM Kajiado County; FAIR Nakuru County, July, 2015.
[299] Corroborating evidence from LIP KIIs in Nakuru, Narok, and Kajiado July, 2015.
[300] APHIAPlus Nuru ya Bonde Quarter 4 2011 report, page 13.
[301] APHIAPlus Nuru ya Bonde Quarter 4 2014 report, pp. 12, 14, 43; A jigger is a parasitic arthropod found in most tropical and sub-tropical climates.

educators) empowered community members to address root causes of poor health outcomes, such as poor hygiene and sanitation.[302]

Rift/ Peer Education as a form of Community Capacity

There are, however, communities where MNCH beneficiaries note that they have had reduced contact with CHWs in recent years. (e.g., based on FGDs with MNCH beneficiaries in Bisil and Ngong in Kajiado; Nanyuki FGD in Laikipia, Kabazi in Nakuru). Notably, CHW focus groups in those communities noted difficulties when the activity stopped providing support such as bicycles and stipends. Although other entities occasionally stepped in to provide support, the withdrawal of Rift's support did affect CHW morale, their relationship with communities, and retention.[303]

Rift/ LIP Functioning

LIP respondents were concerned about their ability to function without the support of the activity, because this support funds LIP employees and provides operational support.[304] Some LIPs (e.g., NADINEF) have graduated and are exploring alternative funding streams with the Government of Kenya, the private sector (Safaricom and Equity Bank), and other donors using a "basket funding".[305]

Rift/ Strengthening CHUs

KAP survey respondents placed great emphasis on training CHWs on crosscutting community issues such as community mobilization, community-based health information systems, and WASH (mentioned by 20-25 percent of CHW respondents in the mini-KAP). County governments have not stepped in make up the funding shortfalls resulting from Rift's reduced support to the Community Health Strategy.[306] However, some CHWs have formed groups around table banking,[307] sold clean water in their communities as a means of income generation,[308] joined self-help groups,[309] and asked community members for small fees.[310]

Attention to quality, whether via developing standard operating procedures for service delivery areas, or introducing of various tools and mechanisms (e.g., job aids and the establishment of Quality Improvement Teams) is another widely cited input that is unique to Rift.[311, 312]

In Rift, many of the targeted counties are planning to absorb HIV testing and counseling staff hired by the activity.[313] The activity continues to play a "gap filling" role on issues such as laboratory networking.[314] Because County Assemblies largely regard HIV, TB, and malaria prevention as donor-driven, they have not dedicated adequate financial resources to addressing these issues and often reduce budgets submitted by CHMTs.[315] There was a decline in the number of outreach sessions when direct support ceased in Year

[302] FGDs with MNCH beneficiaries in Eldama Ravine and Esageri (Baringo), Kajiado (Kajiado), all FGDs with CHW July, 2015.
[303] CHW FGD in Bisil (Kajiado) and Nanyuki (Laikipia); corroborated by MNCH beneficiary FGDs in Narok, Nakuru, and Kajiado July, 2015.
[304] Based on KIIs with LIPs from Nakuru County Elburgon, K-NOTE, and WOFAK July, 2015.
[305] KII with LIP NADINEF, July, 2015.
[306] Noted in all CHW FGDs July, 2015.
[307] FGD with CHW in Nanyuki July, 2015.
[308] FGD with CHW in Eldama Ravine July, 2015.
[309] FGD with CHW in Bisil July, 2015.
[310] FGDs with MNCH in Narok July, 2015.
[311] KIIs with In-charges from Eldama Ravine, Kajiado; CHMTs and SCHMT key informants from Narok, Nakuru East, Nakuru Central, and Nakuru PGH July, 2015.
[312] FGDs with CCC clients in Subukia; MNCH clients in Nanyuki July, 2015.
[313] KIIs with health facility In-charge in Kajiado County and CHMT key informants in Baringo and Nakuru Counties July, 2015.
[314] KIIs with health facility In-charge in Kajiado County and CHMT key informants in Baringo and Nakuru Counties July, 2015.
[315] KIIs with In-charge from Kajiado and CHMTs from Baringo and Nakuru, July, 2015.

3. While there is a possibility that LIPs could take up the responsibility, there was no guaranteed source of funding to enable them take over.[316]

Notably, while counties are still largely dependent on Rift for a range of service delivery functions, there is evidence that various quality improvement mechanisms and structures established by Rift, for example, Quality Improvement Teams, Medical and Therapeutic Committees, and monthly data review meetings, will continue post-activity.[317]

With continuous movement in CHMT and SCHMT counterparts, particularly shortly after the country transitioned to a devolved system of governance, there were instances of the activity's bypassing government structures to advance gains related to supportive supervision, and other capacity development work targeting health facility staff.[318]

APHIAPlus has also fostered linkages with the Government of Kenya cash transfer program, UWEZO fund, bursaries, and scholarships initiatives by both the government and private sectors.[319, 320]

Rift/ Conclusions related to Prospects for Sustainability

1. Rift engaged CHMTs and SCHMTs in mentorship, coaching, and on-the-job training targeting health workers, as well as joint work-plan development. This served a dual purpose: (a) addressing capacity gaps at the point of service delivery and (b) addressing CHMT and SCHMT members' capacity gaps as managers and supervisors.
2. Due to flux in the technical and managerial human resources available at the local level (e.g., as a result of the MoH continually transferring health workers and personnel for health management teams), the extent to which technical and managerial capacity gains will be sustained within counties is unclear.
3. Budget inputs from CHMTs and SCHMTs don't always translate into actual health financing due largely to an over-reliance on APHIAPlus support

4.2.3. Western

When the issue of sustainability was broached with respondents, it was clear that very little thought had gone into ensuring sustainability. In fact, during a group KII with various activity leads, they noted that sustainability had not been a major topic of discussion at their level and that they were unaware of an exit strategy.[321] Further, when the issue of sustainability was raised during KIIs with CHMTs, SCHMTs, and facility-in charges, few were aware that the activity was due to come to a close in December 2015 and noted that they were unaware of any county plans to provide funding for the inevitable gaps that will occur. However, some aspects of the activity's inputs appear to be sustainable.

In Q2 of the Year 1, Western rolled out a performance-based incentive plan covering 2,738 CHWs in consultation with PHMTs and DHMTs'.[322, 323] Stakeholders in Kakamega deemed performance-based financing a successful innovation that could be sustained and brought to scale.[324]

[316] KII with APHIAPlus IPs; corroborated in Quarterly Reports for 2013-14.
[317] KIIs with informants from Baringo county health centers, the CHMT in Narok, a hospital key informant in Nakuru County July, 2015.
[318] KII with key informants from Baringo CHMT July, 2015.
[319] Based on FGDs with OVC Caregivers (FAIR in Nakuru; MAAP in Narok) July, 2015.
[320] Corroborated by KII with LIP key informants in Narok July, 2015.
[321] Group KII conducted with sector leads in Kisumu July, 2015.
[322] APHIAPlus Western Kenya Quarter 2 Report, April-June, 2011, page 26.
[323] APHIAPlus Western Kenya Quarter 4 Report, October -December, 2011, pp. 83-84.
[324] Based on KIIs with Kakamega CHMT; In-charge at Matete HC (Kakamega County) July, 2015.

Through the adoption of a Whole Market Approach, the activity extended various forms of capacity development to both private sector and public sector health providers.[325] One example is the 'Peer Professional/Continuous Development' meeting held in Homa Bay County targeting laboratory officers from both private and FBO health facilities, including the Kenya Medical Laboratory Technicians and Technologists Board representatives for Nyanza. The issues discussed were aimed at registration, licensing, and hiring procedures for lab officers in private and FBO facilities. A total of 42 participants attended the meeting.[326]

To achieve sustainable household-level outcomes (e.g., via household economic strengthening), Rift enhanced the functionality of Community based Organizations (CBOs) in the area of income-generating activities. Interventions emphasized strengthening households' economic capacities; improving food production, farming, and post-harvest management skills and techniques; and enhancing the capacity of targeted households and communities to adopt healthier nutritional practices.[327]

Western placed major emphasis on capacity building around core technical areas (e.g., PMTCT, HIV treatment and care, and malaria case management), and less on the leadership and governance aspects of health system functioning.[328,329.330] In a mini-KAP survey of CHWs, PMTCT was the most frequently cited training provided by Western (88 percent).[331] Notwithstanding the preceding, the evaluation team could not access training records providing the dates of trainings, attendance, and topic.

APHIAPlus Western Kenya introduced OLMIS and provided mentorships to 75 community-based organizations on how it can be used to ensure timely and complete reporting and use of OVC data. OLMIS is widely regarded as a tremendous tool in assisting LIPs with tracking the needs of and service provided to OVCs and their households, thus supporting evidence-based management decision making.[332]

Originally, APHIAPlus provided a CHW/CHV stipend of KES 2000; however, with the strategic shift away from supporting the Community Health Strategy, this stipend ceased, with APHIAPlus providing only a small stipend (KES 500) to cover lunch and transport associated with CHW attendance at monthly performance review meetings.[333] Since Western significantly reduced its support, some CHWs and CHUs have continued to report on their monthly performance, as well as to conduct community dialogue days and quarterly review meetings.APHIAPlus has also supported CHUs in pursuing income-generating activities as a sustainability measure.[334]

Western provided extensive operational support to SCHMTs and CHMTs in fulfilling their mandates around quality monitoring (via supportive supervision) and capacity development (via mentorship)[335] and also provided support for work plan development.[336] APHIAPlus also provided monthly stipends (KES 2000) to peer educators in CCCs and patient psychosocial support groups.[337]

[325] KII with informants from APHIAPlus Western IPs, corroborated by health facility In-charge in Matete/Kakamega July, 2015.
[326] APHIAPlus Western Quarter 1 Report, 2012, page 81.
[327] Ibid p. 10, APHIAPlus Western Quarter 4 Report 2014 page 73.
[328] KII with former PMO Western Nyanza and DMS July, 2015.
[329] Corroborated by KIIs with health facility In-charges: Makunga and Matete (Kakamega), Kopsiro and Bumula HCs (Bungoma) July, 2015.
[330] Further corroborated by KII with SCHMTs in Migori, Busia, and Kakamega July, 2015.
[331] Data source: Mini-KAP conducted with CHWs for the purposes of the evaluation, July, 2015.
[332] KIIs LIPs in Vihiga (Gagi Gagi), Bungoma (Malakisi CIC), Busia (ASIT), and Kakamega (CABDA, Shirere HBC), July, 2015.
[333] Corroborated by evidence from separate KIIs with CHS Focal Persons and other county-level officials in Kakamega July, 2015.
[334] KII with In-charge, Kopsiro Health Center (Bungoma) July, 2015; further evidence provided by the IP in October 2015
[335] KIIs with IPs, In-charge from health facilities in Bungoma County (Kopsiro), Kakamega County (Butere), and CHMT and SCHMT key informants in Kakamega and Bungoma Counties, July, 2015.
[336] KII with high-level county health official in Kakamega County (Western Kenya) July, 2015.
[337] Based on further inputs from the IPs in October 2015 upon review of the draft evaluation report.

APHIAPlus engaged CHMTs and SCHMTs in a range of approaches aimed at improving quality in the health sector.[338] However, within the hierarchy of decision making, SCHMTs are hamstrung and are not empowered to allocate funds and other resources in response to identified needs.[339]

Western/ Conclusions on Prospects for Sustainability

1. Western's trainings established a baseline level of capacity among facility-based providers and CHWs. However, no mechanisms are in place to identify and respond to the need for refresher trainings in the future.
2. There have been tremendous strides in linking OVCs and their households to a range of child services; however, it is unlikely that many of these services will continue without an infusion of support.
3. Because of continued dependence on Western in the area of HIV service delivery, prospects for sustaining both HIV-related strategies and outcomes are low.
4. The culture of data appreciation and the operational aspects of maintaining complete and up-to-date data sources are still being driven by Western. This calls into question the ability to sustain gains related to data availability, quality, and use when the activity ends.

4.2.4. KAMILI

KAMILI/ Direct Staff Support

As part of the "gap filling" role, KAMILI invested heavily in direct service provision through the improvement of infrastructure (physical structures and equipment), as well as in health worker capacity development before FY 2013 and later in conjunction with FUNZO/K.[340]

KAMILI/ Strengthening Health Management Teams

From project inception, KAMILI embedded County Integration Coordinators with DHMTs, with a particular emphasis on HIV treatment and care efforts.[341] However, the newly devolved structures had difficulties in keeping pace with the activity implementation, which has led to the emergence of parallel processes (e.g., supportive supervision).[342] One noteworthy byproduct of devolution was the pooling of the Facility Improvement Funds (FIFs) from the health facilities with the County Revenue Funds, which was not the case pre-devolution.[343, 344]

KAMILI/ Twinning

Twinning was an explicit feature of the KAMILI program approach. Under this arrangement, the international NGOs (Jhpiego, ICAP, PATH) worked closely with Kenyan NGOs (LVCT, the Kenya Red Cross, and NOPE), eventually transferring resources and responsibilities to the Kenyan partners by Year 3, with the expectation that the local IPs and the Government of Kenya would assume responsibility for implementation, with technical assistance from the international IPs.[345]

KAMILI/ Strengthening Community Health Units

Analysis of the KAP survey conducted among CHWs showed community mobilization was the most frequently held training (89 percent) in Central Eastern.[346] When KAMILI reduced its support to the

[338] KII with SCHMT, Sirisa (Bungoma) July, 2015.
[339] KII with sub-IP in Kisumu, July, 2015.
[340] Quarterly reports 2013, 2014.
[341] APHIAPlus KAMILI Quarter 4 Report 2011, pp. 7 and 40.
[342] IKII APHIAPlus KAMILI PRIME DCOP and GKII Team leader APHIAPlus KAMILI Embu County July, 2015.
[343] Based on KIIs with in-charges from multiple facilities in Tharaka County, Kiambu County, and Meru County July, 2015.
[344] Based on The Constitution of Kenya 2010. Revenue Funds for County Governments Cap 207, page 125. Revised Edition 2010 Published by the National Council for Law Reporting with the Authority of the Attorney General.
[345] USAID Cooperative Agreement AID-623-A-11-00008 (APHIAPlus Health Service Delivery Project—Zone 4: Central and Eastern Provinces.
[346] Data source: Mini-KAP conducted with CHWs for the purposes of the evaluation, July, 2015.

Community Health Strategy, CHWs encountered a range of constraints, including but not limited to attrition, low morale, and lack of means to cover their work's operational costs (e.g., transport).[347] However, sensitizing local administrators and Community Advisory Committees also facilitated the work of trained CHWs/CHVs, particularly when the activity was required to scale back its support on the Community Health Strategy.[348] In 2014, some county governments made budget provisions to support CHUs.[349]

KAMILI/ Strengthening Routine Monitoring Data Systems

KAMILI saw the adoption of electronic data capture in health facilities and local implementing partners through fast-tracking use of OVC longitudinal Management information systems (OLMIS) and Electronic Medical Records (EMR).[350, 351]

KAMILI/ Social Determinants of Health

The activity decentralized its regional offices and opened offices in every county where they worked in partnership with county government.[352] This meant the services the program offered became more accessible to beneficiaries at the county level. However, the Children Department is not a devolved structure; and, though KAMILI forged mechanisms to work with devolved structures, the ministry responsible for children is still a national function. As a result, stakeholders working with children will need to work with both the national and the devolved structures.[353]

The activity has linked with county entities on children's issues; however, counties have very little budget and decisionmaking authority to effect sustainable change.[354]

The HES components have high sustainability prospects, with some households showing improvement because of the linkages made to Government of Kenya support mechanisms and household coping capacity addressed through household economic strengthening efforts.[355, 356] As of March 2014, a total of 13,199 OVCs had successfully exited the program due to household economic strengthening efforts.[357] After the introduction of various income-generating activities (cumulative number of households reached: 4,288), APHIAPlus monitored progress and conducted post-vulnerability assessments of income status, to prepare less-vulnerable households for exit.[358] For example, in Quarter 4 of 2014, the post-vulnerability assessment of 1,117 households documented that one-fourth of supported households were less vulnerable, with monthly earnings of KES 2,000 or higher, and an additional 54 percent of household had risen to 'moderately vulnerable' status (monthly household earnings of KES 1000-2,000).[359]

[347] Based on multiple CHW FGDs: Kithimu CU (Embu County), Kyondoni and Kalia CUs (Kitui County), Mbugwa CU (Muranga County), Kiereini CU (Tharaka County) July, 2015.
[348] Based on FGD with CHWs in Tharaka County, July, 2015.
[349] APHIAPlus KAMILI Quarterly Report, October to December 2014, page 35.
[350] APHIAPlus KAMILI Program Quarterly Report, 2013, 2014.
[351] Corroborated by FGDs writh CHWs: Mbugua CU (Maragua County, July, 2015.
[352] KII with Prime, County Government Officials in Embu, Muranga, Kitui; OVC-LIP Tharaka Nithi, Cheer up-Kiambu July, 2015.
[353] Based on KIIs with County Government Officials in Embu, Muranga, Kitui July, 2015.
[354] Based on KII with Embu County focal points from the Departments of Children's Services and Gender, July, 2015.
[355] APHIAPlus KAMILI FY2015 Q1 Report October-December 2014, page 26.
[356] Corroborating evidence from KIIs with APHIAPlus IP Result 4 key informant July, 2015.
[357] APHIAPlus KAMILI Quarterly Report, October-December 2013, page 28.
[358] APHIAPlus KAMILI Quarterly Report, October-December 2014, page 21.
[359] *Ibid*.

KAMILI/ Conclusions related to Prospects for Sustainability

1. Short-term sustainability prospects are favorable with inputs provided by the activity related to improving physical infrastructure and equipment. However, as the quality of these inputs erodes, it is unclear to what degree county governments are equipped to assume responsibility.
2. Challenges brought about by the pooling of the FIF with county revenue funds could dampen health system strengthening efforts.
3. The twinning approach, culminating in the transfer of resources and responsibilities to the Kenyan entities, has great prospects for sustainability since it ensures that health service delivery and OVC support/programming is county-led.
4. Local interest in OVC issues and, more broadly, social determinants of health, will be sustained but the lack of alignment between different government entities at different stages of devolution creates inadequate capacity and resources at the county level to sustain programmatic efforts.
5. There is buy-in and appreciation for management information systems introduced and/or supported by APHIAPlus (OLMIS and EMR), which is an important aspect of the sustainability of those systems.

Overall, sustainability prospects for social determinants of health are favorable, primarily due to the HES component of Result 4.

4.3. Evaluation Question 3

Question 3: For each APHIAPlus activity, what implementation challenges did the activity face during the implementation period? What are the key programmatic and management lessons learned?

4.3.1. Crosscutting Issues

APHIAPlus had to navigate a sea of change over the past four years. The 2013–2014 financial year was particularly challenging, because of the culmination of critical strategic shifts that had been occurring since the activities' inception, which significantly altered both the local operating environments where each implementing consortium worked and each activity's strategic focus. Across the three activities, implementation challenges generally originated from four sources: (1) activity design, (2) the USG-led rationalization process, (3) Kenya's transition to a devolved governance system, and (4) USAID's directive to focus on strategies that directly contributed to PEPFAR core areas. Figure 7 summarizes the effect that each challenge had on implementation, as well as key lessons learned.

A very broad technical scope is inherent in the **activity design**, which, in turn, requires a fairly large consortium of implementers. The original regional focus of each activity is no longer appropriate given Kenya's devolved governance structure. This is now a marked county-specific orientation, with tailored approaches for individual counties rather than blanket approaches applied to large geographical areas (e.g., "Western Kenya"). The broad scope and somewhat disparate organizational competencies required to address Result 3 and Result 4 lead to delinked implementation of Result 3 and Result 4 strategies.[360]

[360] Based on interviews with APHIAPlus Western Result 3 and Result 4 IP Technical Leads and COP, July/August 2015.

***Figure 7**: Key Sources of implementation challenges, APHIAPlus, 2011–2014*[361]

Source/ Catalyst	Nature of Challenge	Effect(s) on Implementation	Lesson(s) Learned
ACTIVITY DESIGN	• Regional orientation of APHIAPlus does not reflect the strong county-specific identity that has emerged since devolution • Broad technical scope of Result 4 component required different technical competencies than Result 3 components • Unwieldy consortium size	• Regional focus did not allow for nuanced approaches (e.g., responding to dynamics of HIV epidemic, variations in county capacity) • Delinked implementation of Result 3 & 4 strategies • Dilution of resources (breadth vs. depth)	Strict geographic parameters & a broad purview can limit implementers' ability to achieve deeper impact, particularly in response to changing local dynamics & needs. As a function of a broad program scope, large consortium size increases the complexity of partnership management, detracting from the ability to be nimble with program implementation.
RATIONALI-ZATION	• Adoption of new sites/geographies • Contending with different implementation approaches and organizational stances on critical issues (e.g., provision of stipends to CHWs)	• Premature transitioning (e.g., CHUs to GoK) • Renegotiation of program inputs with new stakeholders • Akin to 'starting from scratch' in newly assigned sites/locations.	Abrupt changes in program approach can nullify early achievements that serve as the foundation for high-level expected outcomes. Before handover/new entry/early exit, there must be mediated re-negotiation with local stakeholders to ensure success.
DEVOLU-TION	• Introduction of new governance & implementation structures/systems	• New cohort of bureaucrats, many lacking leadership and governance capacity, to be sensitized/trained. • Adjustment of capacity building/HSS approach • Role confusion between governance structures • Erosion of capacity building gains • New complexities in linking with national mechanisms	Timelines to achieve expected outcomes must be adjusted when changes in the local operating environment necessitate changes in the way implementers work with government counterparts.
FOCUS ON PEPFAR "CORE" AREAS	• Communication from USAID re "core" vs. "non-core" areas led to substantial re-programming	• Abandonment/down-sizing of CHS support at a time when momentum was being established. (In some areas, this threatened CHU functionality; in others, it jumpstarted provisions for sustainability.) • Re-doubling of efforts around EBIs that were not perceived to be as appropriate as locally developed interventions • Disconnect between "APHIAPlus priorities" and county priorities	• Changes in program focus must be accompanied by suitable changes in performance measurement. • The ability to objectively evaluate performance is compromised when there are "shifting goalposts." • Prospects for sustainability are jeopardized when changes in strategic direction occurs with little or no lead-time for sufficient handover/capacity development.

[361] Data Source for Figure: Quarter 4 Quarterly Reports for all three APHIAPlus Activities; KIIs with IPs; KIIs with CHMTs and SCHMTs

The **rationalization** process, which took place under the direction of USAID in 2012, did more than reorient the geographic focus of USG partners. It had a destabilizing effect on implementation and some stakeholders have described the process as starting from scratch again.[362]

With **devolution** came new administrative divisions, counties, and counterparts with which each activity had to work. This transition led to role confusion among government entities such as CHMTs and SCHMTs. Furthermore, a brand new cohort of bureaucrats and decisionmakers, many of whom lacked technical leadership or governance capacity, had to be sensitized.[363] Because some national-level mechanisms such as FUNZO/K were launched after APHIAPlus' inception, APHIAPlus IPs were in a precarious position. They identified capacity gaps and HSS needs, but did not have a mandate to address them. Devolution exacerbated this problem.

The 2013 directive for IPs to **focus on PEPFAR's "core areas"** had a destabilizing effect in terms of the Community Health Strategy (CHS), and this shift contributed to tensions between the implementers and county officials.[364] The lack of written communications on changes in strategic direction left IPs with no written frame of reference to renegotiate new action priorities with county governments.[365]

Other Implementation Challenges

The following are additional challenges noted across the three APHIAPlus activities:

Donor-IP Relations:

- Delays in approving work plans and disbursing funds to the prime IP resulted in delays in work plan approval and payment to sub-IPs, hampering their ability to work.[366]
- The spirit of joint problem-solving and constructive oversight of implementation evolved gradually. The introduction of the Site Improvement Monitoring System (SIMS) could bode well for standardized, objectively verifiable means of assessing implementation performance.[367]
- Quarterly meetings with USAID were useful, but in some cases only the prime implementer attended and the meetings lacked the technical representation from the consortium.[368]

IP-National Mechanism Relations:

- The interface between the activities, other USG-funded implementers, and national mechanisms was not seamless. There was competition between different partners to obtain sites for reporting.[369] This led to challenges in reporting and two extremes: double counting or gross omissions.
- There were clear expectations for coordination with national mechanisms; however, ambiguity existed about how that should play out operationally. The evolution of a functional relationship between APHIAPlus implementers and national mechanisms was gradual and numerous key informants noted that they did not hit their stride until 2014.[370]

[362] KIIs with FHI 360 Country Director, APHIAPlus Western COP, APHIAPlus Central/Eastern Result 3 and Result 4 Technical Leads July, 2015.
[363] KII with high-level Bungoma County health key informant Western Kenya July, 2015.
[364] Based on separate Group KIIs with Muranga County Government Officials, Tharaka County officials July, 2015.
[365] Corroborated by national-level interviews with all implementing partners July, 2015.
[366] Based on KIIs with IPs, USAID, and MoH departments July, 2015.
[367] Based on national-level KIIs with informants from IP organizations July, 2015.
[368] Based on national-level KII with a key informant from a sub-IP July, 2015.
[369] Interviews with former PMOs (Western and Rift) July, 2015.
[370] KIIs with field-level and country-level key informants from IPs (EGPAF, Jhpiego) July, 2015.

Routine Monitoring Data Systems:

- Some challenges were noted in terms of coherence of reporting and routine information. KePMS is perceived as a parallel system that is not always aligned with what is documented in national databases.

Learning/Knowledge Management:

- A bona fide learning platform, to inform cross-activity learning, diffusion of innovation, and national scale up was absent. Although the three activities focus on different geographies, there has been overlap in the agencies involved across the three activities. For example, AMREF Health Africa and NOPE were sub-contractors for both Rift Valley and KAMILI. Jhpiego, which is a prime implementing partner for KAMILI, is a sub-contractor for Western. This created a scenario in which there was potential for diffusing innovation and learning across the three activities; the potential was not realized.

4.3.2. Rift Valley

The previously mentioned role confusion between CHMTs and SCHMTs was palpable in Rift Valley.[371] Devolution ushered in new and different support needs and, national mechanisms required an adjustment period. For example, in Nakuru, MSH, through its Health Commodities and Services Management (HCSM) provided training to Provincial and District Health Management Teams (P/DHMTs); however, no such support was available after devolution. Similarly, FUNZO/K could only reach the tip of the iceberg of health worker training needs.[372]

The fledgling leadership and governance capacity of the new cohort of bureaucrats within each county—both within the health sector and outside it (e.g., Children's Departments) presented a challenge to advancing important approaches, such as routine supervision.[373, 374]

SPOTLIGHT ON IMPLEMENTATION CHALLENGES: The Impact of Rationalization

AMPATH, another USAID-funded initiative, operated in the same facilities as Rift since 2011. It also addressed HIV, although its scope of work did not entail capacity building of MoH staff, nor a community mobilization component. In addition, unlike Rift, AMPATH hired health professionals to provide care in facilities. The rationalization in 201213 apportioned service delivery sites between AMPATH and Rfit. When Rift took over facilities once managed by AMPATH, those funded staff positions went away. Consequently, capacity building had to be initiated from scratch.
–SOURCE: KIIs with APHIAPlus Rift Valley IPs, July, 2015

With rationalization, Rift exited North Rift region, which became the responsibility of AMPATHPlus, and AMPATHPlus assumed responsibility for Baringo County. In West Pokot, Rift CHS support was handed over to MCHIP, and the activity entered Molo County to assume responsibility for OVC program activities from the Kenya Red Cross. The organizations took different stances on remunerating of CHWs/CHVs, and MoH staff salary support.[375] In addition, Rift could not absorb medical staff who had beenrecruited and paid directly by AMPATH. [376, 377, 378]

[371] Based on separate KIIs with health facility In-charges in Kajiado County and Nakuru County, July, 2015.
[372] Findings from Nakuru and Subukia gleaned from KII with health facility In-charge in Subukia July, 2015.
[373] APHIAPlus Nuru ya Bonde Quarterly Progress Report, January-March 2015 page 12.
[374] Corroborating evidence from KII with Baringo county government officials July, 2015.
[375] Group KIIs with APHIAPlus Rift Valley IPs July, 2015.
[376] Based on KII with Baringo CHMT key informants, July, 2015.
[377] KII with country-level IP informant July, 2015.
[378] KII with APHIAPlus Western COP July, 2015.

As a result of the rationalization process, planned introduction of innovations and best practices (such as the use of Geographic Information System data to target and design mobile services) never materialized.[379] Pressure to produce results superseded introducing innovative strategies.

Deemphasizing support to the CHS in favor of focusing on "core areas" had far-reaching effects. AMREF, Rift's lead agency on the CHS, left the consortium. The scope and budgets for NOPE and LVCT, responsible for youth strategies and HTC respectively, were significantly reduced.

In addition, given the abruptness with which the new PEPFAR focus had to be implemented in 2014, Rift was unable to institute a formal transfer process with CHMTs and SCHMTs before withdrawing support.[380] It has taken counties time to allocate budget to support existing CHUs, as well as to form new CHUs. The specifics of how available financial resources will be used is yet to be determined.[381]

4.3.3. Western

Western faced challenges with a fledgling county government system and a sense of urgency on the part of its IPs to proceed with their particular strategies. This created scenarios in which Western occasionally bypassed CHMTs and SCHMTs to engage directly with health workers and/or beneficiaries.[382]

Dissemination of new PEPFAR OVC guidelines in 2012 led to increased emphasis on household economic strengthening as a form of OVC support. Western adjusted its approach to building the capacity of the LIPs to align with this new focus. However, cessation of stipends to CHWs/CHVs negatively affected morale and commitment.[383]

Year 2013 was a particularly disruptive period for Western, with stock outs of contraceptive implants, CD4 reagents, rapid test kits (RTKs), and with sites unable to offer HIV testing and counseling; the few RTKs that were available were directed to PMTCT service delivery.[384] Health service delivery was also disrupted by a health workers' strike in December 2013.

As described in the section on Evaluation Question 1 Findings, innovations such as the 'Mama Pack' showed promise in spurring demand. But mechanisms were not in place to execute simple but methodologically sound operations research so decisionmaking could proceed in light of learnings from the small-scale or pilot experiences that had transpired.

4.3.4. KAMILI

With rationalization, KAMILI handed over CHWs/CHUs that were previously within the purview of one consortium partner, AMREF Health Africa, to the county governments. With the exception of Muranga County, the transition was abrupt and had no clear exit strategy.[385] Strategic shifts had a particularly large impact on the implementation of Result 4.

Devolution introduced a major operational challenge: transitioning from collaborating with and supporting two Provincial Health Management Teams (PHMTs) in Embu and Nyeri to engaging 11 CHMTs. APHIAPlus

[379] Based on multiple group KIIs with APHIAPlus Rift Valley IPs; County Government Officials from Nakuru; In charge and other key informants from Kajiado July, 2015.
[380] As gleaned from KII with Baringo CHMT, July, 2015.
[381] Ibid.
[382] Group KIIs with Kakamega & Vihiga government departments; & also KII with CDH Homa Bay July, 2015.
[383] KIIs with Prime IP for APHIAPlus Western Kenya, July, 2015.
[384] APHIAPlus Western FY 2013 Quarterly Report, October-December, page 59.
[385] Corroborated by the following evidence: Group KIIs with Muranga CHMT and Mbugwa CHU (Muranga County); FGDs with CHWs from Kyondoni and Kalia CUs (Kitui County), as well as Kithimu CHU (Embu County), Kiereini CHU (Tharaka County) July, 2015.

had to orient a brand-new cohort of local officials and bureaucrats.[386] This strategic shift prompted IPs to revisit their Year 3 work plans so they would be supporting county transition activities within the devolved system, as well as realigning with the devolution agenda.[387]

Other challenges were introduced when one LIP, Land-O-Lakes, which had been providing OVC support in Ngoliba, left the consortium due to a change in its organizational mission/focus.[388]

4.3.5. Conclusions

Implementation challenges tended to affect all three activities similarly. The following conclusions are drawn from the data from across all three regions.

1. The geographic parameters established when APHIAPlus' was designed are no longer appropriate or relevant given Kenya's new, devolved system of governance. There is a strong "county identity" that now exists at the sub-national level.
2. The overwhelming majority of implementation challenges APHIAPlus implementers encountered resulted from strategic decisions taken by USAID/USG over the first four years of APHIAPlus implementation.
3. The rationalization that occurred under the direction of USAID in 2012 was, in effect, a reset of capacity building and other forms of HSS support.
4. Strategic shifts had a bearing on both implementation and performance measurement/program evaluation because the standards against which APHIAPlus' performance would be evaluated were not completely aligned with the strategies being executed or the indicators being routinely reported.
5. Changes in the local operating environment, such as devolution, created a mismatch between technical support provided by the activities and sub-national support needs.

4.4. Evaluation Question 4

Question 4: Based on the analysis of the evidence generated by this evaluation, what activity implementation strategies/approaches, with particular focus on integration and coordination with national level mechanisms, are most effective and how can they be scaled up in similar future activities?

4.4.1. Crosscutting Issues

There is a lack of evidence regarding what worked from among all the strategies adopted by the three APHIAPlus activities. And, without a bona fide APHIAPlus learning platform, there has been limited cross-activity sharing of lessons learned, limited diffusion of innovation, and limited positioning of APHIAPlus strategies and approaches for national expansion.[389, 390]

Given the absence of an accountability framework that would ensure coordination and linkages with the APHIAs, and the absence of indicators to show that the APHIAs had actually coordinated and integrated with the national mechanisms, coordination efforts were not always tracked.[391] In some cases, USAID and MoH provided a platform for coordination, and this improved working relationships. ASSIST, AfyaInfo,

[386] Group KIIs with APHIAPlus IPs; Muranga CHMT; County Nursing Officer/CHMT-Meru County, SCHMT-Tharaka South, SCHMT-Imenti South July, 2015.
[387] APHIAPlus KAMILI Quarterly Reports: April-June 2013, pp. 1 and 19; July-September 2013.
[388] KII with OVC LIP Head Ngoliba Volunteers without Borders, Thika Sub County, Kiambu County July, 2015.
[389] All KIIs with APHIAPlus implementing partners, USAID and MoH departments August, 2015.
[390] Based on KIIs with national-level GoK counterparts from the DFH/MoH, NASCOP, and National Malaria Program August, 2015
[391] KIIs with APHIAPlus implementing partners July, 2015.

and Kenya Pharma did attempt joint work plan development and implementation of activities, which was viewed as helpful.[392]

All three APHIAPlus activities adopted proven strategies and/or service delivery modalities to facilitate service integration. For example: (1) health worker competency/skill-building through on-the-job training and mentorship (with the engagement of CHMT and SCHMT members as mentors to health facility staff), as opposed to off-site didactic trainings;[393] (2) task-shifting of treatment followup, promotion of adherence, defaulter tracing, and healthy living for PLHIV using mentor mothers and Link Desk volunteers;[394] (3) a family-centered approach to OVC programming; and (4) one-stop shop approaches (e.g., Drop-In Centers) for MARPs and other key target populations.[395]

APHIAPlus introduced OLMIS, which is largely regarded as an innovation in the way it has allowed LIPs supporting OVCs and their households to link their clients with a range of services that address their holistic needs.[396]

The remainder of this section of the report focuses on the experiences of each APHIAPlus activity working with various national-level mechanisms and their approaches.

4.4.2. Rift Valley

Early in its implementation, Rift identified low stocks of HIV rapid test kits as a major bottleneck. The reason for the shortage was that Rift Valley was always the last region to receive commodities from the national mechanism responsible for supplying test kits.[397] Starting in 2012, different national mechanisms deliberately coordinated and collaborated to tackle such health system shortcomings. For example, a co-location arrangement with MSH ameliorated supply-chain challenges.[398] Rift has also pursued linkages with MSH-LMS to train health managers in the counties.[399]

Despite challenges in delineating roles and responsibilities between Rift and the USAID-funded Applying Science to Strengthen and Improve Systems (ASSIST) mechanism,[400] Rift has gained traction in coordinating and collaborating with University Research Company URC-ASSIST, using the Kenya Quality Model of Health (KQMH) as the platform for joint work.[401] For example, URC-ASSIST supported a learning visit to two Quality Improvement Centers of Excellence in Nakuru County, supported Rift in addressing Quality Improvement issues related to OVC program activities (e.g., Child Status Index assessments), and trained both activity staff and MoH personnel as Quality Improvement coaches.[402, 403]

There is also evidence that other entities were engaged around training; for example, joint Antiretroviral Dispensing Tool (ADT) training, in partnership with HCSM, which targets Level 4 health facilities.[404]

[392] Ibid.
[393] Cited across KIIs with health facility in-charges and CHMTs
[394] Ibid.
[395] Cited in KIIs with LIPs serving youth and/or key populations. Very limited data were collected directly from key populations or MARPs; however, one FGD with youth in Central/Eastern (Dallas Tubidii) did yield corroborating evidence.
[396] Based on KIIs with WESTERN key informants: LIP Gagi Gagi (Vihiga County), LIP Malakisi CIC (Bungoma County), LIP ASIT (Busia County), LIP CABDA (Kakamega County), and LIP Shirere HBC (also in Kakamega County); CENTRAL/EASTERN INFORMANTS: LIPs COMEHA (Kiambu County), Cheer Up (Kiambu County), and CDM (Muranga County).
[397] APHIAPlus Nuru ya Bonde Quarterly Report, October to December 2011, page 14.
[398] KIIs with APHIAPlus Rift Valley IPs, July, 2015.
[399] APHIAPlus Nuru ya Bonde Quarterly Report, October to December 2013, pp. 76-77.
[400] Based on KII with national-level key informant from ASSIST, July, 2015.
[401] APHIAPlus Nuru ya Bonde Quarterly Report, July-September 2014, page 82.
[402] APHIAPlus Nuru ya Bonde Quarterly Report, October- December 2013, Page 77.
[403] APHIAPlus Nuru ya Bonde Quarterly Report, April-June 2014, page 62.
[404] APHIAPlus Nuru ya Bonde Quarterly Report, January to March 2012, page 11.

FUNZO/K provided trainings on comprehensive HIV management, BEmONC, and FP (in particular LAPMs).[405]

There was a complementarity of effort, with Rift mentorship teams supporting health facility in-charges to conduct an analysis of staffing gaps, which was then shared with Capacity Kenya to address human resources for health issues within its remit.[406]

Rift/ Conclusions regarding Integration

1. Co-location with MSH was a critical success factor in addressing supply-chain issues.
2. Rift achieved traction in linking with national mechanisms to address Quality Improvement, although there is room for improvement delineating roles and responsibilities between entities. The existence of a sanctioned framework for QI work, the Kenya Quality Model of Health, appears to have created necessary structure by engaging ASSIST, in particular.
3. Clear complementarity of effort, in which the outputs of one partner feeds into the work of another, shows promise in addressing human resources for health gaps.

4.4.3. Western

From its inception, Western identified a need to accelerate the efforts of existing national mechanisms (e.g., HCMS, SCMS, Kenya Pharma, Capacity Project) in response to systemic gaps related to staffing, equipment, drugs, and commodities.[407] SCMS and Kenya Pharma facilitated much of the activity's ad hoc gap filling role (as described earlier in this report); for example, in the procurement of TB/HIV treatment drugs via Kenya Pharma and CD4 testing supplies via SCMS. [408, 409] Western also participated in Kenya Pharma's monthly commodity security meetings.[410]

As implementation has progressed, there is evidence of more extensive, functional linkages to national mechanisms, with national efforts informed by data from the counties.[411] In 2013 and 2014, Western collaborated with Management Sciences for Health (MSH), the implementer of HCSM, on capacity building around commodity management and reporting.[412] This linkage continued through 2014, with collaboration around rapid test kits, CD4 supplies, and malaria commodities.[413] Prior to devolution, HCSM technical advisors were co-located with all three APHIAPlus activities, facilitating joint planning and implementation and fostering team building.[414] Since devolution, HCSM's focus is almost exclusively on Western Kenya (accounting for 10 of its 15 focus counties).

Prior to 2014, there was limited collaboration with FUNZO/K, on training, and the Capacity Project, on human resource for health deployment and supervision. [415] Since 2014, efforts have been more coordinated between Western and FUNZO/K, with Western informing FUNZO's didactic health worker trainings on various aspects of HIV/AIDS, malaria, and MNCH, as well as augmenting the learnings from those trainings with its on-the-job training (OJT) and mentoring.[416]

[405] APHIAPlus Nuru ya Bonde Quarterly Report Jul-Sept 2014, pp. 12-13.
[406] APHIAPlus Nuru ya Bonde Quarterly Report, July to September 2012, page 15.
[407] APHIAPlus Western Kenya Quarter 2 Report, April-June, 2011, pp. 10 and 12.
[408] APHIAPlus Western Kenya Quarter 3 Report, July-September, 2011, page 66.
[409] APHIAPlus Western Kenya Quarter 2 Report, July-September, 2011, page 30.
[410] Based on KII with national-level key informant from Kenya Pharma, July, 2015.
[411] Based on Group KII with APHIAPlus Western Kenya IPs, July, 2015.
[412] APHIAPlus Western Kenya Year 3, Quarter 1 Report, January-March 2013, page 38.
[413] APHIAPlus Western Kenya Year 4, Quarter 4 Report, October-December 2014, page 70.
[414] Based on KII with national-level key informant from HCSM, July, 2015.
[415] APHIAPlus Western Kenya Year 3, Quarter 1 Report, January-March 2013, page 38.
[416] APHIAPlus Western Kenya Year 4, Quarter 4 Report, October-December 2014, page 70.

By 2014, the Leadership, Management and Sustainability (LMS) project began to liaise with Western to assess the status of previous LMS trainees from the MoH, and June 2014 marked the completion of the first cohort of LMS' Leadership Development Program.[417] Similarly, the URC-ASSIST is providing technical assistance around Quality Improvement (particularly in relation to HIV treatment and care, and MNCH), with an ASSIST Quality Improvement advisor working jointly with Western on OJT, mentorship, and supportive supervision.[418, 419]

Western/ Conclusions regarding Integration

1. A catch-up period followed devolution, as national mechanisms achieved greater clarity on how best to address locally identified needs. By 2014, there was greater complementarity of effort between Western and various mechanisms addressing human resources for health issues.
2. Joint work focused on discrete aspects of health system functioning, with routine contact at the field implementation level, were critical factors for forming successful functional linkages between Western and selected national mechanisms.

4.4.4. KAMILI

KAMILI placed an early emphasis on commodity security. In 2011, it worked closely with the Provincial Pharmacist to 1) link health facilities with national mechanisms addressing pharmaceuticals and commodities (i.e., HCSM, KEMSA and Kenya Pharma), and 2) hold a joint consultative meeting between the aforementioned national mechanisms and district pharmacists. [420] KAMILI also engaged in complementary efforts in support of commodity security (e.g., mentorship activities focused on laboratory commodity management at district and provincial hospitals).[421] However, according to KII respondents, when it came down to service delivery, working with the national mechanisms did not always bring about a positive, trickle-down effect.[422]

The national shift towards decentralized governance elevated the role that KAMILI had to play, as a liaison to Kenya Pharmawhen stocks ran out.[423] Through its Whole Market Approach, the activity also established direct linkages between FBO facilities and national mechanisms.[424]

OVC support was a platform for coordination and joint work with USAID-ASSIST. USAID-ASSIST helped adapt the Child Status Index (CSI) tool, and trained LIPs in how to use it.[425] There has also been joint work planning and cost sharing on OVC efforts.[426] KIIs noted there were overlapping mandates in other dimensions of Quality Improvement (e.g., in health facilities).[427] Other aspects of QI support, particularly within health facilities, evolved later in implementation, once the issue of overlapping mandates between the activity and USAID-ASSIST were addressed. As late as December 2013, the activity was still in the planning phases with USAID-ASSIST in rolling out a Quality Improvement approach that was aligned with the Kenya Quality Model of Health.[428]

[417] ibid.
[418] ibid.
[419] Based on KII with national-level key informant from ASSIST, July, 2015.
[420] APHIAPlus KAMILI Program Quarterly Report, October-December 2011 page 38.
[421] Ibid. pp. 38-39.
[422] Based on separate KIIs with a high-level county health key informant in Meru; SCHMT key informants in Tharaka; SCHMT key informants in Kajiado July, 2015.
[423] Corroborated by evidence from Group KIIs with In-charges/CHMT in Tharaka, Mutuati and Muranga; IKIIS with In-charges from Muthale, Kauwi, Chuka, Akachiu, Ngoliba, Kihara and Lari July, 2015.
[424] APHIAPlus KAMILI Program Quarterly Report, October – December 2013, pp. 16-17
[425] Ibid.
[426] Based on KII with national-level key informant from ASSIST, July, 2015.
[427] Ibid. Also corroborated with evidence from national-level key informant from the APHIAPlus KAMILI consortium July, 2015.
[428] APHIAPlus KAMILI Program Quarterly Report, October-December 2013, page 75.

With respect to human resources for health issues, KAMILI coordinated with the Capacity Project and the MoH to match health personnel deployment with priority human resource needs in the region.[429] Therelationship with FUNZO/K also evolved as their efforts became more grounded in the realities of the counties in Central/Eastern Kenya, leading to greater collaboration with KAMILI.[430] The activity has linked with FUNZO/K beyond conventional health technical issues, collaborating on issues such as training trainers in post-rape care, with subsequent cascade-like capacity building via on-the-job training.[431]

KAMILI/ Conclusions regarding Integration

1. APHIAPlus KAMILI took a very strategic approach to commodity management, focusing on both coordination and complementarity of effort among the central mechanisms.
2. The consortium was very forward thinking, but not reactionary, in how it engaged national mechanisms, as evidenced by its collaboration with HCSM, KEMSA, and Kenya Pharma.
3. The activity used national mechanisms to address unconventional aspects of health system strengthening, such as responding to sexual and gender-based violence and Quality Improvement related to Result 4.

In sum, there are no replicable models, per se, related to linkages between IPs and national mechanisms. However, there are valuable lessons learned from APHIAPlus' experiences to date. The mandate and focus of field IPs versus national-level mechanisms require a complete rethink, in light of changes in the local operating environment, as well as the volume of needs for health system strengthening support. The absence of clear milestones, rules of engagement, and dedicated resources to support functional linkages impeded maximizing the impact of national mechanisms in APHIAPlus' target geographies. In addition, support needs were so vast that APHIAPlus' own efforts related to training, HRH, Quality Improvement, and supply-chain management appear to have had a greater impact on local needs than the efforts of national mechanisms. National mechanisms had limited trickledown to the county level.

5. RECOMMENDATIONS

In light of the findings described on the preceding pages, a set of recommendations–cutting across the four Evaluation Questions and the three geographic regions covered by APHIAPlus–follows.

1. In designing future activities, narrow the technical scope of issues addressed in Result 3 ("increased use of quality health services, products and information") and Result 4 ("social determinants of health addressed to improve well-being of targeted communities and populations"). (Responsible entity: USAID Kenya)
    a. Due to the technical and operational challenges of implementing a coherent program that addresses both results, develop scopes of work that focus on synergies between the two streams of work (e.g., ameliorating financial and/or cultural barriers to careseeking in the formal health sector, to increase coverage of high-impact health interventions entailing multiple contacts with the health system: e.g., focused ANC, full immunization of children). Doing so will ensure that (a) adequate effort is devoted to addressing priority factors under each result, and (b) implementing consortia possess the requisite depth and mix of expertise to produce impactful outcomes.
    b. In light of potential synergies between the two streams of work, explore co-location arrangements that place both sets of activities within the same target geographies. Include budget line items for collaboration and coordination between the two activities.
    c. Build on the foundation being established under APHIAPlus to bolster county and sub-county capacity. And, embed project staff within county structures such as CHMTs (or even SCHMTs in

[429] Ibid. page 72.
[430] Based on Group KII with APHIAPlus Central/Eastern Technical Leads, July, 2015.
[431] APHIAPlus KAMILI Program Quarterly Report, October – December 2013, page 36.

locations with high burdens of HIV and/or maternal and neonatal mortality) and/or County Children's Departments (in the case of Result 4 efforts).

2. Disentangle the specific issues and intermediate results achieved under Result 4. For example, OVC support and household economic strengthening might be best addressed as a standalone activity, rather than as one of many issues subsumed under the rubric of "social determinants of health." *(Responsible entity: USAID Kenya)*
3. For sustainability purposes, give strong consideration to placing OVC efforts in the framework of "child protection" or "child-friendly social welfare," since:
   a. The recommended domains entail both prevention and response components.
   b. They would provide a platform for systems-building (akin to what has been accomplished by APHIAPlus in the health sector) to address noted deficiencies and bottlenecks (e.g., multi-sectoral linkages to accelerate access to quality interventions and services for OVCs and their households; inefficiencies and bottlenecks at the county level in issuing birth certificates).

   (*Responsible entities: APHIAPlus IPs, in collaboration with relevant units within County Governments [e.g., Children's Departments])*
4. Given the successes in household economic strengthening and forging linkages to various forms of support (e.g., in health, education), position future USAID-funded efforts addressing social determinants of health as a platform to integrate health and social protection efforts. For example, apply vulnerability criteria to assess the economic status of marginalized, poor and/or underserved segments of society, with clear protocols for linking vulnerable households to social cash transfers (bursaries, OBA, NHIF, etc.) (*Responsible entity: USAID Kenya, in collaboration with Central GoK entities involved in social protection)*
5. Because improved community WASH emerged as a flagship sub-result under Result 4, consider how the concept of "community capacity" can be addressed to sustain health strategies and outcomes, for example:
   a. Using existing community resources (e.g., CHWs/CHVs, CHUs, CACs).
   b. Testing and/or rolling out self-sustaining mechanisms to maintain CHU functionality.
   c. Strengthening the community-facility interface (e.g., the linkages between CHUs and SCHMTs, since the latter are supposed to oversee the former's performance).
   d. Engaging critical household and community gatekeepers (e.g., husbands/partners, religious and community leaders) for optimal health care seeking.
   e. Integrate WASH interventions with broader nutrition and food security efforts.

   (*Responsible entities: Local Implementing Partners; CHMTs and SCHMTs)*
6. Now that there is greater local appreciation for data, redouble efforts related to data quality to ensure that (a) future gains and trends in expected health outcomes can be accurately measured and (b) what is being measured is aligned with what activity implementers are actually supporting/doing in counties and communities.

   (Responsible entities: USAID-funded initiatives such as AfyaInfo, in close collaboration with the Central MoH Division of Health Information Systems and APHIAPlus IPs)
7. This evaluation exercise underscored the importance of having quality strategic information that not only informs USAID's future decisionmaking, but that can also influence policy and program decisionmaking. As a result, enhance documentation and analysis of what works, via means such as:
   a. Conducting cost studies (cost-effectiveness, cost-benefit, value-for-money) related to the Community Health Strategy, the CCC service delivery model, and/or other critical program components that show promise in achieving expected health outcomes.
   b. Developing and operationalizing a learning agenda for future iterations of APHIAPlus, with clear mechanisms to share learning among implementers, and disseminate products to influence policy and diffuse innovation at county and national levels.
   c. In the short term, based on the limited evidence of the effectiveness of APHIAPlus' strategies in contributing to particular health outcomes, as well as suboptimal documentation on critical

success factors in replicating/rolling out APHIAPlus strategies and approaches elsewhere in Kenya, prioritize developing briefs on strategies such as "Mama Packs" in Western Kenya and community-based FP distribution by CHWs in Tharaka Nithi (Central/Eastern Kenya).

(Responsible entities: USAID Kenya and USAID-funded entities/mechanisms supporting operations research, M&E, and learning, in support of APHIAPlus IPs)

8. In response to seemingly dissimilar efforts related to RMNCH, support a more comprehensive approach to sexual and reproductive health (HIV prevention, testing, treatment, and care; FP; STI prevention, diagnosis, and treatment; cervical cancer screening; voluntary medical male circumcision), designed specifically for youth and MARPs. (*Responsible entities: APHIAPlus entities, in collaboration with other USAID-funded initiatives such as MCHIP, county health officials, and LIPs serving youth)*

5.1. Recommendations to further improve Key Health Outcomes

The following recommendations respond to Evaluation Question 1 findings:

5.1.1. Overall Recommendations

The following recommendations are applicable to all three APHIAPlus activities:

In the short term:

1. Promote optimal coverage of postnatal care, which was not a prominent feature of APHIAPlus, nor was it mentioned explicitly by the broad array of persons consulted for the evaluation, despite the importance of the postnatal period in maternal and newborn survival. *(Responsible entities: APHIAPlus entities, in collaboration with other USAID-funded initiatives such as MCHIP, and county health officials)*

In the long term:

1. To curb the silo/vertical program mentality that had to be overcome to promote integrated service delivery among the existing cadre of health workers, (a) mainstream the concept of integration as part of pre-service training for doctors, nurses, and midwives; and (b) incorporate integration (e.g., TB-HIV, FP-HIV) as a part of national clinical protocols and the standards to which health providers must adhere. *(Responsible entities: FUNZO/K, Capacity Kenya, APHIAPlus IPs, and CHMTs)*
2. Building on the traction in Western Kenya, Rift Valley, and KAMILI for the Drop-In Center approach, accelerate rollout of that strategy as a means of integrated service delivery to hard-to-reach, marginalized, and/or most at-risk population groups. *(Responsible entities: APHIAPlus IPs, LIPs, and county health officials)*

5.1.2. Rift Valley

1. Adapt and field-test (a) an integrated service delivery approach and (b) strategies to address social determinants of health that are appropriate for pastoralist populations residing in Rift Valley. *(Responsible entities: APHIAPlus IPs, in collaboration with county health officials, with support from USAID-funded entities that can provide technical assistance on operations research)*
2. It would appear from the relative lack of data related to SGBV that Rift did not give a great deal of attention the SGBV sector. Consider accelerating and expanding efforts related to SGBV prevention and responses. *(Responsible entities: APHIAPlus IPs in close collaboration with LIPs and county health and gender officials)*
3. Apply APHIAPlus' Quality Improvement Team approach to reflect Community-Defined Quality, addressing noted shortcoming such as abusive and disrespectful treatment of clients in maternity wards in some health facilities in Rift Valley. *(Responsible entities: APHIAPlus IPs in close collaboration with CHUs and USAID-supported national mechanisms supporting quality improvement and health system strengthening)*

5.1.3. Western

1. In light of the lower levels of condom use among youth in Western Kenya (compared to the other two regions), and the higher HIV burden in that part of Kenya, further segment the youth population to ascertain which subgroups have suboptimal coverage of high-impact HIV-related interventions (e.g.,

males, unmarried adolescent females, adolescent PLHIV, out-of-school youth, youth in fishing communities), and design tailored interventions accordingly.

2. Reignite efforts related to SGBV, particularly in light of the deterioration of the momentum and structures that existed prior to devolution. *(Responsible entities: IPs and LIPs, in close collaboration with county health and gender officials)*
3. In light of the prominent role of TBAs in Western Kenya relative to the other two regions, enhance efforts promoting skilled delivery. This will also bolster the platform through which PMTCT can be addressed in that part of the country. *(Responsible entities: CHWs, peer educators, Mentor Mothers, CHMTs, and SCHMTs)*
4. Despite being a high-malaria-burden area, given the myriad vertical support mechanisms and initiatives to address malaria prevention and treatment (e.g., via PMI and other initiatives), do not embed malaria programming in the next iteration of APHIA. Focus instead on reducing missed opportunities via better integration, for example, IPT in the context of ANC; proper use of LLINs distributed to pregnant women and children under five via well-child visits; and linkages to appropriate, high-quality providers of malaria treatment upon diagnosis (e.g., via RDTs) in endemic areas. Also strengthen routine reporting on each of those domains. *(Responsible entities: IPs, in close collaboration with CHMTs and National Malaria Program)*

5.1.4. KAMILI

1. Accelerate the rollout of OLMIS. *(Responsible entities: USAID, in collaboration with Central MoH)*
2. Address prevailing myths and misperceptions related to HIV risks in both urban and rural settings in Central/Eastern Kenya. *(Responsible entities: LIPs, CHWs)*
3. Explore creative linkages to optimize treatment and care coverage. *(Responsible entities: CCC in-charges and staff, community volunteers/resources such as peer educators and Mentor Mothers, CHMTs, SCHMTs)*
4. Address supply-chain issues that create missed opportunities to link youth with risk-reduction commodities during contacts with that segment of the population (e.g., Magnet Theater). *(County MoH, CHMTs, LIPs serving youth, IPs and entities addressing FP promotion and provision of FP commodities)*
5. Reignite workplace-based HIV programs that showed promise early in implementation but had to be abandoned at the direction of USAID. *(Responsible entities: USAID, IPs)*
6. As a persistent barrier to HIV treatment care seeking, stigma and fear of stigma should be addressed explicitly as part of behavior-change strategies. *(Responsible entities: LIPs, CHWs, community volunteers such as trained peer educators)*
7. Building on the success of community-based distribution in Tharaka Nithi County, explore using it as a platform to address FGM/C and/or SGBV. *(Responsible entities: APHIAPlus IPs, in support of relevant County Government entities [e.g., County MoH, Gender Departments])*

5.2. Recommendations to improve Sustainability Prospects

The following recommendations respond to Evaluation Question 2 findings:

5.2.1. Applicable to all three APHIAPlus activities

In the short term:

1. Provide (a) evidence-based advocacy support to County Health Directors, CHMTs, and SCHMTs lobbying County Assemblies for requisite budget allocations related to HIV service delivery; and (b) health planning support (on issues such as human resources for health, lab networking and logistics) to counties, with an emphasis on HIV and RMNCH. *(Responsible entities: APHIAPlus IPs)*
2. Support local entities (e.g., CHMTs, SCHMTs, LIPs) in developing and using a readiness tool, with measurable milestones and time frames for assuming full responsibility for functions/inputs currently being executed by APHIAPlus. *(Responsible entities: APHIAPlus IPs)*
3. As part of a broader sustainability strategy, focus on enhancing community participation and local ownership, particularly for CHUs. *(Responsible entities: LIPs, CHWs, SCHMTs)*

In the medium-long term:

1. Subsequent USAID-funded activities should include budget line items for core strategies such as twinning and operational linkages between field implementers and national-level mechanisms. *(Responsible entity: USAID Kenya)*
2. Address health system leadership and governance, with an emphasis on how different entities/players (e.g., CHUs, SCHMTs, CHMTs, County Assemblies) relate to one another within a functional county health system. *(Responsible entities: APHIAPlus IPs, in close collaboration with USAID-funded national mechanisms addressing leadership and governance issues)*
3. In collaboration with national-level mechanism such as FUNZO/K, support county health officials in instituting mechanisms to identify and address refresher-training needs in the cadre of health providers and CHWs reached by APHIAPlus and FUNZO. *(Responsible entities: APHIAPlus IPs, FUNZO/K and other relevant national mechanisms such as Capacity, and CHMTs/SCHMTs)*

5.3 Recommendations related to Implementation Challenges

The following recommendations respond to Evaluation Question 3 findings:

5.3.1 Applicable to all three APHIAPlus activities

(Responsible entities: APHIAPlus IPs and USAID-funded national mechanisms, under the guidance of USAID Kenya):

1. Establish an accountability framework for collaborative HSS between field implementers and national-level mechanisms, along with key milestones and indicators, and a plan with a budget allocation that reflects the resources required for effective collaboration.
2. Based on lessons learned in dealing with abrupt shifts in programming/level of effort, formalize a communication protocol between USAID and IPs, as well as between IPs and county counterparts (e.g., County Health Officer, CHMTs, and SCHMTs).

5.4 Recommendations for Scaling Up Implementation Strategies and Approaches

The following recommendations respond to Evaluation Question 4 findings:

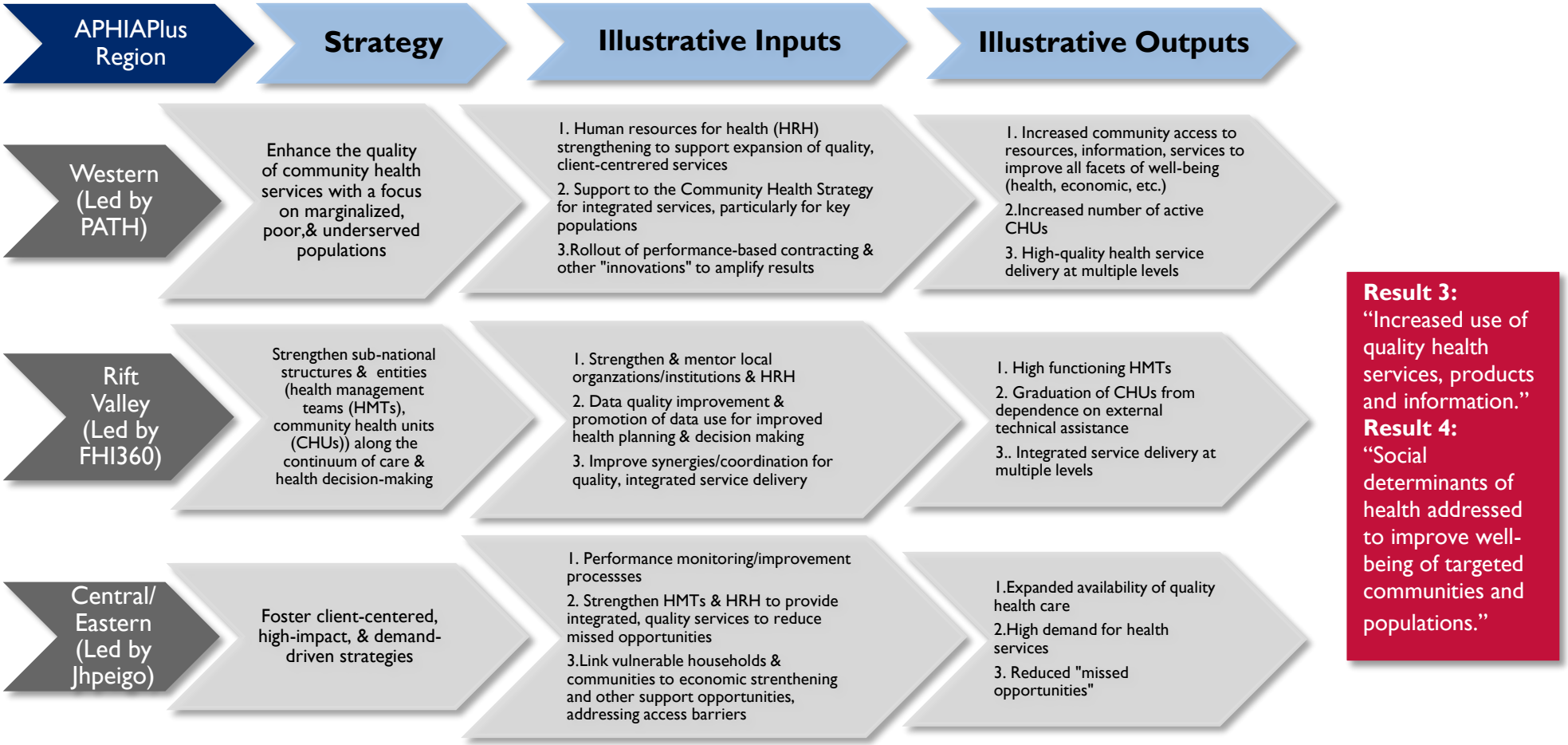
5.4.1 Applicable to all three APHIAPlus activities

(Responsible entities: APHIAPlus IPs and USAID-funded national mechanisms, under the guidance of USAID Kenya):

1. In light of the paucity of evidence to bolster claims regarding the effectiveness of innovative strategies implemented under the auspices of APHIAPlus, include a learning and policy influence component for future iterations of APHIA, with clear budget allocations for operations research to inform national scaleup of innovations and strategies that have demonstrated effectiveness.
2. Delineated responsibilities of field implementers and national-mechanisms should mirror those between counties and central government. In the new governance system, the central level focuses primarily on policy, setting standards & training health care professionals, with limited service provision at the National Teaching and Referral Hospitals. National-level mechanisms should align their scopes of work with that national-level mandate. In contrast, general service provision at level one through three health facilities is within the purview of each county, and field implementers such as the APHIAPlus IPs should engage each county in county-level decisions and responsibilities within the health sector.
3. Co-location arrangements should be explored between county government staff, field IPs, and staff from national-level mechanisms.

ANNEXES

ANNEX 1: Theory of Change for the Three APHIAPlus Activities



Result 3: "Increased use of quality health services, products and information."

Result 4: "Social determinants of health addressed to improve well-being of targeted communities and populations."

If APHIAPlus activities improve the Ministry of Health's capacity at the county and sub-county levels to:

- increase availability of the KEPHS
- create and increase demand for high quality KEPHS package at facility and community
- increase adoption of health behaviors and effectiveness through innovative approaches
- strengthen coordination and collaboration among key stakeholders

The result will be improved health outcomes and impact through sustainable country-led programs and partnerships.

ANNEX 2: List of Intermediate Results for Results 3 and 4 of USAID/Kenya's 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:

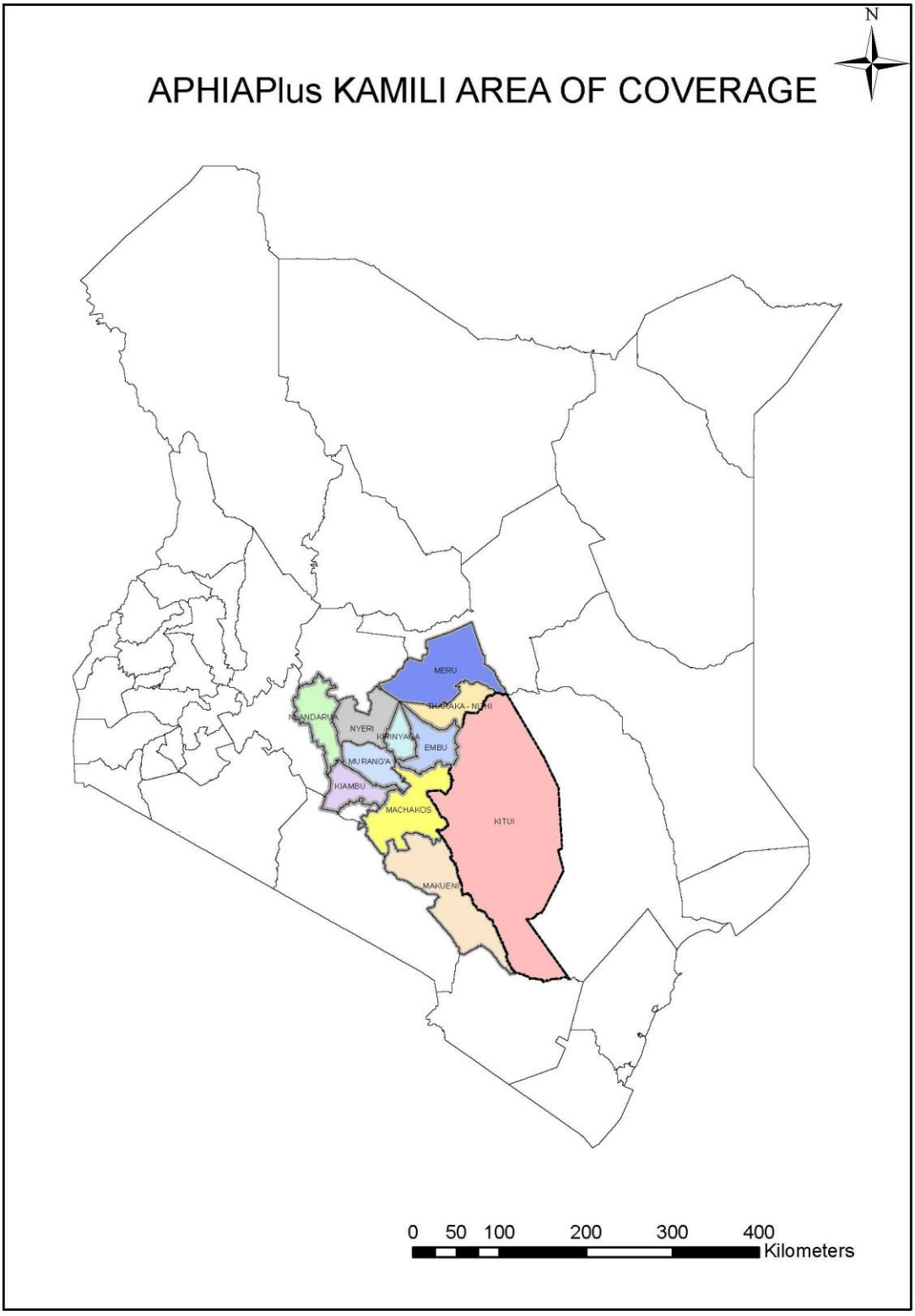
- Quality protective services available to survivors of sexual assault, child maltreatment and children without adequate family care
- MGCSD supported to develop policies, protocols and guidance to support quality social services
- Eligible children and families are identified and linked to available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

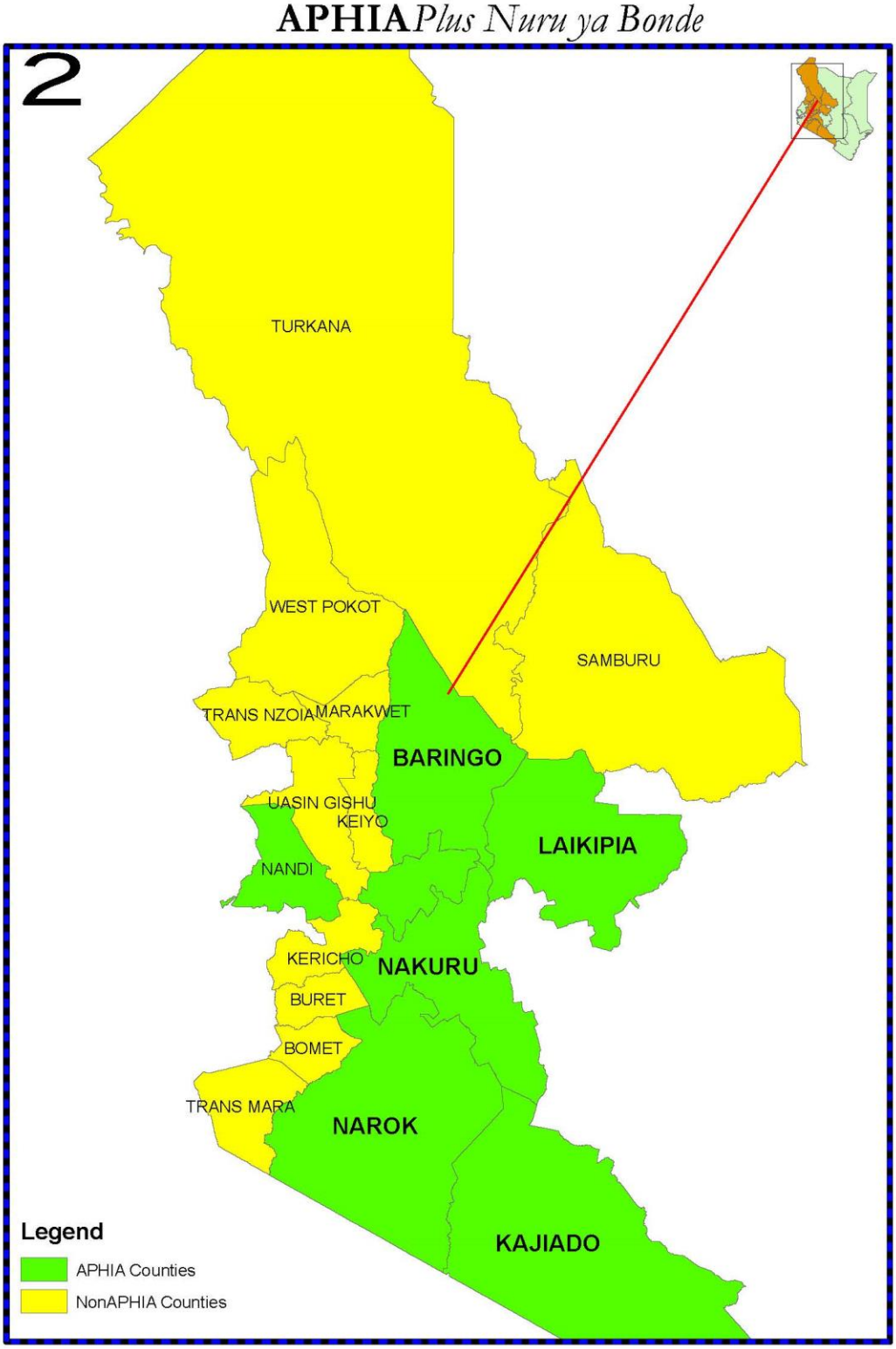
- Improved financial, managerial and technical capacity of indigenous organizations serving social and health needs of marginalized, poor and underserved populations
- District, sub-district and village health committees plan and coordinate implementation of effective multi-sectoral partnerships for 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

ANNEX 3: Maps of APHIAPlus Catchment Areas

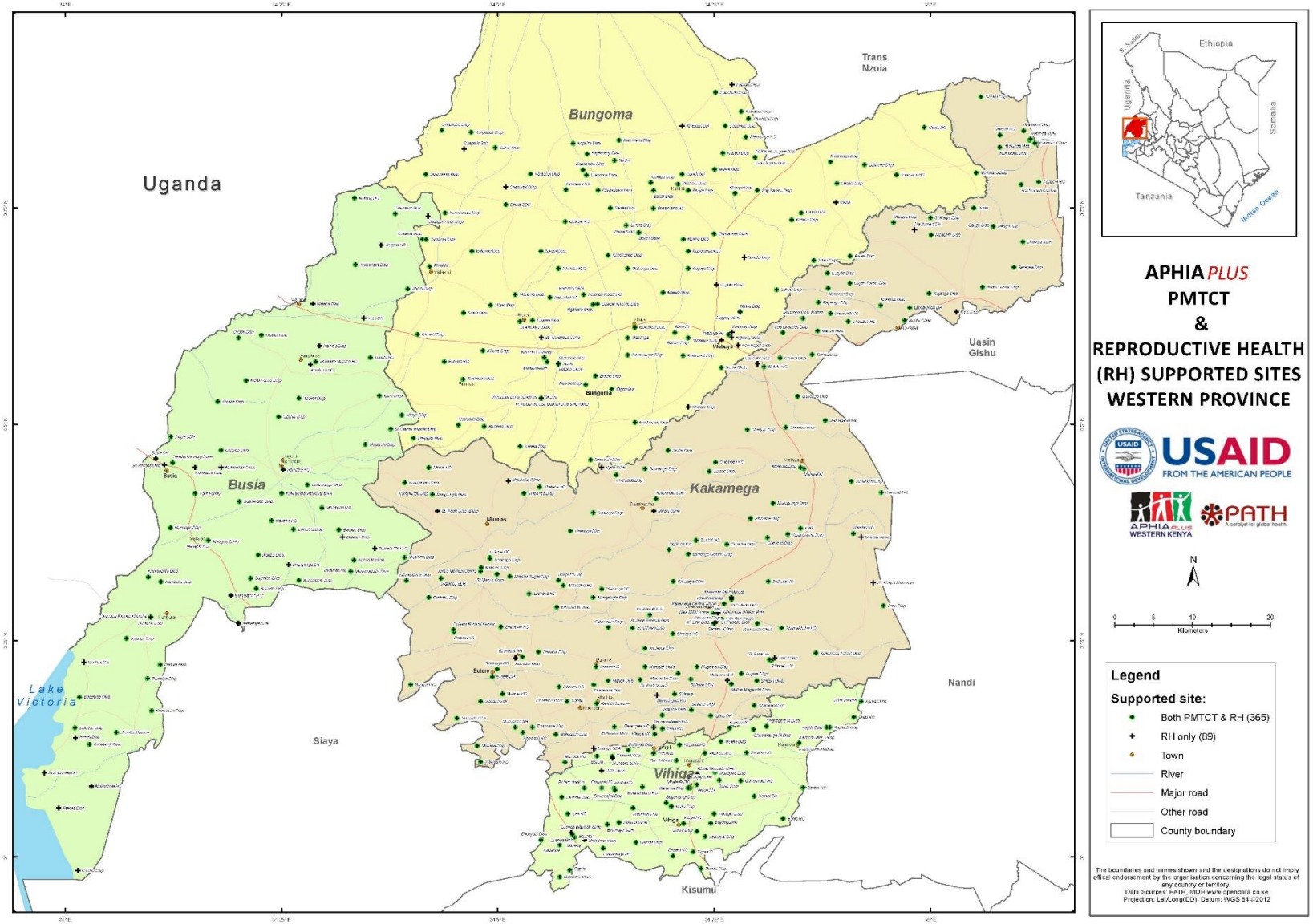
APHIAPlus KAMILI (pre and post rationalization)

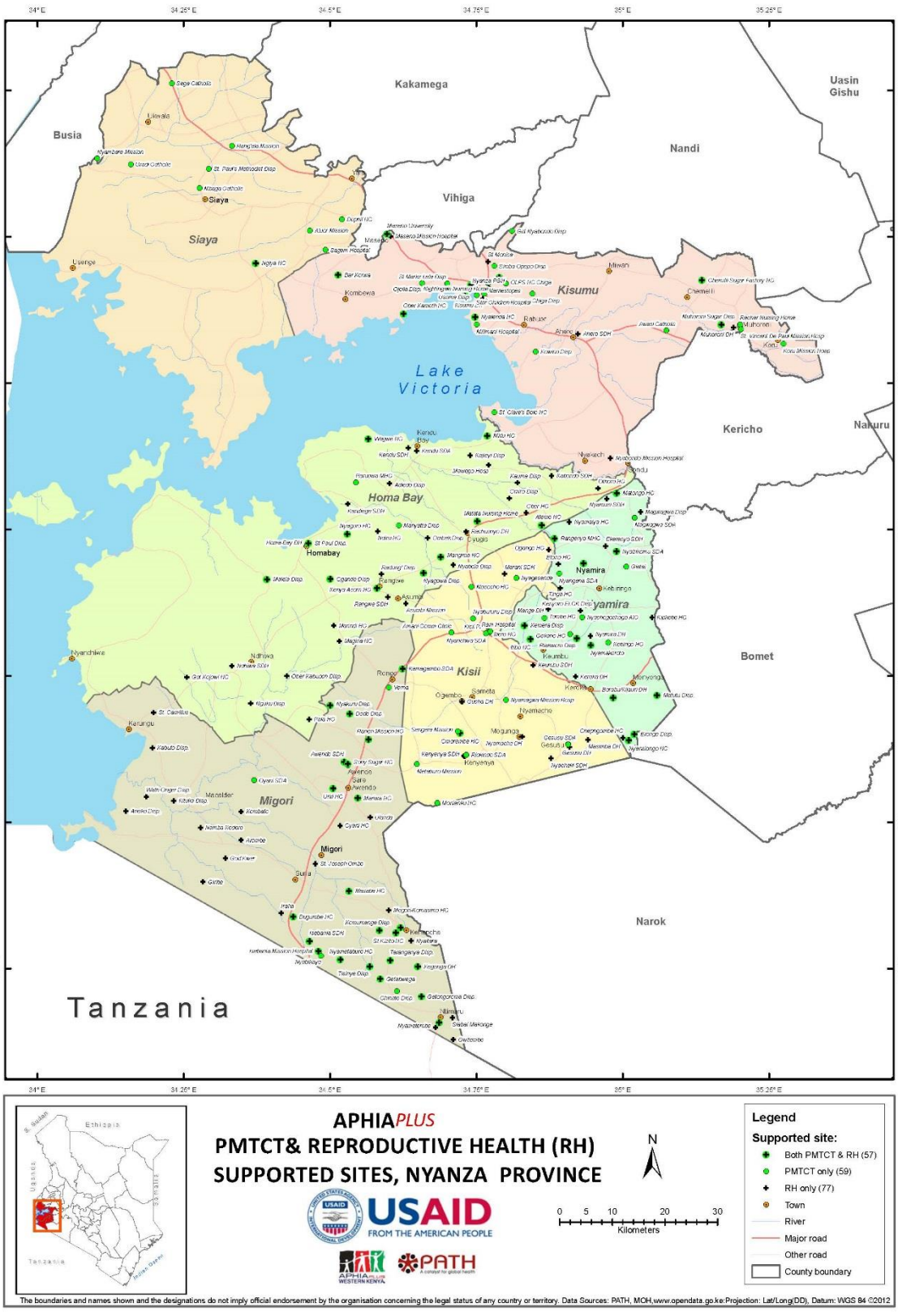


APHIAPlus RIFT VALLEY (post rationalization)



APHIAPlus WESTERN




Kakamega
Uasin Gishu
Busia
Nandi
Vihiga
Siaya
Kisumu
Lake Victoria
Kericho
Nakuru
Homa Bay
Homabay
Nyamira
Bomet
Kisii
Migori
Narok
Tanzania
APHIAPLUS
PMTCT& REPRODUCTIVE HEALTH (RH)
SUPPORTED SITES, NYANZA PROVINCE
USAID
FROM THE AMERICAN PEOPLE
PATH
N
0 5 10 20 30
Kilometers
Legend
Supported site:
Both PMTCT & RH (57)
PMTCT only (59)
RH only (77)
Town
River
Major road
Other road
County boundary
The boundaries and names shown and the designations do not imply official endorsement by the organisation concerning the legal status of any country or territory. Data Sources: PATH, MOH,www.opendata.go.ke;Projection: Lat/Long(DD), Datum: WGS 84 ©2012

ANNEX 4: Evaluation Question Matrix

EVALUATION KEY QUESTION 1: For each APHIAPlus activity, what is the status of the expected health outcomes and to the extent possible, what is the activity's contribution to the observed health outcomes?					
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**
		SOURCE	**METHOD**		
1.1 Based on the activity's theory of change, what have been the actual inputs of the activity in key results/IR at the County, Sub-County, Health facility and community levels?	Contribution and Exploratory	Project Documents CPs, CHMTs, SCHMTs, DGDs, LIP-P, LIP-OVC, CHU-CHEWs	Document Review FGDs & KIIs	As appropriate Purposive sampling	Content analysis on achievements against the targets Contribution analysis
1.2 What is the availability and utilization of high impact interventions in relation to HIV/FP/MNCH/Postnatal care/Malaria/TB services? How did the Activity influence the observed results?	Analytical and Exploratory	Project Documents CHMTs, SCHMTs, HFs, HFBs	Document Review FGDs & KIIs Mini-Survey	As appropriate Purposive sampling Systematic sampling	Content and contribution analysis Content and contribution analysis Content analysis
1.3 What is the availability, appropriateness, relevance and effectiveness of the HIV SBCC messaging and approaches? What was the Activity's contribution to this?	Exploratory and analytical	Project Documents LIP-Y, LIP-P, CHMTs, SHMTs LIP-Y	Document review FGD & KIIs Mini-survey	As appropriate Purposive sampling Systematic sampling	Content analysis Content and contribution analysis Content analysis
1.4 What is the wellbeing of the OVC beneficiaries based on the Child Status Index and Household	Exploratory and analytical	Project Documents	Document review	As appropriate	Content analysis Content analysis

EVALUATION KEY QUESTION 1: For each APHIAPlus activity, what is the status of the expected health outcomes and to the extent possible, what is the activity's contribution to the observed health outcomes?					
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**
		SOURCE	**METHOD**		
Economic Strengthening? What is the Activity's contribution to the observed results?		LIP-C OVC beneficiaries	Mini-survey In-depth Interviews	Systematic sampling Purposive sampling	Content analysis
1.5 What are the status of social, economic, and geographic barriers to accessing and utilizing services? What was the Activity's contribution?	Analytical	HFBs, DGDs, LIP-CHEWs, LIP-OVCs	FGDs & KIIs	Purposive sampling	Content and contribution analysis
1.6 What is the status of capacity of community units to mobilize communities? Has the Activity contributed to the observed results? Explain	Analytical	CHMTs, SCHMTs, HFs, CHU-CHEWs	FGDs & KIIs	Purposive sampling	Content and contribution analysis
1.7 What progress has been made towards the achievement of the expected intermediate and end health outcomes by each intermediate result? What was the Activity's contribution towards the observed results?	Comparative and analytical	Project Documents	Document Review FGDs & KIIs FGDs & KIIs	As appropriate Purposive sampling	Content and contribution analysis
1.8 How did the APHIAplus integration model work for and/or against the achievement of results in each of the key service delivery programs areas (HIV/AIDS, RMNCH, malaria and local capacity building)?	Analytical	CPs, LIP-OVC, LIP-P, CHU-CHEWs, CHMTs, SCHMTs, DGDs, C-HSD, C-SDoH CPs, CG, CHMTs, CCTs, SCHMTs, DGDs, C-HSD, C-SDoH, DPs	KIIs	Purposive sampling Purposive sampling	Content and contribution analysis Content and contribution analysis

EVALUATION KEY QUESTION 1: For each APHIAPlus activity, what is the status of the expected health outcomes and to the extent possible, what is the activity's contribution to the observed health outcomes?					
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**
		SOURCE	**METHOD**		
1.9 How did synergies, collaboration or coordination between different program areas and/or between different USG activities contribute if any, to the observed health outcomes	Analytical	CPs, DPs, C-HSD, C-SDoH, CHMTs, SCHMTs, PPs,			Content and contribution analysis

EVALUATION KEY QUESTION 2: For each APHIAPlus activity, what are the prospects for the sustainability of the implemented strategies and/or systems and structures that contributed to the observed health outcomes produced by this activity?					
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**
		SOURCE	**METHOD**		
2.1 What are the capacity of the CHMTs, SCHMTs and Health facilities, local CBOs/NGOs and village health committees to plan and coordinate implementation of effective multi-sectoral partnerships, manage service delivery including capacity to record, report, and use data for decision making? How did Activity's structures contribute to the observed results?	Exploratory and analytical	CPs, DPs, CHMTs, SCHMTs, LIP-P, PP, LIP-OVC, CHU-CHEWs, HFs,	KIIs	Purposive sampling	Content and contribution analysis
2.2 What implementation innovations/models can be replicated in other geographic locations of the country? What Activity's structures contributed to this?	Exploratory and analytical	Project Documents CG, CHMTs, CP, DGDs, PPs,	Document Review FGDs & KIIs FGDs & KIIs	As appropriate Purposive sampling	Content and contribution analysis Content analysis
2.3 What are the weakest systems/structures at facility, community and administrative levels that might hamper the continuation of the services? How did the Activity contributed to this?	Exploratory and analytical	CHMTs, HFs, DGDs, PPs,	KIIs	Purposive sampling	Content and contribution analysis
2.4 What is the capacity of functional community units to promote preventive health behaviors, identify, refer/manage complications? How did the Activity's	Analytical	SCHMTs, CHMTs,		Purposive sampling	Content and contribution analysis

EVALUATION KEY QUESTION 2: For each APHIAPlus activity, what are the prospects for the sustainability of the implemented strategies and/or systems and structures that contributed to the observed health outcomes produced by this activity?					
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**
		SOURCE	**METHOD**		
structure contribute to the observed outcomes?		CHU-CHEWs	FGDs & KIIs		
2.5 What is the status of financial, managerial and technical capacity of indigenous organizations serving social and health needs of marginalized, poor and underserved populations? Did the Activity's structures contribute to this? Explain	Exploratory and analytical	DGDs, CPs, LIPs-P, LIP-OVC	FGDs & KIIs	Purposive sampling	Content and contribution analysis
2.6 What is the status of economic security among target groups of marginalized, poor and underserved populations? How did the Activity's structures contribute to observed outcomes?	Exploratory and analytical	DGDs, CPs, LIP-OVC	Document Review	Purposive sampling	Content and contribution analysis
			FGDs & KIIs		Content and contribution analysis
2.7 What are the status of established partnership programs, if any, with multi-sectoral partners to expand jobs and other sustained economic opportunities for target groups? How did the Activity's structures contribute the observed results?	Exploratory and analytical	Project Documents	Document Review	As appropriate	Content analysis
			FGDs& KIIs		Content and contribution analysis
		CPs, DGDs, C-SDoH		Purposive sampling	
2.8 What is the status of linking target groups to local market potential for revenue and sustainability? What Activity's structures contributed to this?	Exploratory and analytical	Project Documents	Document review	Purposive sampling	Content and contribution analysis
			FGDs & KIIs		Content analysis

EVALUATION KEY QUESTION 2: For each APHIAPlus activity, what are the prospects for the sustainability of the implemented strategies and/or systems and structures that contributed to the observed health outcomes produced by this activity?					
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**
		SOURCE	**METHOD**		
2.9 To what extent are the investments in programs aimed at achieving sustainable livelihoods for the poor are maximized and coordinated? How did the Activity's structures to the observed results?	Exploratory and analytical	CPs, DGDs, C-SDoH Project Documents CPs, C-SDoH, DGDs, LIP-OVC Project Documents CPs, DGDs, CHMTs, SCHMTs	Documents review FGDs & KIIs Document review FGDs & KIIs	As appropriate Purposive sampling As appropriate Purposive sampling	Content and contribution analysis Content analysis Content analysis Content and contribution analysis Content analysis Content analysis
2.10 Ascertain the innovative approaches developed to increase the use of quality services at community and facility levels? What Activity's structures contributed to the observed outcomes?	Exploratory and analytical				
2.11 What are the effective implementation strategies including local capacity development models with potential for scale up in similar future activities? How did the Activity's structures contribute to observed results?	Exploratory and analytical	Project Documents	Document review KIIs	As appropriate Purposive sampling	

EVALUATION KEY QUESTION 2: For each APHIAPlus activity, what are the prospects for the sustainability of the implemented strategies and/or systems and structures that contributed to the observed health outcomes produced by this activity?					
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**
		SOURCE	**METHOD**		
2.12 How has the Activity's support facilitated sustainability of the CHW's roles? How has the withdrawal of Activity's support to CHWs been addressed?	Exploratory and analytical	CPs, CHMTs, DGDs, C-HSD, C-SDoH Project Documents CPs, CHMTs, SCHMTs, CHU-CHEWs		As appropriate Purposive sampling	

EVALUATION KEY QUESTION 3: For each APHIAPlus activity, what implementation challenges did the activity face during the implementation period? What are the key programmatic and management lessons learnt?						
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**	
		SOURCE	**METHOD**			
3.1 To what extent has the coordination and collaboration between national mechanisms and the activity affected the achievement of expected outcomes? What suggestions do you have for addressing the design shortfalls if any?		Analytical	CPs, CG, CHMTs, C-HSD, PPs, DPs	KIIs	Purposive sampling	Content analysis
3.2 What adjustments were made by the activity to reflect changes in the operating environment including the devolution process and to what extent did these changes impact the implementation?		Analytical	CPs, CHMTs, SCHMTs, PPs, DPs	KIIs	Purposive sampling	Content analysis
3.3 To what extent has the implementation of national and global level policy/guidelines such as PEPFAR blue print, RMNCH strategic shifts affected the original APHIAPlus design and activity implementation?		Analytical	Project Documents	Document review	As appropriate	Content analysis
			CPs, CG, CHMTs, SCHMTs, C-HSD, C-SDoH, DPs, PPs	KIIs	Purposive sampling	Content analysis
3.4 What were the implementation challenges and lessons learnt in addressing health services provision and social determinants of health?		Analytical	CPs, CG, CHMTs,	KIIs	Purposive sampling	Content analysis

EVALUATION KEY QUESTION 3: For each APHIAPlus activity, what implementation challenges did the activity face during the implementation period? What are the key programmatic and management lessons learnt?						
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**	
		SOURCE	**METHOD**			
3.5 What are the other implementation challenges did the Activity face during the implementation period?	Analytical		SCHMTs, C-HSD, C-SDoH, DPs, PPs CPs, CG, CHMTs, SCHMTs, C-HSD, C-SDoH, DPs, PP, LIP-P, LIP-OVC, CHU-CHEWs	KIIs	Purposive sampling	Content analysis
3.6 What important lessons on the activity design and support to MOH/CHMT has the activity learnt over the implementation period?	Exploratory and analytical		Project Documents	Document review	As appropriate	Content analysis
			CG, CPs, CHMTs, SCHMTs, C-HSD, C-SDoH, PP	KIIs	Purposive sampling	Content analysis
3.7 What are the key programmatic and management lessons learnt during the implementation period?			Project Documents		As appropriate	Content analysis

EVALUATION KEY QUESTION 3: For each APHIAPlus activity, what implementation challenges did the activity face during the implementation period? What are the key programmatic and management lessons learnt?						
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**	
		SOURCE	**METHOD**			
		Exploratory and analytical	CG, CPs, CHMTs, SCHMTs, CHU-CHEWs, LIP-P, LIP-OVC, PPs, DGDs	Document review FGDs & KIIs	Purposive sampling	Content analysis

ANNEX 5: List of Documents Included in Document Review

APHIAPlus Rift Valley

1 Approved Contract and RFP
- AID-623-A-11-00007.pdf

2 M&E Plan
- APHIAPlus Rift PMP 31st May 2011-Final.doc

3 Quarterly Reports
- Years 1-4 Quarterly Reports

4 Annual Workplans

5 Baseline Values reports
- Annex I_Key Interventions by IRs_APHIAplusRift Project.docx
- Annex XVII Baselines Values_APHIAPlus Rift (Nuru Ya Bonde).docx
- APHIAPlus Nuru Ya Bonde Baseline Info for EndTerm Doc to Maxwell.docx

6 Evaluations + Assessments
- APHIA Rift OVC Needs Assessment Revised Sep 2011.pdf
- OVC Needs Assessment Revised Sep 2011.pdf

7 Other Important Documents and Files
- APHIAPlus Nuru Ya Bonde Baseline Info for EndTerm Doc to Maxwell.docx
- HH Vulnerability Tool Sept 2011_Final copy.pdf
- Annex XI_List of CBOs implementing evidence based HIV prevention programs.xls
- Annex VII_ IX PMTCT_ANC Sites by Activity_May 2014.xls
- Annex X_OVC CBOs by Activity_May 2014.xls
- Annex XII Community Units supported.xls
- APHIA_Plus Rift ART Sites Data sep 2014.xls
- APHIAplus Rift Valley sites.xls

APHIAPlus Western

1 Approved Contract and RFP
- APHIAplus Western.pdf

2 M&E Plan
- APHIA Nyanza_Western Final PMP_January 19 (Revised)_2012.xlsx
- APHIAPlus Western PMP - Year 5 - Nyanza region.pdf
- APHIAPlus Western PMP - Year 5 - Western region.pdf

3 Quarterly Reports
- Quarterly Reports, Years 1-4

4 Annual Workplans
- APHIAplus Western Yr 1 Work Plan Narrative.pdf
- APHIAPlus Western Yr 2 Work Plan Narrative.pdf

- APHIAPlus Western Yr 3 Work Plan Narrative.pdf
- APHIAPlus Western Yr 4 Work Plan Narrative.pdf
- APHIAPlus Western Yr 5 work plan Narrative.pdf

5 Baseline Values reports
- Annex XVIII Baseline values_Intermediate_End Outcome _ Western Kenya.xlsx
- APHIA Western Health Facility Assessment Baseline Report.pdf
- APHIAPlus Nuru Ya Bonde Baseline Info for EndTerm Doc to Maxwell.docx
- CSI Summary Report_Comparison of 2014 and 2012.pdf
- Health Facility Assessment Baseline Report.pdf
- Section 3 - Performance Data Tables Year 3 Quarter 3 report (1).doc
- Technical report - FINAL HEALTH FACILITY ASSESSMENT REPORT.pdf

6 Evaluations + Assessments
- APHIA Western Quality Of Care Assessment Report_2012.pdf
- APHIA Western Risk Reduction Assessment and Plan Tool.pdf
- BCC Needs Assessment.pdf
- Quality Of Care Assessment Report_2012.pdf
- Risk Reduction Assessment and Plan Tool.pdf

7 Other Important Documents and Files
- Annex III_Key Interventions by IRs_APHIAplus WEstern Kenya Project.docx
- A+ CCC Sites by Volume (CTX).xls
- Annex XI_List of CBOs implementing evidence based HIV prevention programs.xls
- Annex VII_ IX PMTCT_ANC Sites by Activity_May 2014.xls
- Annex X_OVC CBOs by Activity_May 2014.xls
- Annex XII Community Units supported.xls
- Jan 2014 Up dated List of APHIAPLUS WESTERN PARTNERS.xlsx
- Health Strategic Plans

APHIAPlus Kamili

1 Approved Contract and RFP
- APHIAplus KAMILI AID-623-A-11-00008.pdf

2 M&E Plan
- APHIA Kamili M+E Work Plan Jan - Dec 2013.pdf
- APHIA Kamili M+E_Yr3_Workplan_Final30Nov2012_ updated_March-18-2013.pdf
- APHIA Kamili M+E_Yr4_Workplan_11 Mar 2014.pdf
- FINAL APHIAPLUS M E plan NARRATIVE 28042011.pdf
- Monitoring and Evaluation Work Plan2.pdf
- Year 4 program strategies.docx

3 Quarterly Reports
- Quarterly Reports Years 1-4

4 Annual Workplans
- Year 1 - 2011
- Year 2 - 2012

- Year 3 - 2013
- Year 4 - 2014

5 Baseline Values reports
- Annex II_Key Interventions by IRs_APHIAplus_KAMILI Activity.docx
- Annex XIX Baseline Values KAMILI.xlsx

6 Evaluation + Assessments
- APHIA Kamili_Central Province_,Baseline Assessment Report-HIV Care and Treatment.pdf
- APHIA Kamili_Eastern Province_,Baseline Assessment Report-HIV Care and Treatment.pdf
- AphiaPlusKAMILI Year III Partner Readiness Assessment FINAL REPORT 20 September 2012.pdf
- Community Units Assesment Presentation.pptx
- Community Units assessment Narrative report.docx
- Evaluation reports
- Maternal and Perinatal deaths _Confidential Inquiry -IGEMBE AUDIT.pdf

7 Other Important Documents and Files
- APHIAPlus Kamili Strategies
- Newsletters_Success stories and best practice
- Project developed tools
- Protocols
- Annex XI_List of CBOs implementing evidence based HIV prevention programs.xls
- Annex VII_ IX PMTCT_ANC Sites by Activity_May 2014.xls
- Annex X_OVC CBOs by Activity_May 2014.xls
- Annex XII Community Units supported.xls
- APHIAPLUS KAMILI_supported sites 2013.xlsx

Crosscutting files (Applicable to all three actvities)
- APHIAPlus Technical Proposal 3 17 2015.docx
- USAID Scope of Work for APHIAPlus Evaluation.docx
- MWI, National Water Services Strategy Draft.pdf
- Vision 2030 Abridged version.pdf
- 2005-08-01_NHSSP2.pdf
- home_and_community_based_care_in_kenya.pdf
- Kenya_National AIDs strategic plan (2009-2013).pdf
- Strategic Framework for EMTCT in Kenya-2[1].pdf
- IBTCI Methodology and SOW
- APHIAPlus Technical Proposal 3 17 2015.docx
- MOH Documents
- Child Status Index guide.pdf
- Child Status Index Manual.pdf
- Community based HTC operational manual.pdf
- Guidelines for PMTCT of HIVAIDS in Kenya-1.pdf
- HBC Handbook 2006 - Body.pdf
- National Guidelines for PMTCT Peer Education and Psychosocial Support in Kenya (KMMP).pdf
- National Guidelines for HTC in Kenya 2010.pdf
- Operational manual for implementing HTC in clinical settings.pdf
- Quick_Reference_Guide_ for_ Basic_Care_Package.pdf

- Standardized HH Survey Data Collection Tools
- AIDS_Indicator Survey_Individual_QRE_DHS6_8Nov2011.pdf
- DHS7_Household_QRE_EN_24Apr2015_DHSQ7.xlsx
- DHS7_Mans_QRE_EN_20May2015_DHSQ7.xlsx
- DHS7_Womans_QRE_EN_20May2015_DHSQ7.xlsx
- English_MICS_Household_Questionnaire_20131022.docx
- English_MICS_Questionnaire_for_Children_Under_Five_20131022.docx
- English_MICS_Questionnaire_for_Individual_Women_20131022.docx
- Malaria Indicator Survey Woman's Questionnaire.pdf
- Malaria Indicator Survey_Household Questionnaire.pdf
- Standardized HH Survey Data Collection Tools.zip
- Survey and Index
- Cohort Report for 2011.pdf
- HTC-Report-2011.pdf
- Joint Techncial Review M report final.pdf
- KDHS 2008_9.pdf
- Kenya Demographic Health Survey KIR 2014.pdf
- Kenya Service Availalbility and Readiness Assessment Mapping SARAM_KEN_report_2013.pdf
- Lots QA Sampling (LQAS) report.pdf
- Service Provision Assesement 2010.pdf
- USAID-EA Documents
- CDCS-w Annexes Lo.pdf
- USAID K - Five year implementation Plan 2010-2015.pdf
- USAIDEvaluationPolicy.pdf

ANNEX 6: List of Key Informants

RIFT VALLEY

Contacts for Data Collection
HEALTH FACILITIES

Counties	Date	Selected Facilities (By Region)	Nominee
Nakuru	Tuesday July 7	Nakuru PGH	KII: Dr Etemesi MNCH: Rose Lubanga CCC: Alice Barasa
	Wednesday, July 8	Elburgon sub District Hospital	KII: Joshua Mutahi CCC: Jennifer Ayoma MNCH Milka Waithira Karanja
Baringo/Koibatek	Thursday, July 9	Eldama Ravine District Hospital;	KII: Dr. Philip Kamau Dr. Mary Ingabo MNCH: Grace Ruto CCC: Bultut
	Friday, July 10	Esageri Health Centre	KII: Tomno Cheburet MNCH: Peninah Kibichi CCC: Tomno Cheburet
Laikipia	Monday, July 13	Nanyuki District Hospital	KII: Jacinta Muchiri MNCH: Ruth Kuria CCC: Pauline Gatakaa
Nakuru	Tuesday, July 14	Subukia Health Center	KII: Peter Kariuki MNCH Isaac Mwangi CCC: Florence Ndirangu
	Wednesday, 15 July	Kabazi Health Centre	KII: Dr. Faith Bob MNCH: Veronica CCC: Martin Mutegi
Narok	Thursday, July 16	Sogoo Health Centre	KII: Dr. Cheruiyot MNCH: Caroline Kisutu CCC: Nelson Cheruiyot
	Friday, July 17	Narok District Hospital	KII: Caro Saitoti MNCH: Mrs. Maitai CCC: Sirma
Kajiado	Monday, July 20	Kajiado District Hospital	KII: Dr. Moses Ngugi MNCH: CCC: Mr. Sangok Clinical Officer
	Tuesday, July 21	Bisil Health Centre	KII: Sylvia James MNCH: Sylvia James CCC: Sylvia James
	Wednesday, July 22	Ngong Sub-District Hospital	KII: Dr. Joan Borr MNCH: Margaret Kimity CCC: Margaret Kamau

IMPLEMENTING PARTNERS

FHI360	Ruth Odhiambo
LVCT Health	Dr. Lilian Otiso
Catholic Relief Services	Kenneth Otieno

COUNTY GOVERNMENT OFFICIALS

County Government Departments	Date	Names
Nakuru Min of Health Min of Agriculture Min of Education Min of Gender	July 6	 Dr. Benedict Osore Jane Njeri Reuben Mr. Dickson Oyieko Mr. Abdi Sheik Yusuf
Baringo Min of Health Min of Agriculture Min of Education Min of Youth Gender	July 9	 Micah Cherop Collins Cheruiyot_ Joseph Waiharo Kimani_ Wycliff Maritim
Laikipia Min of Health Min of Agriculture Min of Education & Gender	July 13	 Dr. Mogoi James Gichuru Ezekiel Omwansa
Narok Min of Health Min of Agriculture Min of Education & Gender	July 17	 Dr. Francis Kiio Mr. Suji William Osewe Elijah Ngoko
Kajiado Min of Health Min of Agriculture Min of Education Min of gender	July 20	 Dr. Ezekiel Kapkoni Daniel Nyagaka Majani Baridi Mbithi

COUNTY AND SUB-COUNTY HEALTH MANAGEMENT TEAMS

County Health Management Teams Counties	Dates	Names of Nominee
Baringo	July 9	Abraham Sumukwo
Kajiado	July 20	Dr. Ezekiel Kapkoni
Nakuru	July 6	Dr. Benedict Osore
Laikipia	July 13	Dr Mogoi Donald County Director preventive and Promotive
Narok	July 17	Dr. Francis Kiio
Sub-County Health Management Teams Counties	**Dates**	**Names of Nominee**
Nakuru	July 6	Tirop Wendy _ DPHN Grace Kariuki_DASCO
Subukia	July 14	Judith Machani
Koibatek	July 9	Elsie Korir
Kajiado Central	July 20	Joseph Ole Sankok

WESTERN KENYA

Contacts for Data Collection

Affiliation	Name of the Key Contact(s)
PATH	Trangsrud Riika
EGPAF	Dr Eliud Mwangi
WORLD VISION	Daniel Mwebi
JHPIEGO	Dr Isaac Malonza
BROADREACH	Joseph Ondigi
MILD MAY	Steve Adudans
Result Area 3	Dr. Habel Alwang'a
Result Area 4	James Angáwa
Homa Bay	Dr. Gerald Akeche
Nyamira	Dr. Jack Magara
Bungoma	Dr. Kubasu
Kakamega	Dr. Brenda Makokha
Rachuonyo South – Kasipul	Dr. Peter Ogolla
Teso South (Amagoro)	Vincent Kwena
Kakamega Central	Geofrey Mutakha
Bungoma South	Dr. Johnson Akatu
Kuria West	Dr. Geofrey Marwa
Western Province	Dr. Ahindukha Quido
Western Province	Dr. Godrick Onyango
Nyanza Province	Dr. Jackson Kioko
Nyanza Province	Dr.Ojwang Lusi
NDENGELWA	Lilian Oloo
MUANDA	Moses Makhoha
BISUNU	Sunny Wanjila/Maurice Masinde
EMIA	Rodgers Matei/Philemon Ndiema
Kocheku CU	Patrick Namaswa
Shirere A	Patrick Nyayieka
Kivaywa	Joseph Wanyama
Musango CU –Makunga	Keziah Ihachi
Shirembe	Allan Omina
Kehancha	Elizabeth Chacha
TOWNSHIP B	Sharon Koina
Obisa	Eric Banda
Emanda A	Henry Mukuna
Chango	Crispin Oduor Yamo
Kenya Aids NGOs Consortium - KANCO	1. Beatrice Awino 2. Peter Kamau
Keeping Alive Societies' Hope (KASH)	Thomas Odhiambo
Action in Community Environment in Africa (ACE AFRICA)	Augustine Wasonga
Anglican Church of Kenya - Western Region Christian Community Services (ACK-WRCCS)	Elsie Muindi

Affiliation	Name of the Key Contact(s)
SUPPORT ACTIVITIES IN POVERTY ERADICATION AND HEALTH (SAIPEH)	Justine Makari Mutobera , HSC Elizabeth Nawala Wanjala
ACE - Bumula	Augustine Wasonga
ACE - Sirisia	Augustine Wasonga
ACK- WRCCS	Elsie Muindi
YWCA	Paul Mark Odeyo
I Choose Life, Africa - Vihiga	Peter Mitenga
CSA	Jacob Ochieng'
Nyamusi Umoja CBO	Nicholas Omondi
Kagwa_CBO	Brills Oyoko
Kuria District Disability Network (KDDN)	Moses Magwe
Gagigagi	Festo Kihima Misoga
CAMP	Getrude Lwanga
Khwisero Dorcas	Ruth Sungu
CABDA	Ephy Imbali or Faith Gimoi
Amagoro	Mary Gwakau Emadau
SOET	Christiano Nyogesa
Bungoma HBC	Julius odera or Martin W Lukhale
Malakisi	Wycliffe Wanyonyi
Milimo CBO	Jephneah Wakhulumu
Shirere	Benard Hinga
Bungoma District Hospital	Dr. Silvester Mutoro
Bumula Health Centre	Belinda Kipsoi
Sirisia Sub-District Hospital	Dr. Wamalwa Anna Wakora
Kopsiro Health Centre	John Keya
Amukura District Hospital	Linet Adiang
Kakamega Provincial General Hospital	Dr. Ajevy
Matete Health Centre	Salma Echessa
Makunga Health Centre	Judith Anyanje
Butere District Hospital	Dr.John Bolton Otieno
Mbale RHTC	Odipo Owiti
Kuria District Hospital	Dr. Marwa
Rachuonyo District Hospital	Dr. Ogolla Peter
Nyamira District Hospital	Dr Silas Ayunga

County	Ministry/Department/Unit
County Government of Bungoma	Ministry of Education, Youth and Sports
	Ministry of Agriculture, Livestock, Fisheries and Cooperatives
	Ministry of Gender and Culture
	Ministry of Finance and Economic Planning
	Ministry of Gender and Culture
	Ministry of Education (MoE)
	Ministry of Tourist, Forestry, Environment and Natural Resources
County Government of Busia	Ministry of Education (MoE)
	Ministry of Education (MoE)
	Ministry of Education (MoE)
	Ministry of Agriculture
	Ministry of Agriculture (MoA)
	Ministry of Planning (MoP)
	Ministry of Gender, Children and Social Development
	Ministry of Sports, Culture and Arts (Gender and Sports)
	Ministry of Health and Sanitation
	Ministry of Water, Environment and Natural Resources
Kakamega	Ministry of Education Science, Technology and ICT
	Ministry of Education Science, Technology and ICT
	Ministry of Agriculture, Livestock, Fisheries and Cooperatives
	Ministry of Financial, Treasury and Economic Planning
	Ministry of Gender, Children and Social Development (MoGCSD)
	Ministry of Health
	Ministry of Labor, Social Services, Culture, Youth and Sports

County	Ministry/Department/Unit
	Ministry of Environment, Natural Resources, Water and Forestry
Migori	Ministry of Education, Youth affairs and culture
	Ministry of education
	Ministry of Agriculture & Livestock Development
	Ministry of Finance and Economic Planning
	Ministry of Health
	Ministry of Health
	Ministry of Water and Energy
	Ministry of gender, children, women, and social services
	Ministry of gender, children, women, and social services
	Ministry of Agriculture
	Ministry of Agriculture
	Ministry of Agriculture
	Ministry of Agriculture
Nyamira	Ministry of Education and ICT
	Ministry of Agriculture and Livestock
	Ministry of Agriculture and Livestock
	Ministry of Finance and Planning
	Ministry of Labor, Social Securities and Services
	Ministry of Labor , Social security and services,
	Ministry of Health
	Ministry of Health
	Ministry of Environment and Natural Resources
Homa Bay	Ministry of Education and ICT
	Ministry of Agriculture
	Ministry of Finance and Planning
	Tourism, Culture, Sports and Gender
	Ministry of Labor , Social security and services,
	Ministry of Energy and Natural Resources
	Ministry of Health
	Ministry of Health
	Ministry of Health
	Ministry of Water and Environment
Vihiga	Ministry of Education, Science and Technology
	Ministry of Agriculture, Livestock, Fisheries and Cooperatives

County	Ministry/Department/Unit
	Ministry of Planning (MoP)
	Ministry of Gender, Sports and Youth affairs
	Ministry of Sports, Culture and Arts (Gender and Sports)
	Ministry of Environment, Natural Resources, Water and Forestry

KAMILI

DeparDr.tment/Unit/Partner	Name of the Key contact(s)
Jhpiego (Lead Partner)	Dr. Mildred Mudany
NOPE	Job Akuno
	Geofrey Odhiambo
CHAK	Dr. Dennis Osiemo
Result Area 3	Dr. Dan Were
Result Area 4	Dr. Rudia Ihamati
Kitui	Dr. Anthony Mureithi Miano
Meru (Imenti North)	Dr. Elias Nyaga
Muranga	Dr. Kanyi Winfred Wambui
Kiambu	Dr. Stephen Njuguna
Imenti North (CHD Meru)	Dr. Elias Nyaga
Tharaka South Sub County	Dr. Muchiri
Murang'a South	Dr. Juliana Mbuthia
Kitui West	Dr. Antony Mureithi Miano
Central Province (former PMOs)	Dr. Zakayo Gichuki Kariuki
Central Province (former PMOs)	Dr Riara Nthuraku.
Eastern Province (former PMOs)	Dr. John Elija Thiongo
Eastern Province (former PMOs)	Dr. Ephantus Maree
Catholic Diocese Kitui	Rev. Fr. Robert Mutui Rev. Fr. Joseph Mwongela Sr. Margaret Wanda
Shepherds of Life Organization (SOL)	James Wachieni
Ananda Marga Universal Relief Team (AMURT)	Dr. Jitendra Kumar Dr. Kinyanjui
Cheer Up Self Help Group	Samuel Kahura
Catholic Diocese of Murang'a (CDM)	Tiras Githaiga
Engineer Broadvision EBPSHG	Ceciliah Matheri
Food for the Hungry - Meru	Zachary Kaimenyi
Save the Children Fund (Canada) - Meru	Mr. George Gichui
Young Women Christian Association – Chuka	Fridah Gakii
Ngoliba Volunteers Without Boundaries	Daniel Gatuguta
Dallas Key Populations	Salesio Kariuki
Meru Youth Arts Program Group	Nicholas Wallace
Kalimani Malaria / 3K Youth	Monicah Mung'oo Rose Kalekye
FOCUS Youth Group - Kiambu	Mabubi Hillary
Kisima Youth Group - Kiambu	Hiram Kimotho

DeparDr.tment/Unit/Partner	Name of the Key contact(s)
Nkabune Technical Training Institute	Njenga Eunice
Ripples International	Mercy Chidi
Ngoliba Volunteers Without Boundaries	Daniel Gatuguta
Embu Provincial General Hospital	Dr. Gerald Ndiritu
Kihara Sub-District Hospital	Dr. Juma Wahanyanga
Lari Health Centre	Dr. Carolyne Mwangi
Ngoliba Health Centre	Priscilla Mburu
Muthale Mission Hospital	Dr. Andrew Kiura
Kauwi Sub-District Hospital	Dr. Grace Rabut
Maragua District Hospital	Dr. Stephen Kimani Ngige
Meru Central District Hospital	Dr. Macharia
Akachiu Health Centre	Mercy Kendi
Mutuati Sub-District Hospital	Dr. Nyagah Dr. Njeru
Bamboo Health Centre	Mary Ndeithi
Chuka District Hospital	Dr. Elija M. Kameti
Tharaka District Hospital	Dr. Muchiri in-charge
Kangaru CU - Embu	Lucy Marachi
Kihara CU	George Kamau
Kirenga CU - Lari	Meshack Kirenga
Kyondoni C U - Matinyani Disp Near Kauwi	Joan Mueni Mercy Were
Kalia C U - Near Kauwi C/O Matinyani Dispensary	Justus Maundu Rose Muthui
Kiunyene CU - Akachiu	Hosea Ayuki
Kabachi CU - Mutuati	Boniface Mutegi
Mugirirwa CU - Chuka	Maurice Munene
Bamboo CU	Mary Maina
Marimanti CU - Tharaka	Martin Muriira
Ngoliba Volunteers Without Boundaries – Thika	Daniel Gatuguta

Department/Unit/Partner	Name of the Key contact(s)
Embu	
Youth Empowerment and Sports	Mercy Gitiri Mongo
Education, Science & ICT	Arnold Njue Jeremia Wanjau Irere
Lands, Water, Environment & Natural Resources	Moses M. Kigoro
Agriculture, Livestock, Fisheries & Cooperatives Development	Charles Ndwiga Rufuata

Department/Unit/Partner	Name of the Key contact(s)
Gender, Culture, Children and Social Service Development	Jemima Njoki Nyaga
Gender, Culture, Children and Social Service Development	Joan Mwende Kiema-Ngunnzi
Department of Children Services, Embu	Paul Kisavi
Finance and Economic Planning	Edwin Rugendo
Kiambu	
Ministry of Education, Culture & Social Services	Esther Wanjiru Ndirangu
Ministry of Education, Culture & Social Services	Mwambi Mongare
Ministry of Agriculture Livestock & Fisheries (MoALF)	Dr. Monica Mukami Waiganjo
Ministry of Finance, Planning & Development	Mary Ndunge Nguli
Ministry of Health Services	Catherine Muchemi
Ministry of Finance and Economic Planning	Eunice M. Karoki
Water, Environment & Social Services	Esther Wanjiru Njuguna
Kitui	
Ministry of Basic Education, Training and Skills Development	Pauline K. Mwania
Ministry of Agriculture, Water and Irrigation	Jacob M. Mutua
Ministry of Gender, Children and Social Development (MoGCSD)	Philip Nzenge
Ministry of Health Services	Sharia
Ministry of Culture, Youth, Sports and Social Services	Titus K. Mutia
	Johnson Muinde
Ministry of Health Services	Emma Kitemange
Muranga	
Ministry of Education & Technical Training	Gerishon Nyagia Reuben
Ministry of Agriculture, Livestock & Irrigation	Albert Mwaniki
Ministry of Finance, IT & Economic Planning	George M. Kamau
Youth, Sports, Gender, Culture, Social Services, Co-operatives and special programs	Muiruri E. Maina
Youth, Sports, Gender, Culture, Social Services, Co-operatives and special programs	Robert Kuria
Department of Children Services, Murang'a	Alfred Murigi
Health, Water & sanitation	Dr. Susan Muthoni Magada
Environment & Natural Resources	Githirwa M. Macharia
Meru	

Department/Unit/Partner	Name of the Key contact(s)
Ministry of Education and Technology	Monica Kagwima David Baariu Mwirabua
Ministry of Agriculture, Livestock and Fisheries	Dionisia M'Eruaki Severino Kinge Manene
Ministry of Culture, Youth, Gender and Sports	Mr. Nkumbuku Mercy Mwendwa Ndiira
Ministry of Culture, Youth, Gender and Sports	Karen Kagwiria Kiogora
Ministry of Water, Environment and Natural Resources	Mr. Kimathi Eng. David Gitonga
Nyandarua	
	John Mwaniki
Ministry of Agriculture Livestock & Fisheries	Hon. Agatha Wamuyu Daniel Maina Gakara
Ministry of Finance and Economic Planning	Hon. Godfrey Nderi Ndiani Michael Kamau Kuria
Ministry of Health Services	Dr. Zakayo Kariuki Gichuki
Ministry of Tourism, Wildlife and sports	Hon. Peter Mwangi Gathimba John Gitau Njororge
Ministry of Water, Energy, Environment and Natural Resources.	Hon. Grace Wanjiru Gitonga Martin Igecha Kimami
Tharaka Nithi	
Ministry of Education, Youth, Gender, Culture & Social Services	Jane W. Njogu
Department of Children Services, Tharaka Nithi	Julius Wacira
Ministry of Agriculture, Livestock, Fisheries and Water Services	Mululu
Ministry of Health Services	Gilbert Muchiri
Ministry Health Services	Dr. J.E Thiong'o
Ministry of Physical Planning, Land, Energy & ICT	Alfred Mwenda Riungu
Ministry of Gender, Children and Social Development	Julius Wachira Kiragu
Ministry of Health (include CPHO)	Gilbert Muchiri (CPHO)
Ministry of Tourism, Environment & Natural Resources	Patricia Mumbi

NATIONAL-LEVEL KEY INFORMANTS

Date	Time	Institution
Mon July 13	0830-1030	USAID
	1130-1330	USAID
	1430-1630	USAID
Tue July 14	0830-1030	USAID
	1130-1330	USAID
	1430-1630	USAID
Wed July 15	0830-1030	EGPAF Dr. Eliud Mwangi Country Director
	1400-1500	Former PDPHS – Nyanza Dr. Johnson Kioko
Thursday July 16	0830-10:30	LVCT Dr. Cleophas Ondieki
	1130-1330	Catholic Relief services Marcy Trueb Mr. Lane Bunkers
	1430-1630	World Vision Ruth Wangeci
	1130-1330	National Tuberculosis and lung Disease unit Dr. Kamene
	1430-1630	National Organization of Peer Educators (NOPE) Job
Mon July 20	0830-10:30	PATH Rosemarie Muganda
Tue July 21	0830-10:30	AMREF Meshack Ndirangu Damaris Kariuki
	1130-1330	National Malaria Control Program Dr. Waqo D. Ejersa
	1430-1630	Dr. Ephantus Maree Former PDMS Eastern Province
Wed July 22	0900-1030	USAID Isabella Yonga
	1100-1230	USAID Peter Waithaka Alice Micheni
	1400-1500	USAID Emma Mwamburi
Thursday July 23	0830-10:30	AfyaInfo Rose Nzyoka
	1130-1330	Kenya Pharma Ruth Njoroge
	1430-1630	ASSIST Roselyn Were
Mon July 27	0830-10:30	FHI360 Dr. Peter Mwarogo

	1130 -1330	Charles Ouma MSH/Health Commodities and Services Management (HCSM) Program
	1430 - 1500	DFH Dr. Kigen
Tue July 28	0900-1000	DMS Dr. Nicholas Muraguri
	1130 – 1430	NASCOP Dr. Sirengo NASCOP
	Moved from 0900 to 1500 hrs	DMS Dr. Nicholas Muraguri
Wed July 29	0830 - 1030	Jhpiego Dr. Mildred Mudany

ANNEX 7: Data Collection Tools

Informed Consent Statement

INFORMED CONSENT STATEMENT

(Must be read for all respondents, regardless of data collection method)

Good day. My name is _____, and we are conducting an evaluation of the APHIAP Ius Project in collaboration with the Government of Kenya, USAID and other stakeholders. The purpose of this evaluation is to learn how the activities of the project affected different health outcomes at county, sub-county, health facility, and community levels.

You were selected to provide information because you represent an important perspective that we need to consider in this evaluation. Any information you share is strictly confidential. Your name will never be released with any of the findings, and the information you share will NOT have a negative effect on your access to services in the future. This interview is voluntary, and you have the right to withdraw from the interview at any point without consequences.

You will NOT be paid to participate in this interview. However, because we believe your views are important, we hope that you will answer all of the questions I will ask. As part of the interview, I will be asking some very personal questions. Please be as honest as possible because this will help us better understand how the Government of Kenya can improve the access and quality of essential health services that address the different needs of its people.

At this time, do you have any questions? Are you willing to participate in this study?

YES	→	**PROCEED** with data collection.
NO	→	Thank the person. **DO NOT PROCEED**. Select the next eligible respondent.

Interviewee signature

_____

Interviewer signature

_____

DATE (DD/MM/YYYY):

_____

Note the Record No. that will be written on data collection tool: _____

RA Reference Sheet for English-Kiswahili Translation of Selected Terms and Phrases

Counseling – ushauri

Tool 6 (MNCH KAP)

Q29. **Pentavalent vaccine**: Chanjo ya mguu

33 l. **Linkage to GOK cash transfer schemes**- Link to an GOK office or officer to provide financial support for OVC families monthly

33 m. **Referral to GOK grants e.g. UWEZO**

33 n. **Linkage/referral to microfinance institutions and funds**

33 o. **Training on high yield /high return agricultural practices** - Training on agricultural methods to increase their yield and increase profit from their products. Includes use of green houses and drip irrigation. On small livestock, "high yield" includes rabbits only.

35 b. **PwP- Prevention with positives**–The SMEs have provided the following list of PwP components at both the facility and community levels:

PwP—Clinical Setting

- Knowledge of status
- Partner testing and identification of discordant couples
- Disclosure of status
- Adherence counseling
- Risk reduction/alcohol/substance abuse counseling/condom use
- FP counseling and services
- STI diagnosis and treatment
- Meaningful involvement of PLHIV in HIV control interventions.

PwP–Community Setting

- Supporting the HIV infected to disclose status to their partners and relatives
- Couple/partner and/or family counseling and testing
- Reduction in HIV related stigma and discrimination
- Prevention of vertical transmission and of unintended pregnancies
- Supporting adherence to ART;
- Prevention, diagnosis and management of STIs and OIs including TB;
- Strengthening community-level service delivery to PLHIV;
- Sustaining risk reduction behaviors among the PLHIV.
- Meaningful involvement of PLHIV

5f. **IYC**F (Infant and young child feeding) - education on exclusive breastfeeding up to 6 months and how to wean the baby

Tool 7 (CCC KAP)

6a. **Adherence counseling**- (Counseling on consistent use of medication) - Ushauri ya jinsi ya kutumia madawa inavyotakikana

7c. **Cancer screening** - kupimwa cancer/saratani

8 j**. Post exposure prophylaxis**- (ARVs provided when one is accidentally exposed to HIV- within 72 hours) - Dawa za HIV zinazopewa mtu anaposhuku ameamukizwa virusi

6 n**. viral load**- kiwango cha virusi vya HIV kwa damu

9. **Link Desk**- mahali pa kukuelekeza kwa kupata huduma na mashauri tofauti iwe hospitalini au kwenye jamii

17k. **Mother to mother support**- (pairing of 2 HIV +ve mothers so that the experienced mother supports the new HIV +ve mother on MNC health issues)

17m. **Training in financial literacy**- (Training on how to earn money, use and invest it well)

17n. Linkage **to GOK cash transfer schemes**- (Link to an GOK office or officer to provide financial support for OVC families monthly)

17p. **Linkage/referral to microfinance institutions and funds** – Benki ndogo na sacco mashinani zinazokopesha watu wenye biashara ndogo ,kama Faulu bank

17r. **Training on high yield /high returns agricultural practices** – Training on agricultural methods to increase their yield and increase profit from their products; includes use of green houses and drip irrigation. On small livestock, "high yield" includes rabbits only.

Tool 8 (OVC)

7e. **FGM-** kukeketa/ kutahiri/ au kupasha tohara kwa wasichana

SGBV- sexual gender based violence- Dhulma za kijinsia

7f. **Psychosocial support - Ushauri**

8. **SILC (savings and internal lending community**): Kikundi cha kueka akiba nakukopa

9. **IGA (Income Generating Activity):**Biashara au shughuli inayokuletea mapato au pesa

Tool 9 (Youth, 15-24)

27. **Sexual intercourse:** Kufanyamapenzi, kukutana kimwili, ngono, kujamiana

28. **How many sexual partners:** Umefanya mapenzi na watu wangapi

30. **Have you ever engaged in any type of sexual activity with a person in exchange for a gift, favor or cash?** Ushawahishiriki kwa mapenzi na mtu yeyote iliatosheleze mahitaji yako na pesa, zawadi au msaada fulani?

35. **STD-** Magonjwayazinaa

36. **Abnormal discharge from their genitals** – *Note from Central Evaluation Team on Q36 and Q38: for the word "discharge," it is best to use either "uchafu" or the English word "discharge" to retain the correct meaning of the term.

Tool 10 (CHWs) - No need for any translation

TOOL 1: Key Informant Interview Questionnaire

RECORD NO. | | | |

DATE:				**2015**
		(dd)	(mm)	(yyyy)
ACTIVITY:	1…	Western		
	2…	Rift Valley		
	3…	Central/Eastern		
COUNTY/LOCATION:	01…..	Baringo	11…….	Homa Bay
	02…..	Kajiado	12…….	Vihiga
	03…..	Laikipia	13…….	Embu
	04…..	Nakuru	14…….	Kiambu
	05…..	Narok	15…….	Kitui
	06…..	Bungoma	16…….	Muranga
	07…..	Busia	17…….	Meru
	08…..	Kakamega	18…….	Nyandarua
	09…..	Migori	19…….	Tharaka Nithi
	10….	Nyamira	20…….	Thika
TYPE(S) OF RESPONDENT(S) PARTICIPATING IN THE INTERVIEW: *CIRCLE ALL PRESENT. WRITE SPECIFIC NAMES BELOW (NEXT TABLE)*	A……	County Government Official		
	B…..	County Health Management Team		
	C……	Sub-county Health Management Team		
	D…..	APHIAPlus Implementing Partner—PRIME		
	E…..	APHIAPlus Implementing Partner—SUB		
	F…..	APHIAPlus Local Implementing Partner (LIP)		
	G…..	Health Facility/Dept. Head In-charge		
	K….	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:
2.	As part of this evaluation, it is important for us to understand how the local context has changed since 2011. (a) What organizations were the main local actors/players in 2011? ***PROBE SEPARATELY ON: HIV, MALARIA, RMNCH, YOUTH, OVCS, LOCAL CAPACITY BUILDING*** (b) Are they the same main actors/players that exist today? Why or why not? ***PROBE ON: YEAR-TO-YEAR CHANGES (2011-2014).*** ***HAS THERE BEEN A CAPACITY SHIFT/ IMPROVEMENT, OR EVEN A SHIFT IN POWER OR DECISION MAKING BETWEEN LOCAL ACTORS? PLEASE DESCRIBE.*** (c) Thinking about the mix of actors you just described, what was the niche *(special domain, special role)* of APHIAPlus? ***PROBE ON UNIQUENESS OF APHIAPLUS' ROLE, FOCUS, AND APPROACH RELATIVE TO OTHER PROJECTS/PLAYERS.***	

NO.	QUESTION	RESPONSES
3.	How has devolution impacted the local operating (e.g., program, policy) environment? More specifically: (a) How did it affect: -Staffing? -Procurement? -Supply-chain management -Budgeting? -Regulation? (b) How have the roles of national mechanisms (e.g., for drugs, training) changed after devolution? (c) Has devolution affected different service delivery areas (e.g., HIV, RMNCH, malaria, nutrition) differently? Please describe. (d) How has devolution affected local capacity development?	
4.	Were there any other important changes to the local operating environment since 2011? **PROBE ON:** **-FREE MATERNITY CARE** **-SOCIAL PROTECTION** **-BEYOND ZERO CAMPAIGN** **-CHANGES IN COUNTY-SPECIFIC LEGISLATION** ALSO ASK ABOUT NEW SOURCES OF FUNDING FOR DEVELOPMENT PROGRAMMING, ETC.	
5.	Are there marginalized or underserved segments of the population in this part of Kenya? Please describe them. Also, please describe any changes in their access to essential services, or changes in key outcomes over the past 4-5 years.	

NO.	QUESTION	RESPONSES
Contributions of the APHIAPlus Activity		
6.	In your opinion, what was the most important contribution of APHIAPlus to the county's health goals and priorities?	
7.	APHIAPlus was supposed to adopt a 'whole market' approach that involved working with the private sector and faith-based organizations, not just the public sector. (a) How familiar are you with APHIAPlus' Whole Market Approach? Please describe how the approach was implemented. **PROBE: WHAT EFFECT HAS THE APPROACH HAD ON PRIVATE SECTOR INVOLVEMENT IN HEALTH IN THIS COUNTY?** (b) How has the Whole Market Approach impacted health and HIV results in this county? How has it impacted efforts to serve the most marginalized and poor segments of the community? (c) Are there other projects or initiatives focused on public-private partnership in health and social welfare? How are those initiatives similar to the approach taken by APHIAPlus? How are they different?	

NO.	QUESTION	RESPONSES
8.	How different is the APHIAPlus implementation model to that of other donor-funded initiatives in this part of Kenya? **PROBES:** HOW INVOLVED WERE YOU IN THE DESIGN AND DECISION MAKING RELATED TO THE IMPLEMENTATION OF APHIAPLUS? HOW DID GOVERNMENT MINISTRIES PARTNER WITH APHIAPLUS TO INCREASE ACCESS TO HIGH-QUALITY HEALTH SERVICES, PRODUCTS, AND INFORMATION? HOW DIFFERENT ARE THE COMMUNITY UNITS SUPPORTED BY APHIAPLUS VS. THOSE SUPPORTED BY OTHERS? COMPARED TO OTHER PROJECTS OR INITIATIVES, HOW DIFFERENT WAS APHIAPLUS' APPROACH TO SUPPORT COUNTY HEALTH MANAGEMENT TEAMS AND SUB-COUNTY HEALTH MANAGEMENT TEAMS IN PLANNING, PERFORMANCE REVIEW, AND QUALITY IMPROVEMENT? WOULD YOU HAVE PREFERRED A DIFFERENT ARRANGEMENT OR APPROACH? IF SO, PLEASE DESCRIBE.	
9.	(a) How did APHIAPlus contribute to extending the coverage of the Community Strategy, especially for marginalized, poor and underserved groups? **PROBE ON EQUITY ISSUES –AND- COMMUNITY PARTICIPATION ISSUES.** **PROBE ON ROLES AND CONTRIBUTIONS OF APHIAPLUS VERSUS OTHER ACTORS.**	

NO.	QUESTION	RESPONSES
	(b) How well did the transfer of community units between APHIAPlus and other entities work? (c) What are strengths of the APHIAPlus implementation of the Community Strategy? (d) Are there components that may require improvement? (e) Are there any components that should be discontinued? Which ones and why?	
INTEGRATION		
10.	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 (E.G., BETWEEN HEALTH AND EDUCATION; LINKAGES TO SOCIAL PROTECTION)**	
11.	Have there been any unintended or unexpected consequences from the APHIAPlus integration approach? Please describe. These could be positive or negative.	
12.	(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.	

NO.	QUESTION	RESPONSES
IMPLEMENTATION CHALLENGES		
13.	In your opinion, what have been the key implementation successes of APHIAPlus?	
14.	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?**	
15.	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?**	
16.	Are there any aspects of the APHIAPlus program design that helped to minimize implementation challenges? Please describe.	
INNOVATION		
17.	(a) Were there any features of APHIAPlus that you consider to be particularly innovative? (b) Compared to the strategies implemented by other local actors, how innovative were APHIAPlus' strategies and approaches? (c) Has there been any diffusion of innovation, for example, the Government or other stakeholders adopting similar strategies or approaches implemented by APHIAPlus?	
18.	Were there any innovations that were part of the original program design but were NOT implemented? Why?	

NO.	QUESTION	RESPONSES
19.	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		
20.	APHIAPlus had proposed a number of approaches to ensure sustainability of outcomes. Which of those approaches were actually implemented? **PROBE ON:** **-TWINNING** **-CO-LOCATION** **-GRADUATION** **-COMMUNITY STRATEGY** **-DHMT/SCHMT CAPACITY BUILDING** **-LINKAGES TO OTHER INITIATIVES (E.G., UWEZO; LINKING SUPPORT GROUPS WITH MICRO-FINANCE; VALUE-CHAIN LINKAGES TO MARKETS)**	
21.	(a) What is the current capacity of the following key players: (a1) County ministries (a2) CHMT (a3) SCHMTs (a4) Health facilities (a5) Community Units (a6) local CBOs/NGOs (a7) Village health committees **PROBE ON: SUPPORTIVE SUPERVISION; CAPACITY TO PLAN, COORDINATE, & MANAGE SERVICE DELIVERY; GATHER AND USE DATA FOR DECISION MAKING** (b) How has that capacity changed over the past four years?	

NO.	QUESTION	RESPONSES
	PROBE: WHAT ARE THE WEAKEST SYSTEMS/ STRUCTURES AT FACILITY, COMMUNITY AND ADMINISTRATIVE LEVELS THAT MIGHT HAMPER THE CONTINUATION OF THE SERVICES?	
22.	APHIAPlus is supposed to end in December of this year. What will be the impact of withdrawal of APHIAPlus support in the: (a) Short-term (e.g., 12 months after the project ends)? (b) Longer-term (e.g., next 2-5 years)? **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		
23.	What strategies or features of APHIAPlus show promise in being scaled up to other parts of the country? Why?	

End of Core Questionnaire

Depending on the type of respondent, there might be additional questions to ask. Refer below for special modules for implementing partners, health facility in-charges, and LIPs.

- Module 1 = For Implementing Partners
- Module 2 = For Health-facility In-charges
- Module 3 = For LIPs (for youth and OVCs)

MODULE 1: ADDITIONAL QUESTIONS FOR IMPLEMENTING PARTNERS ONLY

NO.	QUESTION	RESPONSES
24.	(a) We are already aware of your official Local Implementing Partners. Did you engage other entities in implementation, particularly in reaching youth and orphans and vulnerable children? As an example, we are interested in learning about any other community-based organizations, or even Drop-in Centers. (b) How many of your original LIPs have 'graduated?'	**NAME OF ENTITY:** **TARGET GEOGRAPHY:** **ESTIMATED NO. OF BENEFICIARIES SERVED PER MONTH:** **ROLE/FUNCTION:**
25.	Thinking through the two result areas of APHIAPlus, what challenges did you encounter in addressing each? **PROBES:** **IN IMPLEMENTING APHIAPLUS, HOW DID YOU ACTUALLY LINK THE EFFORTS AND OUTCOMES THAT FELL UNDER RESULT 3 WITH THOSE UNDER RESULT 4?** **HOW HAVE YOU LINKED TO OTHER EFFORTS THAT ADDRESS SOCIAL DETERMINANTS OF HEALTH?** **ALSO EXPLORE LEVERAGING AND SYNERGIES**.	
26.	We are keen to document any adjustments made by APHIAPlus in response to challenges or changes in the local operating environment. What were those adjustments?	
27.	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? *Can you share any documentation (e.g., operations research reports, facility performance reviews) on the effectiveness of those innovations?*	

NO.	QUESTION	RESPONSES
28.	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?**	
29.	(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?	
30.	**ADDITIONAL DOCUMENT/DATA REQUESTS FROM EVALUATION TEAM:**	

MODULE 2: ADDITIONAL QUESTIONS FOR HEALTH FACILITY IN-CHARGES ONLY

NO.	QUESTION	RESPONSES
24.	Please describe the support APHIAPlus has provided to this health facility. **PROBES:** • **HOW HAS THIS PROJECT IMPACTED SERVICE DELIVERY IN YOUR FACILITY?** ♦ **REMEMBER TO PROBE ON: INFRASTRUCTURE IMPROVEMENT, ISSUES SUCH AS DATA QUALITY, REPORTING, AND USE, QUALITY IMPROVEMENT, ETC.** • **DID APHIAPLUS PROVIDE ANY SUPPORT ON HIV IN THE WORKPLACE PROGRAMS FOR HEALTH WORKERS IN THIS FACILITY? PLEASE DESCRIBE.** • **WHAT WAS THE GREATEST CONTRIBUTION OF THE PROJECT TO YOUR FACILITY?** • **WHAT CHALLENGES, IF ANY, DID YOU ENCOUNTER OR OBSERVE WITH APHIAPLUS SUPPORT?**	
25.	What are your views on any supportive supervision and mentorship received by facility? **PROBE ON SUPPORT FROM DIFFERENT SOURCES (E.G., GOK, OTHER DONOR-FUNDED ENTITIES), NOT JUST APHIAPLUS.**	
26.	APHIAPlus was supposed to support both health facilities AND community resources such as CHWs. What effect has that had on the continuum of care? **PROBE ON ISSUES SUCH AS REFERRAL**	
27.	What are your main concerns given that the project is approaching its end?	

MODULE 3: ADDITIONAL QUESTIONS FOR LIPs ONLY

NO.	QUESTION	RESPONSES
24.	We are interested in learning about all the different entities/ organizations supporting your organization. Please describe.	
25.	How has APHIAPlus assisted your organization with targeting? **PROBES:** **ARE YOU ABLE TO REACH MORE BENEFICIARIES?** **ARE YOU ABLE TO REACH SEGMENTS OF THE POPULATION THAT WERE PREVIOUSLY HARD TO REACH?** **PLEASE DESCRIBE.**	
26.	How has APHIAPlus supported your LIP with structures, systems, resources for mobilization, and greater visibility within your target communities?	
27.	What are the main concerns of your LIP given that the APHIAPlus project is approaching its end?	

TOOL 2: FGD Guide with Health Facility Beneficiaries

Guide for FGDs with Health Facility Beneficiaries
(Target number=7 FGD participants)
****NOTE: Conduct separate FGDs for MNCH beneficiaries and CCC beneficiaries****

DATE:				**2015**
		(dd)	(mm)	(yyyy)
ACTIVITY:		1…	RIFT VALLEY	
		2…	WESTERN KENYA	
		2…	CENTRAL/EASTERN	
COUNTY NAME:				
FACILITY TYPE:		1...	Maternal and Neonatal Health (MNCH) clinic	
		2…	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 GENERAL OBSERVATIONS FROM FACILITATOR:			

Thank you for meeting with me today. We are interested in better understanding the situation affecting health facility 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 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.

ASK MNCH BENEFICIARIES ONLY:

1. **(a) How has the care of mothers and children changed over time in this community?**
   PROBES:
   - *ANTENATAL, INTRAPARTUM, AND POSTPARTUM CARE; PMTCT; NEONATAL CARE; CHILD HEALTH SERVICES*
   - *CHANGES BEFORE AND AFTER* APHIAPLUS *INITIATION*

   (b) What challenges do women and children in your community face in accessing maternal, new born, and child health services?
   PROBES:
   - *WHAT ARE YOUR VIEWS ON THE REPRODUCTIVE, MATERNAL, NEW BORN AND CHILD HEALTH (MNCH) SERVICES PROVIDED AT HEALTH FACILITIES?*
   - *WHAT FACTORS MADE IT EASIER FOR YOU TO ACCESS THOSE SERVICES?*
   - *SOME WOMEN HAVE DIFFICULTIES IN ACCESSING HEALTH SERVICES? HOW WOULD YOU DESCRIBE THESE WOMEN? WHY DO THEY HAVE DIFFICULTIES?*
   - *WHAT ECONOMIC FACTORS, IF ANY, ARE BARRIERS?*
   - *WHAT GEOGRAPHICAL FACTORS ARE BARRIERS?*
   - *WHAT SOCIAL OR CULTURAL FACTORS ARE BARRIERS?*
     - *PROBE: WHAT ROLES DO MEN PLAY IN DETERMINING ACCESS TO AND USE OF HEALTH SERVICES FOR WOMEN AND CHILDREN?*
   - *ARE CERTAIN TYPES OF MATERNAL, NEW BORN, AND CHILD HEALTH SERVICES MORE DIFFICULT TO ACCESS THAN OTHERS? WHICH ONES?*
     - *PROBE ON MALARIA, FAMILY PLANNING, HIV, DELIVERY CARE, ANTENATAL CARE, POSTNATAL CARE, IMMUNIZATION, NUTRITION*

ASK CCC BENEFICIARIES ONLY:

2. **(a) How have CCC services changed over time in this community?**
   PROBES:
   - *CHANGES BEFORE AND AFTER* APHIAPLUS *INITIATION*
   - *HEALTH FACILITY AND COMMUNITY-BASED SERVICES*
   - *OTHER STAKEHOLDERS PROVIDING SIMILAR SERVICES*

   (b) 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?*
     - *PROBE ON: STIGMA ISSUES, STAFF ATTITUDES*
   - *ARE CERTAIN TYPES OF HIV SERVICES MORE DIFFICULT TO ACCESS THAN OTHERS?*
     - *PROBE ON: PREVENTION (PRIMARY AND SECONDARY), TESTING, TREATMENT, CARE & SUPPORT*
   - *HOW WOULD YOU COMPARE ACCESS AND UTILISATION OF CCC SERVICES BY MEN AND WOMEN? PLEASE EXPLAIN.*

ASK BOTH MNCH and CCC BENEFICIARIES:

3. **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?*
     - *PROBE WHETHER THEY HAVE HAD CONTACT WITH A COMMUNITY HEALTH WORKER*
   - *WHAT EXTERNAL SUPPORT IS PROVIDED TO SUPPORT INDIVIDUALS LIKE YOU IN SEEKING CARE AND LIVING HEALTHY LIVES?*
     - *FURTHER PROBE FOR ECONOMIC EMPOWERMENT SUPPORT*
   - *WHAT ROLE(S) DO COMMUNITY HEALTH WORKERS PLAY IN THE ABOVE, IN YOUR COMMUNITY?*
   - *HAVE YOU HAD CONTACT WITH A COMMUNITY HEALTH WORKER?*
   - *HAVE YOU EVER PARTICIPATED IN COMMUNITY DIALOGUES AND ACTION DAYS? WHAT IS YOUR VIEW ABOUT THEM IN REGARDS TO THEIR EFFECTIVENESS IN IMPROVING COMMUNITY HEALTH?*

ASK BOTH MNCH and CCC BENEFICIARIES:

4. **I am interested in getting your views on the treatment of community members when they access health services in this health facility. How would you describe the quality of health services in terms of:**
   a) Ensuring your privacy (audio and visual)?
   b) Ensuring confidentiality?
   c) Treating clients and community members with respect when communicating or interacting with them?

   PROBES:
   - *HOW DO THE ABOVE VARY FOR DIFFERENT TYPES OF HEALTH SERVICES SUCH AS: HIV/TB? FAMILY PLANNING? MATERNAL NEW BORN AND CHILD HEALTH? MALARIA?*
   - *HOW IMPORTANT ARE THOSE FACTORS WHEN PEOPLE ARE DECIDING WHETHER OR NOT TO SEEK HEALTH CARE?*
   - *OVER THE PAST FEW YEARS, HAVE YOU SEEN ANY CHANGES IN THIS FACILITY IN REGARDS TO PRIVACY, CONFIDENTIALITY, AND THE WAY HEALTH SERVICE PROVIDERS TREAT CLIENTS? WHAT CHANGES?*
   - *HOW DO HEALTH WORKERS TREAT CLIENTS?*
     - *DO HEALTH WORKERS SHOW EMPATHY WITH THE PATIENTS AND CLIENTS?*

ASK BOTH MNCH and CCC BENEFICIARIES:

5. **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, AND ATTITUDES)?*
   - *WHAT ARE YOUR VIEWS ON THE AVAILABILITY OF MEDICINES AND SUPPLIES?*
   - *WHAT OTHER FACTORS AFFECT QUALITY?*
   - *HOW GOOD ARE THE LINKAGES AND REFERRAL BETWEEN DIFFERENT TYPES OF SERVICES AND DIFFERENT LEVELS OF SERVICE PROVISION? HOW CAN THOSE LINKAGES AND REFERRALS BE IMPROVED?*
   - *OVER THE PAST FEW YEARS, HAVE YOU SEEN CHANGES IN BEING ABLE TO GET DIFFERENT TYPES OF SERVICES WHEN YOU COME TO A HEALTH FACILITY? ANY CHANGES WHEN YOU HAVE CONTACT WITH A HEALTH WORKER? PLEASE EXPLAIN.*

TOOL 3: FGD Guide with LIP Youth

Guide for FGDs with Youth served by LIPs
(Target number=7 youth participants [10 is the absolute maximum])

DATE:		(dd)	(mm)	**2015** (yyyy)
ACTIVITY:		1…	RIFT VALLEY	
		2…	WESTERN KENYA	
		2…	CENTRAL/EASTERN (KAMILI)	
COUNTY NAME:				
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.

1. **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?*

2. **What should be done to specifically encourage <u>young women</u> 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?*

3. **What should be done to specifically encourage <u>young men</u> to access the available sexual and reproductive health services?**
   PROBES:
   - *Who are the key players in helping young men access those 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?*

4. **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, COUNSELLING, TREATMENT AND CARE SERVICES?*
   - *WHICH INNOVATIONS HAVE BEEN MOST EFFECTIVE? WHY?*
   - *WHICH INNOVATIONS HAVE NOT BEEN EFFECTIVE? WHY?*

5. **Please describe the specific APHIAPlus 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*
       - *MAGNET THEATRE*
   - *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 IS SUPPOSED TO END LATER THIS 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?*

TOOL 4: FGD Guide with OVC Caregivers

Guide for FGDs with OVC Caregivers
(Target number of OVC Caregiver participants =10)

DATE:		(dd)	(mm)	**2015** (yyyy)
ACTIVITY:		1…	RIFT VALLEY	
		2…	WESTERN	
		2…	CENTRAL/EASTERN (KAMILI)	
COUNTY NAME:				
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:** ○ **Age 25-49 years:** ○ **Age 50 or older:** • {MARITAL STATUS} Number of FGD participants who are: ○ **Currently married:** ○ **Not currently married:** • {RELATION TO CHILD} Number of FGD participants who are: ○ **Grandparents of OVC:** ○ **Siblings of OVC:** ○ **Other relative of OVC:** ○ **Non-biological custodian of OVC (e.g., "foster 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 social and economic conditions of your household. How does this affect your ability to provide for the orphans and vulnerable children under your care?**
   PROBES:
   - *IF THE FOLLOWING ARE NOT MENTIONED, ASK:*
     - **HOW DOES IT AFFECT CHILD WELL-BEING SUCH AS: (A) HEALTH, (B) CHILD PROTECTION, (C) SHELTER AND CARE, (D) FOOD AND NUTRITION, (E) EDUCATION AND SKILLS BUILDING, AND (F) PSYCHOLOGICAL WELLBEING?**
   - *HAVE YOU BENEFITTED FROM ANY* APHIAPLUS *SERVICES AIMED AT STRENGTHENING YOUR HOUSEHOLD'S SOCIAL AND ECONOMIC STATUS? PLEASE ELABORATE.*
   - *WHAT SPECIFIC SERVICES? PROBE ON:*
     - **WHAT SPECIFICALLY WAS PROVIDED BY APHIAPLUS IN SUPPORT OF OVCS?**
     - **HOW HAS EACH SERVICE HELPED YOUR FAMILY TO MEET THE NEEDS OF OVCS?**
     - **ARE THE BENEFITS TO (EFFECTS ON) YOUR HOUSEHOLD LONG-LASTING OR JUST SHORT-TERM? PLEASE DESCRIBE.**
     - **HOW ACCESSIBLE ARE THOSE SERVICES TO FAMILIES THAT NEED THEM?**
     - **WHAT CHANGES HAVE YOU NOTED IN APHIAPLUS OVER THE PAST FEW YEARS? HOW HAVE THE OVC SUPPORT SERVICES BEEN AFFECTED BY THOSE CHANGES IN APHIAPLUS?**
     - **HOW LIKELY IS IT THAT THE BENEFITS TO OVCS WILL CONTINUE AFTER THE APHIAPLUS / LIP SUPPORT COMES TO AN END?**

2. **What are the challenges in ensuring that the orphans and vulnerable children in your care are able to enrol in school and continue going to school?**
   PROBES:
   - *How important is their education to you as caregivers? Do you have to prioritize other needs over their educational needs? What are those other needs?*
   - *Are orphans and vulnerable children at a disadvantage compared to other children when it comes to access to education? How?*
   - *Is it more difficult for particular orphans and vulnerable children?*
     - **PROBE ON: AGE OF CHILD, SEX OF CHILD, AND HIV STATUS OF CHILD.**

3. **How effective is the selection criteria for OVC programs and services?**
   PROBES:
   - *Who determines which orphans and vulnerable children receive support?*
   - *How transparent is the targeting (selection) process for orphans and vulnerable children?*
   - *What is the best way to deliver those services?*
   - *Are there certain types of orphans and vulnerable children who are missed by such programs or services? Please describe those children.*

- **PROBE: HOW CAN EXISTING PROGRAMS AND SERVICES IDENTIFY AND REACH THOSE CHILDREN?**

4. **Do orphans and vulnerable children have special <u>health needs</u> compared to other children? What are they?**
   PROBES:
   - *WHAT ARE THE SPECIAL HEALTH NEEDS OF HIV-INFECTED CHILDREN?*
   - *WHAT ADDITIONAL CHALLENGES DO CAREGIVERS FACE IN TAKING CARE OF AN HIV-INFECTED CHILD?*
   - *HAVE YOU ENCOUNTERED CHALLENGES IN ADDRESSING BASIC HEALTH NEEDS SUCH AS NUTRITION OR TREATMENT OF COMMON CHILDHOOD ILLNESSES?*
     - *HOW DIFFERENT ARE YOUR CHALLENGES TO THE CHALLENGES THAT OTHER CAREGIVERS FACE?*
     - *HOW HAVE YOU DEALT WITH THOSE CHALLENGES?*

5. **What are the psychosocial needs of orphans and vulnerable children?**
   PROBES:
   - *HOW DO YOU DEFINE PSYCHOSOCIAL NEEDS?*
   - *HOW ARE THOSE NEEDS BEING ADDRESSED BY CURRENT PROGRAMS AND SERVICES?*
   - *HOW CAN THOSE NEEDS BE BETTER ADDRESSED IN THE FUTURE?*
   - *WHAT ABOUT DISCLOSURE REGARDING THEIR HIV STATUS?*

6. **What are the key issues related to the protection of orphans and vulnerable children?**
   PROBE ON: ISSUES SUCH AS ABANDONMENT, VIOLENCE AGAINST CHILDREN (PHYSICAL AND SEXUAL ABUSE), EXPLOITATION, AND CHILD LABOR
   - *HOW DO THOSE ISSUES DIFFER BETWEEN OLDER AND YOUNGER ORPHANS AND VULNERABLE CHILDREN?*
   - *WHAT RESOURCES EXIST AT COMMUNITY LEVEL TO ENSURE THE PROTECTION OF ORPHANS AND VULNERABLE CHILDREN?*
   - *ARE THERE SERVICES, INITIATIVES OR PROGRAMS THAT ADDRESS PROTECTION ISSUES FOR OVC IN YOUR COMMUNITY?*
     - **PROBE WHICH, AND WHETHER APHIAPLUS/LIP IS INVOLVED.**
   - *PROBE ON: DISINHERITANCE; EARLY MARRIAGES; CHILD LABOR*

TOOL 5: FGD Guide with CHWs

Guide for FGDs with Community Health Workers (CHWs)
(N=10 participants maximum)

DATE:		(dd)	(mm)	**2015** (yyyy)
ACTIVITY:		1…	RIFT VALLEY	
		2…	WESTERN	
		2…	CENTRAL/EASTERN (KAMILI)	
COUNTY NAME:				
NAME OF COMMUNITY UNIT:				
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 interested in better understanding the situation affecting community health workers (CHWs), 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. **To start, please describe your role in promoting health in the community.**
   →PROBES:
   (A) HOW LONG HAVE YOU BEEN SERVING THIS COMMUNITY?
   (B) WHO DO YOU WORK WITH?
   FURTHER PROBES:
   - *FURTHER PROBE ON PARTICULAR COMMUNITY STRUCTURES, OTHER ORGANIZATIONS, ETC.*
   - *DO YOU HAVE ANY LINKAGES THROUGH THE COMMUNITY STRATEGY COMMITTEE?*

   (C) WHO DO YOU TARGET?
   FURTHER PROBE:
   - *HAVE YOU BEEN INVOLVED IN COMMUNITY HOUSEHOLD MAPPING?*

   (D) WHAT SPECIFIC ISSUES DO YOU ADDRESS?
   - *WHAT ARE THE PRIORITY HEALTH PROBLEMS?*
   - *COMMUNITY-BASED MONITORING AND REPORTING TO CHEWS?*

   (E) DO YOU HAVE ANY SUCCESS STORIES RELATED TO THE WORK THAT YOU DO? PLEASE GIVE US EXAMPLES

2. **How has APHIAPlus supported community health workers (CHWs) like you to perform their roles in the community?**
   →PROBE SEPARATELY FOR SPECIFIC ROLES:
   (A) HEALTH PROMOTION
   (B) REFERRALS OF CLIENTS TO THE HEALTH FACILITY
   (C) DEFAULTER TRACING FOR HIV AND TB CASES

3. **How functional is your community unit? How has this changed over the past four years?**
   PROBES:
   - *How do you define "functional?"*
     - *IF NONE OF THE FOLLOWING ARE MENTIONED, PROBE FURTHER:*
       - *TRAINING IN COMMUNITY STRATEGY*
       - *PROVIDING SERVICES AS A CHW (LEVEL I SERVICES)*
       - *ORGANIZING COMMUNITY DIALOGUE DAYS*
       - *ORGANIZING COMMUNITY HEALTH ACTION DAYS*
       - *MONTHLY REPORTING RATE - DISPLAY OF CHALK BOARD*
       - *DHMT/SCHMT SUPPORTIVE SUPERVISION AT LEAST ONCE EVERY 6 MONTHS*
   - *What challenges do you face in carrying out your work?*
     - *For those of you who have been serving this community for many years, what changes have you observed over time? Have the challenges changed or improved over time?*
     - *What role has mentorship and supportive supervision played in your work?*
       - *Have you received mentorship and/or supportive supervision in your work?*
       - *How effective is it?*
       - *How can it be improved?*
   - *What did you do about these challenges?*
   - *How does the work being done by your community unit relate to work done at health centers and hospitals?*
   - *IF NOT ALREADY MENTIONED WHEN THEY TALK ABOUT CHALLENGES, ASK:*
     - *What is your experience making referrals (e.g., using the CHW Facility Referral Form, getting feedback from facilities and clients after referral)? What are your challenges and solutions?*

- *How does the work being done by your community unit relate to the work done by other structures in the community?*
- *Have the roles of the community unit changed? How?*

4. **APHIAPlus is not meant to last forever. How has your community unit ensured that the work will continue in future after the APHIAPlus project ends?**
   PROBES:
   - *What have you done to ensure that your work continues?*
   - *How do you replace CHWs in this CU?*
   - *How do you collaborate/coordinate with other CUs (e.g., exchange visits, cascade training, etc..)*
   - *Have you been involved in income generating activities?*
   - *How do you define "continuity" or "sustainability?"*
   - *How important is community participation in continuing your work without external support?*

5. **What are the key factors that affect your motivation and performance as CHWs?**
   PROBES:
   (A) WE HAVE HEARD THAT CHWS WERE SUPPOSED TO RECEIVE THE FOLLOWING SUPPORT FOR THEIR WORK:
   1. *THE CHW KITS*
   2. *SUPPORTIVE SUPERVISION*
   3. *TRAINING IN HEALTH RELATED ACTIVITIES-CHS, NUTRITION, FP, MNCH, RH, HIV, TB, MALARIA, C-IMCI, WASH*

   - *Please describe your experiences with them. Did you receive them? Is it constant support? How is the quality?*

   - *HAVE YOU BEEN RECEIVING STIPENDS/ALLOWANCES FOR YOUR SERVICES TO COMMUNITY?*
     - *HOW IS/WAS THE STIPEND/ALLOWANCE LINKED TO CHW PERFORMANCE?*
     - *ARE YOU STILL RECEIVING THE STIPEND/ALLOWANCE?*
     - *WHAT HAPPENED WHEN THE PROJECT STOPPED PROVIDING THE STIPEND/ALLOWANCE?*

TOOL 6: MNCH BENEFICIARIES

RECORD NO. | | | |

ACTIVITY:	1……	Western
	2……	Rift Valley
	3……	Central/Eastern

INTERVIEW DAY (DD):				
INTERVIEW MONTH (MM):				
INTERVIEW YEAR (YYYY):	**2**	**0**	**1**	**5**

COUNTY:	01…….	Baringo	11……..	Homa Bay
	02…….	Kajiado	12……..	Vihiga
	03…….	Laikipia	13……..	Embu
	04…….	Nakuru	14……..	Kiambu
	05…….	Narok	15……..	Kitui
	06…….	Bungoma	16……..	Muranga
	07…….	Busia	17……..	Meru
	08…….	Kakamega	18……..	Nyandarua
	09…….	Migori	19……..	Tharaka Nithi
	10…….	Nyamira	20……..	Thika

SITE NAME:		
SITE TYPE	1……	HOSPITAL
	2……	HEALTH CENTER
	3……	DISPENSARY

GEOGRAPHIC LOCATION:	1……	URBAN
	2……	RURAL
SEX OF RESPONDENT:	1……	FEMALE
	2……	MALE

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		SKIP
Socio-demographic Information				
1.	Thank you, again, for agreeing to speak with me today. To start, how old are you? WRITE THE RESPONDENT'S AGE IN COMPLETED YEARS	_____ _____ **YEARS** *(DON'T KNOW = 88)*		
2.	What is your marital status?	1…..	Never married	
		2……	Married	
		3……	Living together	
		4……	Divorced/separated	
		5……	Widowed	
		9……	NO RESPONSE	
3.	What is the highest level of education you attended?	1…..	No education	
		2…..	Primary incomplete	
		3…..	Primary complete	
		4 . . .	Secondary incomplete	
		5…..	Secondary complete	
		6…..	Tertiary and higher	
		8……	DON'T KNOW	
		9……	NO RESPONSE	
Maternal Health				
4.	What services did you **come for** today? MULTIPLE RESPONSES POSSIBLE. CIRCLE ALL MENTIONED. PROBES: Was this a scheduled visit or did you come for a health concern? What was that health concern?	A…..	Antenatal care (ANC)	
		B…..	Cervical cancer screening	
		C…..	Education/counseling	
		D…..	Family planning /contraceptives	
		E…..	Growth monitoring	
		F…..	HIV testing and counseling (HTC)	
		G…..	Immunization	
		H…..	PMTCT	
		I……	Postnatal care (PNC)	
		J……	STI treatment	
		K…..	TB screening	
		L…..	Treatment for sick child	
		L…..	OTHER _____ _____ (Specify)	
5.	What services did you actually **receive** today? MULTIPLE RESPONSES POSSIBLE. CIRCLE ALL MENTIONED. IF NO SERVICES RECEIVED, CIRLCE 'Z' DID NOT RECEIVE ANY SERVICE.	A…..	Antenatal care (ANC)	
		B…..	Cervical cancer screening	
		C…..	Education/counseling	
		D…..	Family planning /contraceptives	
		E…..	Growth monitoring	
		F…..	HIV testing and counseling (HTC)	
		G…..	Immunization	
		H…..	PMTCT	
		I……	Postnatal care (PNC)	
		J……	STI treatment	

NO.	QUESTION	RESPONSES		SKIP
		K…..	TB screening	
		L……	Treatment for sick child	
		M…...	OTHER _____ _____ (Specify)	
		Z….	DID NOT RECEIVE ANY SERVICE	
6.	I am curious if anyone has referred you to this health facility for the services you came for today. Has anyone referred you? If so, who?	1…..	WAS NOT REFERRED BY ANYONE	
		2…..	Community Health Worker (CHW)	
		3…..	OTHER _____ _____ (Specify)	
7.	Did you or your husband/partner receive an SMS reminder to come to the health facility today?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	
DID RESPONDENT MENTION ANTENATAL CARE (Response A) FOR Q. 4. –**OR-** Q.5? IF SO, PROCEED TO Q.8. OTHERWISE SKIP TO QUESTION 12.				
8.	Is this your first pregnancy?	1…..	YES	
		2…..	NO	
9.	How many months pregnant are you?	_____ _____ MONTHS *(DON'T KNOW=88)*		
10.	How many antenatal care visits have you had so far?	_____ _____ NUMBER OF VISITS		
11.	Have you been tested for HIV during this pregnancy?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	
CHECK Q.8: IF RESPONDENT ANSWERED **YES (FIRST PREGNANCY), GO TO Q.31** IF RESPONDENT ANSWERED **NO FOR Q.8, PROCEED TO Q. 12.**				
12.	I would like to ask some questions about your last birth. How old is your youngest child?	1… …	☐☐ DAYS	
		2… …	☐☐ WEEKS	
		3… …	☐☐ MONTHS	
		4… …	☐☐ YEARS	

NO.	QUESTION	RESPONSES		SKIP
13.	Did you see anyone for antenatal care during that pregnancy?	1…..	YES	
		2…..	NO →→→→→→→→→→→→	***Go to Q. 16***
		8……	DON'T KNOW	
14.	How many times did you receive antenatal care during that pregnancy?	NUMBER OF TIMES: _____ _____ (DON'T KNOW=88)		
15.	Were you tested for HIV during that pregnancy?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	
16.	What is the name of your youngest child? {IF A MULTIPLE BIRTH, RANDOMLY CHOOSE ONE CHILD}. **Who assisted with the delivery of (NAME)? Anyone else?** RECORD ALL MENTIONED. PROBE FOR ALL ADULTS PRESENT AT THE DELIVERY.	A….	HEALTH WORKER (Doctor/nurse/midwife)	
		B…	TRADITIONAL BIRTH ATTENDANT	
		C….	COMMUNITY HEALTH WORKER	
		D….	OTHER _____ _ (Specify)	
17.	After (NAME) was born, did anyone check on your health or the health of (NAME)? BEFORE CIRCLING A RESPONSE, PROBE WHETHER NEITHER WERE CHECKED, MOTHER ONLY, BABY ONLY, OR BOTH MOTHER & BABY WERE CHECKED AFTER DELIVERY.	1…..	NEITHER MOTHER NOR BABY→→→→→	***→Go to Q20***
		2…..	MOTHER ONLY	
		3……	BABY ONLY	
		4……	BOTH MOTHER & BABY CHECKED	
		8…..	DON'T KNOW/DON'T REMEMBER→→→	***→Go to Q20***
18.	How long after delivery did the first check take place? IF LESS THAN 1 HOUR, RECORD MINUTES, IF LESS THAN 1 DAY, RECORD HOURS. IF LESS THAN ONE WEEK, RECORD DAYS.	MINUTES: _____ _____ HOURS: _____ _____ DAYS: _____ _____ WEEKS: _____ _____		
19.	Who checked on your health or the health of your baby at that time? MULTIPLE RESPONSES ALLOWED. CIRCLE ALL MENTIONED.	A …	HEALTH WORKER (Doctor/nurse/midwife)	
		B….	TRADITIONAL BIRTH ATTENDANT	
		C….	COMMUNITY HEALTH WORKER	
		D….	OTHER _____ _ (Specify)	
20.		1…..	YES	

NO.	QUESTION	RESPONSES		SKIP
	Since giving birth to (NAME) has anyone discussed family planning options with you?	2…..	NO	
		8……	DON'T KNOW	
21.	Were you counseled on breastfeeding?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	
Immunization				
22.	Do you have a mother and child health (MCH) booklet? If so, may I see it?	1…..	DOES NOT HAVE AN MCH BOOKLET→	***Go to Q. 25***
		2….	HAS MCH BOOKLET, SEEN	
		3…	HAS MCH BOOKLET, NOT SEEN→→→	***Go to Q. 25***
23.	RECORD THE FOLLOWING INFORMATION FROM THE MOTHER-CHILD BOOKLET (page 30)		D D M M Y Y Y Y	
		BCG (dose below 1 year)		
		OPV 0		
		OPV 1		
		OPV 2		
		OPV 3		
		DPT, HEP, HIB 1st dose		
		DPT, HEP, HIB 2nd dose		
		DPT, HEP, HIB 3rd dose		
		Pneumococcal 1st dose		
		Pneumococcal 2nd dose		
		Pneumococcal 3rd dose		
		Rotavirus 1		
		Rotavirus 2		
		Measles (9 mo.)		
		Yellow fever		
24.	Has (NAME) received any vaccinations that are not recorded in the mother-child booklet, including vaccinations received in a national immunization day campaign?	1…..	YES	
		2…..	NO→→→→→→→→→→→→	***Go to Q. 31***
		8…..	DON'T KNOW	
25.	Please tell me if (NAME) received any of the following vaccinations: A BCG vaccination against tuberculosis that is, an injection	1…..	YES	
		2…..	NO	
		8…..	DON'T KNOW	

NO.	QUESTION	RESPONSES		SKIP
	in the arm or shoulder that usually causes a scar?			
26.	Polio vaccine, that is, drops in the mouth?	1…..	YES	
		2…..	NO→→→→→→→→→→→→	***Go to Q. 28***
		8…..	DON'T KNOW→→→→→→→→	
27.	How many times was the polio vaccine received?	_____ _____ NUMBER OF TIMES *(DON'T KNOW =88)*		
28.	A Pentavalent vaccination that is an injection given in the thigh, sometimes at the same time as polio drops?	1…..	YES	
		2…..	NO→→→→→→→→→→→→	***Go to Q. 30***
		8…..	DON'T KNOW→→→→→→→→	
29.	How many times was a Pentavalent vaccination received?	_____ _____ NUMBER OF TIMES *(DON'T KNOW=88)*		
30.	A measles injection- that is, a shot in the right upper arm at the age of 9 months or older - to prevent him/her from getting measles?	1…..	YES	
		2…..	NO	
		8…..	DON'T KNOW	
Other Program Exposure				
31.	I just have a few more questions. Have you ever had any contact with a CHW (Comm. Health Worker)?	1…..	YES	
		2…..	NO→→→→→→→→→→→→→→	***Go to Q. 33***
		8…..	DON'T KNOW→→→→→→→→	***Go to Q.33***
32.	What services did you receive from the CHW? MULTIPLE RESPONSES ALLOWED. CIRCLE ALL MENTIONED.	A… B… C… D… E… F… G…	Nutrition monitoring Health education Breast feeding education Family planning Condom distribution/demonstration Referrals to health facility OTHER _____ __ (Specify)	

NO.	QUESTION	APHIAPlus-supported Interventions	YES, I <u>personally</u> benefited/ participated	YES, I am aware of other community members who benefited/ participated	NO	DK
33.	APHIAPlus supported a number of activities in your communities, I	a) Cleaning of water points	1	2	3	8
		b) Clearing of bushes	1	2	3	8
		c) Household water purification	1	2	3	8
		d) Handwashing campaigns	1	2	3	8

NO.	QUESTION	APHIAPlus-supported Interventions	YES, I personally benefited/ participated	YES, I am aware of other community members who benefited/ participated	NO	DK
	am going to read out some of them. Please tell me whether you personally benefited/participated in those activities, if you are aware of community members who benefited/ participated or not at all.	e) Mobilizing & referring pregnant women to attend ANC and deliver at health facilities	1	2	3	8
		f) Referring children for immunization	1	2	3	8
		g) Assessing children for malnutrition	1	2	3	8
		h) Deworming of children	1	2	3	8
		i) ITN (insecticide treated bed nets demonstration)	1	2	3	8
		j) Follow up of mother and baby pairs by mentor mothers (for PMTCT)	1	2	3	8
		k) Training in financial literacy	1	2	3	8
		l) Linkage/referral to GoK cash transfer schemes	1	2	3	8
		m) Linkage/referral to GoK grants (UWEZO, youth empowerment fund)	1	2	3	8
		n) Linkage/Referral to micro-finance institutions and funds	1	2	3	8
		o) Training on high yield-high return agricultural practices	1	2	3	8
		p) Other (Specify)	1	2	3	8
34.	**Q35.** APHIAPlus supported a number of services in **health facilities**, I am going to read out some of them. Please tell me whether you personally benefited/participated in those	Counseling on HIV treatment adherence	1	2	3	8
		Counseling on prevention with positives	1	2	3	8
		Linkages to PWP support groups, PLWHA support groups and post-test clubs	1	2	3	8
		Screening for TB	1	2	3	8
		Nutrition assessment	1	2	3	8
		Advice on Infant & Youth Child Feeding	1	2	3	8
		FP counseling and contraceptives	1	2	3	8
		Counseling and/or provision of condoms	1	2	3	8

NO.	QUESTION	APHIAPlus-supported Interventions	YES, I personally benefited/ participated	YES, I am aware of other community members who benefited/ participated	NO	DK
	activities OR if you are aware of community members who benefited/participated	Counseling on alcohol and substance abuse	1	2	3	8
		Linkage with mother to mother support	1	2	3	8
		STI screening	1	2	3	8
		Screening for cervical cancer	1	2	3	8

THANK YOU FOR YOUR TIME AND COOPERATION.

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

INTERVIEWER NAME (write RA's name): _____

INTERVIEWER SIGNATURE: _____

REVIEWED BY (Name of Sub-Team Leader): _____

SUB-TEAM LEADER SIGNATURE: _____

DATA ENTERER 1: (write name): _____

SIGNATURE: _____

DATA ENTERER 2: (write name): _____

SIGNATURE: _____

TOOL 7: CCC BENEFICIARIES

RECORD NO. | | | |

ACTIVITY:	1……	Western
	2……	Rift Valley
	3……	Central/Eastern

INTERVIEW DAY (DD):				
INTERVIEW MONTH (MM):				
INTERVIEW YEAR (YYYY):	**2**	**0**	**1**	**5**

COUNTY:	01…….	Baringo	11……..	Homa Bay
	02…….	Kajiado	12……..	Vihiga
	03…….	Laikipia	13……..	Embu
	04…….	Nakuru	14……..	Kiambu
	05…….	Narok	15……..	Kitui
	06…….	Bungoma	16……..	Muranga
	07…….	Busia	17……..	Meru
	08…….	Kakamega	18……..	Nyandarua
	09…….	Migori	19……..	Tharaka Nithi
	10…….	Nyamira	20……..	Thika

SITE NAME:		
SITE TYPE	1……	HOSPITAL
	2……	HEALTH CENTER
	3……	DISPENSARY

GEOGRAPHIC LOCATION:	1……	URBAN
	2……	RURAL

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		SKIP
Socio-demographic Information				
1.	SEX OF THE RESPONDENT	1…..	FEMALE	
		2…..	MALE	
2.	Thank you, again, for agreeing to speak with me today. To start, how old are you? WRITE THE RESPONDENT'S AGE IN COMPLETED YEARS	_____ _____ **YEARS** *(DON'T KNOW = 88)*		
3.	What is your marital status?	1…..	Never married	
		2……	Married	
		3……	Living together	
		4……	Divorced/separated	
		5……	Widowed	
		9……	NO RESPONSE	
4.	What is the highest level of education you attended?	1…..	NO EDUCATION	
		2…..	Primary incomplete	
		3…..	Primary complete	
		4…...	Secondary incomplete	
		5….	Secondary complete	
		6…..	Tertiary and higher	
		8……	Don't know	
Services				
5.	How long ago were you first enrolled in HIV treatment and care? CIRCLE APPROPRIATE CODE (1, 2, 3 OR 4) BASED ON THE UNITS THE RESPONDENT USED IN HIS/HER ANSWER, THEN WRITE THE ANSWER TO THE QUESTION IN THE BOXES PROVIDED. IF RESPONDENT WAS ENROLLED ON INTERVIEW DAY, SELECT DAYS, WRITE '00.'	1…	**DAYS AGO:**	
		2…	**WEEKS AGO:**	
		3….	**MONTHS AGO:**	
		4…	**YEARS AGO:**	
6.	I would now like to ask you about your experiences as a client at this clinic. **What services did you come for today?** MULTIPLE RESPONSES POSSIBLE. CIRCLE ALL MENTIONED. PROBE:	A….	Adherence counseling	
		B….	Antiretroviral therapy (ART)	
		C….	Cancer screening	
		D….	CD4	
		E….	Condoms/family planning	
		F….	Couples counseling	
		G….	General medical care	
		H….	Nutrition counseling/support	
		I….	Pediatric HIV care	
		J….	Post-exposure prophylaxis	
		K….	Preventive treatment—Septrin	

NO.	QUESTION	RESPONSES		SKIP
	Was this a scheduled visit or did you come for a health concern?	L….	Preventive treatment—other	
		M…..	Tuberculosis (TB) screening	
		N…..	Viral load	
		O….	OTHER _____ (Specify)	
7.	What services did you actually receive today? MULTIPLE RESPONSES POSSIBLE. CIRCLE ALL MENTIONED.	A….	Adherence counseling	
		B…..	Antiretroviral therapy (ART)	
		C…...	Cancer screening	
		D……	CD4	
		E…..	Condoms/family planning	
		F……	Couples counseling	
		G…..	General medical care	
		H……	Nutrition counseling/support	
		I…….	Pediatric HIV care	
		J…….	Post-exposure prophylaxis	
		K……	Preventive treatment—Septrin	
		L……	Preventive treatment—other	
		M…..	Tuberculosis (TB) screening	
		N…..	Viral load	
		O…..	OTHER _____ (Specify)	
8.	I am curious if anyone has referred you to this health facility for the services you came for today. Has anyone referred you? If so, who?	1…..	WAS NOT REFERRED BY ANYONE	
		2…..	Community Health Worker (CHW)	
		3…..	OTHER _____ (Specify)	
9.	Are there link desks and volunteers based at this health facility to refer PLHIV to other facility- or community-based services?	1…..	YES	
		2…..	NO→→→→→→→→→→→→→→→	***Go to Q. 11***
		8……	DON'T KNOW→→→→→→→→→→→	
10.	Have you ever used the services provided by those desks/volunteers?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	
11.	Have you ever disclosed your HIV status to your partner, spouse, or family?	1…..	YES	
		2…..	NO →→→→→→→→→→→	***Go to Q. 13***
		8……	DON'T KNOW	
12.	Were you counseled by health workers at this facility on disclosure of your HIV status to other people?	1…..	YES	
		2…..	NO	
13.	Are you currently on ARVs?	1…..	YES	
		2…..	NO →→→→→→→→→→→	***Go to Q. 15***

NO.	QUESTION	RESPONSES		SKIP
14.	In the last **30 days**, have you ever forgotten to take your ARVs?	1…..	YES	
		2…..	NO	
		8…..	DON'T KNOW	
15.	Have you ever received a reminder to attend clinic? If so, how did they send the reminder?	1….. 2….. 3….. 4…..	NO REMINDER EVER RECEIVED→→→ Mobile/SMS CHW visit OTHER _____ (Specify)	***Go to Q. 17***
16.	Did you receive a reminder for today's visit?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	

Other Program Exposure						
17.	Have you received any of the following services provided by APHIAPlus?		**YES**	**NO**	**DK**	
		a) Disclosure of HIV status…….	1	2	8	
		b) Partner testing for HIV……..	1	2	8	
		c) Reduction of HIV transmission to others (secondary prevention)……..	1	2	8	
		d) STI prevention ……	1	2	8	
		e) Counseling or provision of condoms……	1	2	8	
		f) Counseling on HIV treatment adherence …….....	1	2	8	
		g) Linkages to PLHIV support groups …….	1	2	8	
		h) TB screening ……..……	1	2	8	
		i) TB treatment …….	1	2	8	
		j) Nutrition assessment …….	1	2	8	
		k) Support on infant and young child feeding (e.g., timely weaning, continued breastfeeding)…..……	1	2	8	
		l) FP counseling or commodities …….	1	2	8	

NO.	QUESTION	RESPONSES				SKIP
		j) Counseling on alcohol and substance abuse and referral……..	1	2	8	
		k) Mother-to-mother support…. ……	1	2	8	
		l) STI screening……	1	2	8	
		m) Screening for cervical cancer ……	1	2	8	
		n) Training in financial literacy……	1	2	8	
		o) Linkage/referral to GoK cash transfer schemes…….	1	2	8	
		p) Linkage/referral to GoK grants (UWEZO, youth empowerment fund)……..	1	2	8	
		q) Linkage/referral to micro-finance institutions and funds..	1	2	8	
		r) Training on high-yield/ high-return agricultural practices……	1	2	8	
		s) OTHER (Specify below) _____				

THANK YOU FOR YOUR TIME AND COOPERATION.

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

INTERVIEWER NAME (write RA's name): _____ CODE: _____ _____

INTERVIEWER SIGNATURE: _____

REVIEWED BY (Name of Sub-Team Leader): _____

SUB-TEAM LEADER SIGNATURE: _____

DATA ENTERER 1: (write name): _____ CODE: _____ _____

SIGNATURE: _____

DATA ENTERER 2: (write name): _____ CODE: _____ _____

SIGNATURE: _____

TOOL 8: OVC CAREGIVERS

RECORD NO.

ACTIVITY:	1……	Western
	2……	Rift Valley
	3……	Central/Eastern

INTERVIEW DAY (DD):				
INTERVIEW MONTH (MM):				
INTERVIEW YEAR (YYYY):	**2**	**0**	**1**	**5**

COUNTY:	01…….	Baringo	11……..	Homa Bay
	02…….	Kajiado	12……..	Vihiga
	03…….	Laikipia	13……..	Embu
	04…….	Nakuru	14……..	Kiambu
	05…….	Narok	15……..	Kitui
	06…….	Bungoma	16……..	Muranga
	07…….	Busia	17……..	Meru
	08…….	Kakamega	18……..	Nyandarua
	09…….	Migori	19……..	Tharaka Nithi
	10…….	Nyamira	20……..	Thika

LOCAL IMPLEMENTING PARTNER:	

GEOGRAPHIC LOCATION:	1……	URBAN
	2……	RURAL

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		SKIP
Socio-demographic Information				
1.	SEX OF RESPONDENT	1……	FEMALE	
		2……	MALE	
2.	Thank you, again, for agreeing to speak with me today. To start, how old are you? WRITE AGE IN COMPLETED YEARS	_____ _____ **YEARS** *(DON'T KNOW = 88)* *(REFUSED TO ANSWER = 99)*		
3.	What is your marital status?	1…..	Never married	
		2……	Married	
		3……	Living together	
		4……	Divorced/separated	
		5……	Widowed	
		9……	NO RESPONSE	
4.	What is the highest level of education you attended?	1…..	No education	
		2…..	Primary incomplete	
		3…..	Primary complete	
		4……	Secondary incomplete	
		5…..	Secondary complete	
		6…..	Tertiary and higher	
		8…..	DON'T KNOW	
		9…..	NO RESPONSE	
5.	How many orphans and vulnerable children (OVC) have been in your care over the last 4 years?	_____ _____ NUMBER OF OVC		
6.	How many of the above OVCs are of primary- and secondary-school age?	_____ _____ NO. OF SCHOOL-AGE OVCs		***IF '00' Go to Ques. 8***
7.	Of those school-age children, how many of them are currently attending school?	_____ _____ NO. OF OVCs ATTENDING SCHOOL		
8.	Thinking about all of the OVCs you are currently caring for, what services do the OVCs in your care receive? MULTIPLE RESPONSES POSSIBLE. CIRCLE ALL MENTIONED. IF NO SERVICES, CIRCLE X.	A……..Educational support (school fees, scholarships, uniforms, books, school supplies) B……..Health C……..Food & Nutrition (Kitchen gardening, training on food preparation) D……..Household economic empowerment (livelihood support, cash transfer) E……..Protection (birth certificate, shelter, blankets, FGM, SGBV) F……..Psychosocial support G…..OTHER (Specify)_____ X…….NO ADDITIONAL SERVICES		
9.	Are you a member of a SILC (savings and internal lending community) group?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	

NO.	QUESTION	RESPONSES		SKIP
10.	Have you individually or as part of a group initiated any income-generating activities (IGAs) through the support of APHIAPlus?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	
11.	REFER TO PAGE 1 FOR THE NAME OF THE LIP. Have you participated in any trainings or special sessions with{NAME OF LIP} for caregivers of OVC?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	
12.	Has {LIP NAME} assisted you in accessing support or services from the Government or other agencies such as Wings to Fly, KCB, or CDF?	1…..	YES	
		2…..	NO →→→→→→→→→→→→	***END***
		8……	DON'T KNOW →→→→→→→→→→→→	***END***
13.	What is the <u>one</u> service or support your household has received that has helped you the most as a caregiver of orphans and vulnerable children?	1…..	Educational support	
		2…..	Food and nutritional support	
		3……	Income-generating support	
		4……	OTHER _____ (Specify)	

THANK YOU FOR YOUR TIME AND COOPERATION.
RECORD STOP TIME OF INTERVIEW (HH:MM) _____ _____ **:** _____ _____

INTERVIEWER NAME (write RA's name): _____ Code: _____ _____

INTERVIEWER SIGNATURE: _____

REVIEWED BY (Name of Sub-Team Leader): _____

SUB-TEAM LEADER SIGNATURE: _____

DATA ENTERER 1: (write name): _____ Code: _____ _____

SIGNATURE: _____

DATA ENTERER 2: (write name): _____ Code: _____ _____

SIGNATURE: _____

TOOL 9: YOUTH

RECORD NO. | | | |

ACTIVITY:	1……	Western
	2……	Rift Valley
	3……	Central/Eastern

INTERVIEW DAY (DD):				
INTERVIEW MONTH (MM):				
INTERVIEW YEAR (YYYY):	**2**	**0**	**1**	**5**

COUNTY:	01…….	Baringo	11……..	Homa Bay
	02…….	Kajiado	12……..	Vihiga
	03…….	Laikipia	13……..	Embu
	04…….	Nakuru	14……..	Kiambu
	05…….	Narok	15……..	Kitui
	06…….	Bungoma	16……..	Muranga
	07…….	Busia	17……..	Meru
	08…….	Kakamega	18……..	Nyandarua
	09…….	Migori	19……..	Tharaka Nithi
	10……..	Nyamira	20……..	Thika

READ INFORMED CONSENT STATEMENT (see separate sheet)

LOCAL IMPLEMENTING PARTNER NAME:	

GEOGRAPHIC LOCATION:	1…….	URBAN
	2……	RURAL

☐ 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		SKIP
Socio-demographic Information				
1.	SEX OF THE RESPONDENT	1…..	FEMALE	
		2…..	MALE	
2.	How old are you? WRITE AGE IN COMPLETED YEARS	_____ _____ **YEARS**		
3.	What is your marital status?	1…..	Never married	
		2……	Married	
		3……	Living together	
		4……	Divorced/separated	
		5……	Widowed	
		9……	NO RESPONSE	
4.	Do you have any children?	1…..	YES	
		2…..	NO	
		8…...	DON'T KNOW	
5.	Have you ever attended school?	1…..	YES	
		2…..	NO →→→→→→→→→→→→	***Go to Q. 8***
6.	Are you currently attending school?	1…..	YES	
		2…..	NO	
7.	What is the highest level of education you have attended?	1…..	No education	
		2…..	Primary incomplete	
		3…..	Primary complete	
		4…..	Secondary incomplete	
		5…..	Secondary complete	
		6…..	Tertiary and higher	
		8…..	DON'T KNOW	
		9…..	NO RESPONSE	
Comprehensive Knowledge on HIV and AIDS				
8.	Now I would like to talk about something else. Have you ever heard of an illness called AIDS?	1…..	YES	
		2…..	NO →→→→→→→→→→→→	***Go to Q. 24***
9.	Can people reduce their chance of getting the AIDS virus by having just one uninfected sex partner who has no other sex partners?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	
10.	Can people get the AIDS virus from mosquito bites?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	
11.	Can people reduce their chance of getting the AIDS	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	

NO.	QUESTION	RESPONSES		SKIP
	virus by using a condom every time they have sex?			
12.	Can people get the AIDS virus by sharing food with a person who has AIDS?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	
13.	Is it possible for a healthy-looking person to have the AIDS virus?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	
14.	Do you know of a place where people can go to get tested for HIV?	1…..	YES	
		2…..	NO →→→→→→→→→→→→	***Go to Q. 16***
		8……	DON'T KNOW	
15.	Where is that? Any other place? MULTIPLE ANSWERS ALLOWED. CIRCLE ALL MENTIONED.		<u>PUBLIC SECTOR</u>	
		A…	GOVT. HOSPITAL	
		B….	GOVT. HEALTH CENTER	
		C….	STAND-ALONE VCT CENTER	
		D….	FAMILY PLANNING CLINIC	
		E….	MOBILE CLINIC	
		F….	FIELDWORKER	
		G….	SCHOOL-BASED CLINIC	
		H….	OTHER PUBLIC SECTOR _____ (Specify)	
			<u>PRIVATE SECTOR</u>	
		I…	PRIVATE HOSPITAL/CLINIC/DOCTOR	
		J…	STAND-ALONE VCT CENTER	
		K….	PHARMACY	
		L….	MOBILE CLINIC	
		M….	FIELDWORKER	
		N….	SCHOOL-BASED CLINIC	
		O….	OTHER PRIVATE MEDICAL _____ (Specify)	
			<u>OTHER SOURCE</u>	
		P….	HOME	
		Q….	CORRECTIONAL FACILITY	
		X….	OTHER _____ (Specify)	
16.	Do you know of a place where youth can get condoms?	1…..	YES	
		2…..	NO →→→→→→→→→→→→	***Go to Q.18***
		8……	DON'T KNOW	
17.	Where is that? Any other place?		<u>PUBLIC SECTOR</u>	
		A…	GOVT. HOSPITAL	
		B….	GOVT. HEALTH CENTER	
		C….	STAND-ALONE VCT CENTER	
		D….	FAMILY PLANNING CLINIC	

NO.	QUESTION	RESPONSES		SKIP
	MULTIPLE ANSWERS ALLOWED. CIRCLE ALL MENTIONED	E…. F…. G…. H…. I… J… K…. L…. M…. N…. O…. X….	MOBILE CLINIC FIELDWORKER SCHOOL-BASED CLINIC OTHER PUBLIC SECTOR _____ (Specify) <u>PRIVATE HEALTH SECTOR</u> PRIVATE HOSPITAL/CLINIC/DOCTOR STAND-ALONE VCT CENTER PHARMACY MOBILE CLINIC FIELDWORKER SCHOOL-BASED CLINIC OTHER PRIVATE _____ (Specify) OTHER _____ (Specify)	
18.	Do you know a place where youth can get tested for HIV?	1…..	YES	
		2…..	NO →→→→→→→→→→→→	***Go to Q.20***
		8……	DON'T KNOW	
19.	Where is that? Any other place?	 A… B…. C…. D…. E…. F…. G…. H…. I… J… K…. L…. M….	<u>PUBLIC SECTOR</u> GOVT. HOSPITAL GOVT. HEALTH CENTER STAND-ALONE VCT CENTER FAMILY PLANNING CLINIC MOBILE CLINIC FIELDWORKER SCHOOL-BASED CLINIC OTHER PUBLIC SECTOR _____ (Specify) <u>PRIVATE SECTOR</u> PRIVATE HOSPITAL/CLINIC/DOCTOR STAND-ALONE VCT CENTER PHARMACY MOBILE CLINIC OTHER _____ (Specify)	
Attitudes toward HIV/AIDS				
20.	Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had the AIDS virus?	1…..	YES	
		2…..	NO	
		8……	DK/NOT SURE/DEPENDS	
21.		1…..	YES	

NO.	QUESTION	RESPONSES		SKIP
	If a member of your family **got infected** with the AIDS virus, would you want it to remain a secret?	2…..	NO	
		8……	DK/NOT SURE/DEPENDS	
22.	If a member of your family **became sick** with AIDS, would you be willing to care for her or him in your own household?	1…..	YES	
		2…..	NO	
		8……	DK/NOT SURE/DEPENDS	
23.	In your opinion, if a female teacher has the AIDS virus, but is not sick, should she be allowed to continue teaching in the school?	1…..	YES	
		2…..	NO	
		8……	DK/NOT SURE/DEPENDS	
Other Sexual and Reproductive Health Issues				
24.	Now I would like to ask some questions about sexual activity in order to gain a better understanding of some important life issues among youth. As a reminder, your name will not be attached to any of the information you share with me. **Have you ever had sexual intercourse?**	1…..	YES	
		2…..	NO →→→→→→→→→→→→→→→→→→→→	***Go to Q.30***
		8……	DON'T KNOW→→→→→→→→→→→→→→→→→	***Go to Q.30***
		9……	NO RESPONSE→→→→→→→→→→→→→→→→→	***Go to Q.30***
25.	How old were you when you had sexual intercourse for the very first time? PROBE FOR SPECIFIC ANSWER.	_____ _____ YEARS OLD		
26.	When was the **last time** you had sexual intercourse? IF LESS THAN 12 MONTHS, ANSWER MUST BE RECORDED IN DAYS, WEEKS OR MONTHS. IF 12 MONTHS (ONE YEAR) OR MORE, ANSWER MUST BE RECORDED IN YEARS.	1…...	DAYS AGO ☐☐	
		2……	WEEKS AGO ☐☐	
		3……	MONTHS AGO ☐☐	
		4……	YEARS AGO ☐☐	
27.	The last time you had sexual intercourse, was a condom used?	1…..	YES	
		2…..	NO	
		8…..	DON'T KNOW	
28.	How many sexual partners have you had <u>over the past 12 months</u>?	_____ _____ NUMBER OF PARTNERS (88=DON'T KNOW)		

NO.	QUESTION	RESPONSES		SKIP
29.	Was a condom used <u>every time</u> you had sexual intercourse in the last 12 months?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW	
30.	Have you ever engaged in any type of sexual activity with a person in exchange for a gift, favor, or cash?	1…..	YES	
		2…..	NO →→→→→→→→→→→→	***Go to Q.32***
		9……	REFUSED TO ANSWER→→→→	***Go to Q.32***
31.	Has this happened in the last 12 months?	1…..	YES	
		2…..	NO	
		9…..	REFUSED TO ANSWER	
32.	Have you ever been tested for HIV?	1…..	YES	
		2…..	NO →→→→→→→→→→→→	***Go to Q.35***
		8……	DON'T KNOW→→→→→→→	***Go to Q.35***
		9……	REFUSED TO ANSWER→→→→	***Go to Q.35***
33.	When was the last time you were tested for HIV? IF LESS THAN 1 MONTH, RECORD WEEKS. IF LESS THAN 1 YEAR, RECORD MONTHS. IF 12 MONTHS (1 YEAR) OR MORE, RECORD YEARS.	1….	WEEKS AGO …… ☐☐	
		2….	MONTHS AGO …… ☐☐	
		3…	YEARS AGO …… ☐☐	
34.	Did you receive the results?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW/NOT SURE	
35.	During the last 12 months have you had a sexually transmitted disease?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW/NOT SURE	
		9……	REFUSED TO ANSWER	
36.	Sometimes people experience an abnormal discharge from their genitals. During the last 12 months, have you had a bad smelling or unusual discharge from your genitals?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW/NOT SURE	
		9…...	REFUSED TO ANSWER	
37.	Sometimes people have a genital sore or ulcer. During the last twelve months have you or your sexual partner had a genital sore or ulcer?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW/NOT SURE	
		9……	REFUSED TO ANSWER	

NO.	QUESTION	RESPONSES		SKIP
DID THE RESPONDENT ANSWER 'YES' FOR EITHER QUESTION 36 OR QUESTION 37? IF YES, PROCEED. IF NO, SKIP TO QUESTION 39.				
38.	The last time you had a genital ulcer, sore, or discharge, did you seek any kind of advice or treatment?	1…..	YES	
		2…..	NO	
		8……	DON'T KNOW/NOT SURE	
39.	Some youth are concerned about unwanted pregnancy. What are some ways to prevent unwanted pregnancy? RECORD ALL MENTIONED	A… B…. C…. D…. E…. F…. G…. H…. I…… J……. X…..	NO METHOD MENTIONED ABSTINENCE PILL EMERGENCY CONTRACEPTION (e.g. Postinor 2) MALE CONDOM FEMALE CONDOM IUD INJECTABLE / DEPO-PROVERA IMPLANT OTHER _____ (Specify) Don't know/Not sure	
40.	Is there a method that prevents both pregnancy and HIV or other sexually transmitted infections? If yes, what is the method? Anything else? RECORD ALL MENTIONED.	A… B…. C….. D….. E… F… G…. H…. I…… J……. X…..	NO METHOD MENTIONED ABSTINENCE PILL EMERGENCY CONTRACEPTION (e.g. Postinor 2) MALE CONDOM FEMALE CONDOM IUD INJECTABLE / DEPO-PROVERA IMPLANT OTHER _____ (Specify) Don't know/Not sure	
Other Program Exposure				
41.	Have you ever received youth-friendly services?	1…..	YES	
		2…..	NO →→→→→→→→→→→→	***Go to Q.43***
		8……	DON'T KNOW/NOT SURE	
42.	Where did you receive the youth-friendly services?	A….	Health facility	
		B …..	Youth Empowerment Centre	
		C……	Drop-in center (DIC)	
		D…..	OTHER _____ (Specify)	
43.	Have you participated in any of the following services?		**Y** **N** **DK**	
		a) Community Midwifery (comprehensive Adolescent Reproductive Health)	1 2 8	
		b) TUUNGANE (Young Men as Equal Partners)	1 2 8	

NO.	QUESTION	RESPONSES				SKIP
	READ EACH SERVICE ALOUD. FOR EACH, CIRCLE A CODE (1=YES, 2=NO, 8=DON'T KNOW).	c) Families Matters! Program	1	2	8	
		d) Magnet Theatre Plus	1	2	8	
		e) Youth Empowerment Centers	1	2	8	
		f) Shuga 1	1	2	8	
		g) Shuga 2	1	2	8	
		h) Friends of Youth	1	2	8	
		i) Youth friendly services	1	2	8	
		j) JIJUE UJIPANGE	1	2	8	
		k) NIME CHILL	1	2	8	
		l) Youth Ambassadors/ Ambassadors of Youth	1	2	8	
		m) Safe and Smart Savings	1	2	8	
		n) Sita Kimya	1	2	8	
		o) One2One Hotline	1	2	8	
		p) Life-skills education	1	2	8	
		q) Financial literacy and entrepreneurial skills training	1	2	8	
		r) Referral to HIV treatment & care	1	2	8	
		s) Voluntary Medical Male Circumcision (Kutahiri ni Kujijali)	1	2	8	

THANK YOU FOR YOUR TIME AND COOPERATION.

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

INTERVIEWER NAME (write RA's name): _____ Code: _____ _____

INTERVIEWER SIGNATURE: _____

REVIEWED BY (Name of Sub-Team Leader): _____

SUB-TEAM LEADER SIGNATURE: _____

DATA ENTERER 1: (write name): _____ Code: _____ _____

SIGNATURE: _____

DATA ENTERER 2: (write name): _____ Code: _____ _____

SIGNATURE: _____

TOOL 10: COMMUNITY HEALTH WORKERS

RECORD NO. | | | |

ACTIVITY:	1……	Western
	2……	Rift Valley
	3……	Central/Eastern

INTERVIEW DAY (DD):				
INTERVIEW MONTH (MM):				
INTERVIEW YEAR (YYYY):	**2**	**0**	**1**	**5**

COUNTY:	01…….	Baringo	11……..	Homa Bay
	02…….	Kajiado	12……..	Vihiga
	03…….	Laikipia	13……..	Embu
	04…….	Nakuru	14……..	Kiambu
	05…….	Narok	15……..	Kitui
	06…….	Bungoma	16……..	Muranga
	07…….	Busia	17……..	Meru
	08…….	Kakamega	18……..	Nyandarua
	09…….	Migori	19……..	Tharaka Nithi
	10…….	Nyamira	20……..	Thika

COMMUNITY UNIT (CU):	

GEOGRAPHIC LOCATION:	1……	URBAN
	2……	RURAL

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		SKIP
Socio-demographic Information				
1.	SEX OF RESPONDENT	1……	FEMALE	
		2……	MALE	
2.	Thank you, again, for agreeing to speak with me today. To start, for how long have you been working as a community health worker (CHW) in this community?	1…	**WEEKS:** ☐☐	
		2…	**MONTHS:** ☐☐	
		3…	**YEARS:** ☐☐	
3.	How old are you? WRITE AGE IN COMPLETED YEARS	_____ _____ **YEARS** *(DON'T KNOW = 88)*		
4.	What is your marital status?	1…..	Never married	
		2……	Married	
		3……	Living together	
		4……	Divorced/separated	
		5……	Widowed	
		9……	NO RESPONSE	
5.	What is the highest level of education you attended?	1…..	No education	
		2…..	Primary incomplete	
		3…..	Primary complete	
		4…..	Secondary incomplete	
		5…..	Secondary complete	
		6…..	Tertiary and higher	
		8……	DON'T KNOW	
		9……	NO RESPONSE	

TRAINING

6. Have you received training/orientation on any of the following? READ EACH TOPIC/THEME ALOUD. COMPLETE THE FOLLOWING TABLE. IF DID NOT RECEIVE A SPECIFIC TRAINING, WRITE N/A IN EACH CELL FOR THAT TRAINING.

TOPIC/THEME OF TRAINING	TRAINING PROVIDED BY: (NAME OF ORGANIZATION)	FOR HOW MANY DAYS?	HOW LONG AGO? (CIRCLE WEEKS, MONTHS, OR YEARS)
(a) PMTCT			_____ _____ (WRITE ANSWER & CIRCLE: weeks/months/years)
(b) Community-based Integrated management of childhood illnesses (C-IMCI)			_____ _____ (WRITE ANSWER & CIRCLE: weeks/months/years)
(c) Integrated community case management (iCCM) *(for treatment of malaria, diarrhea, and pneumonia)*			_____ _____ (WRITE ANSWER & CIRCLE: weeks/months/years)

NO.	QUESTION	RESPONSES			SKIP
	(d) Maternal, Newborn & Child Health (MNCH)			_____ _____ (WRITE ANSWER & CIRCLE: weeks/months/years)	
	(e) HIV/HCBC			_____ _____ (WRITE ANSWER & CIRCLE: weeks/months/years)	
	(f) Orphans & Vulnerable Children (OVC)			_____ _____ (WRITE ANSWER & CIRCLE: weeks/months/years)	
	(g) Sexual & gender-based violence (SGBV)			_____ _____ (WRITE ANSWER & CIRCLE: weeks/months/years)	
	(h) Tuberculosis (TB)			_____ _____ (WRITE ANSWER & CIRCLE: weeks/months/years)	
	(i) Water, sanitation, & hygiene (WASH)			_____ _____ (WRITE ANSWER & CIRCLE: weeks/months/years)	
	(j) Community mobilization			_____ _____ (WRITE ANSWER & CIRCLE: weeks/months/years)	
	(k) Advocacy			_____ _____ (WRITE ANSWER & CIRCLE: weeks/months/years)	
	(l) Community-based health information system (CB-HIS) reporting and data use			_____ _____ (WRITE ANSWER & CIRCLE: weeks/months/years)	
	(m) ANY OTHER TRAINING? (Specify):			_____ _____ (WRITE ANSWER & CIRCLE: weeks/months/years)	

7.	Have you been provided with any of the following to help you do your work? READ EACH ALOUD. CIRCLE THE APPROPRIATE CODE	**TYPE OF COMMODITY**	**YES**	**NO**	**DK**
		(a) IEC materials	1	2	8
		(b) Bags, T-shirts, badges	1	2	8
		(c) Bicycles	1	2	8
		(d) Reporting tools	1	2	8
		(e) Phones, PDAs	1	2	8

NO.	QUESTION	RESPONSES			SKIP
	BASED ON THE RESPONSE (1=YES, 2=NO, 8=DON'T KNOW)	(f) ANY OTHER COMMODITY? (Specify in the space below):	1	2	8
8.	What services do you provide in your community? MULTIPLE RESPONSES ALLOWED. RECORD ALL MENTIONED BY RESPONDENT.	A….. Follow up of mother-baby pairs B… ARV adherence support C…… Defaulter tracing D….. Community mobilization E….. Referral for health facility services F….. Community-based distribution G….. Health promotion H….. OTHER 1 (Specify) _____ I…… OTHER 2 (Specify) _____ J…… OTHER 3 (Specify) _____			
9.	Does your community unit hold monthly CHW meetings?	1….. YES 2….. NO →→→→→→→→→→→→→→→ 8…… DON'T KNOW →→→→→→→→→→→→			 ***Go to Q. 11*** ***Go to Q. 11***
10.	How often do you attend those meetings?	1….. NEVER 2….. MONTHLY 3…… QUARTERLY 4….. ANNUALLY			
11.	How often do you submit routine reports on your activities?	1….. NEVER 2….. MONTHLY 3…… QUARTERLY 4…. ANNUALLY			
12.	How many mothers did you refer to health facilities over the past month?	_____ _____ _____ _____ **MOTHERS PER MONTH**			

THANK YOU FOR YOUR TIME AND COOPERATION.

RECORD STOP TIME OF INTERVIEW (HH:MM) _____ _____**:** _____ _____

INTERVIEWER NAME (write RA's name): _____ Code: _____ _____

INTERVIEWER SIGNATURE: _____

REVIEWED BY (Name of Sub-Team Leader): _____

SUB-TEAM LEADER SIGNATURE: _____

DATA ENTERER 1: (write name): _____ Code: _____ _____

SIGNATURE: _____

DATA ENTERER 2: (write name): _____ Code: _____ _____

SIGNATURE: _____

TOOL 11a: DATA ABSTRACTION TEMPLATE

Tool 11a: DATA ABSTRACTION TEMPLATE *(*APHIAPlus *End-of-Activity Evaluation, 2015)*

ACTIVITY:

	1….APHIAPlus Western
	2….APHIAPlus Rift
	3….APHIAPlus Central/Eastern

COUNTY:

NAME OF SITE:

DATE OF ABSTRACTION:

				2	0	1	5
D	*D*	*M*	*M*	*Y*	*Y*	*Y*	*Y*

NAME OF ABSTRACTOR/ RESEARCH ASSISTANT:

RA CODE:

HIV AND TB *(The following four indicators will be abstracted for each month of 2010 and 2014)*

INDICATOR	**WHERE TO FIND THE INFORMATION:**	**YEAR: 2010**											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1. Total no. of TB patients recorded in register	**MOH TB Register (TALLY patients recorded in the register for each month)**												
2. No. of TB patients with "POS" recorded in the HIV Test column of the register	**MOH TB Register (Look at information recorded in the HIV test column)**												
3. Source of Referral to TB Clinic*	**MOH TB Register (Look at "Referred BY" column in register)**												
CODES FOR **"Referred BY" are as follows: VCT, HCC, STI, HBC, PS, ANC, SR, CI, CP*													
4. Service referred to by TB clinic	**MOH TB Register (Look at "Referred**												

	TO" column in register)												

CODES FOR **"Referred TO" are as follows: NS, VCT, HCC, HBC, STI, PS, ANC*

INDICATOR	**WHERE TO FIND THE INFORMATION:**	**YEAR: 2014**											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
HIV AND TB													
1. Total no. of TB patients recorded in register	**MOH TB Register (TALLY patients recorded in the register for each month)**												
2. No. of TB patients with "POS" recorded in the HIV Test column of the register	**MOH TB Register (Look at information recorded in the HIV test column)**												
3. Source of Referral to TB Clinic*	**MOH TB Register (Look at "Referred BY" column in register)**												
CODES FOR **"Referred BY" are as follows: VCT, HCC, STI, HBC, PS, ANC, SR, CI, CP*													
4. Service referred to by TB clinic	**MOH TB Register (Look at "Referred**												

	TO" column in register)												

CODES FOR **"Referred TO" are as follows: NS, VCT, HCC, HBC, STI, PS, ANC*

SUPERVISION

For this section, ask the In-charge for any available supervision logs/registers from 2011 through 2014

IF SUPERVISION RECORDS NOT AVAILABLE, TICK BOX: ☐

		2011	2012	2013	2014
5. No. of supervision visits by County Supervisor/CHMT member	**Supervision logs/registers; Quality Assurance logs/registers**				
6. No. of supervision visits by Sub-County Supervisor/SCHMT					

TRAINING

For this section, ask the In-charge for any available training logs/registers from 2011 through 2014

IF TRAINING RECORDS NOT AVAILABLE, TICK BOX: ☐

	2011	2012	2013	2014
7. No. of Training Needs Assessments Conducted:				
8. No. of health care workers in that facility who received in-service training in:				
a) PMTCT				

b) MNCH	**DATA SOURCE: Training logs or registers (ask In-Charge)**				
c) Nutrition					
d) Recordkeeping					
e) Data Use					
f) OTHER-- Specify: (e.g., HTC}	_____				
	_____				
	_____				

TOOL 11b: Data Abstraction Form for HEI and ANC Registers (HIV Exposed Infant and Antenatal Care)

APHIAPlus End-of-Activity Evaluation

Data Abstraction Form for HIV Exposed Infant (HEI) Registers and Antenatal Care (ANC) Registers

INSTRUCTIONS

Form Column	HEI Register Column	Remarks
1	a	Count all children
2	L	Count all children aged <3 months
3	q and L	Count all children aged <3 months with positive PCR
4	aj	Count all children aged ≤ 9 months
5	ao and aj	Count all children aged ≤ 9 months with a positive PCR
6	ap	Count all children aged ≤ 18 months
7	aq and ap	Count all children aged ≤ 18 months with a positive antibody
8	aa	Count all children with a CTX **or** NVP entry
9	ag	Count all children with a CTX **or** NVP entry
10	s,u,w, y, aa, ac, ae AND ag	Count all fields or times when the child does not have CTX or NVP entry Note that here you are not counting down the columns but across all rows

Form Column	ANC Register Column	Remarks
11	C and S	Count only mothers who are making their first ANC visit (col c = Yes) **and** whose initial HIV test (column S) is either Known positive (KP) or Positive (P)
12	C and S and P	Count all HIV+ mothers making first ANC visit who were counselled on infant feeding ie column p has 7

Name of facility _____

Activity / APHIA _____

Date _____

Name of RA _____

Birth cohort	Number of children in the cohort (i)	Number of children with 1st PCR before 3 months of age (ii) Subset of (i)	Number whose First PCR was positive (iii) Subset of (ii)	Number with PCR at 9 months (iv) Subset of (i)	Number whose 9th month PCR was positive (v) Subset of (iv)	Number with 18th month antibody test (vi)	Total whose 18th month antibody test was positive (vii)	Number active at 9 months (viii) Subset of (i)	Number active at 18 months (ix) Subset of (i)	Total **Missed** visits from week 6 to month 18 (x) *(CTX/NVP columns)*	*ANC Register (MoH 405)*	From ANC Register: Total HIV+ mothers on First ANC visit (xi)	From ANC Register: HIV+ mothers counselled on Infant feeding (xii) Subst of (xi)
Column on HEI register	**Col (a)**	**Col (l) <3 months**	**Col (q)**	**Col (aj)**	**Col (ao)**	**Col (ap)**	**Col (aq)**	**Col (aa) NOT BLANK**	**Col (ag) NOT BLANK**	**Week (6,10,14) month (6,9,12,15,18) are BLANK**		**Col c = Y and [Col s = KP or P)**	**Col p =7**
July 2010											J		
Aug 2010											A		
Sep 2010											S		
July 2011											J		
Aug 2011											A		
Sep 2011											S		
July 2012											J		
Aug 2012											A		
Sep 2012											S		
July 2013											J		
Aug 2013											A		
Sep 2013											S		

TOOL 12: National Level Key Informant Interview Guide

RECORD NO. | | | |

DATE:				**2015**
		(dd)	(mm)	(yyyy)
TYPE(S) OF RESPONDENT(S) PARTICIPATING IN THE INTERVIEW:	A……	USAID HPN staff		
	B…..	National Government Departments (specify)		
	C……	Development partner		
	D…..	APHIAPlus Implementing Partner—PRIME		
	E…..	APHIAPlus Implementing Partner—SUB		
	F….	OTHER (Specify):		

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)

☐ 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			
1.	The three activities have a regional/county/sub county approach, what are your opinions about this approach?, (Probe: what are some strengths and weaknesses of this approach)	USAID, MoH Departments, IPs at national level	
2.	What systems/processes were inbuilt within the activities to ensure that best practices and lessons learned are feeding to the national level policies and strategies, what about systems/process for ensuring that APHIAPlus activities are aligned to national level policies and priorities?	USAID, MoH, IPs at National level	
3.	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,	USAID, MoH departments,	
4.	How has the country led approach contributed to the achievement of the observed health outcomes?	USAID & MoH Departments	
5.	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}	USAID, National Mechanisms, MoH departments, IPs	

No.	Question	Targeted Respondent	Responses
6.	In addition to the "health related result areas", APHIAPlus design included result 4 that focused on *"social determinants of health addressed to improve the wellbeing 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?	USAID, MoH departments, IPs at national level	
7.	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)	
8.	How has the situation of {mention specific technical area} changed over time since inception of the activities under evaluation in 2011{**Probe for**: national and the regions of focus}, in your opinion what has been the contribution of the three 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}	MoH departments, USAID	

No.	Question	Targeted Respondent	Responses
9.	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 }	USAID, MoH Departments, development partners such as CDC	
10.	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.**}**	USAID, MoH departments	
Strategic Shifts			
11.	What were the key strategic shifts that happened during the APHIAPlus implementation period, how did this affect the APHIAPlus design and implementation? How did APHIAPlus 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 blue print, budget	USAID, MoH departments, IPs at national level	

No.	Question	Targeted Respondent	Responses
	cuts/rationalization, new program such as the Beyond Zero Campaign, epidemiological changes}		
Implementation Challenges and Management			
12.	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)	USAID, MoH departments, IPs at national level	
13.	What strategies did USAID use to provide program oversight, guidance and management? How effective were the management strategies used?, what are some management lessons that can be drawn from this?, what do you think could be done to strengthen these? **Probe for**: Designated AOR for each activity, field supportive supervision, Quarterly meetings with the implementers,	USAID, , IPs at National Level	
14.	What were the management approaches used between the prime and the subs?, how effective was the management structure/approach used?, how effective was the approach in contributing to the achievement of the observed health outcomes, what are the challenges in the consortium management and how did this affect the implementation?, what are some of the management lessons that can be drawn from this approach? {**Probe for**: Project Management committee made up of the prime and the subs, or the all management being done by the prime, use of project advisory	USAID & IPs at national level	

No.	Question	Targeted Respondent	Responses
	committees, capacity strengthening including transitioning to local organizations}		
Innovation			
15.	(a) Were there any features of APHIAPlus that you consider to be particularly innovative? (b) Compared to the strategies implemented by other local actors, how innovative were APHIAPlus' strategies and approaches? (c) Has there been any diffusion of innovation, for example, the Government or other stakeholders adopting similar strategies or approaches implemented by APHIAPlus?	USAID, MoH departments, IPs at national level, development partners	
Sustainability through working with local NGOs			
16.	The APHIAPlus activity designed various strategies for ensuring sustainability including approaches to work with and build capacity of local NGOs; in your opinion how well did this work?, has this approach increased the capacity of the local NGOs participating in the consortium?, what have been the challenges?, how do you think this approach could have been strengthened ?	USAID, Implementing partners	
Interventions for Scale UP			
17.	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	
18.	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.)	USAID, MoH departments, IPs and development partners	

ANNEX 8: Evaluation Scope of Work

A. BACKGROUND INFORMATION

A.1: Purpose of Evaluation: USAID Kenya Office of Population and Health (OPH) intends to conduct an end of project evaluation for three of its flagship activities namely APHIAPlus Rift Valley, APHIAPlus Western Kenya and APHIAPlus Central Eastern (also known as KAMILI). The planned 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; and 2) to inform the design of follow-on service delivery activities.

The three APHIAPlus activities are scheduled to come to an end in December 2015. The planned evaluation will help OPH in reaching decisions related to: (1) the effectiveness of the APHIAPlus model as was envisioned in the Five Year Implementation Framework in strengthening the capacity of Ministry of Health to better deliver on an integrated package of high quality and high impact Kenya Essential Package of Health Services (KEPHS) package; (2) the model of integration of service delivery and health systems strengthening to use in any future activity design for the health sector; and (3) the nature and scope of possible future interventions in the health sector, based on challenges experienced and lessons learned from the current APHIAPlus activities' architectural design. USAID therefore expects this evaluation to be an effective learning tool that can be used by the Mission, and its strategic partners including implementing mechanisms, Ministry of Health and development partners to further their support to the health sector.

A.1.1: Audience for the Evaluation:

The primary audience for the findings of this evaluation is USAID/Kenya, Office of Population and Health leadership and its technical team and the implementing partners – Program for Appropriate Technology in Health (PATH), JHPIEGO and Family Health International 360 (FHI360) USAID/Kenya's program office, Office of Agriculture Business and Energy, Office of Education and Youth, and Office Democracy and Governance are part of the next level of primary audience for the evaluation findings. The first line secondary users of the evaluation findings will include 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 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:

Information generated from this evaluation will inform planning, development and implementation of follow-on activities which will be aligned to the new USAID/Kenya Country Development and Coordination Strategy (CDCS), supporting primarily Development Objective 2 *Health and Human Capacity Strengthened.*

At the time of development, the APHIAPlus service delivery activities were designed to align to the five-year USAID/Kenya Implementation Framework (2010-2015) with the strategic objective 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 towards reducing unintended and mistimed pregnancies, improving infant and child health, reducing HIV/AIDS transmission, and reducing the threat of infectious diseases.

APHIAPlus service delivery activities are integrated health activities that also respond to social determinants of health in the technical areas of HIV and AIDS, malaria, family planning and tuberculosis, and MNCH, and water and sanitation.

Basic Activity Information:

Activity Name	Activity Number	TEC	Period of Performance
APHIAPlus Rift Valley	AID – 623 – A – 11 – 0007	$ 70,980,677	Jan 1, 2011 to Dec 31, 2015
APHIAPlus Western	AID – 623 – A – 11 - 0002	$ 143,360,992	Jan 1, 2011 to Dec 31, 2015
APHIAPlus Central Eastern	AID – 623 – A – 11 - 0008	$ 99,999,921	Jan 1, 2011 to Dec 31, 2015

Consortium membership by every activity:

APHIAPlus *Rift Valley (FHI360)*	**APHIAPlus *Western (PATH)***	**APHIAPlus, *KAMILI (JHPIEGO)***
AMREF	***EGPAF***	***AMREF***
LVCT	***JHPIEGO***	***LVCT***
NOPE	***World Vision***	***Kenya Red Cross***
CRS		***NOPE***
		PATH

A.2.1: Problem Statement:

While there has been remarkable progress in addressing the health situation in Kenya through government of Kenya and donor support, health indicators in HIV/AIDS, MCNH, FP/RH, malaria still point to the need for increased efforts towards improving health outcomes and impact.

HIV/AIDS and Tuberculosis (TB): An estimated 6.2 percent of adults aged 15–49 in Kenya are infected with HIV. HIV prevalence is highest in the counties of former Nyanza province, Nairobi, and the counties of the former Coast Province. About 130,000 new adult infections and 32,500 new infant infections (via vertical transmission) occur each year, but modes of transmission are markedly different in these three provinces. Even though HIV is typically more clustered in urban areas and along transport corridors, increasing prevalence in rural areas has been documented. New patterns of infection have also been documented highlighting discordant couples, casual sex, and Most At-Risk Populations (MARPs). Gains have been achieved over the last ten years. Consistent condom use has increased from 27 to 58 percent among youth, with similar increases in condom use at last sex.

Malaria: More than 70 percent of Kenyans are at risk of malaria. This preventable disease is responsible for the loss of 170 million working days each year and 13 percent of all deaths among children under five (34,000 deaths). Malaria still accounts for 30 percent of outpatient attendance and 19 percent of admissions to the health facilities. In the last 10 years major gains have been made in the fight against malaria. Malaria is no longer the leading killer of children under 5, while data from a variety of surveys and operational research show declines in malaria parasite prevalence, malaria trends, and vector densities over the last ten years.

Family Planning and Reproductive Health: The gap between demand for FP methods and use of modern methods – unmet need – is extremely high. The modern contraceptive prevalence rate (CPR) is 42 percent, with an unmet need of 25 percent (KDHS 2008). Recent studies conducted by PSI/Kenya reveal that unmet need in young women is high, at 53 percent. However, that unmet need is significantly

higher for young unmarried women; 76 percent of sexually active unmarried women reported a desire to protect against an unplanned pregnancy, but did not use a modern method.

The Ministry of Health has adopted provision of an ***essential package of primary care services***, which includes ***investing in health at the community level.*** Operationalizing this approach has been a challenge due to systemic hindrances. Some of the examples include, e.g., insufficient human capital, inadequate performance monitoring systems, nonexistent incentive programs, isolation, lack of feedback mechanisms. While policymakers at the national level continue to debate the best way to mobilize communities to take ownership of their health, a few Community Units (CUs) have been established but there are gaps in the implementation and coverage community health strategy hampering efforts to the anticipated gains.

A.2.1.1: Development Hypothesis:

If APHIAPlus activity improves the Ministry of Health's capacity at the county and sub-county levels to increase availability of the KEPHS, to create and increase demand for high quality KEPHS package at facility and community, to increase adoption of health behaviors and effectiveness through innovative approaches, to strengthen coordination and collaboration among key stakeholders, and address social determinants of health to improve well-being of marginalized communities and population; the result will be improved health outcomes and impact through sustainable country-led programs and partnerships. This hypothesis was developed as part of this evaluation based on the logic model used in the Implementation Framework 2011 – 2015.

A.2.2: ACTIVITY DESIGN

Broadly, APHIAPlus activities have a regional/county and sub-county approach of 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 implemented by a consortium of several local and international organizations that bring specific expertise to contribute to the achievement of the overall goals and objectives. As part of the five-year Implementation Framework 2011 – 2015, USAID also designed national health system related activities. These activities covered human resources for health (FUNZO and Capacity), supply-chain management (Kenya Pharma, KEMSA Support, Health Commodities and Services Management), health information (Measure Evaluation – PIMA, National Health Management Information System – AfyaInfo), among others. These activities were work at the national level while at the same time collaborating with the service delivery activities at the devolved levels. Specific designs and approaches for the three activities that this SOW covers are described below:

A.2.2.1: APHIAPlus Rift Program Strategy

The APHIAPlus Rift Valley team's technical approach recognized that Kenyan institutions – from provincial and district health management teams to hospitals and clinics to local NGOs and Community Health Units (CHUs) – must be at the forefront of planning, integrating, leading, monitoring and evaluating service delivery to make local ownership a reality. APHIAPlus Rift Valley is a consortium of several partners who bring specific expertise in contributing to the achievement of the overall project goal and objectives. These include local and international organizations, the former being the majority. The project aims at strengthening and mentoring local organizations over the project period so they can assume stronger leadership roles in HIV and broader health programming and become the organizations of first choice for donor funding in the future. Central to the achievement of expected results for this activity are the integrated service delivery model; development, implementation and management of partnerships; use of practical, evidence-based approaches; and use of efficient coordination and synergy

models over the course of implementation. The key interventions by IRs that were implemented by this activity are included in **Annex I**.

A.2.2.2: APHIAPlus Western Program strategy

The fulcrum of APHIAPlus Western is the community, upon which all initiatives pivot. To adequately serve the targeted populations, effective service delivery at health facilities will be integrated with the MoH community strategy to increase demand for services. The activity's framework also forges strong links between facilities and communities that enhance the economic and social capital gains at a household level to foster an undercurrent of activity that improves family health. The activity seeks to:

- Expand integrated facility-based services through mentorship, supportive supervision, and innovative, high impact programming;
- Activate synergies for whole market planning and implementation through district-level annual operational plan mechanisms and anchor the APHIAPlus work plan as a subset of district work plans;
- Foster dynamic integration and enhanced linkages between households and health and social services through community health workers, referrals, and community structures; and
- Strengthen community capacity to advocate for their rights, monitor and evaluate services in their community and own, lead and participate in education and programs tailored to their needs.

Activity interventions include integrated services and systems to serve the clients—marginalized, poor, and underserved populations, including youth, most-at-risk populations (MARPs), PLWHA and those on antiretroviral (ARVs), orphans and vulnerable children (OVC), women of reproductive age, highly vulnerable adolescent girls, neonates, and infants. APHIAPlus Western is aligned to the GOK's vision 2030, plan for the health sector (2008 – 2012) and the Kenyan National AIDS Strategic Plan (2009 – 2013) and other sector strategic plans and policies. The key objective of the activity is to facilitate an effective transition from an emergency services response to building sustainable, Kenyan-owned leadership, management and governance capacity to deliver improved health outcomes. Key implementation strategies included the Client Centered Approach, Performance-Based Contracting (PBC), District-Based Structural Management, Leveraging for Maximum Impact and Seamless, Integrated Planning. The key interventions implemented under each Intermediate Result for every activity are included in **Annex III.**

A.2.2.3: APHIAPlus KAMILI Program Strategy

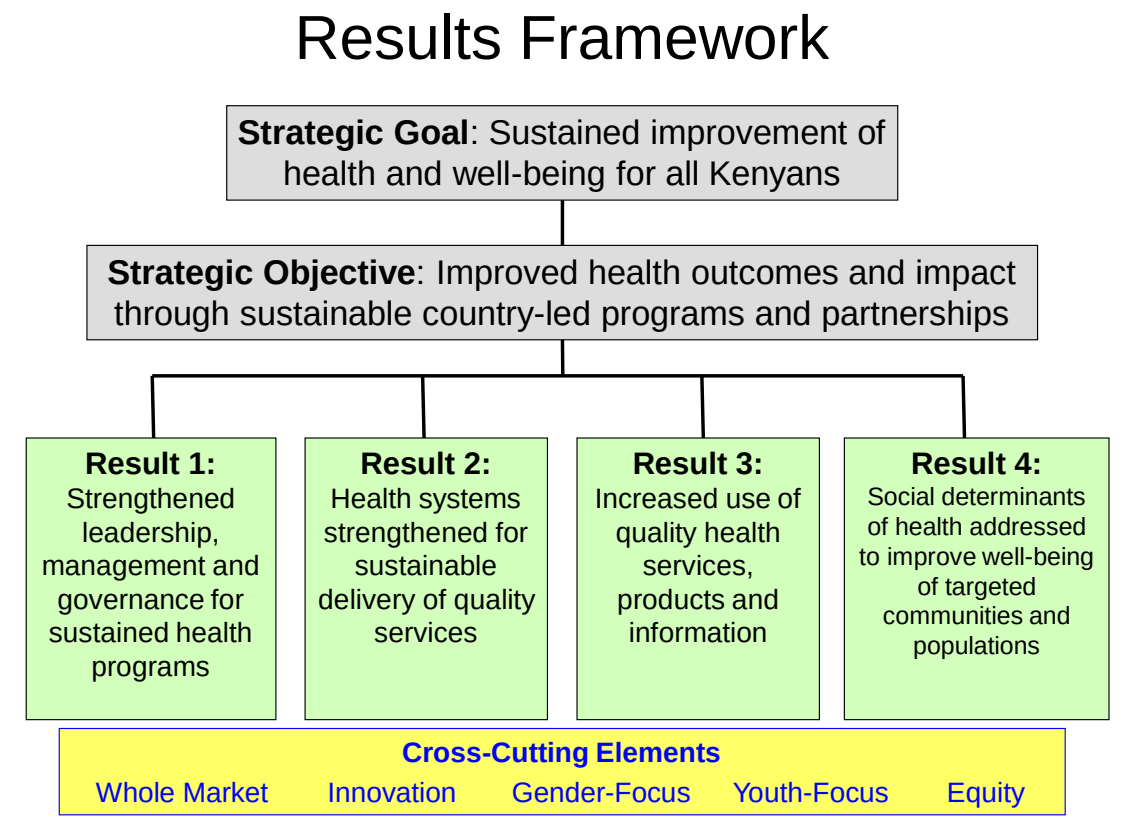
APHIAPlus KAMILI was designed to use a demand**-**driven strategy for improving health outcomes and impact through sustainable country led programs and partnerships. This support include a menu of evidence-based best practices and innovations including: activities to build skills and confidence (e.g., on-the-job mentoring and supportive supervision), systems to improve operations and processes (e.g., quality assurance systems, monitoring and evaluation systems), platforms to bring people together in supportive problem-solving networks (e.g., SMS-based communities) and incentive systems to foster motivation and change. APHIAPlus KAMILI's approach to increasing use of quality health services, products and information, is client-centered and high-impact. The activity strives to maximize service integration at all levels, ensuring "no missed opportunities" to offer clients a full complement of HIV, tuberculosis, family planning/reproductive health, maternal, neonatal and child health, nutrition, water sanitation/hygiene services in private, faith-based and public sector facilities. Support to providers is meant to be minimally disruptive and use technological innovations for efficiency. To ensure humane and dignified care, the activity adds client feedback into performance monitoring processes. APHIAPlus

KAMILI targets individuals and communities most-at-risk with effective community outreach designed to overcome geographic, social and economic barriers to healthy behavior.

The activity's vision is to empower every actor in the household-to-hospital continuum of care to deliver the KEPH. Central to the achievement of expected results are the use of integrated service delivery models, use of demand driven and people centered approaches, Whole market approach, managing for results with mutual accountability approach, and investments in leadership, capacity building, and systems for long-term sustainability. The key interventions being implemented under each Intermediate Result for this activity are included in **Annex II.**

A.3: Activity Results Framework:

The theory of change that was envisioned for the APHIAPlus activities was that depicted in the Results Framework below. Specifically, for the USAID/Kenya to achieve its mandated strategic goal of sustained improvement of health and well-being for all Kenyans, the three APHIAPlus activities 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 the strategic objective and in the long-term results in the achievement of the strategic goal as presented on the framework below:



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

A.3.1.1: Program Results:

In the 2010 – 2015 Implementation Framework, APHIAPlus Activities were designed to respond to Results 3 and 4 (see results framework above). The Activities were 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 policy/guidelines, adoption of county level government and changes in Ministry of Health division/departmental leadership happened that were not initially envisioned and may have impacted on the observations made or implementation plans developed by the three activities. To the extent possible, programs in these technical areas were to be ***integrated*** to ***reduce vertical programming and avoid duplication of effort.***

The primary beneficiaries of the activities 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 post-partum 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 as per Implementation Framework 2011 - 2015:

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

A.3.1.3: Priority Outcome level Indicators:

The priority intermediate and end outcome level indicators for this evaluation are as follows:

Priority Indicators	Baseline Available (Y/N)	Comments
HIV Retention in Care & Treatment (disaggregated by gender)	Y	
% HIV+ tested for TB/annually disaggregated by gender	Y	
% TB/HIV co-infected enrolled into care	Y	
% HIV+ patients enrolled into care	Y	

Priority Indicators	Baseline Available (Y/N)	Comments
% eligible HIV+ patients started on treatment	Y	
MTCT rate at 18 – 24 months	Y	
Proportion of exposed infants testing at 8 weeks	Y	
Retention at 9, 18, 24 months	Y	
Proportion of HIV+ mothers supported on feeding infants & young children	Y	
Proportion of exposed infants that received regular follow up care	Y	
Wellbeing of OVC based on Child Status Index (CSI).	Y	
Enrolment, attendance and progression	Y	
Adequate shelter, child under good adult care	Y	
% of births attended by skilled health care worker	Y	
ANC 1st Visit Coverage among pregnant women	Y	
ANC 4th Visit Coverage among pregnant women	Y	
Proportion of children under 1 year fully immunized	Y	
DPT1 coverage	Y	
DPT3 Coverage	Y	
Measles Coverage	Y	
% health care workers reporting improved knowledge, attitude and practices	N	Will need to be extracted from work plans and quarterly progress reports
% health facilities where TNA was conducted & TNA report available	N	Will need to be extracted from work plans and quarterly progress reports
% health care workers that received in-service training by program area (Care & Treatment, PMTCT, MNCH, Nutrition, Records Keeping/Data Use)	N	Will need to be extracted from work plans and quarterly progress reports
% health facilities that received activity-supported DHMT/CHMT supportive supervision	N	Will need be extracted from district Health Management Team (DHMT)/County Health Management Team (CHMT) supervision records at the facility and/or county/sub-county level
% health facilities with programs performance review forum/committee that meets regularly with meeting records available	N	Will need be extracted from DHMT/CHMT supervision records at the facility and/or county/sub-county level

Priority Indicators	Baseline Available (Y/N)	Comments
% youths 15 – 24 reporting improved HIV knowledge and healthy behaviors (health seeking behavior for HTC, seeking STI treatment, condom negotiation and use, linkage to care and treatment)	N	Will need to be extracted from work plans and quarterly progress reports
% targeted youths 15 – 24 that successfully completed conducted EBI sessions/activities	N	Will need to be extracted from work plans and quarterly progress reports
% completion rate of planned EBI activities based on the yearly work plans	N	Will need to be extracted from work plans and quarterly progress reports
Existence of established and functional systems/structures for program quality improvement at health facility	N	Will need to be extracted from DHMT/CHMT management records and through KII with health facility in charges
Existence of Quality Improvement Multi-Disciplinary Committee	N	Will need to be extracted from DHMT/CHMT management records and through KII with health facility in charges
Use of performance measurement data to improve quality of services	N	Will need to be extracted from DHMT/CHMT management records and through KII with health facility in charges
Use of national guidelines/protocols by health care workers	N	Will need to be extracted from DHMT/CHMT management records and through KII with health facility in charges
Use of program data for developing work plans, plan supportive supervision by health managers	N	Will need to be extracted from DHMT/CHMT management records and through KII with health facility in charges

B: EVALUATION SOW

This is 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 directions for USAID Kenya in activity design, development, implementation and management. This evaluation will the implementation period from January 2011 to December 2014

B.1: Evaluation Questions:

The following questions are numbered in terms of priority, with a lot of interdependency and must be answered with empirical evidence. IBTCI is required to develop sub-questions that would add details for each main question and that will be subject to approval by USAID Kenya:

1. For each APHIAPlus activity, what is the status of the expected health outcomes, and to the extent possible, what is the activity's contribution to the observed health outcomes?

2. For each APHIAPlus activity, what are the prospects for the sustainability of the implemented strategies and/or systems and structures that contributed to the observed health outcomes produced by this activity?
3. For each APHIAPlus activity, what implementation challenges did the activity face during the implementation period? What are the key programmatic and management lessons learnt?
4. Based on the analysis of the evidence generated by this evaluation, what activity implementation strategies/approaches, with particular focus on integration and coordination with national level mechanisms, are most effective and how can they be scaled up in similar future activities?

B.2: Resources provided by USAID

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

1. Activity description documents
2. Annual work plans
3. M & E Plans and PMPs
4. Health Strategic Plans (NHSSP, KNASP 111)
5. Activity quarterly reports, annual reports
6. List of other technical/implementation strategy documents for every activity is included as A**nnex IV - VI**

C. EVALUATION METHODS, APPROACHES AND PROCEDURES

C.1.1: Evaluation Team Organization

An eleven person evaluation team will carry out this SOW under the direct leadership and overall management of the Team Leader. S/he upon the formation of the evaluation team will further form three evaluation sub-teams, each with a designated sub-team leader. One sub-team will be responsibility for each activity, and will throughout the data collection process be based in either Nakuru (APHIAPlus Rift), Kisumu (APHIAPlus Western Kenya) or in Embu (APHIAPlus Central/Eastern – KAMILI).

C.1.2: Evaluation Design

A non-experimental evaluation design that uses pre-post analysis of project health outcomes to analyze trends is recommended for this evaluation with a mix of qualitative and quantitative methods to strengthen the rigor of the evaluation design. This will include content review/analysis of resource documents, review 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 (FGDs), key informant interviews (KIIs), mini-surveys, and records from meeting minutes held at health facilities. A sequential mixed method design is recommended, and the evaluation team will sequentially use qualitative – qualitative approaches in data collection. This approach will help the team in grounding evidence around the key priority intermediate and end outcome indicators. IBTCI is however encouraged to use its technical niche to propose other innovative ways of using qualitative and quantitative approaches in similar complex evaluations that could enhance better and well-grounded evidence on the expected health outcomes.

C.1.3: Data Collection Methods

1) Content Analysis of the scope of work in the activity agreements, 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 surveys such as Lots Quality Assurance Sampling (LQAS) reports, Child Status Index (CSI) reports, programmatic quality assessment reports, etc.

2) Review of quantitative data posted on the National AIDS and STI Control Program's (NASCOP) Early Infant Diagnosis (EID) database, and District Health Information System 2 (DHIS2) and associated health information system primary data sources.
3) FGDs with two small groups of between 7 – 10 health facility beneficiaries (1 MNCH group and 1 CCC), one group of 7 – 10 OVC caregivers attached to each sampled community based organization (CBO), one group of 7 – 10 youths that participated in HIV prevention services supported by each sampled CBO, and one group of 7 – 10 Community Health Workers (CHWs) attached to each sampled community unit (CU) to collect data about specific and appropriate priority outcome indicators. It is generally stated in the literature that the manageable number of Focus Group Discussions (FGDs) ranges between 7 – 10 participants largely because large groups of more than 10 participants are difficult to control and they also limit each of the participant's 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 of any inferences or generalization of issues into the general population, but largely to provide insights and observations critical for grounding evidence emerging from quantitative and other forms of qualitative data. In total, the evaluation team will carry out a total of five FGDs.
4) 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; 5) National MOH leadership (DMS, heads of directorates; and 6) staff from collaborating institutions. The total number of KIIs will depend on how many people the evaluation team would identify for follow up interviews after FGDs.
5) Mini-surveys – develop a few set of specific questions in the form of a short quantitative questionnaire for every target group to collect data on knowledge, attitude and practices that directly answer priority outcome indicators and administer it to two small groups of 10 – 15 health facility beneficiaries depending on the level and type of health facility. These target groups may include: 1 group of MNCH/PMTCT and 1 group of CCC beneficiaries, one group of 10 – 15 OVC caregivers for each CBO sampled depending on the total number of OVCs that a sampled CBO serves, one group of 10 – 15 youths aged 15 – 24 that participated in HIV prevention services supported by each sampled CBO, and one group of 10 - 15 Community Health Workers that support community work within each sampled health facility that has a functional Community Unit.

C.1.4: Data Sources:

Primary sources of data for the priority indicators will include the Health Information System for HIV, RMNCH and TB programs at the facility, DHMT support supervision records, and the implementing partner quarterly/annual progress reports, and program records/reports generated through child status index assessments. Other facility level data sources will include NASCOP's EID database and DHIS2. Key informant interviews and focus group discussions with health care workers will provide valuable baseline, intermediate and end term information on knowledge, attitude and practices upon which to conduct trend and content analysis to determine the extent of contribution that activity inputs had on the observed outcomes. Data on quality improvement will be collected 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; health care workers on availability and use of national service delivery guidelines. Data on

adoption of health behaviors due to HIV evidence based interventions will be collected through mini surveys and focus group discussions with youth 15 – 24 years. The Service Provision Assessment 2010 and Service Availability and Readiness Assessment Mapping (SARAM) Report 2013, will provide both baseline and intermediate outcomes data on the availability and readiness of facilities to provide critical health services. Preliminary Report on the Demographic and Health Survey 2014 will provide valuable data on end outcome level indicators that the team is expected to use to validate results on similar outcome indicators from DHIS2, and to draw conclusions on the extent of change on intermediate and end outcome level indicator values to which that the activity has contributed. The Demographic and Health Survey Report 2008/09 would also provide some useful baseline information on priority indicators as much as report analytical tabulations were limited to the former provincial administrative boundaries

C.1.5: Data Analysis Approaches

The proposed data analysis methods are illustrative and IBTCI is required to use its technical niche to propose any other appropriate data analysis technique. During the period of proposal and/or work plan development, it is expected that IBTCI would consult with IPs to come up with intervention strategies that have more likelihood of affecting expected program outcomes such as types of program activities/interventions, level of intensity such as amount of services – number of contacts /sessions held and the length of the intervention just to mention a few. These factors will aid in the analysis of the extent to which they affected the observed outcomes. For outcomes related to knowledge, practices and healthy behaviors, it is proposed that the evaluation team uses comparative analytical techniques to determine the level of improvements/change that health care workers and youth 15 – 24 years attribute to the Activity's inputs. In particular, the analytical approaches adopted will help the evaluation team to determine the extent to which health care workers and youth 15 – 24 participation in activity's supported interventions contributed towards the changes in their knowledge, practices and adoption of healthy behaviors (***health seeking behavior for HTC, seeking STI treatment, condom negotiation and use, linkage to care and treatment***) respectively. A combination of trend and comparative analyses will help determine the overall activity contributions on the priority intermediate and end health outcomes between 2011 and 2014. Gender analysis including disaggregation of results that shows how different gender groups (men/women, boys/girls for youth targeted interventions participated in the activities should be incorporated in all the analytical work as much as possible.

The evaluation team will apply both quantitative and qualitative data analysis techniques. The analysis on the current status of the outcome level indicators would require that the evaluation team reconstructs the baseline values for the outcome indicators without baseline values. Reconstructed and available baseline values for every outcome indicator will be organized by facility and activity level after which trend and/or comparative analysis is conducted. 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 intermediate and end outcomes is a result of the inputs provided by the activity. Some quantitative indicators will be analyzed for a period of 4 years, while some longitudinal quantitative indicators such as MTCT rate will be analyzed into cohorts of 18 - 24 months to determine the extent to which the desired outcomes were achieved

The proposed data analysis approaches in this evaluation include:

Trend analysis – determine the overall change in key quantitative indicators over the last four 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.

Contribution Analysis – some of the priority intermediate and end outcome health indicators have baseline values posted in District Health Information System2 (DHIS2), activity progress reports and baseline assessment reports; while some don't. The evaluation team is required to reconstruct baseline values from various source documents that include facility level data from registers, DHIS2, activity reports, facility program management records/reports held at sampled health facilities, records on OVC service provision and other available secondary survey data such DHS2008/2009 and Service Provision Assessment (SPA) 2010. Each activity also conducted baseline assessments and therefore such reports would also provide baseline values for some intermediate and end health outcome indicators. The evaluation team, while using the theory of change/cause – effect logic model that the design of the three activities was based on, shall determine using contribution analytical technique the likely contribution (to the extent possible) that the interventions/support that the activity provided - inputs (TA, mentorship, supplies provided by the activity), the outputs from the inputs on the observed intermediate and end health outcomes. Using the theory of change and/or the causal logic approaches the evaluation team should explore and estimate the extent to which each activity has contributed to the intermediate outcomes and end health outcomes. 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.

Comparative analysis - knowledge gains and application, adopted best practices and application among health care workers that benefited from interventions/programs supported by the activity such as mentorship programs, and service delivery quality improvement programs at the facility and community levels.

Grounded theory analysis – this technique will help build 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 and 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 help the team develop very substantive and evidence based conclusions.

Content & Triangulation Analysis – taking 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. This technique should help the evaluation team understand the technical support that was provided over time by the activity and as much as possible attempt to associate the observed health outcomes with these processes**.**

Cross Tabulation Analysis - examine the effect of different program characteristics on the intermediate and end outcomes, especially for the knowledge and practices, and healthy behaviors on health care workers and youth 15 – 24 years respectively.

C.1.6: Sampling Strategy:

To ensure that the breadth and depth of each activity is included in the data collection process, different sampling strategies are suggested for different points of data collection as detailed below:

1) 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 – 500+/half year) and dispensaries (ANC/PMTCT clients 200+/half year) are included. **(See** Annex **VII - IX: List of PMTCT/ANC sites based on SAPR14).** IBTCI team will first stratify facilities into rural and urban and then use systematic random sampling to select recommended sample size that includes all sub-county hospitals, health centers and dispensaries. All

former provincial general hospitals and county hospitals will purposively be included in the sample. Given the time and available resources, the evaluation team will cover between 10 – 20 percent of the high volume facilities. The variation in coverage of between 10–20 percent is adopted to ensure equal workload for every sub-evaluation team that would cover APHIAPlus Western, Rift and KAMILI.

APHIAPlus Rift Counties	Total Facilities Selected by Counties	Sample Size=12 (15%)
Baringo	11	2
Kajiado	22	3
Laikipia	7	1
Nakuru	30	4
Narok	11	2
	81	
APHIAPlus Western Kenya Counties		**Sample Size=13 (10%)**
Bungoma	38	4
Busia	9	1
Kakamega	37	4
Migori	15	1
Nyamira	9	1
Homa Bay	4	1
Vihiga	10	1
	126	
APHIAPlus Central Eastern Counties		**Sample Size = 13 (20%)**
Embu	7	1
Kiambu	7	1
Kitui	2	1
Muranga	5	1
Meru	23	5
Nyandarua	5	1
Tharaka Nithi	4	1
Thika	6	1
	61	

Please note that sample size for APHIAPlus Western Kenya and KAMILI is increased by 1 each to accommodate county hospitals.

2) The total number of health facility beneficiaries will range from 10 – 15 depending on the region and facility type. IBTCI will determine which sampling interval to use in systematic sampling of beneficiaries depending on the average number of patients that are expected to visit sampled facility on the day of the visit.

3) Community Based Organizations (CBOs) supporting Orphans and Vulnerable Children (OVC) will purposively be selected based on 1) total time of supporting OVC in years, 2) total number of OVC that it supports, 3) geographical location to ensure good representation of the activity's geographic coverage. Systematic random sampling method will be used in the selection of OVC households to be home visited, using OVC service provision files held at the CBO offices. **(See** Annex **X: List of CBOs supporting OVC work by each activity)**

4) Collaborating/partner institutions/county MOH program representatives will be selected based on the length of time in months/years that have been closely working with the activity. Those that worked with the activity for a period of between 2 – 3 years will be accorded high priority in the selection process. **See** Annex **XII - XV: List of collaborating/partner institutions/MOH representatives for every activity.** IBTCI will make determination on the level of efforts after consulting with each activity Management team. Respondents from the collaborating/partner institutions will be selected using a purposive sampling method and shall be guided by the potential number of key respondents with relevant knowledge about the activity performance on thematic areas of interest. IBTCI is required to use its technical judgment on the right mix of respondents for Focus Group Discussions (FGD), Round Table Discussions (RTD) and Key Informant Interviews (KII) sessions.

C.1.7: Synthesis of Conclusions and Recommendations

It is expected that the evaluation team will develop strategies that would ensure that for every key finding, explanations and validations are sought from key data sources including follow up KIIs for better presentation and development of substantive conclusions. These follow up data collection strategies (Key Informant Interviews, Subject Matter Expert Consultations, Focus Group Discussions) should help the evaluation team to 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. Each technical expert, jointly with the Senior M&E Expert, in the evaluation team is expected to guide the development of three to five key recommendations for every evaluation question, that are well-thought out, action-oriented and practically possible to implement. Recommendations are required around thematic areas such as sustainability, promising strategies for scale up, management, coordination/collaboration and partnerships among other areas that will come up.

C.1.8: Threats to validity

IBTCI is required to manage the evaluation team and 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. It is therefore expected that IBTCI will take the evaluation team through the parameters outlined on the USAID's "Checklist for Reducing Threats to Validity for Qualitative Methods".

C.1.6: Evaluation Design Matrix: Illustrative evaluation sub-questions, evidence type, data sources, sampling methods and data analysis methods.

Main Evaluation	Evaluation Sub-Question	Type of Evidence	Data Source/ Collection Methods	Sampling Method/ Selection Criteria	Data Analysis Method
1. **For each APHIAPlus activity, what is the status of the expected health outcomes and to the extent possible, what is the activity's contribution to the observed health outcomes?**	a) Based on the activity's theory of change, what have been the actual inputs of the activity in key result/intermediate results at the county, sub-county, health facility and community levels? b) How have these activity inputs led to the observed health outcomes at the level of analysis? c) What progress has been made towards the achievement of the expected intermediate and end health outcomes by each intermediate result? d) How did the APHIAPlus integration model work for and/or against the achievement of results in each of the key service delivery programs areas (HIV/AIDS, RMNCH, malaria and local capacity building)? e) How did synergies, collaboration or coordination between different program areas and/or between different USG activities contribute if any, to the observed health outcomes? f) What other service delivery support systems/structures has the activity initiated and/or strengthened at the county, sub-county, facility and community levels?	• Comparative, • Analytic, • Contribution, • Exploratory	• Desk Review • Data abstraction • Focus Group Discussions • Key Informant Interviews • In-depth Interviews	Systematic random sampling Purposive sampling	Basic statistical analysis Trend analysis Content analysis Contribution analysis Comparative analysis Exploratory analysis

Main Evaluation	Evaluation Sub-Question	Type of Evidence	Data Source/ Collection Methods	Sampling Method/ Selection Criteria	Data Analysis Method
2. For each APHIAPlus activity what are the prospects for the sustainability of the implemented strategies and/or systems and structures that contributed to the observed health outcomes produced by this activity?	a) How effective was the capacity building of county/health facility management teams, health care workers and local CBOs/NGOs? b) Is the local capacity (county and facility level) and CBOs developed enough to sustain observed outcomes? c) What implementation models can be replicated in other geographic locations of the country? d) What are the weakest systems/structures at facility, community and administrative levels that might hamper the continuation of the services?	• Comparative, • Analytic, • Contribution, • Exploratory	• Desk Review • Data abstraction from different sources • Focus Group Discussions • Key Informant Interviews • In-depth Interviews	Systematic random sampling Purposive sampling	Trend analysis Content analysis Contribution analysis Comparative analysis Case study analysis
3. For each APHIAPlus activity, what implementation challenges did the activity face during the implementation period? What are the key programmatic and management lessons learnt?	a) To what extent has the coordination and collaboration between national mechanisms and the activity affected the achievement of expected outcomes? b) What suggestions do you have for addressing the design shortfalls if any in (a) above? c) What adjustments were made by the activity to reflect changes in the operating environment including the devolution process and to what extent did these changes impact the implementation? d) To what extent has the implementation of national and	• Comparative, • Analytic, • Contribution, • Exploratory	• Desk Review • Focus Group Discussions • Key Informant Interviews • In-depth Interviews	Systematic random sampling Purposive sampling	Content analysis Comparative analysis Case study analysis

Main Evaluation	Evaluation Sub-Question	Type of Evidence	Data Source/ Collection Methods	Sampling Method/ Selection Criteria	Data Analysis Method
	global level policy/guidelines such as PEPFAR blue print, RMNCH strategic shifts affected the original APHIAPlus design and activity implementation? e) What important lessons on the activity design and support to MOH/CHMT has the activity learnt over the implementation period?				
4. Based on the analysis of the evidence generated by this evaluation, what activity implementation strategies and/or approaches are more effective and how can they be scaled up in similar future activities?	a) What are the more effective implementation strategies including local capacity development models with potential for scale up in similar future activities? b) What activity management models (partner level and USAID for oversight, guidance and direction on overall vision) are more effective and efficient in producing better health outcomes and accountability for results?	• Comparative, • Analytic, • Contribution, • Exploratory	• Data triangulation • Evaluation team brainstorming sessions • Expert(s) consultations	Snowball sampling especially for expert consultations	Content analysis Comparative analysis Case study analysis

C.1.7. Limitations to the Proposed Evaluation Design and Methodology

The known data limitations are twofold: 1) data quality and 2) availability of data 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), collection, collation and reporting of data, especially longitudinal data, is always incomplete and does not reflect the actual outputs. Availability of health records at health facilities is a major limitation especially for the records that cover earlier periods that goes back to 2010. Recall bias from health care workers is another major limitation especially in situations where facilities have gone through staff transfers. Contribution analysis is based on the activity's theory of change and determination of the actual inputs that directly correspond to the every priority outcome indicator could prove challenging. The completeness and accuracy of the reconstructed baseline data on selected indicators is another potential limitation. IBTCI is expected to propose ways through which such limitations will be addressed and/or minimized to the extent possible.

D. TEAM COMPOSITION

It is anticipated that the evaluation will be carried out by an eleven-person team ("evaluation team"). Given that this SOW is used to cover three activities, a three member sub-evaluation team with one of the technical experts designated as the regional team leader will be based in Nakuru (APHIAPlus Rift), Kisumu (APHIAPlus Western Kenya) and Embu (APHIAPlus Central Eastern/KAMILI). The evaluation team will be assisted by six research assistants who will mainly support data collection processes as will be determined by the team leader and/or her/his regional designate. Research assistants will only be used for a period of 48 days including Saturday and they are not considered part of the evaluation team. Team leader and technical experts will have the following specific expertise and experience:

1) **Team Leader (TL):** The TL will be a senior expatriate (Health/Population/Nutrition/HIV-AIDS Analyst) in public health with strong program management and team leadership experience, especially in managing evaluation teams in developing countries. S/he will have a master's degree and significant experience in program management, team leadership and evaluation is required. 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 IBTCI will present to USAID for review a copy of the last three evaluations that he/she led 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 as guided by the senior M&E expert.

2) **Public Health Evaluation experts (PH experts) (3):** Each Public Health Evaluation expert will be a senior local (Health/Population/Nutrition/HIV-AIDS Analyst) expert, and must be a clinician with a master's degree in Public Health or International Development, Social Science or a closely related field. S/he will have significant work experience in HIV/AIDS programming especially in HIV care and treatment and HIV/TB program areas. Experience in participatory evaluation methodologies, design, and end of program evaluations with between six to eight 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 RMCH and SS experts 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.

3) **Reproductive, Maternal Child Health Evaluation experts (RMCH experts) (3):** Each Reproductive, Maternal Child Health Evaluation expert must be a senior local (Health/Population/Nutrition/HIV/AIDS Analyst) expert with a master's degree in Public Health or International Development. S/he will have significant work experience in RMNCH programming areas. Experience in participatory evaluation methodologies, design, and end of program evaluations with between six to eight 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. While working with PH and SS experts, 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.

4) **Social Scientist experts (SS experts) (3):** Each Social Scientist expert will be a senior local (Social Scientist/Other Technical Advisor) social scientist with strong understanding of OVC and other HIV prevention programming in Sub-Saharan Africa. S/he must have a master degree in public health, anthropology, social work/sociology and/or any other related field with a working experience in participatory evaluation methodologies, design and end of program evaluations, and between five and six years' experience working 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. While working with RMCH and PH experts s/he will provide technical area leadership in OVC, social determinants of health, and in other social-related technical area interventions in the data collection, analysis of key findings, development of substantive and evidence based conclusions and action-oriented and practical recommendations.

5) **Senior M&E Expert (1):** The M&E Expert will be a senior local (Monitoring and Evaluation or Research Specialist) with a master's 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 between 7 – 10 years' experience in participatory evaluation methodologies, qualitative data analytical techniques that include ability to triangulate findings from different methods. Proof of participation in end of program evaluations is a must.

6) **Research Assistants (6):** Each Research Assistant will be a university graduate in social sciences disciplines such as sociology, M&E, information management, anthropology and project management who will assist in, among other tasks, reconstructing baseline values and/or validating sampled values. The person will also assist recordings during KII and/or FGDs.

Evaluation Management:
IBTCI will provide overall direction to the evaluation team; avail all the key project documents, provide all the logistical support required to perform this evaluation. IBTCI/evaluation team shall be responsible for arranging all roundtable discussions, Key Informant Interviews (KII) and booking meeting places. **An evaluation team of 3 (public health evaluation expert, reproductive, maternal child health**

evaluation expert and social scientist expert) upon finalization and approval of evaluation work plan, will move to each of the activity's region and be based there throughout the data collection process. IBTCI is responsible for quality control and delivery of the required report as agreed to by USAID. IBTCI shall be responsible for arranging all domestic travel and hotel arrangements for the selected county health executives listed below.

E. TASKS AND DELIVERABLES:
IBTCI will submit a timetable for all the deliverables together with the work plan and/or proposal for carrying out this SOW.

A. **Briefings**: The evaluation team will provide regular in-country briefs to USAID/Kenya on progress and discuss problems and issues including data collection challenges every two weeks via email communications. A mid-term briefing will be held at the mid-point of data collection process and every designated regional team leader will make a presentation on the progress made by mid-point and include any data collection challenges that would require USAID/Kenya's attention. Additional debriefings will be convened as required and upon agreement by the two parties.

B. **Proposal/Work plan**: The evaluation team will provide a detailed proposal/work plan to USAID before commencing the evaluation. The proposal/work plan will outline how the evaluation will be undertaken, the methods to be used considering the proposed methods in this SOW and the data analysis plan for every main evaluation question. The work plan must be approved by USAID/Kenya before commencing field work.

C. **In-Country Presentation**: The evaluation team will make an in-country PowerPoint presentation with handouts to USAID and other stakeholders on the main findings at the end of the evaluation and before the draft report is written.

D. **Draft Report**: Acceptance of the draft report by USAID/Kenya will be contingent upon the report adequately fulfilling the scope of work and addressing major important areas of inquiry outlined in the SOW and meeting the requirements as presented in the USAID evaluation checklist. The format of the draft report will follow the required format for the final evaluation report as outlined in Section F.

E. **Final Evaluation Report.** Upon final approval of the content by USAID/Kenya, IBTCI will share the edited and formatted report with USAID for clearance before producing the final report. The final report will be submitted both electronically and in hard copy. Four hard copies of the report will be provided to USAID/Kenya. In addition, all the raw data will be submitted to USAID on CD labeled "APHIAPlus EOP Data" for future reference. Once USAID approves the final report, IBTCI will submit it to the Development Experience Clearinghouse (DEC) as provided for in the ESPS contract. All raw data, supporting documents and Metadata will be submitted to USAID and the Development Data Library (DDL) in nonproprietary formats- CSVs, XMLS or JSONs as per ADS 579.3.2.2.

F. **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 50 pages:

1. Table of Contents **(1pg);**

2. Executive Summary— should stand alone as an abbreviated version of the report. All the content in the report is summarized and the summary contains no new information. **(4-5pg);**

3. Evaluation Purpose and Questions **(1-2pg);**

4. Activity Background—Summarize the activity, including the problem is was designed to address and the underlying development hypothesis. **(1-3pg);**

5. Methodology and Limitations—brief description of the evaluation methods and why they were chosen, description on data limitations, and impact if any on drawn conclusions/recommendations, constraints and gaps **(5pg);**

6. Key Findings/Conclusions/Recommendations—for each main evaluation question **(30 - 34 pg);**

7. Annexes —that document the evaluation methods, schedules, interview lists and tables should be succinct, pertinent and readable. These include references to bibliographical documentation, meetings, interviews tools, mini survey tools, and focus group discussions.

G. Dissemination Seminar: Organize one national dissemination forum to present key and finalized findings, conclusions, recommendations to the key stakeholders.

Quality of Deliverables: IBTCI must ensure that all evaluation questions in Section B, are met using the evaluation methods, approaches, and procedures stated in Section C in addition to the evaluation methods, approaches and procedures that IBTCI may propose. Additionally, all the reporting requirements in this Section E must be delivered within the time frame of the contract. Finally, the Scope of Work must be carried out by team members who meet the key personnel requirements in Section D, Team Composition. IBTCI is expected to review USAID's requirements and expectations on the draft and final reports as detailed on the "Checklist for Assessing Evaluation Reports", **see** Annex **XVI**. It is important to note that USAID will subject the structure and content of the report to the parameters outlined on the checklist and will use this as a basis for accepting and/or rejecting the reports.

G. DUTY STATION AND PERIOD OF PERFORMANCE

The period of performance for this evaluation is 8 weeks (2 months). The evaluation will begin on or about January 26, 2015 and end no later than March 26, 2015. The place of performance is Nairobi, Kenya as head office for fieldwork coordination but a team of three evaluation experts will be based in Nakuru (APHIAPlus Rift Valley), Kisumu (APHIAPlus Western Kenya) and Embu (APHIAPlus KAMILI). The evaluation team will coordinate the three sub-teams from Nairobi with planned visits to the three regions during the data collection period. A six-day work week is authorized under this contract without premium pay.

H. ESTIMATED COST AND LOE:

The proposed budget for this Scope of Work is $600,000 and its breakdown is provided through an Independent Government Cost Estimate (IGCE) that will be shared with the Contracting Officer. The IGCE provides details on LOE for every team member, travel and associated costs. The proposed budget is based on the estimated number of days that this evaluation will take as detailed out on the IGCE.

ANNEX 9: List of Sites Selected for the Evaluation

APHIAPlus Central/Eastern				
Counties	**Facilities (By Region)**	**LIPs (Support for OVCs)**	**LIPs (implementing EBI)**	**Community Units**
Embu	Embu Provincial General Hospital	Food for the Hungry-Kenya ACK (Anglican Church of Kenya)	Dallas Key Populations	Kangaru CU
Kiambu	Kihara sub-District Hospital Lari Health Care	Ananda Marga Universal Relief Team (AMURT) Cheer up self-help group	Kisima Group Kingeero	Kihara/Gachie/Mahindi/Karia Kirenga CU
Kitui	Muthale Mission Hospital Kauwi Sub-district Hospital	Catholic Diocese of Kitui (Mwingi District)		Kalia CU Kauwi/Kyondon CiU
Murang'a	Muragua District Hospital	Catholic Diocese of Muranga		Mbugua CU
Meru	Meru Central District Hospital Akachiu Health Centre Mutuati Sub-County Hospital Chuka District Hospital	FH COMEHA Young Women Christian Association	Meru Youth Art Program group Nkabune Technical	 Kiunyene CU Kabachi CU Mugirirwa CU
Nyandarua	Bamboo Health Centre	Engineer Broadvision		Bamboo CU
Tharaka Nthi	Tharaka District Hospital	Shepherd of Life		Marimanti CU
Thika	Ngoliba Health Center	Ngoliba		Ngoliba/ Gatiiguru CU

APHIAPlus Rift Valley				
Counties	**Selected Facilities (By Region)**	**LIPs (Support for OVCs)**	**LIPs (implementing EBI)**	**Community Units**
Baringo/Koibatek	Eldama Ravine District Hospital; Esageri Health Centre	Kenya Council of Imams and Ulamaa (KCIU) WOFAK (Mogotio)		Eldama Ravine CU Esageri
Kajiado	Kajiado District Hospital; Ngong Sub-District Hospital; Bisil Health Centre	Beacon of Hope (BOH) Apostles of Jesus AIDS Ministries (AJAM) MAAP (MAA Partners)		Olkiloriti Gichagi Bissil
Laikipia	Nanyuki District Hospital	Living in Faith Association (LIFA)		Majengo
Nakuru	Nakuru PGH; Subukia Health Center; Kabazi Health Centre; Elburgon sub District Hospital	FAIR KCIU - Kenya Council of Imams & Ulamaa Women Fighting AIDS in Kenya (WOFAK) Kabazi	OVC-FAIR K-NOTE I Choose Life Subukia Lady of Victories	Langalanga Subukia East
Narok	Sogoo Health Centre; Narok District Hospital	Catholic Diocese of Ngong' (CDoN) Narok District Network Forum (NADINEF)		Sogoo CU Olotipo CU.

APHIAPlus Western				
Counties	**Facilities (By Region)**	**LIPs (Support for OVCs)**	**LIPs (implementing EBI)**	**Community Units**
Bungoma	Bunguma District Hospital Bumula Health Center Sirisia sub-District Hospital Kopsiro Dispensary	Bungoma HBC (OVCs) Malakisi CIC Milimo SOET	ACE ACE ACE CSA	Ndengelwa Muanda Bisunu Emia
Busia	Amukura District Hospital	Amagoro (ASIT)	ACK-WRCCS ADS Western	Kochek CU
Kakamega	Kakamega PGH Matete Health Center Makunga HC Butere District Hospital	CABDA CAMP TBD Kwisero	KANCO SAIPEH	Shirere A Kivaywa Musango CU Shirembe
Migori	Kuria District Hospital	KDDN		Kehancha
Nyamira	Nyamira District Hospital	Nyamusi Umoja (OVCs)	NOPE** YWCA	Township B
Homa Bay	Rachuonyo District Hospital	Kagwa	KASH	Obisa
Vihiga:	Mbale PRHTC	Gagi (OVC)	i-Choose Life, Africa	Chango CU

ANNEX 10: List of USAID Priority Indicators

33 Priority Outcome Indicators	
1	HIV Retention in Care & Treatment (disaggregated by gender)
2	% HIV+ tested for TB/annually disaggregated by gender
3	% TB/HIV co-infected enrolled into care
4	% HIV+ patients enrolled into care
5	% eligible HIV+ patients started on treatment
6	MTCT rate at 18–24 months
7	Proportion of exposed infants testing at 8 weeks
8	Retention at 9, 18, 24 months
9	Proportion of HIV+ mothers supported on feeding infants & young children
10	Proportion of exposed infants that received regular follow up care
11	Wellbeing of OVC based on Child Status Index (CSI).
12	Enrolment, attendance and progression
13	Adequate shelter, child under good adult care
14	% of births attended by skilled health care worker
15	ANC 1st Visit Coverage among pregnant women
16	ANC 4th Visit Coverage among pregnant women
17	Proportion of children under 1 year fully immunized
18	DPT1 Coverage
19	DPT3 Coverage
20	Measles Coverage
21	% health care workers reporting improved knowledge, attitude and practices
22	% health facilities where TNA was conducted & TNA report available
23	% health care workers that received in-service training by program area (Care & Treatment, PMTCT, MNCH, Nutrition, Records Keeping/Data Use)
24	% health facilities that received activity-supported DHMT/CHMT supportive supervision
25	health facilities with programs performance review forum/committee that meets regularly with meeting records available
26	% youths 15–24 reporting improved HIV knowledge and healthy behaviors (health seeking behavior for HTC, seeking STI treatment, condom negotiation and use, linkage to care and treatment)
27	% targeted youths 15–24 that successfully completed conducted EBI sessions/activities
28	% completion rate of planned EBI activities based on the yearly work plans
29	Existence of established and functional systems/structures for program quality improvement at health facility
30	Existence of Quality Improvement Multi-Disciplinary Committee
31	Use of performance measurement data to improve quality of services
32	Use of national guidelines/protocols by health care workers
33	Use of program data for developing work plans, plan supportive supervision by health managers

ANNEX 11: Additional Data Tables

HIV

Proportion of eligible patients who have been started on ART (source: DHIS)

Row Labels	2011	2012	2013	2014
Kamili	57.8	51.5	57.0	73.9
Rift	39.9	54.6	70.4	61.4
Western	59.8	73.4	65.8	82.0

Proportion Retained on ART at 12 mos. (source: DHIS)

	2012	2013	2014
Kamili	101.3	102.2	93.8
Rift	68.9	68.4	99.4
Western	195.9	318.2	81.4

APHIAPlus Central/Eastern: Selected CCC-related Outcomes, CCC Mini-KAP, July 2015

INDICATOR	GEOGRAPHIC LOCATION		
	Urban	*Rural*	*All Areas*
No. of respondents	16	44	60
Median age of CCC clients (in years)	43 years	42.5 years	43 years
Median duration of enrollment in the CCC (in months)	96 mos.	54 mos.	72 mos.
% of CCC clients referred by CHWs to attend CCC on day of visit	0%	0%	0%
% of CCC clients citing available of 'link desks' at their CCC	88%	41%	53%
% of CCC clients who have used 'link desks'	15%	53%	37%
% of CCC clients currently on ARVs	96%	100%	97%
% of CCC clients who have forgotten to take their ARVs in the past 30 days	--	--	24%

APHIAPlus Central/Eastern: CCC Client Exposure to Selected Interventions, CCC Mini-KAP, July 2015

INDICATOR	
	All Areas
No. of respondents	60
% of CCC clients exposed to selected intervention strategies:	
• Disclosure of HIV status	100%
• Partner HIV testing	87%
• Secondary HIV prevention	100%
• STI screening	67%
• STI prevention	95%
• Linkages to PLHIV support groups	67%
• TB screening	70%
• TB treatment	58%
• FP counseling/commodities	77%
• Screening for cervical cancer	50%
• Training on financial literacy	18%
• Linkages/referral to cash transfer schemes	5%
• Linkages/referral to UWEZO	15%
• Linkages/referral to microfinance initiatives	5%
• Training on high-yield agriculture	18%

APHIAPlus Rift Valley: Selected CCC-related Outcomes, CCC Mini-KAP, July 2015

INDICATOR	GEOGRAPHIC LOCATION		
	Urban	*Rural*	*All Areas*
No. of respondents	5	55	60
Median age of CCC clients (in years)	46 years	36 years	37.5 years
Median duration of CCC enrollment (in months)	24 mos.	36 mos.	36 mos.
% of CCC clients referred by CHWs to attend CCC on day of visit	NC	--	3%
% of CCC clients citing available of 'link desks' at their CCC	NC	--	50%
% of CCC clients who have used 'link desks'	NC	--	87%
% of CCC clients currently on ARVs	NC	--	93%
% of CCC clients who have forgotten to take their ARVs in the past 30 days	NC	--	13%

NC = Not calculated due to small number of cases

APHIAPlus Rift Valley: CCC Client Exposure to Selected Interventions, CCC Mini-KAP, July 2015

INDICATOR		
	All Areas	
No. of respondents	60	
% of CCC clients exposed to selected intervention strategies:		
• Disclosure of HIV status	77%	
• Partner HIV testing	53%	
• Secondary HIV prevention	85%	
• STI screening	42%	
• STI prevention	80%	
• Linkages to PLHIV support groups	47%	
• TB screening	40%	
• TB treatment	33%	
• FP counseling/commodities	43%	
• Screening for cervical cancer	22%	
• Training on financial literacy	32%	
• Linkages/referral to cash transfer schemes	5%	
• Linkages/referral to UWEZO	13%	
• Linkages/referral to microfinance initiatives	15%	
• Training on high-yield agriculture	25%	

APHIAPlus Western Kenya: Selected CCC-related Outcomes, CCC Mini-KAP, July 2015

INDICATOR	GEOGRAPHIC LOCATION		
	Urban	*Rural*	*All Areas*
No. of respondents	31	34	65
Median age of CCC clients (in years)	40 years	44.5 years	44 years
Median duration of CCC enrolment (in months)	60 mos.	48 mos.	48 mos.
% of CCC clients referred by CHWs to attend CCC on day of visit	0%	3%	2%
% of CCC clients citing available of 'link desks' at their CCC	67%	47%	56%
% of CCC clients who have used 'link desks'	57%	63%	59%
% of CCC clients currently on ARVs	--	--	98%

INDICATOR	GEOGRAPHIC LOCATION		
	Urban	*Rural*	*All Areas*
% of CCC clients who have forgotten to take their ARVs in the past 30 days	--	--	22%

APHIAPlus Western Kenya: CCC Client Exposure to Selected Interventions, CCC Mini-KAP, July 2015

INDICATOR	*All Areas*
No. of respondents	65
% of CCC clients exposed to selected intervention strategies:	
• Disclosure of HIV status	94%
• Partner HIV testing	82%
• Secondary HIV prevention	92%
• STI screening	67%
• STI prevention	74%
• Linkages to PLHIV support groups	63%
• TB screening	57%
• TB treatment	31%
• FP counseling/commodities	63%
• Screening for cervical cancer	25%
• Training on financial literacy	35%
• Linkages/referral to cash transfer schemes	18%
• Linkages/referral to UWEZO	23%
• Linkages/referral to microfinance initiatives	20%
• Training on high-yield agriculture	58%

PMTCT

HEI testing and PCR Results at 2 Months (8 weeks)
(SOURCE: Abstracted data from HEI registers, n=38 facilities)

APHIAPlus Activity	HEI tested at 2months				Positive PCR results @ 2months			
	2010	2011	2012	2013	2010	2011	2012	2013
Central/Eastern	72.1%	80.9%	82.0%	92.3%	3.2%	3.9%	2.0%	6.9%
Rift	37.5%	92.2%	95.2%	92.2%	0.0%	6.3%	5.7%	11.9%
Western	64.7%	72.2%	85.8%	94.3%	4.5%	8.5%	11.0%	23.6%

HEI Retention at 9 months
(SOURCE: Abstracted data from HEI registers, n=38 facilities)

APHIAPlus Activity	2010	2011	2012	2013
Central/Eastern	67.4%	53.2%	59.8%	74.6%
Rift	50.0%	23.4%	60.5%	64.2%
Western	29.4%	33.0%	62.2%	67.7%

HEI Retention at 18 months
(SOURCE: Abstracted data from HEI registers, n=38 facilities)

	Retention at 18 months			
	2010	2011	2012	2013
Central/Eastern	27.9%	34.0%	48.4%	51.4%
Rift	50.0%	15.6%	38.9%	39.4%
Western	32.4%	19.8%	40.7%	27.1%

Proportion of HIV+ mothers supported on feeding infants & young children
(SOURCE: Abstracted data from HEI register; n=38 facilities)

	IYCF Counseling for HEI and their mothers			
	2010	2011	2012	2013
Central/Eastern	36.1%	68.3%	92.6%	93.5%
Rift	90.6%	90.2%	93.0%	74.6%
Western	21.2%	50.8%	35.2%	39.9%

Proportion of exposed infants that received regular follow up care
(SOURCE: Abstracted data from HEI register; n=38 facilities)

	HEI in active follow-up				
	2010	2011	2012	2013	2014
Central/Eastern	No data	No data	No data	81.6	54.1
Rift	No data	No data	No data	88.0	87.5
Western	No data	90.9	88.9	69.5	66.85

MNCH

APHIAPlus Rift: Status of Selected MNCH Outcomes, 2015 MNCH Mini-KAP

INDICATOR	GEOGRAPHIC LOCATION		
	URBAN	RURAL	ALL AREAS
No. of respondents with at least one child under 5 years	23	22	45
Skilled delivery attendance (%)	96%	91%	93%
% of deliveries assisted by traditional birth attendants	NC	NC	4%
% of deliveries assisted by CHWs	0%	0%	0%
ANC-1 Coverage (%)	100%	100%	100%
ANC-4 Coverage (%)	68%	68%	67%

NC= not calculated due to the small number of cases

APHIAPlus Central/Eastern: Status of Selected MNCH Outcomes, MNCH Mini-KAP, 2015

INDICATOR	GEOGRAPHIC LOCATION		
	URBAN	RURAL	ALL AREAS
No. of women with at least one child under 5 years	6	30	36
Skilled delivery attendance (%)	100%	93%	94%
% of deliveries assisted by traditional birth attendants	0%	0%	0%
% of deliveries assisted by CHWs	0%	0%	0%
ANC-1 Coverage (%)	100%	97%	97%
ANC-4 Coverage (%)	*(57%)*	33%	53%

APHIAPlus Western Kenya, Status of Selected MNCH Outcomes, MNCH Mini-KAP, 2015

INDICATOR	GEOGRAPHIC LOCATION		
	URBAN	RURAL	ALL AREAS
No. of women with at least one child under 5 years	23	22	45
Skilled delivery attendance (%)	78%	64%	71%
% of deliveries assisted by traditional birth attendants	13%	18%	16%
% of deliveries assisted by CHWs	0%	5%	2%
ANC-1 Coverage	100%	100%	100%
ANC-4 Coverage	70%	45%	58%

Data source: MNCH Mini-KAP, 2015

	APHIAPlus Western	APHIAPlus Rift	APHIAPlus Central/Eastern
% of MNCH KAP Respondents Who Have Had Contact with CHWs	58%	20%	15%

YOUTH

APHIAPlus Rift Valley: Selected Youth HIV-related Outcomes, Youth Mini-KAP, July 2015

INDICATOR	GEOGRAPHIC LOCATION		
	Urban	*Rural*	*All Areas*
No. of respondents	15	26	41
% with correct knowledge of HIV	33%	46%	41%
% of youth who know of a place where youth can get an HIV test	93%	100%	98%
% ever tested for HIV	87%	85%	85%
% of youth who have been tested for HIV in the last 12 months and received the results	92%	95%	94%
% of youth who have ever had sex	87%	77%	80%
% of youth with two or more sex partners in the past 12 months	13%	19%	17%
% of sexually active youth reporting condom use at last higher risk sex	50%	80%	71%
% of youth with signs of an STI in the past 12 months	15%	15%	15%
% of youth with signs of an STI in the past 12 months who sought treatment for the STI	NC	NC	40%

NC = Not calculated due to small number of cases

APHIAPlus Central/Eastern: Youth HIV-related Outcomes, Youth Mini-KAP, July 2015

INDICATOR	GEOGRAPHIC LOCATION		
	Urban	*Rural*	*All Areas*
No. of respondents	26	5	31
% with correct knowledge of HIV	73%	NC	68%
% of youth who know of a place where youth can get an HIV test	100%	NC	97%
% ever tested for HIV	92%	100%	94%
% of youth who have been tested for HIV in the last 12 months and received the results	96%	100%	97%
% of youth who have ever had sex	77%	NC	77%
% of youth with two or more sex partners in the past 12 months	%	NC	19%
% of sexually active youth reporting condom use at last higher risk sex	100%	NC	100%
% of youth with signs of an STI in the past 12 months	8%	NC	8%

% of youth with signs of an STI in the past 12 months who sought treatment for the STI	NC	NC	NC

NC = Not calculated due to small number of cases

APHIAPlus Western Kenya: Youth HIV-related Outcomes, Mini-KAP, July 2015

INDICATOR	GEOGRAPHIC LOCATION		
	Urban	*Rural*	*All Areas*
No. of respondents	29	10	39
% with correct knowledge of HIV	86%	90%	87%
% of youth who know of a place where youth can get an HIV test	97%	90%	95%
% ever tested for HIV	100%	100%	100%
% of youth who have been tested for HIV in the last 12 months and received the results	83%	80%	82%
% of youth who have ever had sex	100%	100%	100%
% of youth with two or more sex partners in the past 12 months	38%	30%	36%
% of sexually active youth reporting condom use at last higher risk sex	82%	33%	71%
% of youth with signs of an STI in the past 12 months	14%	0%	10%
% of youth with signs of an STI in the past 12 months who sought treatment for the STI	NC	NC	50%

NC = Not calculated due to small number of cases

OVCs

APHIAPlus Rift Valley: OVC Caregiver Exposure to Various Interventions, OVC Caregiver Mini-KAP, July 2015

INDICATOR	% Participating in/Receiving
Membership in Savings and Internal Lending Communities (SILC)	81%
Individual or group income-generating activities (IGAs)	83%
Participated in LIP special training/sessions on OVCs	97%
Assisted by LIP to access support or services (e.g., by the GoK or Constituencies Dev. Fund)	66%
% reporting that they are currently receiving specific types of support for their OVCs	
• educational support	98%
• medical support	70%
• food and nutrition support	65%
• household economic strengthening support	38%
• child protection support	63%
• psychosocial support	68%

APHIAPlus Central/Eastern: OVC Caregiver Exposure to Various Support Interventions, OVC Mini-KAP, July 2015

INDICATOR	% Participating in/Receiving
Membership in Savings and Internal Lending Communities (SILC)	77%
Individual or group income-generating activities (IGAs)	73%
Participated in LIP special training/sessions on OVCs	92%
Assisted by LIP to access support or services (e.g., by the GoK or Constituencies Dev. Fund)	52%
% reporting that they are currently receiving specific types of support for their OVCs	
• educational support	98%
• medical support	55%
• food and nutrition support	59%

• household economic strengthening support	67%
• child protection support	88%
• psychosocial support	36%

APHIAPlus Western: OVC Caregiver Exposure to Various Support Interventions, July 2015

INDICATOR	% Participating in/Receiving
Membership in Savings and Internal Lending Communities (SILC)	78%
Individual or group income-generating activities (IGAs)	89%
Participated in LIP special training/sessions on OVCs	95%
Assisted by LIP to access support or services (e.g., by the GoK or Constituencies Dev. Fund)	68%
% reporting that they are currently receiving specific types of support for their OVCs	
• educational support	100%
• medical support	35%
• food and nutrition support	69%
• household economic strengthening support	43%
• child protection support	77%
• psychosocial support	54%

ANNEX 12: Complete List of Evaluation Team Members and Contributors

APHIAPLUS EVALUATION TEAM		
No.	**Name**	**Assigned Role**
1	Philip Wambua[435]	Team Leader
2	Donna Espeut, PhD	IBTCI/ESPS STTA (Senior Evaluation Specialist, Lead Author and de-factor TL)
3	Haron Njiru	Data Manager
	Western/Nyanza Team	
1	Kennedy Manyonyi	Sub-Team Leader
2	Johnstone Kuya	RMNCH Expert
3	Joseph Ochieng'	Social Science Expert
4	Lorraine Koyengo	Research Assistant
5	Derrick Hamadi	Research Assistant
6	Alfred Maero	Research Assistant
7	Eunice Were	Transcriber
8	Ben Kwach	Transcriber
	Rift Valley Team	
1	John Kimani	Sub-Team Leader
2	Margaret Makumi	Public Health Expert
3	Jack Buong'	Social Science Expert
4	Caroline Mramba	Research Assistant
5	Deborah Sang	Research Assistant
6	Susan Gathuthu	Research Assistant
7	Narkiso Owino	Transcriber
8	Nelson Omondi	Transcriber
	Central/Eastern Team	
1	Teresa Kinyari	Sub-Team Leader
2	Ruth Muthoni	Public Health Expert
3	Stephen Gichobi	Social Science Expert
4	Janette Munyi	Research Assistant
5	Jackson Musembi	Research Assistant
6	Eric Mugendi	Research Assistant
7	Wangechi Matindi	Transcriber
8	Florence Thungu	Transcriber

[435] Philip Wambua was the TL for Phases 1 and 2 after which he departed and Donna Espeut became de-facto TL

	IBTCI SUPPORT TEAM	
	Evaluation Tech. Support	
1	Cynthia Scarlett	ESPS Western/Nyanza focal point
2	Paul Mwai	ESPS Central/Eastern focal point
3	Maxwel Omondi	ESPS Rift Valley focal point
	Logistics	
1	Apollonia Ochieng	Western/Nyanza
2	Caroline Mbithuka	Rift Valley
3	Daniel Muli	Central/Eastern/National
4	Rosemary Were	Central/Eastern/National

ANNEX 13: Key Personnel CVs

Mr. Philip Wambua **Nationality:** Kenyan **Affiliation:** IBTCI

Position Title: Public Health Expert
Labor Category: Health/Population/Nutrition/HIV-AIDS Analyst

Education/Study:

PhD, Public Health, Jomo Kenyatta University of Agriculture	Ongoing
Master in Public Health (MPH), Kenyatta University	2007
BSc, Environmental Health, Moi University	2000

Relevant Experience:
Mr. Philip Wambua has over 15 years' experience in Public Health programming. He has consulted in most Eastern and Southern African Countries. His key programming areas include: HIV and AIDS, malaria programming, reproductive, maternal, and newborn and child health. Mr. Wambua is knowledgeable in program design, implementation, monitoring and evaluation and has excellent experience in both qualitative and quantitative research. As a Kenyan Public Health Specialist, he has a clear understanding of the Kenyan health systems and structure.

Selected Professional Experience: **Consultancies**

JSI USA Maternal and Child Health Integrated Program (MCHIP) **Team Member**
2015: Conducted qualitative research and report writing for two USAID-supported projects in Uganda and Zambia.

UNICEF RMNCH Trust Fund New York **Team Member**
2014: Consulted with the Ministry of Health Uganda, H4+ counterparts (WHO, UNICEF & UNFPA to identify RMNCH priorities, funding gaps and developed proposals to RMNCH trust fund.

HelpAge International: **Team Member**
2014: Developed a program design focusing on analysis detailing impact of HIV/AIDS on older people including care givers for OVC and people living with HIV/AIDS in Uganda and Kenya. Designed an innovative program model.

Mothers to Mothers **Team Member**
2014: Conducted situational analysis on OVC, ECD and RMCH initiatives.

UNICEF USA, Sierra Leone **Team Member**
2014: Provided technical assistance to the Ministry of Health in Sierra Leone to map out and align resources for implementing RMNCH interventions.

MCHIP, Kenya
2014: Conducted literature review and documented local evidence on the use of RDTs by CHWs.

ICCM Secretariat USA **Technical Assistance Consultant**
2014: Provided technical support to Ministry of Health Kenya in review of the National Malaria Strategic Plan, ensured inclusion of integrated community case management.

Save the Children **Team member**
2014: Provided support to SADC in development of minimum standards for Sexual Reproductive Health and HIV/AIDS integration.

IBTCI **Public Health Specialist**
2013: Provided technical advice in designing evaluations for USAID funded health programs in Kenya.

SIDA **Lead Consultant**
2013: Conducted an end term evaluation of Sida funded Eastern and Southern Africa Program.

UNFPA/MOH Rwanda **Team Leader**
2013: Conducted national rapid assessment on SRHR and HIV/AIDS integration.

BraodReach Health Care LLC; APHIAPlus IMARISHA **Team Leader**
2013: Provided programmatic leadership for BroadReach Health Care staff within the USAID funded Maternal and Newborn Child Health and HIV/AIDS program.

Columbia Global Centers Africa **Regional HIV/AIDS Advisor**
2010-2012: Provided advisory services for integration of PMTCT into Maternal, Neonatal and Child Health in the MDG supported Millennium Villages in Southern and Eastern Africa countries.

UNFPA/MOH Zimbabwe **Team Leader**
Led a national team in conducting a national rapid assessment on SRH and HIV integration. Key areas of responsibility included development of qualitative assessment tools, KII and FGDs.

Languages:
English (fluent); Kiswahili (fluent); Kamba (Native)

Dr. Donna A. Espeut **Nationality:** American **Affiliation:** IBTCI

Position Title: Monitoring & Evaluation Expert
Labor Category: Monitoring and Evaluation or Research Specialist

Education/Study:

Doctor of Philosophy **(Ph.D),** RH&FP
John Hopkins University School of Hygiene & Public Health 2002
Master of Health Science **(M.H.S)**
John Hopkins University School of Hygiene & Public Health 1995
Bachelor of Arts, **(A.B),** Human Biology,
Stanford University 1993

Relevant Experience:

Dr. Espeut has over 26 years' experience in global health (Monitoring and Evaluation; Reproductive, Maternal, Neonatal and Child Health; HIV/AIDS; Sexual Transmitted Infection (STI); TB; Child Survival; Nutrition; Health System Strengthening). She has worked with numerous donor organization (I-TECH, CCF, JHPIEGO, Macro International, FHI, DFID, WHO, CDC, MSI, John Snow, UNICEF, UNDP, Health Poverty Action, PATH, CREDES). Dr. Espeut has excellent skills in project management, including development of performance monitoring plans, M&E work plans, quantitative & qualitative data analysis, survey methodology, policy analysis, data management, as well as documentation and dissemination of results. She has authored and co-authored numerous papers in health and peer-reviewed journals.

Selected Professional Experience: **Consultancies**

United Nations Children's Fund – Ethiopia (UNICEF) **Expert**
2015: Conducted a national equity situation analysis update of children and women in Ethiopia.

PATH **Expert**
2015: Prepared nutrition country brief for Kenya, Pakistan, Myanmar, Nigeria and Uganda for the European Commission project.

World Health Organization (WHO) – Global **Expert**
2013: Supported development of operational guidelines on sustaining maternal and neonatal tetanus elimination worldwide.

United Nations Children's Fund – Sierra Leone (UNICEF) **Expert**
2014: Conducted a national, multi-sectorial situation analysis on children's and women rights in Sierra Leone.

Health Poverty Action – Somaliland **Evaluator**
2013: Evaluated two European Commission (EC) funded projects addressing sexual and gender - based violence and sexual and reproductive health among internally displaced persons in Maroodi Jeex Somaliland.

Concern Worldwide U.S- New York **Deputy Director**
2011-2012: Provided strategic direction, technical leadership and quality assurance for a US$41 million, multi-country health innovation initiative funded by the Bill & Melinda Gates Foundation.

DFID Kenya **Team Member**
2012: Provided M&E support to grantees of DFID's 2009-2013 Kenya Health Program.

Marie Stopes International (MSI) - Kenya **Regional Research Manager**
2009-2010: Led sexual and reproductive health specialists in Pakistan and sub-Saharan Africa in research and M&E.

International HIV/AIDS Alliance **Team Member**
2007: Conducted female condom assessments among female sex workers.

U.S Centers for Disease Control & Prevention – Trinidad **Team Leader**
2005-2006: Led U.S Government HIV specialists and regional health agencies in the areas of HIV/TB M&E and surveillance.

Family Health International, Kenya **Senior Technical Officer**
2004-2005: Strengthened HIV/STI TB planning, M&E and knowledge management efforts in Eritrea and neighboring countries.

CREDES – Caribbean **Public Health Expert**
2003: Conducted midterm evaluation of the European Union's strengthening the Institutional Response to HIV/AIDS/STI (SIRHASC) Project.

Macro International, Inc. **Reproductive Health & HIV/AIDS Specialist**
1999-2004: Assisted NGOs funded by USAID with design, implementation and M&E of community based health and nutrition projects across the globe.

John Snow, Inc. **Research Specialist**
1996-1998: Supported research and knowledge management efforts related to maternal and perinatal health in focus countries (Bolivia, Egypt, Indonesia)

Languages:
English (fluent); Spanish (proficient); French (working knowledge)

Kennedy A. Manyonyi **Nationality:** Kenyan **Affiliations:** IBTCI

Position Title: Public Health Expert
Labor Category: Health/Population/Nutrition/HIV-AIDS Analyst

Education:

Diploma in Palliative Medicine (DipPallMed), University of Wales	2001
DLSHTM, London School of Hygiene & Tropical Medicine	1996
Diploma in Tropical Medicine & Hygiene (DTM&H), Royal College of Physicians of London	1995
MSc Infection & Health in the Tropics, (Tropical Medicine & HIV), University of London, UK	1995
MB ChB (Bachelor of Medicine & Bachelor of Surgery), University of Nairobi, Kenya	1989

Relevant Experience:
Dr. Manyonyi has over 20 years' experience in conceptualizing, establishing, managing, monitoring and evaluating health programs in diverse rural areas and informal urban settings in Eastern Africa. He is highly skilled in molding multi-disciplinary teams to pursue extra-ordinary assignments in a manner that delivers outstanding program results against demanding targets. Dr. Manyonyi is familiar with the requirements of various donors and is comfortable with most of the commonly employed rapid assessment approaches as well as program monitoring and evaluation methodologies, with an excellent command of the English language and report writing skills. Dr. Manyonyi is a diligent and versatile clinician who has ably managed high performance teams.

Selected Professional Experience:

Afya Na Uzima **Team Leader**
2014: Designed and established a one-stop comprehensive and affordable outpatient health service targeting low-and-mid-income earners in the informal sector.

AMREF, Kenya **Chief of Party, APHIAPlus Northern Arid Lands**
2012-2013: Led and oversaw the establishment and implementation of an integrated support package for HIV/AIDS, TB, Malaria, RH/FP, Maternal, New born and Child Health, alongside interventions addressing the social determinants of health (Nutrition; access to safe Water; improved Sanitation and Hygiene Education; Livelihoods; plus Household Economic Strengthening) in the eight counties of Kenya's arid north.

Jhpiego, Kenya **Senior Technical Advisor**
2011-2012: Guided various teams to develop and apply technically robust approaches in their respective projects, and instilled a spirit of innovation, as well as a culture of teamwork with attention to key details.

Jhpiego, Kenya **Deputy Project Director, APHIA II Eastern**
2007-2010: Managed Jhpiego's first major implementation project that was also the pioneer of health development project in the former Eastern Province of Kenya. Many remarkable achievements of the innovations undertaken by this project inspired the development of the APHIAplus program.

Gedo Health Consortium **Medical Coordinator**
2002-2007: Established, led and managed Somalia's first ever primary health care system and shared the lessons with various players through technical working groups (TWG), for improved program implementation in Malaria, Communicable Disease Control, EPI, TB, HIV, Hospitals development, RH, Lab development, Nutrition & HIS under the auspices of the Somalia Aid Coordination Body (SACB).

AAR Health Services **Head Physician**

2000-2002: Spearheaded the pioneer rescue services in the East African Region, establishing the first three modern medical centers and overseeing service quality assurance for the franchised model of outpatient care.

The Nairobi Hospice **Senior Medical Officer**
1996-1999: Successfully introduced and established Palliative Medicine as a recognized Speciality in Kenya and incorporated it into the training programs of Kenya Medical Training College and University of Nairobi.

Medecins Sans Frontiers, Holland **Volunteer Physician, Dadaab Refugee Camps**
1992: Led the team of Kenya Ministry of Health personnel at Dadaab, the largest refugee camp in the world at that time, in attending to the high influx of refugees fleeing civil strife at the height of the Somalia Crisis.

St Mary's Hospital, Mumias **Medical Officer**
1991-1994: Led the Faith Based Facility's health services and pioneered in community based health care in response to emerging health challenges such as HIV/AIDS, malnutrition and non-communicable diseases.

Languages:
English (Fluent); Kiswahili (Fluent); French (Fluent), Luhya (Native)

Johnstone Kuya **Nationality:** Kenyan **Affiliation:** IBTCI

Position Title: Reproductive Maternal and Child Health Expert
Labor Category: Health/Population/Nutrition/HIV-AIDS Analyst

Education:

PhD Public Health, Texila American University, Guyana	Ongoing
Master of Public Health, (MPH) Manchester Metropolitan University, UK	2013
BSc. Public Health, Kenyatta University, Kenya	2010

Relevant Experience:

Mr. Johnstone Kuya has over 8 years' experience in the field of public health, research and training of health professionals. He possesses extensive experience in managing donor funded public health projects both in developmental and humanitarian contexts in design and implementation in Eastern Africa. He has been involved in several health projects primarily focusing on Reproductive Health, Maternal and Child Health, PMTCT, TB/HIV Water and Sanitation, Livelihood and Nutrition programs funded by EC, DFID, OFDA, UNICEF, WFP, PEPFAR, ECHO and USAID. Mr. Kuya has also been involved in various consultancies in Health Systems Strengthening, Policy and Guidelines Development, Operational Research and conducting baseline assessments, midterm reviews, end term evaluation and surveys as both a team member and team leader. He is knowledgeable in both quantitative and qualitative research methods, statistics, epidemiology, data collection, analysis and data manipulation. Mr. Kuya serves as member of Editorial Board of the "International Journal of Excellence in Healthcare Management" (IJEHM) [ISSN: 19938659] and a member of Research Committee at the Center for the Study of Adolescent.

Selected Professional Experience: **Consultant**

Kisumu Medical Education Trust (KMET) **Co-investigator**
2014-2015: Conducted operational research study on telemedicine system feasible and effective approach to increasing Sexual Reproductive Health (SRH) services and information for 10-24 year olds in Kisumu.

Network of Adolescents and Youth of Africa **Co-investigator**
2014-2015: Conducted operational research on E&M approaches (with reference to Twitter, Facebook and Googleplus) influence access and uptake of SRH information by young people 16-24 years in Nyanza, Kenya.

Sexual and Reproductive Health Rights (SRHR) Alliance **M&E Coordinator**
2014: Provide technical assistance for M&E and OR aspects of Programme**.**

FHOK **Co-investigator**
2014-2015: Conducted operational research exploring the factors and actors that influence usability of SRH services for young people (10-24years) in three different health service provision models: stand-alone, integrated, and regular health facility in Nairobi, Uasin Gishu and Kisumu counties.

Centre for the Study of Adolescence **Co-investigator**
2014-2015: Conducted operational research study on attitudes and perceptions of learners about Sexual and Reproductive Health information through newspaper pullouts in Nyanza, Kenya.

County Government of Nyamira **Lead Trainer**
2014: Conducted training on occupational health and safety for Jua Kali sector.

UNICEF & MOPHS **Survey Data Manager**
2011: Conducted Nutrition Survey in Turkana.

Merlin International **Team Member**
2011: Evaluated Turkana Health and Nutrition Project and provided an impact analysis.

Kenya Anti-corruption Commission **Team Member**
2011: Evaluated the integrity assurance officers' activities under the auspices of the public sector integrity, Kenya Anti-corruption Commission (KACC) Lands Sector corruption survey study in 47 counties.

USAID/Jhpiego **Data Consultant**
2010: Conducted End Term Evaluation of USAID/Jhpiego- AIDS, Population, and Health Integrated Assistance Program (APHIA II Eastern) Project.

AMREF Kitui MNCH Project **Data Consultant**
2010: Conducted Baseline Survey, strengthening community capacity to improve Maternal, Newborn and Child Health in hard-to reach areas of Kenya Kitui and Makindu districts.

UNICEF/MoPHS) **Review Team Member**
2010: Conducted Mid Term review and Evaluated Community Health Strategy in Coast, Eastern, Nyanza, Rift valley, Western and Central provinces.

AMREF **Team Member**
2009: Conducted a Baseline Survey for Kibera community based initiative to improve Maternal New Born and Child Health project.

AMREF –PHASE Project **Team Member**
2009: Conducted Mid Term Evaluation of the AMREF-Kibera PHASE project Moving Phase from Rural to Urban.

Kisumu District Hospital **Public Health Officer Intern**
2008: Provided technical support for training of CHWs on hygiene promotion and HWTs, carried out community health diagnosis.

Languages:
English (Fluent); Kiswahili (Native); Luhya (Native)

Joseph Ochieng **Nationality:** Kenyan **Affiliation:** IBTCI

Position Title: Social Scientist
Labor Category: Social Scientist/Other Technical Advisor

Education:

Masters in Development Studies, University of the Free State, Bloemfontein, South Africa	2012
Diploma in Care and Management of PLHIV Manchester University, UK	2003
Diploma in Clinical Medicine, Kenya Medical Training College, Nairobi, Kenya	1991

Relevant Experience:

Mr. Joseph Ochieng has over 20 years progressive experience in HIV/AIDS, Adolescent Sexual and Reproductive Health (ASRH), and OVC programming in both the civil service and NGO sector. He has wide experience in consortium and grants management, having managed large and complex projects involving different strategic partners working together, and funded by various funding agencies namely: CIDA, and PEPFAR through CDC and USAID. Throughout his work, Mr. Ochieng has gained valuable knowledge in project cycle management including project design, planning, implementation, and monitoring and evaluation. Since 1999, he has been involved in project evaluations in different capacities at the district, provincial and national levels in the areas of health and HIV/AIDS.

Selected Professional Experience: **Consultancies**

MOH Technical Working Group **Researcher**
2014: Evaluated the Leadership, Management and Governance (LMG) implemented by the MOH and development partners i.e. UNICEF, GiZ, JICA, and MSH under the Health Systems Strengthening.

Herald Consultants **Team Member**
2014: Conducted an end term evaluation of the Four Pillars Plus Project implemented by FHI 360 in Siaya County.

Catholic Relief Services **Project Manager/Senior Technical Advisor**
2013-2014: Managed the Social Determinants of Health and OVC component in the APHIAPlus Rift Valley Project funded by PEPFAR through USAID. Managed to improve the OVC service provision reporting rates from 54% at the time of joining the project to 94% at the time he left.

International Medical Corps **Program Manager**
2009-2012: Managed the Kenya Prisons HIV/AIDS and TB Program funded by PEPFAR through CDC as the Regional Manager for Nyanza and Western Provinces.

University of the Free State, South Africa **Researcher**
2012: Assessed the gaps in the care and support services for orphans and vulnerable children in Kisumu West District, Kenya.

Plan Kenya and the Ministry of Health **Team Member**
2007: Conducted a Knowledge, Attitude, Practice and Coverage (KAPC) survey as a baseline in relation to HIV and Aids and OVC situation in Kisumu West district.

Plan Kenya **Project Coordinator**
2005-2009: Managed the OVC care and support project, the adolescent and youth sexual and reproductive health project for Plan Kenya in Kisumu and Bondo districts.

Ministry of Health and Central Bureau of Statistics **Team Member**
2004: Conducted the National Household Economic and Health Survey.

Mildmay International and Ministry of Health **Team Member**
2003: Carried out a participatory action research in relation to quality of HBC services in Nyanza Province.

Family Health International and the Ministry of Health **Team Member**
2000: Conducted a Knowledge, Attitude and Practice (KAP) survey among the communities of Nyanza province in regard to STI/HIV/AIDS.

AMREF and the Ministry of Health **Team Member**
1999: Carried out a survey to assess the quality of STI services provided by private practitioners conducted by AMREF in Nyanza province, as a research assistant.

Languages:
Dholuo (Native); English (Fluent); Kiswahili (Fluent)

John Karuga Kimani **Nationality:** Kenyan **Affiliation:** IBTCI

Position Title: RMNCH Expert
Labor Category: Health/Population/Nutrition/HIV-AIDS Analyst

Education/Study:

PhD Candidate, Public Health	Current
Kenyatta University, Kenya	
MPH	2013
University of London, UK	
Post Graduate Diploma in Public Health	2010
London School of Hygiene and Tropical Medicine	
BSC, Environmental Health	2001
Moi University, Kenya	

Relevant Experience:

Mr. Kimani is a public health professional with 14 years of experience in the design and implementation of health programs in both humanitarian and development. He has provided TA and leadership in the areas of reproductive health, maternal, newborn and child health, communicable disease control (particularly in diarrhea, malaria, HIV/AIDS and TB). Mr. Kimani has experience in designing and implementing M&E plans, data collection, analysis and report writing.

Selected Professional Experience:

HelpAge International **Consultant**

2012-2015: Participated in the validation and piloting of the Health Outcomes Tool (HOT) for evaluation of impact of integrated programming for older people in Africa. Conducted a health equity impact assessment and analysis and developed the strategic plan for improving access to equitable health services for older persons in four countries – Mozambique, Zimbabwe, Tanzania and Ethiopia. Conducted an end-term evaluation of the project *"Ensuring Improved Access for Older People and Other Vulnerable Croups to Treatment for Chronic Conditions and Other Healthcare Support."* Kasasule Community, Kibwezi District. Conducted final impact evaluation of the emergency drought response in Mandera, Kenya.

AMREF **Consultant**

2015 – Conducted an end-of-term review of the Strengthening HIV Strategic Information (SSI) in Kenya project, a five-year PEPFAR-funded project.

Save the Children **Consultant**

2014 – Conducted client satisfaction survey for MCH activities in the Lindi region of Tanzania.

MCHIP Kenya **Consultant**

2014- Documented evidence on the use of malaria rapid diagnostic tests by CHWs in Kenya.

Swedish Cooperative Center **Consultant**

Participated in end-term evaluation of HIVE/AIDS and gender mainstreaming project in Nyanza, Rift and Eastern counties in Kenya.

Essence International **Consultant**

2012 – Conducted KAP survey on MCH in Karkaar Region of Puntland, Somalia.

Family Health Options Kenya/International Planned Parenthood Federation **Consultant**
2011 – Rapid assessment of the implementation of the Minimum Initial Service Package (MISP) for reproductive health, Daadab refugee camps and host communities.

Save the Children UK **Regional Health Advisor**
Emergency Health Advisor (Somalia)
Health Advisor (Kenya)
2010-2014: Provided support and technical support to a number of Save the Children's programs covering Ethiopia, Somalia, Kenya, South Sudan, Tanzania and Rwanda. Led the program team in the design of evidence-based programming. Provided capacity building to staff. Following are a select number of programs to which TA was provided: Delivering Increased Family Planning Access across Rural Kenya. This DFID-funded program aims to reduce the unmet for family planning in Kenya's underserved rural areas by 25%; *Boresha* – accelerating reduction in maternal and newborn mortality in Bungoma County, Kenya. This GSK-funded program aimed at enhancing delivery of high impact MNCH activities at the facility and community levels. Adolescent Girls Initiative Action Research Program. This DFID-funded program targets adolescent girls between the ages of ten and fourteen years improving their access to health, education, economic assets and protection from violence. Operational research was conducted to test which combination of interventions are the most cost effective and achieve the greatest impact for girls.

MERLIN **Program Manager**
2004-2010: Provided program implementation and oversight to a variety of MERLIN activities in Kenya, South Sudan and Somalia including: USAID/PEPFAR-funded HIV/AIDS care and treatment; Global Fund TB, malaria and HIV/AIDS projects; USAID/PMI-funded Malaria Communities project. Oversaw the scale-up of care and treatment services from less than ten to over 50 comprehensive care centers (CCCs). Provided capacity building of over 100 health workers; addressed commodity supply chain; nutrition and WASH programming, disease surveillance and drafted emergency preparedness plans.

Languages:
English (native); Kiswahili (native)

Dr. Margaret Makumi **Nationality:** Kenyan **Affiliation:** IBTCI

Position Title: Public Health Expert
Labor Category: Health/Population/Nutrition/HIV-AIDS Analyst

Education/Study:

MA, Gender Development	Current
Nairobi University, Kenya	
Takemi Fellow in International Health	2004
Harvard School of Public Health	
MPH	1996
Nairobi University, Kenya	
Bachelor of Medicine, Bachelor of Surgery	1988
Nairobi University, Kenya	

Relevant Experience:

Dr. Makumi has over 20 years of experience as a public health specialist in the design, implementation, monitoring and advising programs in HIV/AIDS/TB, RH/FP, gender issues, social determinants for health and institutional strengthening in Kenya and the East Africa region. Her work in HIV/AIDS includes comprehensive care and treatment, HTC, PMTCT and HIV/TB prevention and treatment integration. Dr. Makumi has a proven track record in leadership encompassing programmatic, financial and administrative oversight to complex national health programs that have required on-time reporting to donors, evaluating lessons learned as well as best practices and ensuring staff capacity to implement programs.

Selected Professional Experience: **Consultancies**

International Planned Parenthood Federation **Expert**
2014-2015: Review of Maputo Plan of Action, Mozambique

The Health Rights Advocacy Forum (HERAF) **Researcher**
2014-2015: Conducted baseline assessment on governance and management of the health sector in Narok, Siaya, Kiambu and Isiolo, Kenya
2013 – Conducted study on family planning service provision in Kenya and provide report on GOK investments towards FP contraceptives.

World Bank **Evaluator**
2014 – Validated baseline information collected by the MOH in 2014 of equipment needs in Kenya and provided IFC report on feasibility of MOH requests.

Kenya Medical Association **Researcher**
2013 – Finalized KAP study report on safe and legal abortion and contraception.

Kenya Ministry of Health **Team Member**
2012 – Provided quality assurance and technical assistance in the development of the minimum package for reproductive health and HIV integration services in Kenya at all levels of service delivery.
2010 – Provided quality assurance and technical assistance in the development of PMTCT guidelines.
2010 – Reviewed the 2004-2008 reproductive health research agenda and developed the 2010-2014 research agenda.
2009 – Provided quality assurance and technical assistance in the development of the RH/HIV/AIDS integration strategy.
2005 – Provided quality assurance and technical assistance in the development of the National Health Sector Strategic Plan for Kenya 2005 – 2010.

National AIDS Control Council, Kenya **Team Member**
2009 – Provided quality assurance and technical assistance in the development of the Kenya National AIDS Strategic Plan 2009-2013.
2005 - Provided quality assurance and technical assistance in the development of the Kenya National AIDS Strategic Plan 2005 – 2009.
2003 – Coordinated the development of national program guidelines for OVC.
2002 – Worked on mainstreaming gender into the Kenya National HIV/AIDS Strategic Plan.

AMREF **Researcher**
2005 – Conducted needs assessment of reproductive health services and midwifery training in South Sudan.

DANIDA **Researcher**
2003 – Conducted operational research on the OVCs in three districts of Kenya.

Pathfinder International **Deputy Country Director/Deputy Project Director**
2011-2013: Worked closely with the Country Director to set the strategic direction for the USAID-funded APHIAPlus Nairobi-Coast activity. Responsibilities included work planning, budgeting and monitoring, grants management oversight and ensuring timely reporting to USAID. Provided technical assistance and capacity building to staff as well as technical assistance to the MOH at the national level in the development of RH and HIV policies, strategic plans, clinical standards, guidelines, job aids and training curricula.
2006-2011: Deputy Country Director, APHIA II activity funded by USAID.
2006-2007: Deputy Project Director, APHIA II. Responsible for the implementation of project work plans, preparation of reports, documenting best practices and lessons learned. Capacity building of staff and provided technical assistance to MOH at the national level in the development of RH/HIV policies, strategic plans, clinical standards, protocols and guidelines.

Ministry of Health, Kenya, Division of Continuing Professional Development **Head**
2005-2006: Oversaw the establishment of this new division including the development of work plan and M&E plan, liaised with regulatory bodies to develop criteria for awarding CPD points. Initiated the development of criteria for accreditation of health facilities, training institutions and the national training policy. Coordinated CPD activities of public-sector health care service providers.

Office of the President of Kenya **NACC Field Coordinator**
2002-2004: Responsible for coordinating HIV/AIDS field activities and community HIV response initiatives. Led in the development of policies related to community HIV responses, liaised with stakeholders regarding community HIV response. Conducted program assessments; Developed field coordination units, coordinated training curricula and material, coordinated training to ensure quality. Conducted training in project implementation and financial management to grantees. Visited sites to conduct monitoring.

Kenya Ministry of Health **Deputy Head, Health Sector Reform**
2001 – Responsible for the decentralization component of the GOK Health Sector Reform Secretariat. Coordinated stakeholders and ensured effective implementation of M&E activities geared towards decentralization of health services. Developed guidelines for district work planning. Assisted the Provincial Health Management Teams to develop monitoring plans and facilitative supervision work plans to improve quality of health care provision. Provided TA to the District Health Management Teams

through the PHMTs to develop integrated work plans. Coordinated and facilitated training of health care workers.

Languages:
English (native); Kiswahili (proficient)

Jack Amayo Buong **Nationality:** Kenyan **Affiliation:** IBTCI

Position Title: Social Scientist Expert
Labor Category: Social Scientist/Other Technical Advisor

Education:

Masters in Community Health and Development (MCHD)
Great Lakes University of Kisumu (GLUK), Kisumu, Kenya 2007
B.Ed. Moi University, Eldoret Kenya 1999

Relevant Experience:

Mr. Jack Buong is a community health and development specialist with 11 years' experience in strengthening health systems, health institutions, community health strategy, research and training. He possesses extensive hands on experience in; capacity building in leadership development and health systems, community health and strategy development, research, OVC programming and development. Mr. Buong has broad knowledge in HIV/AIDs prevention, care and control and has participated in researches, surveys and evaluations.

Selected Professional Experience:

2002-Present **Consultant**

Kenya School of Government **Trainer**
2015: Trainer of Trainers-Health Systems Strengthening (HSS)

Management Sciences for Health (MSH) **Team Member**
2014: Consultant on Leadership, Management and Governance (LMG)

Management Sciences for Health **Leadership Management & Governance Tech. Advisor**
2012-2014: Enhanced collaboration between LMS/Kenya and APHIAplus and identified Leadership, Management and Governance (LMG) priorities in the assigned region (Kakamega, Vihiga, Bungoma and Busia counties).

Great Lakes University of Kisumu USAID Funded OVC Program **Program Coordinator**
2009-2012: Coordinated the community based support program funded by USAID in the four technical intervention areas namely: nutrition, early childhood development, HIV/AIDS (OVC care) and microfinance in 4 districts.

Great Lakes University of Kisumu (GLUK) **Partnership Coordinator**
2005-2006: Coordinated TICH-MOH-Community and other partners' capacity building of manpower for community strategy, trainings for Community Health Workers (CHW's), Community Health Extension Workers (CHEW's) and Community Health Committees (CHC's).

Kenya Italian Debt Development program (KIDDP) **Team member**
2009: Designed, trained and carried out a community assessment survey on the contribution of Community Strategy on Health outcomes a quasi-experimental research. Conducted feedback workshop to District stakeholders on the findings, guided action plan on key areas and follow up.

APHIA II-Western -World Vision **Team Member**
2007: Conducted quality assessment aimed at exploring the roles, knowledge, skills and performance of community volunteer service providers, also called Home Visitors (HV) and derived lessons for enhancing their training, supervision and support.

WEMOS –Netherlands, Lusaka Zambia **Researcher**
2007: Participated in a study titled, 'The Effect of Externally Funded programs on Human Resource for Health (HRH) a multi-country study in Kenya and Zambia'.

CARE-Kenya **Facilitator**
2002-2003: Facilitated the Ministry of Education/CARE-Kenya Peer Education Programme.

AMREF **Team Member**
2005: Facilitated baseline survey, AMREF MAANISHA Programme on Knowledge, Practice and Coverage (KPC) on HIV/AIDS in Suba district.

SIMAVI **Team Member**
2005: Participated in the assessment of District Health Systems for improvement towards achieving the Millennium Development Goals.

Languages:
English (Fluent); Kiswahili (Fluent); Luhya and Luo

Dr. Teresa Kinyari Mwendwa **Nationality:** Kenyan **Affiliation:** IBTCI
Position Title: Public Health Expert **Labor Category:** Health/Population/Nutrition/HIV-AIDS Analyst

Education:

Masters Public Health MPH [Epidemiology] University of Washington, Seattle, Washington, USA	2004
Postgraduate Diploma in STI/HIV Control and Management, University of Nairobi, Kenya	2001
Bachelor of Medicine and Bachelor of Surgery (MBChB) University of Nairobi, Kenya	1996
Bachelor of Science in Medical Physiology University of Nairobi, Kenya	1992

Relevant Experience:

Dr. Teresa Kinyari Mwendwa is a skilled and dedicated medical doctor, lecturer and clinical epidemiologist in the Department of Medical Physiology and the University of Nairobi Institute of Tropical and Infectious Diseases. She has over 10 years' experience in teaching and mentoring and over 18 years' experience in infectious disease research especially HIV and malaria. She specifically worked as a service provider in STI and HIV clinics in Nairobi between 1998 and 2004. She later provided comprehensive HIV care and treatment at the Kenyatta National Hospital. She is adept at providing technical advice in maternal child and newborn health in her current malaria research and in reproductive health related to HIV infection and sexually transmitted infections.

Selected Professional Experience: **1998 – Present**

Department of Medical Physiology and UNITID **Lecturer**

2004-Present: Responsibilities include: Teaching undergraduate and postgraduate students in medical physiology, epidemiology, biostatistics and infectious disease; lecturing in medical statistics, immunology, endocrinology and reproduction; providing practical demonstration in hematology, respiratory physiology and vision**;** conducting basic and applied research in implementation science**;** Teaching and demonstration of the HIV common course in all level 1 students –regular, module 2 and module 3 at the Colleges in the University of Nairobi.

University of Nairobi HIV Fellowship **Consultant**

2014 - Track lead epidemiology and biostatistics. Led in the development of the epidemiology and biostatistics curriculum for HIV Fellows. Funded by CDC and implemented in collaboration with the University of Washington, Seattle, USA.

IBTCI **Consultant**

2014: Team member conducting the mid-term review of the USAID-funded FUNZO/KENYA activity. Conducted desk review of background documents, focus group discussions of pre-service and in-service beneficiaries, training institutions, collaborators and directors; conducted key informant interviews of the Heads of training institutions and health facilities where training induction occurred. Analyzed data and contributed to the draft report.

Regional AIDS Training Network (RATN) **Consultant**

2012 - Reviewed the status of HIV capacity building in the East African Community (EAC) and Southern African Development Community (SADC) through the 2012. Conducted research, analysis and drafted report.

Global Fund (Ministry of Health-Division of Malaria Control) **Consultant**

2011 - Developed Participants and Trainers Manuals for Community Malaria Case Management curriculum - Ministry of Public Health and Sanitation-Division of Malaria Control (WHO). Conducted key informant interview with stakeholders representatives to determine the priority areas in CMCM.

The Diana Princess of Wales' Fund (KEHPCA) **Consultant**

2010 - Developed the National Palliative Care Manual for Health Workers – Kenya Hospice and Palliative Care Association (KEHPCA). Conducted focus group discussions with stakeholders on the priority areas in palliative care. Developed of guideline for palliative care integrating home based care for HIV patients.

WHO **Consultant**

2009 - Malaria Program Review Phase 1–Ministry of Public Health and Sanitation-Division of Malaria Control (WHO). Conducted desk review of malaria research and program implementation since 1905 and analyzed data to describe trends in malaria over the same period drafted report.

Management Sciences for Health **Consultant**

2008-2009: Strengthening health systems to improve adherence performance in health facilities providing ART in Kenya: an intervention study [MSH/NASCOP/ INRUD-KENYA]; Revised MOH 257 Blue Card for ART adherence; Mapped health facilities with < 95 percent ART adherence; Conducted focus group discussions with health workers working at Comprehensive Care Clinics (CCCs); Conducted exit interview of clients attending the CCCs; Conducted key informant interviews with the CCC in-charges; analyzed data, assisted in drafting report.

School of Medicine, University of Nairobi **Assistant Lecturer**

2002-2005: Responsibilities included: Teaching undergraduate and postgraduate students in medical physiology, epidemiology, biostatistics and infectious disease; lecturing in medical statistics, immunology, endocrinology and reproduction; Teaching and demonstration of the HIV common course in all level 1 students –regular, module 2 and module 3 at the Colleges in the University of Nairobi

University of Washington, Seattle, USA **Scholar**

2002-2004: International AIDS Research and Training Program (IARTP). Conducted focus group discussions among female sex workers in Korogocho slums in Nairobi Kenya; Provided HIV care and treatment among HIV infected sex worker clinic attended; Conducted screening for STIs and HIV especially HPV infection; Developed communication and advocacy strategies to reduce HIV stigma.

1998 – 2002 **Position Project Physician**

Pelvic Inflammatory Disease Project, University of Nairobi, Department of Obstetrics and Gynecology in collaboration with the University of Washington, Seattle, USA at the WHO Collaborative Centre for STD and HIV Research and Training in Nairobi, Kenya

- Screening patients at high risk for HIV and STIs at the Casino, Special Treatment Clinic, Nairobi
- Couples screening and counseling for STIs and HIV STD clinic attending
- Promoting good clinical and laboratory practice among the clinical and laboratory staff
- Side lab microscopy for vaginal discharge to distinguish between yeast and bacterial vaginosis
- Condom promotion, contact tracing, treatment compliance and counseling on high risk behavior

Languages:

English: Excellent; Kiswahili: Excellent; Kikuyu: Excellent

Dr. Ruth Muthoni **Nationality:** Kenyan **Affiliation:** IBTCI

Position Title: RMNCH Expert
Labor Category: Health/Population/Nutrition/HIV-AIDS Analyst

Education/Study:

PhD Public Health 1979
Tulane University, School of Public Health, USA

MPH 1976
Tulane University, School of Public Health, USA

BS, Biological Sciences 1975
South Dakota State University, USA

Relevant Experience:

Dr. Muthoni has over 20 years of successful experience within the health sector in Kenya and East Africa. She has worked in program development, implementation, monitoring and evaluation in RMNCH, FP, malaria, HIV/AIDS, nutrition, WASH and infection prevention and control. She has experience in developing training materials and providing capacity building to health care professionals. Dr. Muthoni has worked across a variety of donor projects including USAID, DFID, SIDA, CIDA and the Rockefeller Foundation

Selected Professional Experience:

Jhpiego, Maternal and Child Health Integrated Program **Program Director**
2012-2014: This USAID-funded program was implemented at the national, county, sub-county and community levels covered MNCH interventions aimed at decreased maternal/child mortality. Responsibilities included ensuring programmatic leadership, ensuring quality of programming and reporting to the MOH, Jhpiego and the USAID.

Jhpiego, Mothers and Infants, Safe, Health and Alive **Senior Program Manager**
2008-2012: Based in Tanzania, this USAID-funded program implemented by Jhpiego collaborated with the Tanzanian MOH to strengthen antenatal care, basic emergency obstetric and newborn care, control and prevention of malaria in pregnancy and community services to reduce maternal and neonatal morbidity and mortality. Responsibilities included: providing program oversight, advocacy to decision makers at the national and regional levels, training health care providers on focused antenatal care, training health managers on planning and management of health programming and ensuring annual and quarterly reports were completed on time and submitted to Jhpiego, the MOH and USAID.

Jhpiego, ACCESS **Program Manager**
2004-2008: Based in Tanzania, ACCESS program activities were a continuation of the MNH program with the added components of PMTCT/HIV/AIDS interventions. This CDC-funded project worked closely with CSOs, women's groups and FBOs to implement activities. Responsibilities also included conducting a participatory rapid appraisal of community members, conducting a baseline and final assessments of the malaria prevention and control program and participated in the final program evaluation of the ACCESS program.

Jhpiego, Maternal, Newborn Health program (MNH) **Country Director**
2002-2004: Based in Tanzania, was instrumental in setting up the Jhpiego Tanzania program. Responsibilities included: recruiting staff, setting up administration and financial systems in concert with Jhpiego's Kenya and Baltimore offices; oriented, mentored and supervised staff; established the health program in Tanzania and provided support, management and coordination of the technical staff in the design, implementation and monitoring of the program; providing advocacy to the MOH to support the program; ensure reports to the donor were accurate and timely.

AMREF, a variety of programs and positions
1995-2001: Coordinator/Program Manager for Health Policy and Systems Reform, a regional position funded by USAID, CIDA and DFID supporting East African Countries NGOs and CBOs to develop skills and capacities in district health management, planning and systems reforms to improve the quality of health care service delivery.
1990-1995: Director, Health Policy and Management Department (HPM). HPM was established to develop the capacity of district and provincial health management teams in Kenya, Uganda and Tanzania in planning, management and M&E of quality health services. Provided TA to the MOH in the areas of planning, management, health care financing, policy analysis and dissemination within the context of health sector reform. Provided training, monitoring and assessing progress in these technical areas. Directed all activities, supervised staff, coordinated training and M&E.
1986-1990: Head, Health Planning and Management Unit (HPMU) whose mandate was to develop the skills and build capacities of district and provincial health management teams. Unit was expanded in 1990 and was promoted to Director.
2000-2001: Principal investigator of the Makueni Equity Study. Designed and conducted the study in collaboration with the MOH district-based staff.

UNFPA **Consultant**
2001-2002: Evaluated the Nairobi City Council's reproductive health project for informal settlements in Nairobi. The evaluation assessed progress made towards achieving the program's objectives.
1996 – Evaluated the national reproductive health program which was implemented by the MOH, division of family health looking at the impact of the training provided to nurses and CHWs.

Nairobi City Council, Epidemiology & Disease Control **Section Head**
1979-1986: Provided surveillance and control of communicable diseases in the city of Nairobi and provided on-the-job training of nurses enrolled in public health study. Led teams of doctors, public health officers and nursing students to control cholera and typhoid epidemics in Mathare, Korogocho, Kibera and Mukuru and other slums in Nairobi. Led in the development of IEC/BCC materials for health education and advocated with leaders and policy makers to provide water in the slums.

Languages:
English (native); Kiswahili (proficient)

Stephen K. Gichobi **Nationality:** Kenyan **Affiliation:** IBTCI

Position Title: Social Scientist
Labor Category: Social Scientist/Other Technical Advisor

Education:

Master of Public Health (Health Services Management) Moi University 2013
B.A (Hons) Sociology& Linguistics, Kenyatta University 1999

Relevant Experience:

Mr. Stephen Gichobi has over 10 years progressive experience in private sector working as a programme management specialist both at District, Provincial and National Programming. He has regional experience having worked with NACC, MoPHS, PHMTs, USAID funded partners like the APHIA II now APHIAPlus. Mr. Gichobi specializes in Health Services Management, Health Care Financing, Health Economics, Project Management and Evaluation, and Epidemiology. Mr. Gichobi is a certified USAID Grants Manager, Measure Evaluation M&E Specialist & TOT.

Selected Professional Experience **Consultant**

National AIDS Control Council Rift Valley **Regional M&E Officer**

2012-2015: Provide technical support to CACCs, District Technical Committees (DTC), conduct M&E of HIV/AIDS activities within the region, review and approve work plans for DTC, ensure acceptable quality of data collection from community health system, and health facility system, collate, analyze and disseminate it to all stake holders.

TOWA program **Team Leader**

2013: Conducted assessment of health service provision gaps by targeting the Marginalized and Vulnerable Groups (VMGs) in Rift Valley, the findings were used in developing a successful campaign of providing HIV Testing and Counselling Services (HTC) among these groups , which are part of mobile populations in Rift Valley Province (Kericho, Narok, Samburu, Baringo, Laikipia ,Nakuru Counties)

National AIDS Control Council **Team Leader**

2011: Lead the regional NACC team in conducting capacity gaps assessment in Western Province, using Organization Development Systems Strengthening (ODSS) in partnership with AMREF MAANISHA Program. In the assessment Mr. Gichobi used participatory approaches including Key Informants (KI) and Focus group discussion FGDs. The finding of the assessment was used in developing a 2 year capacity building initiative targeting CSOs implementing HIV programs in Western Province.

WORLD VISION INTERNATIONAL-Bungoma District. ARK-HIV/AIDS COORDINATOR

2005-2008: Initiated the ARK -project radio outreach program using the local FM Station to reach youths across the whole of Western and Nyanza province. Trained youth mentors including teachers in both primary and Secondary schools in the larger Bungoma District to facilitate addressing youth Reproductive health and HIV/AIDS issues.

WORLD VISION INTERNATIONAL-Teso District. **Public Health Consultant**

2004: Conducted baseline survey for PMTCT programme, trained enumerators and FGD leaders, oversaw data entry, analysis and report preparation

MAHUDE WESTERN ALLIANCE ORGANIZATION **Project Manager**

2003: Effectively coordinated more than 40CBOs implementing HIV activities in Western Province.

Languages:

English (Fluent); Kiswahili (Fluent); Kikuyu (Native)

ANNEX 14: Data Collection Schedule

RIFT VALLEY

Respondent Groups:
FGDs -LIP Youth, LIP OVC, CCC, MNCH, Community Units and Devolved Government
KIIs -COP of Prime Partner, former PMOs, OVC LIP head, County Directors of Health, Sub County MOH and Health Facility in-charge
KAP surveys: - LIP Youth, LIP OVC, CCC, MNCH and CHWs
County Government Departments: - For Result 4: County Children's department, Education, Youth, Community strategy contact person, Ministry of Agriculture

SUNDAY JULY 5TH TRAVEL TO FIELD RIFT VALLEY REGION				
1400-1600	Depart from ESPs offices for Nakuru at 2pm – Arrive and Check Jumuia Guest House Nakuru			SMEs (3), ESPS Team (1) – PHS RAs (3) Transcribers (2);
1700-1900	Team Meeting 5pm – 7pm at Jumuia Guest House			
MONDAY JULY 6TH NAKURU REGION Day 1 Field work APHIAPlus Rift Valley				
0800	Depart for APHIAPlus Rift Valley Offices			
0830-1700	SME (3) Total of 3 KII Assumption of 3KIIs Chief of Party Group KII - Result area 3 Tech team Group KII - Result area 4 Tech Team (1) Combine all relevant people except COP	SME (1) Total of 2 KIIs: Assumption of 2 KIIs: County Health Director Sub-county MOH	SME (3) Total of 1 FGD County Government Departments Result 4: County Children's department Education, Youth, Community strategy contact person, (Ministry of Agriculture Transcribers (2) Assumption is - all day transcribing at the hotel RA (3) Preparation for KAP surveys and Facility Record review	SME (3); Transcribers (2); RAs (3); ESPS staff (1) – Public Health Specialist

1800-1900	Team Debrief at Jumuia Guest House			All
TUESDAY JULY 7TH NAKURU REGION **Day 2 Field work** **Nakuru Provincial General Hospital** **Nakuru County**				
0800	Depart for Nakuru Provincial General Hospital			
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person Total KII (2) Facility in charge OVC LIP Head FAIR	RA-1 (with Maxwell) Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA-2 & RA-3 Nakuru Provincial General Hospital (County) KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcriber (2); RAs (3); ESPS staff (1) – PHS
1630	Return to Jumuia Guest House			All
1800-1900	Team Debrief			All
WEDNESDAY JULY 8TH **Day 3 Field work** **Elburgon District Hospital** **Nakuru County**				
0700	Depart for Elburgon District Hospital			
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person Total of 2 KIIs Facility in charge OVC LIP Head **Sub-County (1) is an alternative**	RA-1 (SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA-2 & RA-3 Elburgon District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcriber (2); RAs (3);

1600-1800	Return to Jumuia Guest House			All
1800-1900	Team Debrief			All
THURSDAY JULY 9TH **Day 4 Field work** **Eldama Ravine District Hospital** **Baringo County**				
0700	Depart for Eldama Ravine District Hospital			All
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Government Departments) Assumption of 2 FGD/person Total of 3 KIIs Facility in charge OVC LIP Head **County DH** **Sub-County MOH (1) - alternative**	RA-1 (SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility	RA-2 & RA-3 Eldama Ravine District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcriber (2); RAs (3);
1630	Team return to Jumuia Guest House Nakuru			All
1800-1900	Team Debrief			All
FRIDAY JULY 10TH **Day 5 Field work** **Esageri Health Centre** **Baringo County**				
0700	Depart for Esageri Health Centre			All
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person Total of (2) KIIs Facility in charge	RA-1 SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility	RA-2 & RA-3 Esageri Health Centre KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2)	SME (3); Transcriber (2); RAs (3);

	OVC LIP Head (1)		Assumption is - all day transcribing at the hotel	
1630	Team return to Jumuia Guest House			All
1800-1900	Team Debrief			All
SATURDAY JULY 11TH NAKURU **Day 6 Field work**				
0800-1200	Complete transcription for all notes/data entry and respond to any queries from IBTCI by COB			All
SUNDAY JULY 12 NAKURU **Day 6 Field work**				
0800-1200	TEAM DAY OFF (with travel)			All
1300 - 1600	Team depart for Nanyuki – Check in at Sportsmans Arms Hotel			
MONDAY JULY 13TH **Day 7 Field work** **Nanyuki District Hospital** **Laikipia County**				
0730	Depart for Nanyuki District Hospital			All
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Government Departments) Assumption of 2 FGD/person Total of (3) KIIs Facility in charge OVC LIP Head **County DH**	RA-1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility	RA-2&RA-3 Nanyuki District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcriber (2); RAs (3);
1630	Check out Sportsmans Arms Hotel			All
1800-1900	Team Debrief			All
TUESDAY JULY 14TH **Day 8 Field work** **Subukia District Hospital** **Nakuru County**				
0700	Depart for Subukia District Hospital			All
0830-1600	SME (3) Total of 5 FGDs	RA-1 (SME (1), Community to conduct KAP Survey = 15 total	RA-2&RA-3 Subukia District Hospital KAP Survey respondents	SME (3); Transcriber (2); RAs (3);

	(Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person Total of (3) KIIs Facility in charge OVC LIP Head **Sub-County KII**	5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	(5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	
1630	Depart for NAKURU – Check in at Jumuia Guest House			All
1800-1900	Team Debrief			All
WEDNESDAY JULY 15TH **Day 9 Field work** **Kabazi Health Centre** **Nakuru County**				
0700	Depart for Kabazi Health Centre			All
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person Total of (2) KIIs Facility in charge OVC LIP Head	RA-1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA-2&RA-3 Kabazi Health Centre KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcriber (2); RAs (3);
1630	Team return to Jumuia Guest House			All
1800-1900	Team Debrief			All
THURSDAY JULY 16TH **Day 10 Field work** **SOGOO HEALTH CENTRE** **Narok County**				
0630	Depart for Sogoo Health Centre			All
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW)	RA-1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth	RA-2&RA-3 Sogoo Health Centre KAP Survey respondents (5CCC, 5 MNCH) in the morning	SME (3); Transcriber (2); RAs (3);

	Assumption of 2 FGD/person Total of (2) KIIs Facility in charge OVC LIP Head	5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	
1630	Depart NAROK – Check in at Seasons Hotel			All
1800-1900	Team Debrief			All
FRIDAY JULY 17TH **Day 11 Field work** **Narok District Hospital** **Narok County**				
0800	Depart for Narok District Hospital			All
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Government Departments) Assumption of 2 FGD/person Total of (2) KIIs Facility in charge OVC LIP Head **County HD**	RA-1 (SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA-2 & RA-3 Narok District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcriber (2); RAs (3); TL; M&E Expert
1630	Return to Seasons Hotel - Narok			SME (3); Transcriber (2); RAs (3); TL; M&E Expert
1800-1900	Team Debrief			All
SATURDAY JULY 18TH **Day 12 Field work** **NAROK**				
0800-1200	Complete transcription for all notes/data entry and respond to any queries from IBTCI by COB			All
SUNDAY JULY 19TH **KAJIADO**				
1400	DEPART FOR KAJIADO – Check in at Masai Echo Lodge - Kajiado			
MONDAY JULY 20TH				

Day 13 Field work **Kajiado District Hospital** **Kajiado County**				
0700	Depart for Kajiado District Hospital			All
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Government Departments) Assumption of 2 FGD/person Total of (4) KIIs Facility in charge OVC LIP Head County HD Sub-County MOH	RA-1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA-2&RA-3 Kajiado District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcriber (2); RAs (3);
1630	Return to Masai Echo Lodge - Kajiado			All
1800-1900	Team Debrief			All
TUESDAY JULY 21ST **Day 14 Field work** **Bisil Health Center** **Kajiado County**				
0700	Depart for Bisil Health Center			All
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Government Departments) Assumption of 2 FGD/person Total of (2) KIIs Facility in charge OVC LIP Head)	RA-1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA-2&RA-3 Bisil Health Centre KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcriber (2); RAs (3);
1630	Return to Masai Echo Lodge - Kajiado			All
1800-1900	Team Debrief			All

WEDNESDAY JULY 22ND **Day 15 Field work** **Ngong Sub-District Hospital** **Kajiado County**				
0700	Depart for Ngong Sub-District Hospital			All
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Government Departments) Assumption of 2 FGD/person Total of (3) KIIs Facility in charge OVC LIP Head **Sub-County MOH**	RA-1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA-2&RA-3 Ngong Sub-District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcriber (2); RAs (3); TL; M&E Expert
THURSDAY JULY 23RD **Day 16 Field work** **NAIROBI**				
0800-1700	Complete transcription for all notes/data entry and respond to any queries from IBTCI by COB			
FRIDAY JULY 24TH **Day 17 Field work** **NAIROBI**				

WESTERN

Respondent Groups:
FGDs - LIP Youth, LIP OVC Caregivers, CCC Clients, MNCH Clients, Community Health Workers/Volunteers and County Government Departments
KIIs - COP of Prime Partner, former PMOs, OVC LIP head, County Directors of Health, Sub County MOH and Health Facility in-charge
KAP surveys: - LIP Youth, LIP OVC, CCC, MNCH and CHWs

County Government Departments: - For Result 4: County Children's department, Education, Youth, Community strategy contact person, Ministry of Agriculture

SUNDAY JULY 5TH TRAVEL TO FIELD WESTERN REGION				
1800 - 1900	Fly to Kisumu – Departure at 1800 Arrive at 19.15; Check in at Jumuia Guest House			SMEs (3), ESPS Team (1), RAs (3) Transcribers (2);
1930 - 2030	Team Meeting -Jumuia Guest House - Kisumu			
2030	Dinner			All
MONDAY JULY 6TH KISUMU Day 1 Field work APHIAPlus Western-Nyanza office Kisumu				
0800	Depart for APHIAPlus Western/Nyanza Offices			
0830-1600	SME (3) Total of 3 KII Assumption of 3 KIIs Chief of Party (1)James Mukabi Group KII with Result 3 and Result 4 Tech. team (1) Combine all relevant people except COP PDMS(1) Dr. Ojwang Lusi	SME (3) Total of 1 KIIs Assumption with Dr. Ojwang Lusi – former PDMS (1), Nyanza,	RA (3) Preparation for KAP and Record review	SME (3); Transcribers (2); RAs (3); ESPS staff (1) - COP
1600-1700	Depart for Kakamega check in at Golf hotel Team briefing			All
TUESDAY JULY 7TH Day 2 Field work Kakamega Provincial General Hospital Kakamega County				

0700	Depart for Kakamega PGH			All
0830-1500	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Government departments) Assumption of 2 FGD/person Total KII (3) Facility in charge (1)Dr. Ajevy OVC LIP Head (1) **Sub-County MOH KII (1)Godfrey Mutakha**	RA-1 (Cyndi) Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA-2 & RA-3 Kakamega PGH KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); TRANSCRIBER (2); RAs (3); ESPS staff (1) – COP;
1630-1800	Return to Golf hotel			All
1800-1900	Team Debrief			All
WEDNESDAY JULY 8TH **Day 3 Field work** **Matete Health Center** **Kakamega County**				
0700	Depart for Matete Health Centre in Lugari			All
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person 3) Facility in charge (1) OVC LIP Head (1) CDH (1)	RA-1 (with ESPS staff) Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA-2 & RA-3 Matete HC KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	Depart for Bungoma and check in Greenville hotel			All
1800-1900	Team Debrief			All
THURSDAY JULY 9TH				

Day 4 Field work **Bungoma District HOSPITAL** **Bungoma County**				
0800	Depart for Bungoma District Hospital			All
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, CGvtD) Assumption of 2 FGD/person KII (3) Facility in charge **(1)** OVC LIP Head (1) **County DH (1)**	RA 1(SME (1), RA-1 (with ESPS staff) Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA2 & RA3 Bungoma District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	Return to Greenville hotel in BUNGOMA			All
1800-1900	Team Debrief			All
FRIDAY JULY 10TH **Day 5 Field work** **Kopsiro Health Centre Hospital** **Bungoma County**				
0730	Depart for Kopsiro Health Centre			All
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person Total KII (3) Facility in charge (1) OVC LIP Head (1) Former PDMS (1)	RA1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA2 & RA3 Kopsiro Health Centre KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	Return to Greenville hotel			All
1800-1900	Team Debrief			All
SATURDAY JULY 11TH BUNGOMA **Day 6 Field work**				

0800-1600	Complete transcription for all notes/data entry and respond to any queries from IBTCI by COB			All
MONDAY JULY 13TH **Day 7 Field Work** **Sirisia Sub-District Hospital** **Bungoma County**				
0700	Depart for Sirisia Sub-District Hospital			All
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person Total KII (2) Facility in charge (1)Dr. Wamalwa OVC LIP Head (1)	RA1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA2 & RA3 Sirisia Sub-District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	Return to Greenville hotel			All
1800-1900	Team Debrief			All
TUESDAY JULY 14TH **Day 8 Field work** **Bumula Health Centre** **Bungoma County**				
0800	Depart for Bumula Health Centre			All
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person Total KII (3) Facility in charge **(1)** OVC LIP Head (1) **SCMOH (1)**	RA1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA2 & RA3 Bumula Health Centre KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	DEPART FOR BUSIA and check in Rastopark			All
1800-1900	Team Debrief			All
WEDNESDAY JULY 15TH				

Day 9 Field work **Amukura District Hospital** **Busia County**				
0730	Depart for Amukura District Hospital			All
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, CGvtD) Assumption of 2 FGD/person Total KII (3) Facility in charge (1)Linet Adiang OVC LIP Head (1) Sub-County MOH (1) Vincent Kwena	RA1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA2 & RA3 Amukura District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	Return to Rastopark hotel			All
1800-1900	Team Debrief			All
THURSDAY JULY 16TH **Day 10 Field work** **Makunga Health Centre** **Kakamega County**				
0700	Depart for Makunga Health Centre			All
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person Total KII (2) Facility in charge(1)Judith Anyanje OVC LIP Head (1)	RA1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA2 & RA3 Makunga Health Centre KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	DEPART FOR KAKAMEGA check in Golf hotel			All
1800-1900	Team Debrief			All
FRIDAY JULY 17TH **Day 11 Field work**				

Butere District Hospital **Kakamega County**				
0700	Depart for Butere District Hospital			All
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person Total KII (2) Facility in charge (1)Jesca Olubayo OVC LIP Head (1)	RA1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA2 & RA3 Butere D H KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	**Return to Golf hotel**			All
1800-1900	Team Debrief			All
SATURDAY JULY 18TH **Day 12 Field work** **KAKAMEGA**				
0800-1600	Complete transcription for all notes/data entry and respond to any queries from IBTCI by COB			All
SUNDAY JULY 19TH **KAKAMEGA**				
MONDAY JULY 20TH **Day 13 Field work** **Mbale Rural Health Training Centre** **Vihiga County**				
0730	Depart for Mbale Rural Health Training Centre			
0830-1500	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Gvt Dpt) Assumption of 2 FGD/person Total KII (3) Facility in charge (1) OVC LIP Head (1)	RA1, (SME (1), (with ESPS staff) Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA2 & RA3 Mbale RHTC KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3); ESPS staff (1) - COP

	FPMOs(1)			
1630	DEPART FOR KISUMU Check in Jumuia Guest House			ESPS COP
1630-1900	Team Debrief			All
TUESDAY JULY 21ST **Day 14 Field work** **Nyamira District Hospital** **Nyamira County**				
0700	Depart for Nyamira District Hospital			All
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Gvt Dept) Assumption of 2 FGD/person Total KII (3) Facility in charge (1)Dr. Silas Ayunga OVC LIP Head (1) **County DH (1)**	RA1 (SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA2 & RA3 Nyamira District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
WEDNESDAY JULY 22ND **Day 15 Field work** **Rachuonyo District Hospital** **Homa Bay County**				
0800	Depart for Rachuonyo District Hospital			
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Government Departments) Assumption of 2 FGD/person Total KII (4) Facility in charge (1)Dr. Peter Ogolla OVC LIP Head (1) County CDH (1)	RA1 (SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA2 & RA3 KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3); TL; M&E Expert

	SCMOH (1)			
1630-1800	Return to PEBO hotel Kisii			All
1800-1900	Team Debrief			All
THURSDAY JULY 23RD **Day 16 Field work** **KURIA DISTRICT HOSPITAL** **Migori County**				
0630	Depart for Kuria District Hospital			All
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Government Departments) Assumption of 2 FGD/person Total KII (3) Facility in charge (1) OVC LIP Heads (1)**)** **SCMOH (1)**	RA1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs (at health facility)	RA2 & RA3 Kuria District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3); TL; M&E Expert
1630-1800	Depart and check in Boarder Point hotel			All
1800-1900	Team Debrief			All
FRIDAY JULY 24TH **Day 17 Field work** **MIGORI**				
0800-1100	All team member transcribe notes			All
1100-1400	TRAVEL TO KISUMU			All
1600-1700	Team fly back to Nairobi in the Afternoon			All
SATURDAY JULY 25TH **Day 18 Field work** **NAIROBI**				

KAMILI

Respondent Groups:
FGDs - LIP Youth, LIP OVC Caregivers, CCC Clients, MNCH Clients, Community Health Workers/Volunteers and County Government Departments.
KIIs - CoP of Prime Partner, Former PMOs, OVC LIP Head, County Directors of Health, Sub County MOH and Health Facility in-charge.
KAP surveys – LIP Youth, LIP OVC, CCC, MNCH and CHWs
County Government Departments - For Result 4: County Children's department, Education, Youth, Community strategy contact person, Ministry of Agriculture

SUNDAY JULY 5TH TRAVEL TO FIELD EMBU REGION				
1400-1600	Depart from ESPs offices for Embu at 2pm – Arrive and Check in at Hotel Panesik			SMEs (3), RAs (3) ESPS Team (1) – Senior M&E Advisor; Transcribers (2);
1700-1900	Team Meeting at Panesik Hotel			
MONDAY JULY 6TH EMBU REGION Day 1 Field work APHIAPlus KAMILI				
0800	Depart for APHIAPlus KAMILI Offices			
0830-1700	SME (3) Total of 3 KII Assumption of 3KIIs 1 – Chief of Party Group KII with Result Area 3 and Result Area 4 Tech. team (2) Combine all relevant people except COP	SME (3) Total of 1 FGD Total of 1 FGD County Government Departments Result 4: Director Children's Services, Education, Youth, Ministry of Agriculture Community strategy contact person	SME (3) (Transcribers (2) Assumption is - all day transcribing at the hotel	SME (3)); RAs (3); ESPS staff –M&E Advisor (1)
1800-1900	Team Debrief at Panesik Hotel			All
TUESDAY JULY 7TH EMBU REGION Day 2 Field work Embu Provincial General Hospital Embu County				
08000	Depart for Embu Provincial General Hospital			

0830-1500	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person KII (2) Facility in charge (1) OVC LIP Head (1) **County KII (1)** **(Embu is an alternative county)**	RA-1 (with ESPS staff) Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs Venue: Embu PGH	RA-2 & RA-3 Embu Provincial General Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); TRANSCRIBER (2); RAs (3); ESPS staff (1) – Senior M&E Advisor;
1530-1900	Depart for Kitui – check in at Kitui Cottage Hotel			All
1900	Team Debrief			All
WEDNESDAY JUL 8TH **Day 3 Field work** **Muthale Mission Hospital** **Kitui County**				
0700	Depart for Muthale Mission Hospital and County Government Meeting			
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, Kitui County Government Departments) Assumption of 2 FGD/person Total of 3 KIIs Facility in charge (1) OVC LIP Head (1) County Director of Health (1)	RA-1 (SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs Venue: Muthale Mission Hospital	RA-2 & RA Muthale Mission Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	Return to Kitui Cottage hotel			All
1800-1900	Team Debrief			All
THURSDAY JULY 9TH **Day 4 Field work** **Kauwi Sub-District Hospital** **Kitui County**				

0730	Depart for Kauwi sub-District Hospital			
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person Total of 3 KIIs Facility in charge (1) Sub-county MOH – Kitui West (1)	RA-1 (SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs Venue: Kauwi SDH	RA-2 & RA-3 Kauwi Sub-District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1600	Depart for Embu – Check in Panesik Hotel			All
1900	Team Debrief			All
FRIDAY JULY 10TH **Day 5 Field work** **Tharaka District HOSPITAL** **Tharaka Nithi County**				
0700	Depart for Tharaka District Hospital			
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person Total of 4 KIIs Facility in charge (1) OVC LIP Head (1) Sub-county KII (1) Former PDPHS Eastern: **CDH** Tharaka Nithi (1), **County KII (1) an alternative**	RA-1, SME (1) Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs Venue: Tharaka DH	RA-2 &RA-3 Tharaka District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	Check in at Panesik Hotel			All
1800-1900	Team Debrief			All

SATURDAY JULY 11TH **Day 6 Field work**				
SUNDAY JULY 12TH				
				All
MONDAY JULY 13TH **Day 7 Field work** **Chuka District Hospital** **Tharaka Nithi county**				
0700	Depart for Chuka District Hospital			All
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW, County Government Departments) Assumption of 2 FGD/person Total of 3 KIIs Facility in charge (1) OVC LIP Head (1) Sub-county KII (1)	RA-1 (SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs Venue: Chuka District Hospital	RA-2 & RA-3 Chuka District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	Depart to Meru – Check in Hotel Three Steers			All
1800-1900	Team Debrief			All
TUESDAY JULY 14TH **Day 8 Field work** **Meru District Hospital** **Meru County**				
0800	Depart for Meru District Hospital			All
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Government Departments) Assumption of 2 FGD/person	RA-1 (SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices	RA-2&RA- Meru District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon	SME (3); Transcribers (2); RAs (3);

	Total of 3 KIIs Facility in charge (1) OVC LIP Head (1) County Director of Health (1) **Sub-county KII (1) is an alternative**	5 – CHWs Venue: Meru District Hospital **Former PMOs:** **PDMS (1), Central** **Venue: At his clinic**	Transcriber (2) Assumption is - all day transcribing at the hotel	
1630-1800	Check in at hotel Three Steers			All
1800-1900	Team Debrief			All
WEDNESDAY JULY 15TH **Day 9 Field work** **Mutuati Sub-District Hospital** **Meru County**				
0700	Depart for Mutuati Sub-District Hospital			All
0830-1600	SME (3) & Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW,) Assumption of 2 FGD/person Total of 3 KIIs Facility in charge (1) OVC LIP Head (1) County Director of Health (1) **Sub-county KII (1) is an alternative**	RA-1 (SME (1) Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs Venue: Mutuati SD Hospital	RA-2 & RA-3 Mutuati Sub-District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	Return to hotel Three Steers			All
1800-1900	Team Debrief			All
THURSDAY JULY 16TH **Day 10 Field work** **Akachiu Health Centre** **Meru County**				
0800	Depart for Akachiu Health Centre			All

0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW,) Assumption of 2 FGD/person Total of 3 KIIs Facility in charge (1) OVC LIP Head (1) County Director of Health (1)	RA-1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs Venue: Akachiu Health Centre	RA-2 & RA- Akachiu Health Centre KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3); TL; M&E Expert
1630-1800	Depart for Embu – Check in at Panesik Hotel			All
1800-1900	Team Debrief			All
FRIDAY JULY 17TH **Day 11 Field work** **Maragua District Hospital** **Murang'a County**				
0700	Depart for Maragua District Hospital			All
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Government Departments) Assumption of 2 FGD/person Total of 4 KIIs Facility in charge (1) OVC LIP Head (1) County Director of Health – Murang'a (1), Sub-county KII (1)	RA-1 (SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs Venue: Murang'a District Hospitla	RA-2 & RA-3 Maragua District Hospital KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1600-1800	Depart and check in at Hotel Cravers - Thika			All
1800-1900	Team Debrief			All
SATURDAY JULY 18TH				

SUNDAY JULY 19TH NYANDARUA				
	Depart for Ol Kalou in Nyandarua – Check in at Tranquil Hotel - Ol Kalou			
MONDAY JULY 20TH Day 11Field work Bamboo Dispensary Nyandarua County				
0700	Depart for Bamboo Health Center			
0830-1600	SME (3) Total of 6 FGDs (Youth, OVC, CCC, MNCH, CHW, County Government Departments) Assumption of 2 FGD/person Total of 4 KIIs Facility in charge (1) OVC LIP Head (1) County Director of Health (1), <u>Former PDPHS Central</u>: Nyandarua (1), **Sub-county KII (1) is an alternative**	RA-1(SME (1), Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs Venue: Bamboo Health Centre	RA-2&RA- Bamboo Dispensary KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	Depart and check in at Hotel Cravers - Thika			All
1800-1900	Team Debrief			All
TUESDAY JULY 21ST Day 14 Field work Ngoliba Health Center Thika Sub-County				
0630	Depart for Ngoliba Health Center			
0830-1600	SME (3) Total of 5 FGDs	RA-1 (SME (1) Community to conduct KAP Survey = 15 total	RA-2 & RA-3 Ngoliba Health Centre KAP Survey respondents	SME (3); Transcribers (2); RAs (3);

	(Youth, OVC, CCC, MNCH, CHW,) Assumption of 2 FGD/person Total of 2 KIIs Facility in charge (1) OVC LIP Head (1) **County Director of Health (1) is an alternative**	5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs Venue: Ngoliba Health Centre	(5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	TL; M&E Expert
1630-1800	Return to hotel Cravers			All
1800-1900	Team Debrief			All
WEDNESDAY JULY 22ND **Day 15 Field work** **Kihara Sub-District Hospital** **Kiambu County**				
0700	Depart for Kihara Sub-District Hospital			
0830-1600	SME (3) Total of 5 FGDs (Youth, OVC, CCC, MNCH, CHW) Assumption of 2 FGD/person Total of 2 KIIs Facility in charge (1) OVC LIP Head (1)	RA-1 (SME (1) Community to conduct KAP Survey = 15 total 5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs Venue: Kihara SD Hospital	RA-2 & RA-3 KAP Survey respondents (5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	SME (3); Transcribers (2); RAs (3);
1630-1800	Return to hotel Cravers			All
1800-1900	Team Debrief			All
THURSDAY JULY 23RD **Day 16 Field work** **Lari Health Centre** **Kiambu County**				
0730	Depart for Lari Health Centre			All
0830-1600	SME (3) Total of 5 FGDs	RA-1 (SME (1) Community to conduct KAP Survey = 15 total	RA-2&RA- Lari Health Centre KAP Survey respondents	SME (3); Transcribers (2); RAs (3);

	(Youth, OVC, CCC, MNCH, CHW, County Government Departments) Assumption of 2 FGD/person Total of 2 KIIs Facility in charge (1) OVC LIP Head (1)	5 – Youth 5 – OVC Caregivers Venue: LIP Offices 5 – CHWs Venue: Lari Health Centre	(5CCC, 5 MNCH) in the morning Facility Record Review in the afternoon Transcriber (2) Assumption is - all day transcribing at the hotel	
1630-1800	DEPART FOR NAIROBI			All
FRIDAY JULY 24TH **Day 17 Field work** **NAIROBI**				

NATIONAL KIIs

Date	Time	Institution
Mon July 13	0830-1030	USAID
	1130-1330	USAID
	1430-1630	USAID
Tue July 14	0830-1030	USAID
	1130-1330	USAID
	1430-1630	USAID
Wed July 15	0830-1030	EGPAF
	1130-1330	Open
	1400-1500	Former PDPHS – Nyanza
Thur July 16	0830-1030	LVCT
	1130-1330	Catholic Relief services
	1430-1630	World Vision
Fri July 17	0830-1030	Open
	1130-1330	National Tuberculosis and Lung Disease Unit
	1430-1630	National Organization of Peer Educators (NOPE)
Mon July 20	0830-1030	PATH
	1130-1330	Open
	1430-1630	Open
Tue July 21	0830-1030	AMREF
	1130-1330	Head, National Malaria Control Program
	1430-1630	
Wed July 22	0900-1030	USAID
	1100-1230	USAID
	1400-1500	USAID
Thur July 23	0830-1030	AFYA Info
	1130-1330	Kenya Pharma
	1430-1630	ASSIST
Mon July 27	0830-1030	FHI360
	1130 -1330	MSH/Health Commodities and Services Management (HCSM) Program
	1430 - 1500	DFH
Tue July 28	0900 -1000	DMS
	1130 - 1430	NASCOP
	500 hrs	DMS
Wed July 29	0830 - 1030	Jhpiego