USE OF CASH ASSISTANCE TO ADDRESS MATERNAL, NEWBORN AND CHILD HEALTH OUTCOMES

AN EVALUATION REPORT OF THE TAITA TAVETA CASH FOR HEALTH IN EMERGENCIES PROJECT

Complied by Kenya Red Cross Society and British Red Cross (East Africa Office)

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LIST OF ABBREVIATIONS

EBF	Exclusive Breast Feeding
CHV	Community Health Volunteer
CHA	Community Health Assistant
CVA	Cash and Voucher Assistance
MNCH	Maternal, Neonatal and Child Health
SCPHO	Sub County Public Health Officer
PNC	Post Natal Care

EXECUTIVE SUMMARY

British Red Cross funded KRCS to implement a 6 months' project from October 2020 to March 2021 in Taveta Sub county aiming at improving Maternal, newborn and child health indicators through cash transfers to families with children under five years of age and expectant women. The unconditional cash transfer was meant for vulnerable pregnant and lactating mothers/adolescent girls and those with children under five years to improve key MNCH indicators included Antenatal Care, Post-natal care, health facility deliveries and immunization coverage. The cash transfer was equally meant to cushion the target beneficiaries following the socio-economic effects of COVID-19. The project was implemented in Chala, Mahoo and Mata wards through the community health strategy.

This evaluation sought to measure the effects of the interventions on the target communities in relation to MNCH. A comparative study design was adopted where the three intervention wards were compared to a similar target group in a control ward that was identified to be Mboghoni ward within the same sub county and bordering Mata and Chala wards. Since the project reached 915 mothers, a sample size of 170 was randomly determined. The sample size was proportionately allocated to the three wards and a systematic sampling approach was used to identify the mothers to be interviewed. An equal number of 170 mothers were randomly identified in the Mboghoni ward through the guidance of the village elders. The target respondents were the mothers with children under five years.

The results indicate that all the beneficiaries were happy with the whole targeting and verification process. Priority expenditure for the recipients were food at 84% and healthcare access as reported by 79% of the CVA recipients. The MoH facility data showed a general higher uptake of the MNCH services in the intervention areas compared to the control areas health facilities There was however revealed a slight difference between the intervention and control groups in relation to the targeted MNCH indicators. 66% of mother in the control group and 65% of the intervention group made at least 4 ANC visits during there last pregnancy. 88% of mothers in control group and 87% in the intervention group delivered their last child in a health facility; with most preferring government facilities. PNC uptake was slightly higher in intervention groups at 76% and 70% in the control group. In addition, 49% of children between 12 and 23 months in the intervention group were observed to be fully immunized compared to 33% in the Control group.

CVA enabled mothers to access health facilities in both public and private facilities. In the wake of healthcare workers strike and the COVID-19 pandemic, the Cash enabled payment of medical costs as many sought services in private facilities. Apart from supporting access to healthcare, families were able to put food on the table with 81% affording at least three meals a day compared to 31% before CVA. 33% of beneficiaries also reported starting income generating activities, mainly livestock keeping and small businesses.

CHVs supported the mothers to honor their clinic appointments and sensitized them on the importance of the different aspects of MNCH. The CHVs equally supported the registration and verification processes for CVA beneficiaries. Men participation in MNCH indicated that most men supported their wives' attendance of clinics.

Regarding community engagement, transparent communication and feedback handling had gaps as 65% of the intervention groups reported not be aware of feedback mechanisms put in place.

Key recommendations include extension of the project period to consolidate the gains made so far and upscaling to cover neighboring

wards, need to integrate/promote men involvement, SGBV and COVID-19 sensitization interventions, advocacy for CHVs allowances by the MoH and continued MNCH sensitization in the community.

1.BACKGROUND

Kenya reported its COVID-19 index case on 13th march, 2020 and subsequently the Ministry of Health put into place various containment measures including curfew hours (4am to 9pm), ban of large meetings, closure of learning institutions, wearing of masks in all public places, hygiene practices, ban on foreign flights, large gatherings among others. Some of the measures have been lifted gradually such as ban on foreign flights. The containment measures however resulted in far reaching effects on way of life, loss of business, jobs and disrupted learning programs affecting women, children and young people mostly. The Ministry of Health, Education and Internal Coordination reported increased cases of teenage pregnancies attributed to 'stay at home' measures for COVID-19 prevention; teenage pregnancies have been compounded by poor health-seeking behaviors among these teenage girls. The fear of contracting the virus also greatly affected other essential health services uptake such as immunization, ANC/PNC clinic visits, family planning, skilled childbirth/hospital deliveries and nutrition services. Most pregnant or lactating women did not seek clinical and immunization services at the hospitals for fear of contracting COVID-19 and this resulted in significant reduction in uptake of these services.

According to the WHO *Working paper for considering cash transfers programming for Health in humanitarian contexts*, cash and voucher assistance can be used to improve access to, and utilization of health services in humanitarian settings by reducing direct and indirect financial barriers and or by incentivizing the use of preventive services[1]. A recent systematic review found an increase in uptake of antenatal care and skilled attendance at childbirth with use of cash.

1.1. Project Overview:

KRCS secured funding from the British Red Cross to implement a 6 months' project from October 2020 to March 2021 in Taveta Sub county aiming at improving health indicators through cash transfers to families with children under five years of age and expectant women. The project used conditional and unrestricted cash transfers to encourage vulnerable pregnant and lactating mothers/adolescent girls and those with children under five years to visit health facilities for uptake of services as well as hospital child deliveries. The services included antenatal and postnatal clinic, hospital delivery and immunization schedule for children under-five as summarized as indicators below.

- Number of antenatal appointments attended by pregnant mothers/adolescent girls
- Number of postnatal visits undertaken (within 30 days of delivery)
- Number of hospital deliveries or deliveries attended by trained attendant
- Number of children under five immunized (following routine schedule)

The cash transfers were also meant to improve the economic status of the households which had been affected negatively by the impacts of COVID-19.

The project was implemented through the community health strategy structure working with the Community Health Workers and in

[1] Global Health Cluster and WHO cash Task team, 2018

close collaboration with local administration like the office of the chief. Targeting and registration of households with children under five and expectant women was done by CHVs working with KRCS volunteers and the chiefs/assistant chiefs.

2. METHODOLOGY

2.1 Study design

A mixed methodology of quantitative and qualitative approaches was applied. For the quantitative methods, a comparative approach was utilized where intervention and control groups were engaged.

- **Intervention group**: this group included pregnant women or women and those who had recently delivered a child or with children under 5y who received cash from Kenya Red Cross Society.
- **Control/comparison group**; this group included Pregnant women or women who have recently delivered a child (under 1y) or with children under 5y from an alternative ward in Taita Taveta County who have not received cash assistance from Kenya Red Cross Society.

2.2 Sampling design:

Intervention group:

The target population of the study will comprise of approximately 915 mothers in the three intervention wards from Taveta sub county. The sampling frame consisted of the list of all Cash assistance beneficiaries within an intervention area. From the constructed sampling frame, simple random sampling procedures was used to select the study sample. 18% from the total list of beneficiaries (915) were selected to realize a sample size of 171. Probability proportionate to size allocation was used to assign the sampled 170 beneficiaries to each ward based on the distribution of beneficiaries within the three wards as follows;

Name of Ward	Sample size
Mata	103
Challa	34
Mahoo	34
Total	171

Control/comparison group:

The same sample size of 170 was applied to Mboghoni ward which was selected as the control area since it was homogenous to the intervention wards. The mothers were randomly sampled at the field level by the Kenya Red cross volunteers.

Sampling of Key Informants and FGD Participants:

Sampling of key informants and FGD participants was purposively done. The list of Key Informants and FGDs were as follows.

Intervention Area:	Control group:
KII With the Sub County In charge/Sub County Public Health Nurse	FGD With 10 CHVs– Mboghoni
Facility In charge Rekeke and 1 CHA Rekeke	Men (Control Group Mboghoni)
FGD-Men (spouses to beneficiaries)-Rekeke	FGD-CHVS Mahandakini
KII- PHO Challa	

2.3 Data Collection

Household data was done through structured questionnaires designed on mobile data collection platform (Kobo). This was done by the enumerators. KII and FGDs were conducted by KRCS and BRC team leads, i.e. one note taker and one moderator. The data collection exercise took four days. Secondary data on various MNCH indicators was

collected from DHIS through the Sub-Country Health records officer.

Training of Enumerators:

Extensive training was conducted in Taveta for one day. The training was devoted on discussing and revising of the study tools as well as the mobile data collection software. A total of 10 KRCS volunteers were trained as enumerators. The evaluation team was trained on the evaluation objectives and methodology. This was preceded by a brief on the project, the target and expected outcomes.

Pilot testing

The questionnaire was pilot tested jointly by all the teams. This was done to assess its reliability (i.e., consistency and clarity, in terms of yielding the desired data) and the exercise's planned logistics. One village (Rekeke) was selected from this exercise. Ten Mothers (from the beneficiary list0 were purposively selected for the pilot process. Discussions were held after the exercise to reflect on; time taken, the experience with the questionnaires. The feedback from the enumerators on the questionnaire was adopted and questionnaires revised before the actual data collection process.

2.4 Data Processing and Analysis

During fieldwork, all the e-forms submitted via the mobile application were adequately checked for accuracy and completeness before analysis, and any inconsistencies noted will be promptly addressed. After all the data was received, it was analyzed using Statistical Package for Social Sciences (SPSS) as well as Ms. Excel.

Qualitative data was analyzed thematically where a full list of themes was generated for categorization within a hierarchical framework of main and sub-themes. The thematic framework was then systematically applied to all of the interview transcripts. Patterns and associations of the themes were identified and compared and contrasted within and between the different groups of respondents (CHWs, KII and Community members) to enhance triangulation of data.

3.0 RESULTS AND DISCUSSIONS

This section aligns to the key indicators that the project purposed to track; presenting comparisons between the intervention and control groups sampled during the data collection. The findings triangulate the different sources of data to enrich the quantitative results. Mboghoni ward selected as the control group on the farthest end of Taveta sub county, however borders Mata and Mahoo intervention wards.

3.1 SOCIO-DEMOGRAPHY

A total of 363 mothers were interviewed, with 183 being in the intervention group and 180 in the control group. Most of the respondents (65.6% and 68.3%) in the intervention and control groups respectively were aged 25 to 59 years of age. On average 1% of the targeted mothers in both groups were under the age of 18 years. Most respondents (79% in the control and 72% in the intervention groups) were married. Those who were single were 19% in the intervention group and 13% in the control group; most of whom were young girls still in their parents' or guardians' custody. 96.3% of the intervention group had children under five years at the time of the interview.

Marital Status	**Control (n=180)**	**Intervention (n=183)**
Married	79%	72%
Separated/ divorced	5%	6%
Single	13%	19%
Widow/ widower	2%	4%
Total	**100%**	**100%**
Age of the respondent	**Control (n=183)**	**Intervention (n=183)**
18-24 years	31%	34%
25-59 years	68%	66%
Under 18 years	1%	1%
Total	**100%**	**100%**

Table 1: socio demography

3.2 CASH TRANSFER

Cash transfer was the main intervention undertaken, besides a few outreaches conducted. This covered the intervention wards of Chala, Mata and Mahoo.

Recipient of cash transfer

78% (142) of the intervention group indicated to have personally received the cash,22% (41) had alternates who received the cash on their behalf as they lacked either a cell phone or an ID card. The alternates were mainly husbands to the targeted women. Only 4.9% of the 41 women that had alternate recipients indicated to have had challenges getting the cash from the alternate. One recipient said the husband received the Cash and kept saying that the same had been used to meet household expenses, including renovation of their house. Culturally the Maasai women in the community will not question their husbands and so the recipient would only believe the husbands 'narrative.

Selection criteria

81.4% (149) of the respondents understood how they were selected and knew the general selection criteria used as indicated below. Women with children under five years and those lactating were the most common responses as represented by 40% and 35% of the total responses given by the intervention group.

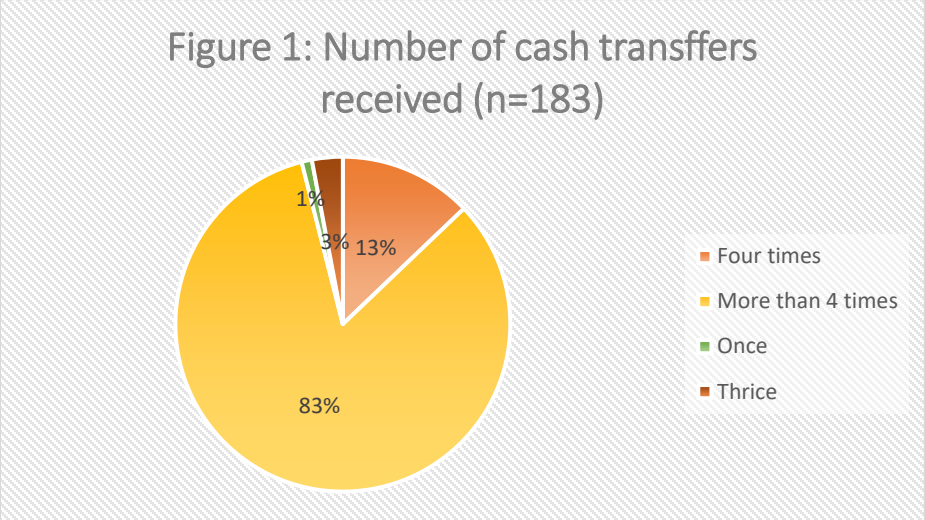
Selection criteria	Frequency/total responses (n=305)	Proportion (%)
Widower/Widows or divorced household heads without source of income	19	6%
Households with children under 5 years of age	123	40%
Households with pregnant or lactating mothers	107	35%
Households with orphan children	5	2%
Households with severely malnourished children or child	20	7%
Households headed by a disabled person without any source of income	5	2%
Households headed by chronically ill parents	5	2%
Households headed by elderly with dependents and no source of income	1	0%
Others	20	7%

Table 2: Reported selection criteria

Almost all (99.5%) thought the selection process was fair. CHVs in Mahandakini Community unit however indicated that the communications were not regularly done during the registration and verification phases thus a number of community members who were in the initial registered list still expected to end up in the program as they felt they had met the criteria. The project officer confirmed that the initial assessment and registration phases yielded more than 1,000 vulnerable households which forced the KRCS teams in consultation with community leaders to review the listing and held a validation exercise in a community meeting. It was indeed acknowledged that community engagement process in terms of enhancing transparent communication was not adequately managed.

Cash distribution

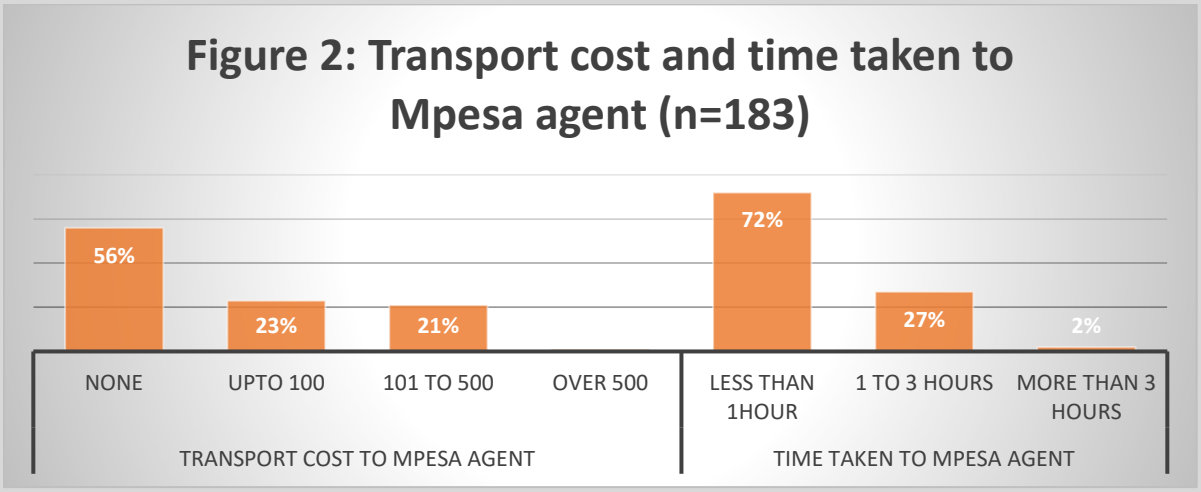
By the time of the end term evaluation,83% of the respondents indicated to had received more than 4 transfers as most had received the fifth. Differences in the number of transfers depended on when the verification processes were cleared to ensure the right beneficiary got the support.



98% of the CVA recipients indicated that cash came right on time to enable them to meet their needs. None of them had to give any favors or money to get the cash.

`…My baby fell sick one time and I did not have enough money to pay at the private facility. The treatment cost was about 2,100 ksh. and I could only afford 1,000 ksh. I negotiated with the healthcare provider who allowed me to pay later in the week and had to hand over my ID as security. However, as I was just leaving the hospital my MPESA message from KRCS came in with 2,034 ksh. It was such a relief for me. Thank you, Red cross,….', *Beneficiary mother Mata*

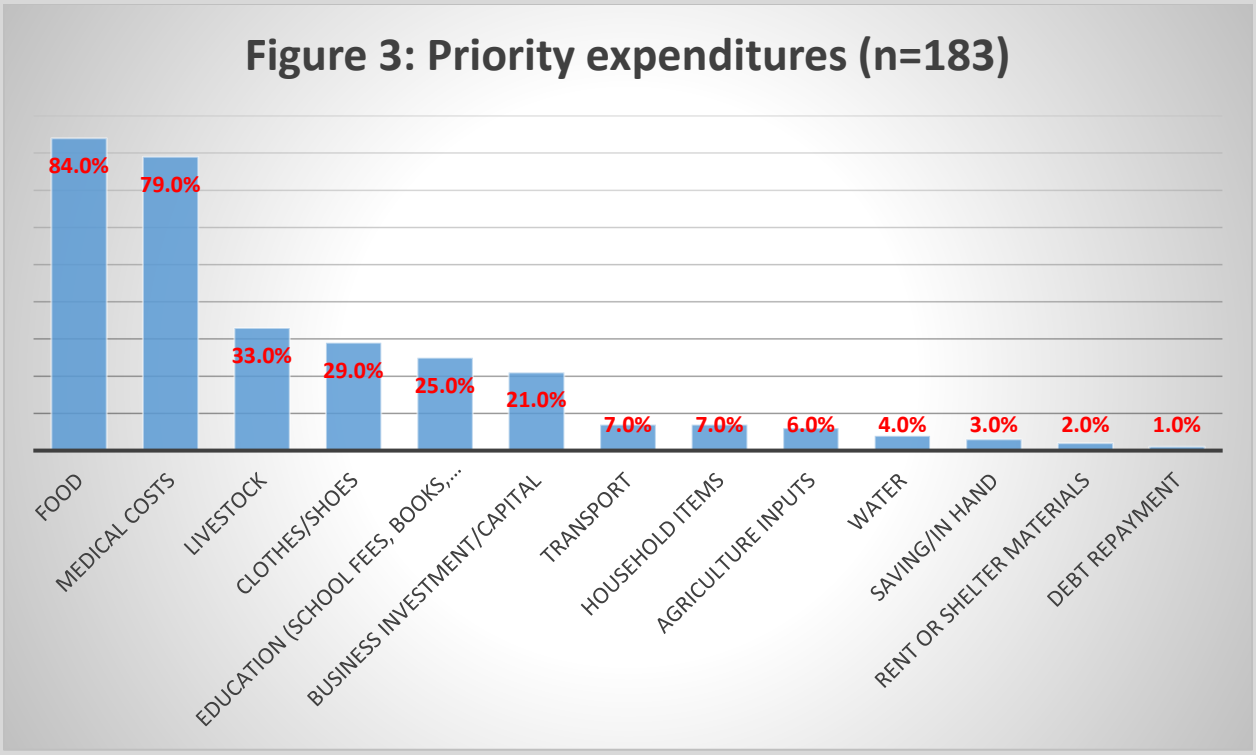
All cash recipients received their transfers through MPESA mobile Money.72% (132) indicated they took less than an hour to access the Mpesa agent shops while 3% used more than three hours to and from the agent shops. On the other hand,56% (102) of the respondents did not spend any money on transport to the Mpesa agents.23% spent up to Ksh.100, 21% up to Ksh.500. and 1% spent over Ksh.500.



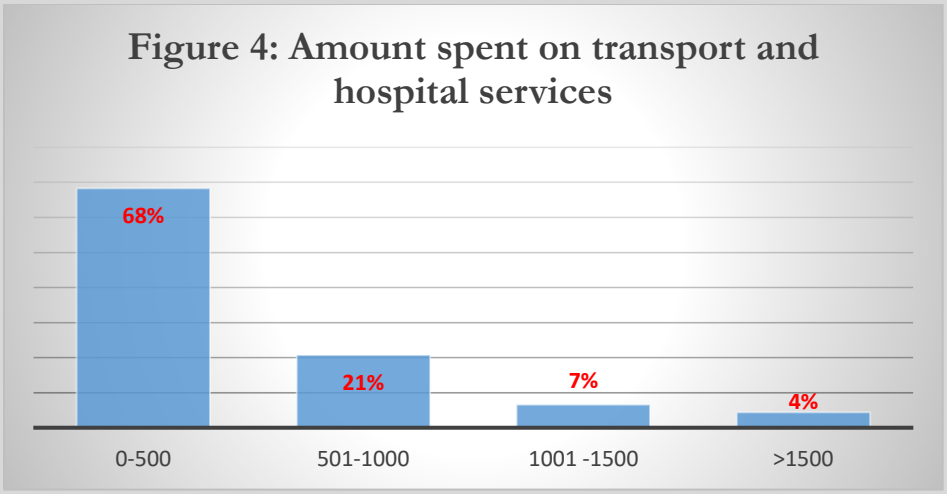
99% felt very safe at the cash distribution agent and 100% were satisfied with the CVA process. 98% had received their last disbursement in the month of march when the documentation was taking place. 81% indicated that they had not been informed when the cash was to be distributed.

Cash Utilization

The top three priorities that recipients spent their Cash on was Food (84%), Medical costs (79%) and livestock (33%).Livestock was an IGA initiative for most people who bought young goats, sheep and poultry to enhance sustainability for child support. Business investment was mentioned as a priority by 21% of the respondents as a number of them started grocery shops, baking businesses and some sold children clothes and items amongst others. Transport costs were mainly linked to medical expenditures as most had to visited private facilities far from their homes following healthcare workers strike.

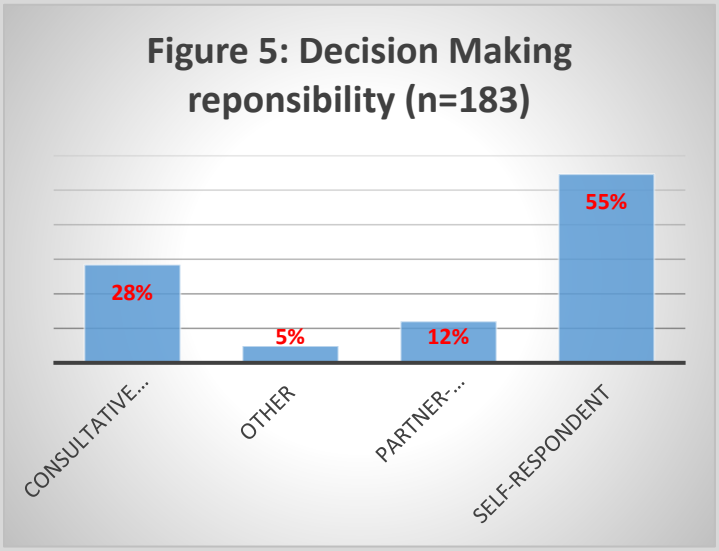


With 7% (13) prioritizing transport as a key expenditure, only 2% (4) of the respondents indicated not to use Cash on transport to health facilities in the past one month.66% (121) spent up to Ksh.500 to access health facilities while 4% spent more than Ksh.1,500 on the same. A number of respondents indicated to go facilities in Tanzania while some sought private facilities after the healthcare worker's strike. On the other hand, establishment of isolation centers made people to seek alternative facilities for care due to fear of infection.



While food was the highest priority for most households that received cash transfer,32% (59) indicated they could not get the food they needed in the local market. The contributing factor to this were the travel restrictions that were enforced by the government to restrict spread of COVID-19. Movement of goods from neighboring towns, counties and across the Tanzanian borders were thus hampered. This led to increased food and other items' prices forcing a number of households to determine coping strategies due to food insecurity.

93% (170) of the people reported that they would still prefer CVA to receiving food and nonfood items should the program be extended. This was justified by the fact that a lot of their needs would require cash and not prescribed items that might not be a preference to them.

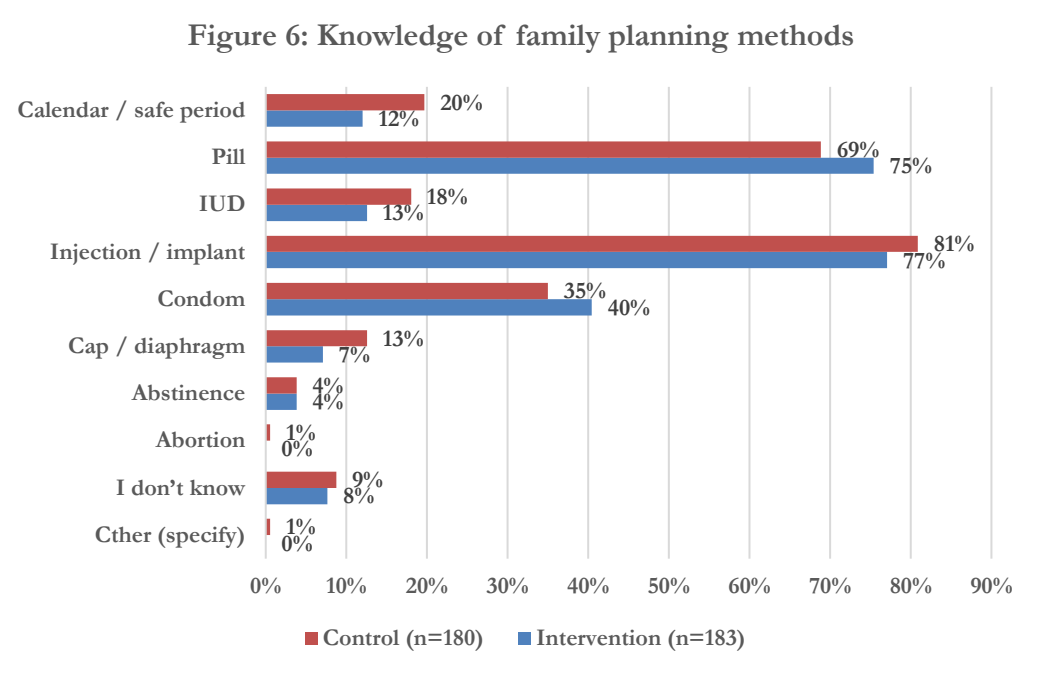


55%(101) of the respondents reported to have made their own decisions on how to utilize the funds received.28% (51) had a consultative process where the decision was made together with the partner. On the other hand, 12%(22) reported that its their partners that solely made decisions on the same; this was mostly reported amongst the Maasai community in the area.98% reported that there was no conflict in the family following the cash transfer while all of them indicated that there were no reported cases of tension at the general community level. A few (2%) that reported conflicts at the family level was because of their husbands who received and did not avail the cash to them neither did they agree with them on priority expenditures for the cash. 53% reported price increase in commodities that were not necessarily because of the CVA but mainly due to inaccessibility of usual products in the market. Transport costs for traders increased and availability of suppliers reduced; this basically meant that the traders had to increase the commodity prices to meet increased trading costs following the Impact of COVID-19.

3.3 ACCESS TO MNCH SERVICES

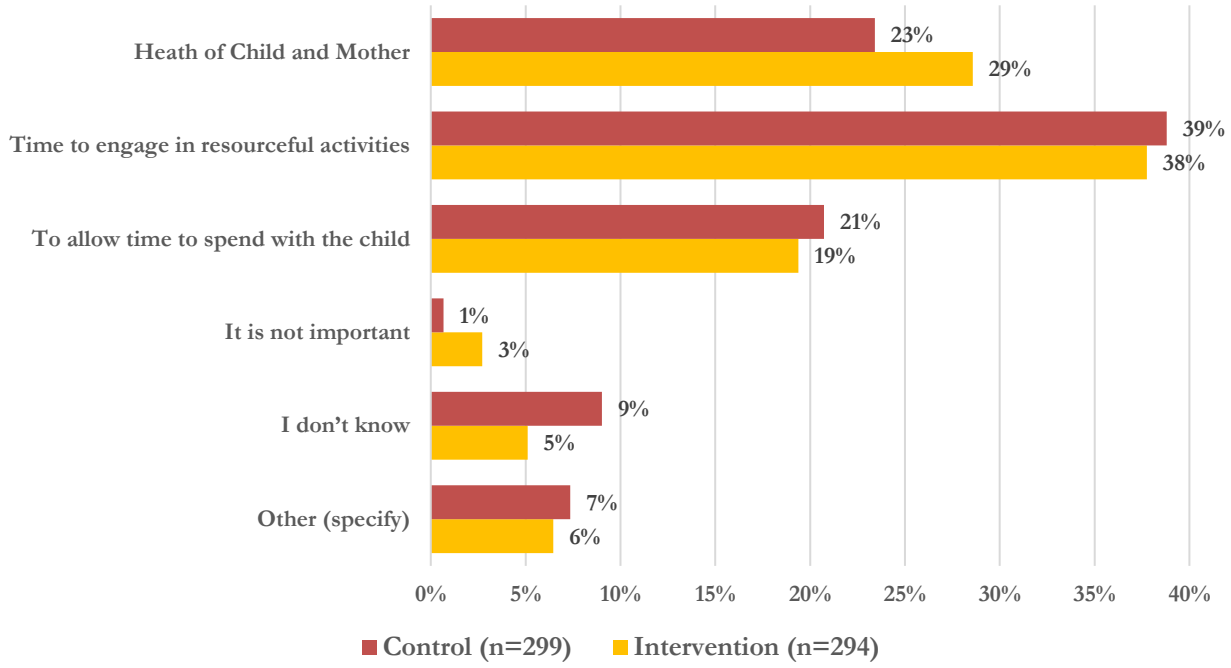
3.3.1 Family Planning (FP)

Injections and implants were the most common FP methods mentioned by the respondents at 81% and 77% amongst the control and intervention groups respectively. Pills are the second highest utilized method as reported by 69% of the control and 75% of the intervention groups. On the other hand, 1% of the control group believes that abortion is a family planning method. Almost the same proportion of the two groups (9% control and 8% intervention group) indicated not to know any FP method. The knowledge of FP methods is not significantly different between the two groups.



Most respondents reported that FP promoted the health of the mother and child as the body of the mothers have enough time to recuperate while the baby is given enough time for care enhancing its nutrition and development. Respondents equally reported that spacing children gave them time to focus on other resourceful activities including business set up and farming. 9% of the control and 5% of intervention group respondents did not know any importance of FP.

Figure 7: Importance of Family planning

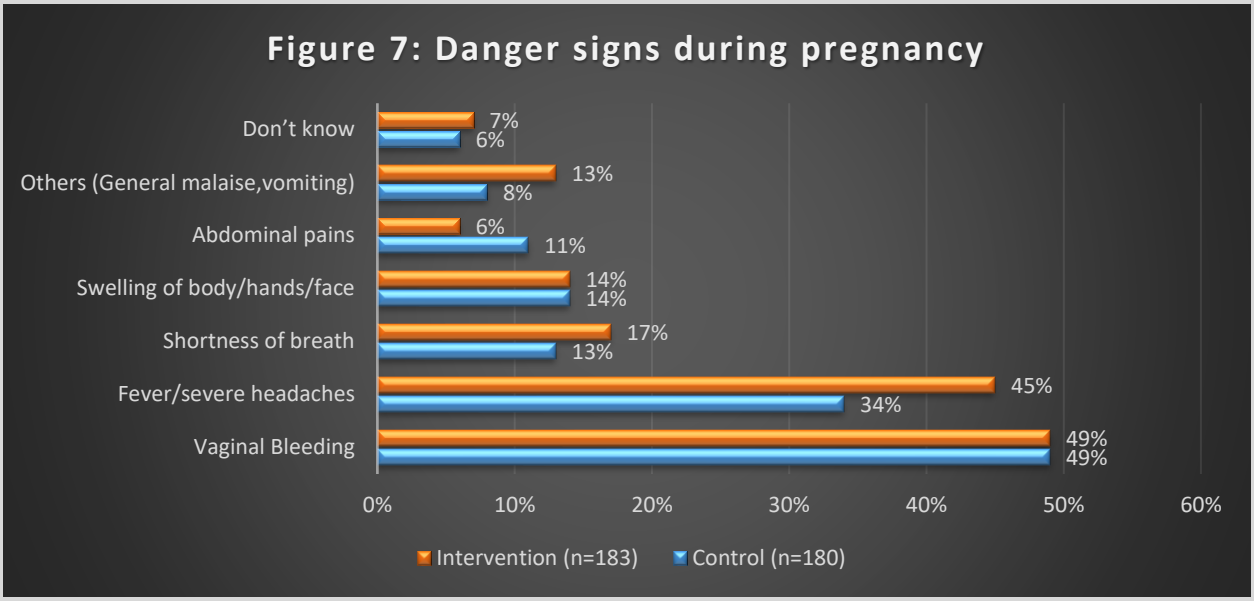


The Mahandakini sub county public health officer reported that uptake of FP is high, with about 90% using injections while quite a number using long term methods. He highlighted that Marie stopes, a family planning organization visits the area every three months and serve an average of 20 to 30 mothers turning up for the long-term FP methods. He however reported that in 2017, Marie stopes officers were chased away from Njukini as men were protesting that their women were not giving birth anymore.

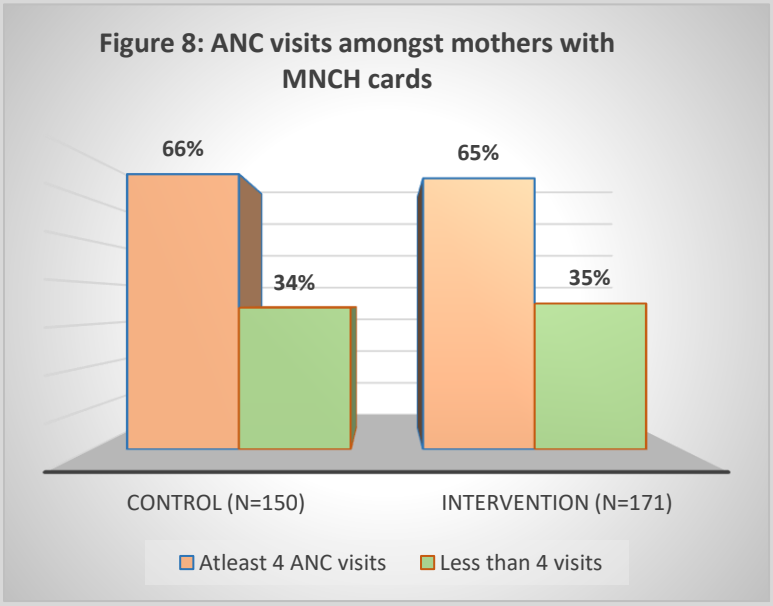
CHVs in Kimorigo engaged in a heated debate between the men and women in the FGD meeting, with men complaining that the women in their communities were on long term FP methods and getting children is a problem in families. They explained that some of them had to get other wives who were ready to bear children and this has contributed to domestic violence in many homes. The women in the group confirmed that most ladies giving birth currently are the younger ones in their tens and twenties but older women are on FP. They indicated that there is gender imbalance in many homes with almost all family responsibilities left for the woman. Most of them thus understand that the more children they deliver, the more responsibilities they would add to themselves. As highlighted by one KII, with the continued promotion of FP for the last decade in the area, women in the community have internalized and embraced the FP message.

3.3.2 Antenatal Care (ANC)

6% of the control group and 7% of the intervention group reported to not know any signs of danger during pregnancy. About fifty (49%) of both groups mentioned vaginal bleeding while 45% of intervention group and 34% of control group mentioned Fever/Headache. 11%(19) of the control group mentioned abdominal pains compared to 6% (11) of the intervention group. Other signs mentioned included vomiting and general malaise at 13% for the intervention group and 8% for control group.



93% (171) of respondents in the intervention group had MNCH cards that were used to verify the tracked mother and child indicators under the MoH. The equivalent was 82% (150) respondents under the control group. 65% and 66% of the mothers with children under 5 years in the intervention and control group respectively made at least 4 ANC visits the last time they were expectant.



At the onset of COVID-19 and during the HCWs strike, the turn up for ANC visits was low. About four months down the line after the pandemic was reported, the mothers slowly started visiting the facilities for services. Most mothers felt that it was risky to hospitals because they handled many people and thus infection rates would be higher. They reported that they would sit on the bench outside while waiting to be seen by the HCWs; and that posed a high risk for them as a single bench accommodate many patients. Some felt that the HCWs themselves would still infect them as they observed many people from the communities.

The CHVs did a lot of work in following up of defaulters, calling them to find out their plans of attending the clinic. CHVs in Kimorigo however indicated that most mothers in the area would go to the facility for the first visit then wait until almost due date to go for the next visit. They however decried cases of misdiagnosis by HCWs at times.

`…There is an expectant woman who went to the public health facility for ANC visit and was advised that the baby was dead in the womb since there was no movement. The lady had felt that the baby had not moved for some time but was not convinced it was dead. So she called me and I advised her to calm down and go to the sub county hospital for a scan. When she went, the scan revealed that the baby was ok. Since that time, she feared going to the public facility for next ANC visits and I had to keep accompanying her every time …CHV Kimorogo CU'

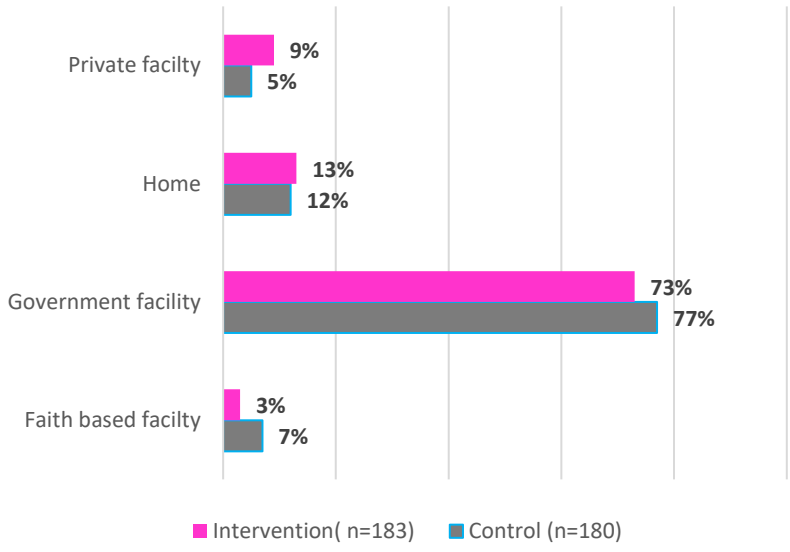
Beneficiary mothers in an FGD indicated that once a mother has information like they now do, they would easily go to the health facilities for the necessary services. They said that if a mother is vulnerable e.g. living with HIV/AIDs or has a troubled pregnancy, she is more motivated to visit the facilities as scheduled. The mothers also explained that at times they were asked to go for the visits with the husbands and yet for some, their husband live elsewhere; so they fear going back to the facility without them as the HCWs would reprimand them. In addition, transport costs for the minimum four visits with the current economic hardships made most mothers not to regularly go to the revisits. CVA was reported to have been a great motivator for mothers to make ANC visits as they could afford transport costs for the minimum four visits.

3.3.3. Health facilities assisted deliveries

88% and 87% of mothers in control and intervention groups respectively, delivered their youngest child in a health facility under observation of skilled health care workers.13% of intervention group and 12% of the control group on the other hand had home deliveries. Government facilities were the most preferred because of affordability. Most respondents that delivered in a private or faith based facility were forced by circumstance either due to the health care workers strike or due the COVID-19 that saw most government facilities at county and sub county level used as isolation centers. Home deliveries were said to have increased due to the pandemic as most women feared contracting COVID-19 in health facilities due to the large numbers of people that the facilities serve. Some health facilities were reported not to operate at night as the HCWs didn't have accommodation near the facilities thus such mothers would opt to deliver at home with support of a family members.

The public health officer in Mahandakini reported that many boarder communities in the area believe that there is no COVID-19 in Tanzania following communications that have been going around. This had caused many of the catchment population to prefer visiting Ngoyoni facility in Tanzania than Mahandakini. The SCPHO reported three home deliveries in the last three months prior to the interview as some of the mothers could not afford to get to either Njukini or Ngoyoni facilities due to high transport costs. On the other hand, the Community Health Assistant

Figure 9: Place of last delivery



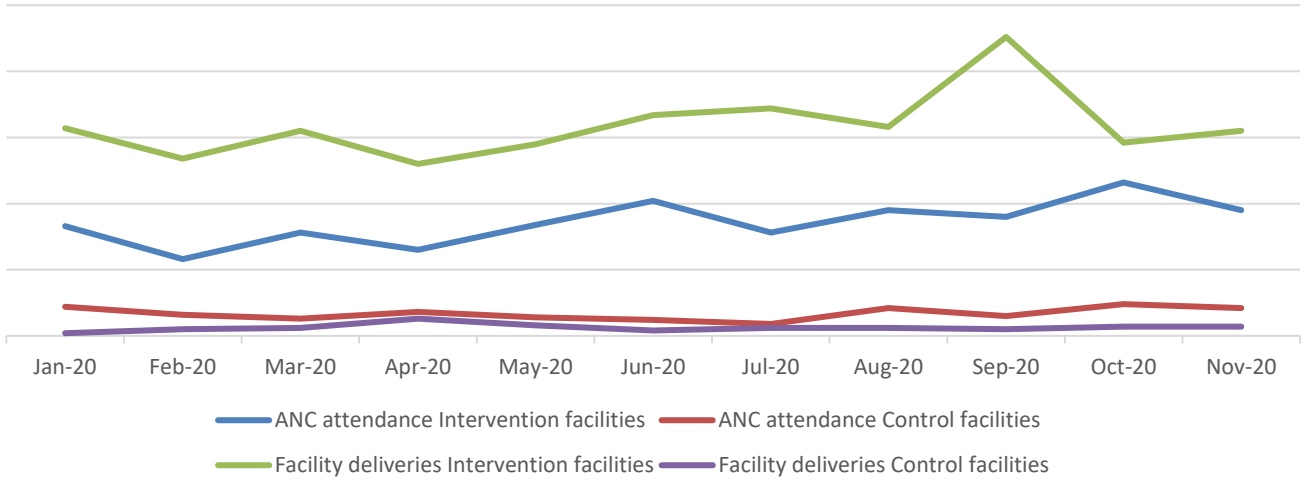
(CHA) representing Mata and Rekeke Community Units reported to have documented 11 home deliveries between November 2020 and February 2021.Most of the home deliveries were reported at the start of the pandemic but with the onset of the project these numbers significantly reduced. He explained that the reduction has been due to the cash assistance that had enabled access to health facilities and also the CHVs who have been motivated to support the follow ups. Men in the Rekeke FGD reported to have received a lot of support from the health facility as they had an agreed referral mechanism with the facility in charge. When deliveries were due or an emergency occurred, they would call the facility in charge on his personal mobile handset and he would send an ambulance for response.

Rekeke facility in charge indicated that during the health workers industrial strike, mothers preferred home deliveries as the traditional birth attendants charged very little money compared to private facilities that charge up to Ksh.8,000 per delivery.

The attitude of healthcare workers was reported to be a hindrance to a number of mothers in Kimorigo as reported by the CHVs and corroborated by Men in Mtisoni. `…*The local public health facility has no well-trained HCWs and their attitude is wanting. A mother was brought to the facility by a TBA and was turned back indicating that the delivery was still days away, the TBA tried to have the mother observed from the facility because her observation indicated the mother was due any time of the day but this was not agreed, she went back with the mother and delivered her on the way home….' CHV FGD Kimorigo*

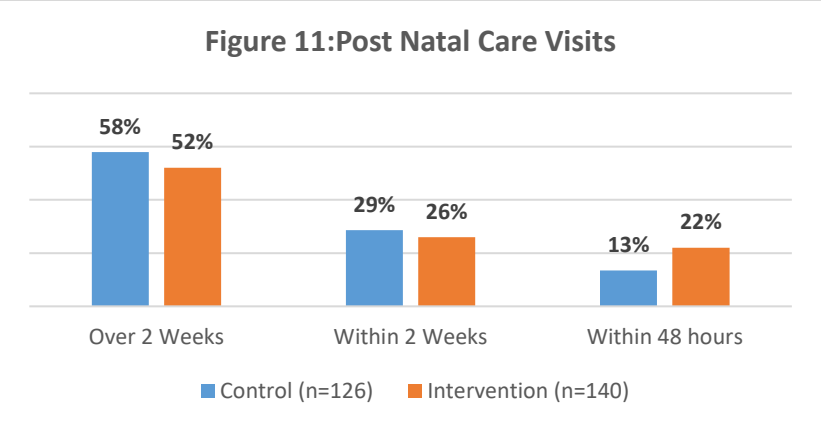
MoH facility data below from January to November 2020 indicate an overall high ANC attendance rate and facility deliveries in Intervention wards compared to control wards. The health facility deliveries numbers take an upward trend in November in the intervention group as the projects CVA started off. The same is reflected in October for ANC attendance. The last quarter of the year 2020 was largely affected by the health care workers strike and thus most facilities did not report between December 2020 and January 2021.

Figure 10:ANC visits and facility deliveries in intervention and control facilities-moh facility data



3.3.4 Post Natal Care (PNC)

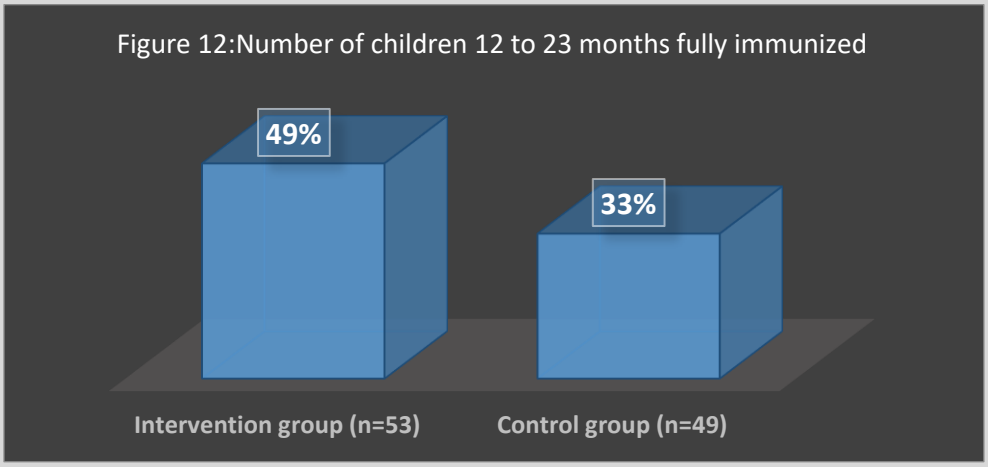
More mothers (76%) in the Intervention group made at least one PNC visit within a month compared to 70% in the control group.22% of them made their first visit within the first 48 hours of delivery compared to 13% in the control group. Most mothers in both groups made PNC visits after two weeks of delivery.



The facility in charges indicated that most mothers who deliver in health facilities only come back for immunization services. The few cases that happen to deliver at home are followed up by the CHVs and accompanied to facilities for checkup and first immunization. After Measles immunizations, no mother comes back to the facility for growth monitoring. Rekeke facility in charge reported that apart from the CVA, Linda mama programme undertaken by the MoH had contributed a lot to the uptake of the MNCH services as the facility gets some allowances for mothers visiting the facility for ANC and PNC. The in charge indicated that the program reimburses the facility Ksh.600 for a first ANC visit and Ksh.300 for subsequent visits while PNC is Ksh. 300 per visit.

3.3.5 Children fully immunized

Measles Rubella vaccine administered at 9 months was used as an indicator of full immunization. The children recorded were those that had vaccination cards that were observed by the enumerators. As guided by the MoH, the indictor is measured against children aged 12 to 23 months. 49% of the children in the intervention group were found to have been fully immunized compared to 33% in the control group.

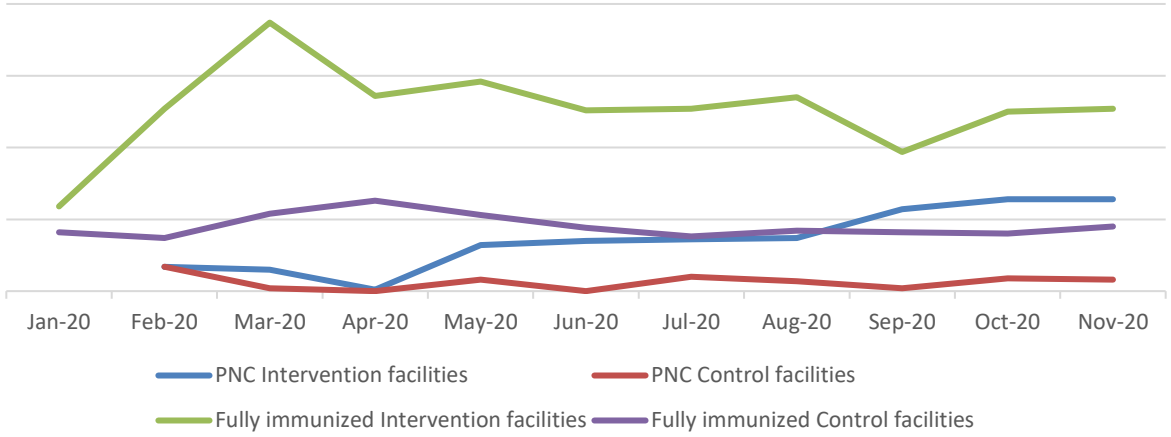


Rekeke health center in charge reported that immunization uptake was generally good. He said that during the Strike, mothers went to Chumvini private facility in which an injection costs an average of Ksh.40. At the onset of the pandemic between March and August 2020 the area CHA reported 64

immunization defaulters. Since the onset of the project, the CHA did not report any immunization defaulters. He indicated that the Cash assistance came in handy to cater for transport costs and payment for the injections in private facilities thus enhancing immunization accessibility to most mothers.

The MoH data indicates that uptake of immunization and PNC services is higher in the intervention's wards compared to the control sites. The figure below indicates a sharp increase for the immunization indicator from January 2020 to March when the first case of COVID-19 was reported. There is then a downward trend to September after which the numbers increase between October and November when the project started. The PNC numbers equally increase during the same period.

Figure 13: MoH data on PNC and immunization in intrevetion and control facilities



3.3.6 Exclusive breast feeding (EBF)

Most families were reported to be farmers and thus spent a lot of time in farms in addition to engagement in other small business activities. This was reported across different respondents to be a contributing factor to why mothers do not exclusively breast feed. It was estimates that only 20% of mothers in the community practice exclusive breastfeeding for six months. Beneficiary mothers explained that since most of their husbands had lost jobs, they were forced to also work and thus making them to be away from home engaging in different economic activities, which leads to early weaning of babies.

Men FGD in Mtisoni reported that EBF could only be done for three months in most cases. Factors raised by the men included loss of means of livelihood which had led both men and women to fend for the families and lack of sufficient knowledge on the importance of EBF. The men also raised a concern where stigma is attached to exclusive breastfeeding in that it is associated with HIV/AIDs. This means that if one is exclusively breastfeeding, they are thought to be living with HIV/AIDs.

3.4 EFFECT OF CASH ASSISTANCE ON MNCH

The CVA was reported to have started on time as many were struggling in their families after loss of means of livelihoods during the COVID-19 pandemic. Facility in charges reported that growth monitoring activities in the facility increased as mothers would come back to the facilities after the measles vaccination, which was a rare occurrence in the area. With this program, mothers would be motivated by the cash which would only be transferred once all expected MNCH services had been taken and confirmed. The CHVs were equally reported to have been encouraged by the programme and thus kept following up the mothers.

Many beneficiary mothers started IGAs with the Cash in order to enable sustainability for the needs of the children after the programme. Some of the IGAs include poultry, rabbit and goat rearing, baking and selling cakes, children clothes and grocery stalls. Two women beneficiaries reported to have started a small business of making and selling half cakes. One reported to be making a profit of Ksh.350 daily and the other Ksh.500 daily. They reported to have used the cash in providing for their families and for accessing medical services.

The CHVs indicated a reduction in defaulter rates in Immunization and ANC as there has been a lot of efforts from them to follow up the mothers and ensure they met their appointments before next cash transfer. On the other hand, the Men in their discussions reported that the CVA enabled them to meet transport costs to health facilities as due to the HCWs strike and set up of isolation centers in public facilities many opted to visit private facilities. They reported that average transport cost on motorbikes to the facilities was Ksh.250 while the cost of immunization and other injections were on average Ksh.100 which they indicated they would not normally afford and thus the CVA was a great relief to the families.

One of the women beneficiaries reported that she had a malnourished child. When she received the first CVA she bought food for the family and started nutrition clinics for her child. She also started selling Irish potatoes from which she was able to buy three chicken which had hatched and at the time of the interview had 20 chicken. She reported to make an average of Ksh.100 daily from the potatoes business and the health of her malnourished child improved.

> One mother beneficiary said `…I paid 3,000 sh. for my child's school admission in January. I later bought a dozen panties for sale and so far the last purchase I bought was 4 dozens…. I used most of my profits in hospital too because my other child is asthmatic…that asthma is very expensive please help us continue, God has really blessed us through Red Cross'

Change story 1: Caregiver supports mother with special needs to access MNCH services

Area: Malukiloriti Village

Person telling the story: Pricilla Kiita (beneficiary caregiver)

Person Writing Story: Evelyn Kisamo (project officer)

At 28 years of age, Dorcas Kiita is a quiet and shy woman from Malukiloriti village in Taveta Sub-county. She lives with her young daughter under the primary care of her mother, 68-year old Priscilla Kitiva Kiita. They share a two-room mud house. Dorcas, who is mentally handicapped delivered her daughter in a local dispensary and her mother has been responsible for ensuring her daughter and grand daughter are taken to the clinic for MNCH services. When the pandemic struck, times became even harder and clinic visits had to stop. Priscila said that only after the Red Cross stepped in with sensitization and financial help she has been able to resume clinic visits.

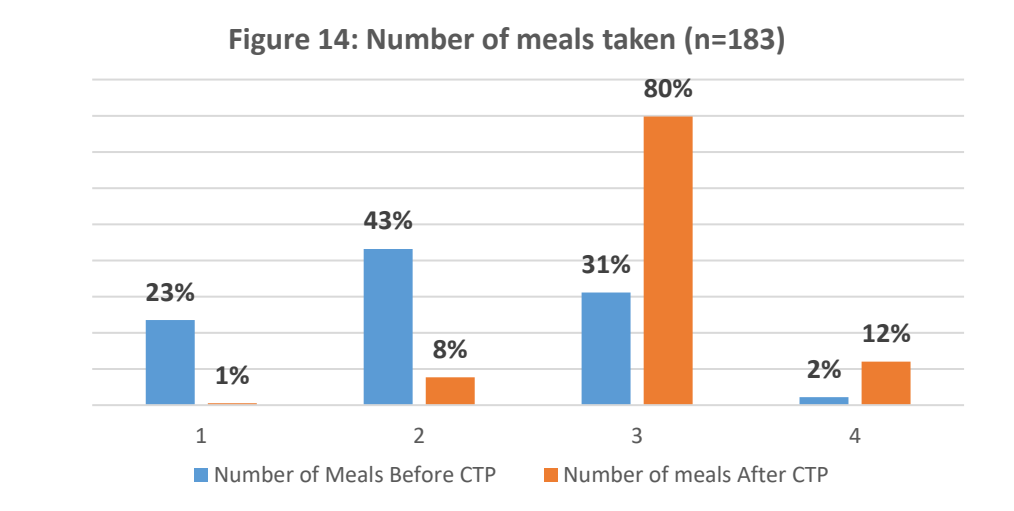
Dorcas' mental condition is not formally diagnosed, but she has difficulties with general interactions, which are limited to her family and a few neighbors. According to her mother, Dorcas had a normal childhood until age 6 when she developed complications after she contracted yellow fever disease. Multiple trips to various hospitals did not yield much as the prolonged illness resulted in limited awareness and comprehension of her surroundings. Despite these hardships, her mother supported her education up to class 7 and had to drop out due to her pregnancy.

Priscilla, who depends on seasonal farming and often works as a casual laborer in a quarry, says that it has been hard to take care of Dorcas and her young granddaughter. Priscilla is grateful to KRCS for the cash transfer project. Since it began, her burden has been eased and the cash has benefited Dorcas in various ways. They have been using the cash to buy food, clothes and taking Dorcas's child to the clinic for growth monitoring. 'With the health care workers strike, and now the cash assistance from Kenya Red Cross, I have afforded to take my granddaughter to a private health facility. I also ensure Dorcas eats well so there is enough breast milk for the baby...'

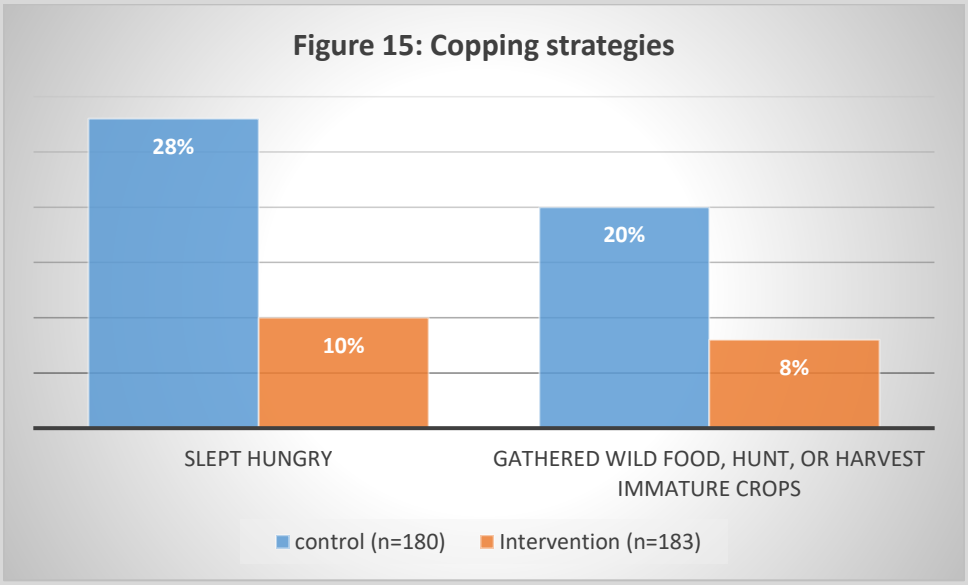
1st Photo: Dorcas standing in front of her mother's house.

2nd Photo: Dorcas and the Mother during the interview with red cross staff and volunteers

The stories told by the beneficiary is corroborated by the finding that 43% of people had two meals daily while 23% had only one meal a day before the CVA. After the CVA most families (80%) could afford at least three meals a day in comparison to only 31% before the CVA as depicted in the figure below:



In a period of thirty days prior to the data collection, 28% and 10% of the control and intervention groups respectively had to go to bed hungry at least once due to lack of food in the house. On the other hand, 20% of the control and 8% of the intervention group had to gather wild food, hunt or harvest immature crops due to lack of food in the household.



Change story 2: Food security for Persons Living with disability

Area: Mahoo ward, Rekeke

Person telling the story: Selina Nariwoi-Woman beneficiary

Age: 35years

Person writing the story: Barbra Mwashashu (Project Volunteer)

Selina Nariwoi gave birth in Rekeke government health facility for the first time; her last-born son is now two months old. She is a single mother of three. Following her husband's sudden disappearance, Selina had to work harder than ever. Her husband, being a Tanzanian, allegedly fled to Tanzania because he was afraid of being arrested for not having a passport and other legal documentation.

Selina is partially deaf and uses sign language. However, she was not born this way. When she was ten years old, she was diagnosed with malaria and was prescribed for drugs that had serious side effects on her which impaired her hearing up to date. Her relationship with her mother and sisters is not so good since her mother is an alcoholic.

Like many single mothers in the area, she has struggled to make ends meet. "My life was difficult and the cash I got from working as a casual worker was barely enough to feed her children. I used to have one meal but since the Cash for Health project started, I was among the first vulnerable women in Rekeke Location to be enrolled and since then, life has changed. Through this provision, I managed to provide three meals a day for my family and bought a goat and two chicken for rearing; with some of the cash received I bought clothes for my two months old baby, food and school fees for my ten-year-old son. Additionally, I was able to pay medical bills especially since the public facilities were closed during the time due to health workers' strike'.

Though the 'cash for health in emergency' project is coming to an end, "I wish it to continue so that I can take My daughter back to school and build my own temporary house since I currently live in my brother's house"

3.5 THE ROLE OF COMMUNITY HEALTH VOLUNTEERS (CHVs) IN MNCH

The CHVs operate under the community health strategy platform within the MoH structures. The community health strategy establishes a level one care unit (community unit) to serve a local population of 5,000 people. Each community unit has a cadre of well-trained CHVs who each provide services to an average 100 households depending on population distribution in the unit. For every 25 CHVs there is one Community Health Assistant (CHA) providing supervision and technical support. CHAs are trained health personnel with certification in nursing or public health and are MoH employees. The CHAs responsibilities in the community health strategy include facilitating trainings in the community, providing facilitative supervision to CHVs, and providing a link between CHVs and health facility.

CHVs in the target intervention communities reported to undertake the following roles in the promotion of MNCH services:

- Referral of mothers to health facilities for routine medical checkups or treatment. Accompanied referrals are often preferred by the CHVs in the area to ensure mothers make their required visits.
- Defaulter tracing and support on clinic appointments tracking
- Health sensitization on various health related issues affecting mothers and children including danger signs during pregnancy, need for ANC, PNC, Facility delivery, immunization and EBF.
- Growth monitoring
- Support for development and monitoring on the individual birth plans
- Reporting and validation of clinic visits from the MNCH clinic cards.
- Support targeting and registration exercise in readiness for CVA

CHVs reported the need to be paid some allowances by the county government as was the initial plan on starting community health strategy. Some of them said they had been CHVs since the roll out of the national community heath strategy and had not been given any allowances which forced many CHVs to opt out of their roles. CHVs in Kimorigo, a control group indicated that at the onset of CHS, they were 52 but are currently 37. Due to lack of motivational allowances and increased economic constraints, the CHVs indicated that they were not able to cover the usual number of households monthly and thus in most cases they check on select clients who need attention. They have equally shared out their contacts in case someone in the community needs their advice.

On the other hand, the CHVs in the Mata and Rekeke CUs where the interventions of the project were being undertaken felt a little bit motivated with the small allowances paid to them by the project during this project period. They however indicated the Ksh.500 monthly allowances need to be reviewed upwards to keep them motivated. The county government initial deliberations which applies across the country for CHVs monthly allowances was reported to be Ksh.2,000.

The CHVs in the intervention area said that they have equally supported mothers with special needs including those who were mentally challenged, deaf and dump. They mainly relied on close family members to communicate to the individual mothers. They requested to have a few of them trained in sign languages to enable better communication with community members with special needs.

3.6 MALE INVOLVEMENT IN MNCH SERVICES

Men involvement in MNCH services was reported to be good in the target communities as at least 40% of men accompanied their wives to ANC clinics at least once during the last pregnancy. One

men FGD participant said '*. I learnt in one visit that the baby responds well when relationships between both parents is good. My wife had complications so I ensured I accompanied her throughout the nine visits..'* Male FGD Rekeke

On the day of the interview at Mahandakini dispensary, it was immunization clinic day and it was observed that many men had either accompanied their wives or supported their transport to the facility. The beneficiary women acknowledged that their men ensured the household chores were done by themselves including gathering firewood, washing clothes and cooking. There was however reported need for sensitizing the men to understand their roles in MNCH services.

3.7 COMMUNITY FEEDBACK HANDLING

35% (64) of the intervention group compared to 2% in the control group were aware of KRCS community feedback mechanisms. The channels mentioned included the toll free line, CHVs/RCVs and office walk ins. 17% of those who knew about the mechanisms in the intervention group reported to have used the channels to raise issues about the programe, mainly about timings and numbers of CVAs expected. 91% of those who raised complaints had their issues solved within 3 days and were 100% certified with the handling of the feedback. Regarding General communication with communities, people prefer using chief's barazas, religious leaders, Health facilities in charges and CHVs as these were said to be structures, they interacted with mostly and thus developed trust with them.

3.8 COVID-19 EFFECTS

The pandemic contributed to many households losing their sources of income and thus increasing Stress levels in homes. Families became food insecure because of increased food prices as access to suppliers by vendors was cut off following lock downs and restrictions in movement. With the school children staying home, there were increased cases of SGBV including pregnancies amongst school going children and domestic violence which in most cases were solved at home.

The pandemic made people to fear visiting health facilities due to risk of infections and also because they were forced to wear face masks, which many indicated they could not afford. Continued sensitization saw the fear subside and currently many are visiting health facilities and are able to afford the reusable face masks.

On average 76% of intervention group and 54% of the control group were willing to get the vaccine if availed to them. The motivation was the need to keep themselves healthy and prevent the infection. For those that were not ready they mostly reported safety concerns as voiced in social media. People still have many questions including: Should someone who has COVID-19 be vaccinated? what of those with pre-existing condition like diabetes, what about pregnant and lactating mothers, Is the vaccine meant to treat COVID-19? Shall we still have to wear masks and observe curfew time after vaccination? Many of the respondents reiterated the need to be sensitized about the vaccine to enable them make informed decisions.

4.0 AFTER ACTION REVIEW

This review was a discussion held with the project staff and volunteers to deliberate on the whole project process. The review sought to detail what was planned to be done, what was done, what were the success and weaknesses that need to be addressed on scaling up or replication of the interventions. The summary is depicted in the table below:

Thematic area	What worked well	What Did Not Work Well
Conduct project inception with key stakeholders (County, Sub County, Community levels)	• Conducted inception meetings with the CHMT, SCHMT, Volunteers, and community members –through meetings and community barazas. • Through the inception meetings we were able to identify a number of concerns/insights of which some were addressed during implementation.	• A rapid analysis (Baseline Survey) before starting the project was not done • Private health facility team not included in inception meetings
Coordination with other partners and actors implementing cash transfers in the County (If any) as well as CWG	Coordinated with other stakeholders i.e. Social development officers, world vision and NDMA • Shared data from other stakeholders to avoid duplication • Sensitized stakeholders on project implementation	
Identification of volunteers and sensitization to support beneficiary registration and verification	• 40 KRCS active volunteers were identified and trained to support in registration and verification. The volunteers were drawn from different villages in the sub county which made it easier to distribute the team among the 56 target villages. The volunteers were required to have NHIF card and must have officially registered with KRCS.	• The trained volunteers registered a higher number (1088) over the target number (915). • Some of the volunteers registered male on behalf of the women instead of indicting the male as alternate, it later on brought confusion while conducting verification on uptake of the services through facility registers.
Mobilization, targeting and registration of beneficiaries in Matta, Mahoo and Challa wards	• Mobilization of the beneficiaries was done well. The community health volunteers supported in **mapping** the villages and households that had the targeted pregnant, lactating and mothers with children under five. The CHVs supported the KRCS volunteers in **registration**, and after registration the team supported in conducting verification of the registered beneficiaries through community meeting where each name was read out for	• The number of pregnant and lactating mothers registered was more than the targeted number, hence took so much time in verification. A number of registered mothers had to be dropped which brought about complaints from the communities.

	confirmation and **verification** of details. The verification exercise through community meetings was a success since a number of issues were identified i.e. double registration, registration of both spouses, wrong contacts/identification	• Lack of harmonized system i.e. Kenya's Single Registry for Social protection to facilitate the validation of data and to minimize double registrations whilst observing recipient data security • Limited logistics – only one vehicle was used to support in registration and verification in such vast areas, this resulted to delays and too much work load.
Training of Community Health Volunteers on MNCH and KEPI integrating COVID-19 facts and IPC	• Trained 40 CHVs and 8 KRCS volunteers, on KEPI and Covid-19 IPC measures. The team was well equipped with information that was to help in conducting sensitization and verification through facilities.	• The training was conducted for only two days that were not enough considering the number of topics that were to be covered.
Monthly follow up on beneficiary hospital visits by community health volunteers	• The monthly follow ups were done on time by the CHVs, which included conducting sensitizations on ANC, PNC, Immunization and IPC On Covid-19 through household visits	• Not all reports from CHVs were clear, some lacked accuracy, that forced the project officer to conduct confirmation through calls and visits. • Monthly allowances of 500 sh. To CHVs was reported to be inadequate
Verification of beneficiary hospital visits with health facilities	• Only one verification through hospital visits was done, however the Sub County Public health nurse supported in link up in private facilities for verification	• The health workers strike interrupted the verification through facilities • During registration the names of under-fives were not captured, only the mothers' names were captured, that became a challenge in the first month while verifying in facility registers. The reporting tool for the CHVs had to be adjusted/changed to capture all under-fives in households to allow proper

		verification on immunization registers.
Cash transfers using MPESA	• Cash transfers process was smooth; all the 915 contacts details were validated through mobile Cash transfer - Mpesa services. Out of the 915 beneficiaries only 113 had issues with their details that had to be re-validated and verified for the second time. • Mpesa proved the most accessible, effective than any other Cash transfers outlets in the target areas. • All 915 beneficiaries received five tranches	• Use of alternate numbers for the beneficiaries who did not own phones or IDs became a challenge since some claimed not to have received cash from their alternate (mostly spouses)
Conduct PDM	• Received feedback on the impact of the project from the community ,the target beneficiaries and other partners	• Sampled beneficiaries who were visited were not found at home (inadequate time for mobilization and lack of consideration of the social events i.e. Sunday and Saturday) • The PDM exercise was only done ones
Conduct community health outreaches in remote areas	• Turnout was high, mobilization was done well and timely • Both community members and targeted beneficiaries benefited from the outreaches • All the 8 planned outreaches were conducted	• Insufficient vaccines and drugs for the outreaches- *concern was addressed to the county health department*
CEA Activities - community feedback/review meetings including project exit meetings	• High turnouts in some target areas, People felt that their voices were heard and issues affecting them addressed in an open forum • The first community engagement meeting offered a platform for the community members to understand the project, own it, share feedbacks, and ways they would wish to use the unrestricted stipend i.e. for IGAs • Beneficiaries were well informed on the purpose of the project, project life and the project donor and sensitized on uptake of the health services and investing the little amount they could	• Male chauvinism displayed in some communities thus the women could not address themselves freely • Low turnout for the men who were mobilized to participate in the meetings • Community complaints channels were not well embedded within the project thus most beneficiaries did not know how to reach KRCS with their feedback. • Engagement of CHVs in the review of the initial registration was not adequate as some thought KRCS were selective

		regarding the individual beneficiaries and thus dropped many whom the CHVs thought disserved to be in the programme.
Visibility, communication and information activities	• Procured t-shirts and caps with Covid-19 messages • Conducted review meetings with CHVs and the beneficiaries each month	• The feedback line was not introduced early, however the team shared the line during the outreaches
Mainstreaming of protection and inclusion in the project	• Gender mainstreaming was observed as men were invited to community meetings. • Special case beneficiaries were monitored and followed up closely • All beneficiaries could access the meeting area easily, conducted in a central place and Covid-19 regulation observed to the latter • The project has 915 registered beneficiaries (there are three beneficiaries with mental challenges, 1 physical disability, 2 who were deaf) while other beneficiaries have family members in their households who are abled differently.	• Capacity building or identification of volunteers with sign languages capabilities. The volunteers relied on the caregivers.

Table 3: After Action Review

5.0 CONCLUSION AND RECCOMMENDATIONS

The cash for health in emergencies project reached 915 mothers with cash transfer and outreach interventions that were meant to improve MNCH indicators including ANC, PNC, facility deliveries and immunization coverage. 81% of the intervention group respondents were aware of the selection criteria and all the beneficiaries were happy with the whole targeting and verification process. Priority expenditure for the recipients were food at 84% and healthcare access as reported by 79% of the CVA recipients.

The evaluation adopted a comparative design in which a sample of mothers was randomly selected in the targeted wards of Mata, Challa and Mahoo in Taveta sub county which were the intervention areas. A neighboring ward of Mboghoni was selected as the control group. The findings reveal a slight difference between the intervention and control groups in relation to the targeted MNCH indicators. The MoH facility data however shows a general higher uptake of the MNCH services in the intervention areas compared to the control areas health facilities. 66% of mother in the control group and 65% of the intervention group made at least 4 ANC visits during there last pregnancy. 88% of mothers in control group and 87% in the intervention group delivered their last child in a health facility; mostly being government facilities. ANC uptake was slightly higher in intervention groups at 76% and 70% in the control group. In addition, 49% of children between 12 and 23 months in the intervention group were observed to be fully immunized compared to 33% in the intervention group.

CVA enabled mothers to access health facilities in both public and private facilities. In the wake of healthcare workers strike and the COVID-19 pandemic, the Cash enabled payment of medical costs as many sought services in private facilities. Apart from supporting healthcare access, families were able to put food on the table with 81% affording at least three meals a day compared to 31% before CVA.A number of beneficiaries also reported starting income generating activities.

CHVs supported the mothers to honor their clinic appointments and sensitized them on the importance of the different aspects of MNCH. The CHVs equally supported the registration and verification processes for CVA beneficiaries. Men participation in MNCH was reported with many supporting their wives' attendance of clinics. On the other hand, transparent communication and feedback handling had gaps as 65% of the intervention groups reported not be aware of feedback mechanisms put in place.

The following recommendations are made based on the analysis of the evaluation findings:

- The interventions are found to be beneficial as these has improved uptake of MNCH services and thus enhanced the health of the mother and the child. Considering this has been done for just a few months, it is recommended that the project be extended to consolidate the gains made and enable significant changes in the intervention group. Considering that the ANC and delivery indicators are almost the same between the intervention and control group, the project extension should consider upscaling to cover the neighboring wards in the targeted sub county.
- Entrench specific activities that would promote understanding and implementation of male involvement approaches in MNCH. Men raised concerns about the high rates of FP amongst women which have created disagreements in a number of families. Male involvement initiatives could address some of these issues.
- 19% of the targeted mothers were single mothers most of whole were young girls that had to drop out of school due to early pregnancies. There is need for Integration of SGBV component and more outreaches targeting young girls.

- KRCS should advocate for the county government to consider payment of CHV allowances for the work they are undertaking under the community health strategy. This will ensure continued sensitization of mothers on the importance of MNCH amongst other important health aspects.
- With the socio-economic effects of COVID-19 on the target communities' uptake of MNCH services, KRCS should integrate COVID-19 sensitization within the larger Taveta branch activities.
- The MoH in Taveta sub county, should continuously enhance capacity of healthcare workers in the lower level health facilities to enable positive attitudes amongst them as they handle community members.

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