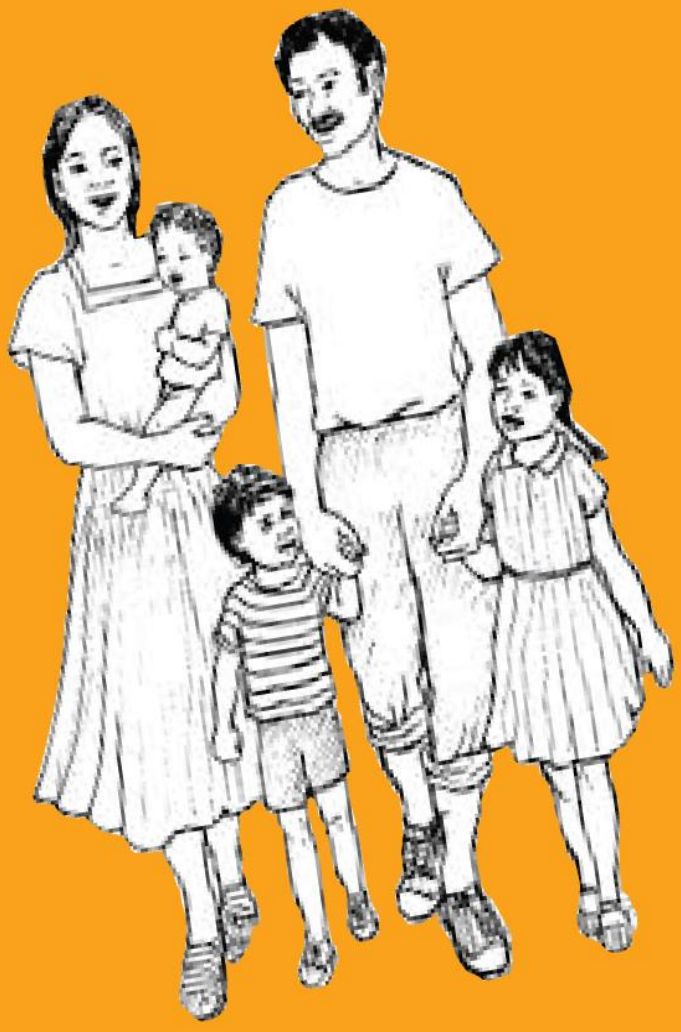
World Vision

Mobilizing for Maternal and Neonatal Health through Birth Spacing and Advocacy (MOMENT) in Siaya Sub County



End line Evaluation Report, 2016

Mobilizing for Maternal and Neonatal Health through Birth Spacing and Advocacy (MOMENT) in Alego Usonga, Siaya County

CREDITS AND ACKNOWLEDGEMENTS

Contributors
Dr. Elizabeth Echoka
Richard Mutisya
Cynthia Nyakwama
Bevalyn Kedogo
Dr. Margaret Njenga

Published
October 2016

Acknowledgements
World Vision Kenya would like to acknowledge the funding provided by the Bill and Melinda Gates Foundation through World Vision USA to support the work upon which this end term evaluation was implemented.

We deeply appreciate the various individuals who were involved, first in the project design and successful implementation over the three years, and secondly, in designing and fruitfully carrying out this end term evaluation. We recognise the support provided by several individual towards this success: Beverly Kedogo, the MOMENT Project Manager, Evans Osumba, Manager Karemo ADP, where the MOMENT project was housed, and all World Vision Kenya staff in Karemo, for their invaluable support in facilitating and ensuring success implementation of this project, and consequently this end of project evaluation. Ministry of Health in Siaya County, local leadership, and the Alego Usonga community, for which this project would not have been successful without their co-operation, we appreciate the collaboration and partnership.

Finally, World Vision Kenya also acknowledges consultancy team: Dr Elizabeth Echoka and Richard Mutisya, all the research assistants, and team leaders for successfully conducting this end of project evaluation.

To you all we say, ASANTE SANA!

Citation: World Vision Kenya (2016). Mobilizing for Maternal and Neonatal Health through Birth Spacing and Advocacy (MOMENT) in Alego Usonga, Siaya County: End of project evaluation Report. Nairobi, Kenya

ABBREVIATION AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CHVs	Community Health Volunteers
CVA	Citizen Voice and Action
CMs	Critical Milestones
EBF	Exclusive Breast Feeding
FBOs	Faith Based Organisations
FGDs	Focused Group Discussions
FP	Family Planning
HH	Household
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HTSP	Healthy Timing and Spacing of Pregnancy
CPR	Contraceptive Prevalence Rate
COH	Channels of Hope
IDIs	In-Depth Interviews
LARC	Long Acting Reversible Contraceptive
PM	Permanent Method
IUD	Intra Uterine Devices
KII	Key Informant Interview
KDHS	Kenya Demographic and Health Survey
KPC	Knowledge, Practice and Coverage
LAM	Lactation Amenorrhea Method
MNCH	Mother and New-born Child Health
mCPR	Modern Contraceptive Prevalence Rate
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MOMENT	Mobilizing for Maternal and Neonatal Health through Birth Spacing and Advocacy
MoH	Ministry of Health
NGO	Non-Governmental Organisation
ODK	Open Data Kit
PNC	Post Natal Care
RH	Reproductive Health
STI	Sexual Transmitted Infections
SPSS	Statistical Package for Social Sciences
SDM	Standard Days Method
TFR	Total Fertility Rate
UNICEF	United Nations Children's Fund
WRA	Women of Reproductive Age
WVK	World Vision Kenya
WV	World Vision

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF BOXES

EXECUTIVE SUMMARY

Background

In 2013, a three year Mobilizing for Maternal and Neonatal Health through Birth Spacing and Advocacy project (MOMENT) was initiated in Karemo, Alego Usonga sub County, one of six sub-counties in Siaya County, Kenya. The project was funded by World Vision US and the Bill & Melinda Gates Foundation and implemented in collaboration with World Vision Kenya, Siaya County government and the Kenya Ministry of Health (MoH) as key partners. The main objective of the MOMENT project in Kenya was to strengthen community awareness and civic action for improved understanding of Health Timing and Spacing of Pregnancy (HTSP) messages (Box 1), information on Family Planning (FP), and increase use of FP services in Siaya County, Kenya. The overarching goal was better health for women, mothers, and children. World Vision's Theory of Change is that if people understand the meaning and benefits of healthy timing and spacing of pregnancies, then they are more likely to seek out family planning services to help them achieve the right and healthy times to space their pregnancies.

Box 1: Four key messages on Healthy Timing and Spacing of Pregnancies (HTSP)

- ✓ Delay pregnancy until you are at least 18 years old (Too Young).
- ✓ Limit pregnancies to a mother's healthiest years, ages 18 to 34 (Too Old).
- ✓ Wait until your child is at least 2 years old before trying for another pregnancy (Too Close).
- ✓ Wait 6 months after a miscarriage or abortion, before trying for another pregnancy (Too Soon).

Project Milestones: The MOMENT project had seven critical milestones. The targets for the first four were set after the 2014 baseline (page 16):

1. To increase community knowledge of the 4-HTSP messages.
2. To increase health provider knowledge of the 4-HTSP messages and counseling in the modern methods of family planning available at Ministry of Health facilities.
3. Increase the number of new users of contraceptives.
4. Increase in the number of public and private health facilities that provide modern methods of contraception.
5. Two local level champions (e.g. faith leaders, opinion leaders, civic leaders, influencers) publicly advocate for HTSP/FP per year.
6. One local-level program finding is highlighted in national media and/or advocacy bulletin per year.
7. Four documented community and service provider discussions held per year.

Evaluation purpose: The three-year MOMENT project in Alego Usonga sub County, which started in July 2013, came to an end in July 2016. The purpose of this end term evaluation is to find out if the critical milestones of the MOMENT project was achieved. This evaluation has generated data that provides evidence on the effectiveness of or lack thereof, of the interventions/activities executed within the project design. We envisage that the evidence generated from the evaluation will contribute to a learning and knowledge exchange platform for the implementing partners to improve future project activities and Ministry of Health programs. The four key HTSP messages was the basis of the baseline and endline surveys.

Methodology

This evaluation was conducted between August and September 2016. The evaluation employed concurrent mixed methods study design, in which both quantitative and qualitative triangulation of data collection methods was applied. The quantitative approach entailed conducting a survey with 724 eligible households, comprising of women of reproductive age and children aged below five years. In addition, 215 men of reproductive age were targeted for the quantitative study. The qualitative approach entailed the following: in-depth interviews (IDIs) with 11 women and 13 men; key informant interviews (KIIs) with 7 service providers and 8 faith leaders; 2 with World Vision programme staff and 1 Ministry of health representative. Focus group discussions (FGDs) were also conducted with 4 groups of community health volunteers (CHVs) and 3 Citizen Voice and Action (CVA) groups.

Limitations: Though similar sample sizes were used in the baseline and endline, different evaluation tools were used in the two surveys. Therefore, only the first four critical milestones can be directly compared. In addition, the baseline only interviewed women with children 0-59 months. The endline added interviews with women with children 0-23 months as part of a learning agenda.

At baseline the MCHIP KPC had not been developed and so the project team crafted their questions to provide them responses to develop targeted HTSP/FP interventions. In Year-2 the MCHIP KPC tool had been developed with emphasis on HTSP/FP and so this was used as a tested tool for the endline survey. The baseline survey did not capture Critical Milestones 6,7, and 8 and they will be referenced as starting from zero. However, individual assessments were done to help craft targeted project strategies/activities.

MOMENT included a learning agenda that included a mid-survey LQAS and individual assessments that captured a broader perspective, showing how the project evolved, and highlight new learnings and lessons learned.

Executive Summary of the Results of Selected Key Critical Milestones

Critical Milestone #1: Increase in community knowledge of accurate Health Timing and Spacing of Pregnancy (HTSP) Messages

The largest percentage increases in knowledge of the HTSP messages were in the “Too Young”, 48.3%, and the “Too Old” (37.9%) messages.

Knowledge increase of HTSP messages

1. “Too Young”: By endline the percentage point increase in knowledge of the “Too Young” message was 25.2% (52.1% baseline, 77.3% endline) for women with children under 0-59 months. It is an important result and an opportunity for Siaya County health, education, and community development authorities to message and help families support girls to stay in school and delay early childbearing.

2. "Too Old": The percentage point increase from baseline was 10.8% (28.5% baseline, 39.3% endline) among women with children under 0-59 months. The level of knowledge in the group with children 0-23 months were almost the same.

3. "Too Close": Knowledge of the spacing message was 80.3% among mothers with children 0-23 months. Though we do not have a baseline, it is an important finding that they understand the importance and benefits of spacing pregnancies, especially as 60% of the women indicated the new-born will have more time to breastfeed (Table 3.4). However, the percentage increase stayed the same among mothers with children 0-59 months and has implications for further investigation.

4. "Too Soon": Although knowledge of this message showed 61% among mothers with children 0-59 months and 44% of mothers with children under-2, only 8.4% and 6.7 % respectively, could categorically mention"wait at least 6 months after a miscarriage before attempting another pregnancy." per the HTSP message (Table 3.5). The majority (45%) responded "below 6 months". This result may suggest a re-think of how to effectively deliver the message to all mothers and women.

Male Involvement: Faith leaders, Men and Implication for Future Programs:

136 faith leaders (out of the target of 100), and 120 men received training in HTSP/FP messaging and served as champions within communities. Project data showed that 6,086 women went to a health facility to seek HTSP, FP, or MCH services because they were referred there by a faith leader. From this number, more than half of the women referred (3,847) decided to use a method of contraception. Forty-two per cent (42%) of these women also chose a longer acting and permanent method of contraception.

Exposure to HTSP messages

The findings show that the medium that worked best for delivering HTSP messages for ***women*** was at the health facility (28.8%), followed by radio (19.1%), and CHVs (15.4%). Exposure to key HTSP messages and FP services for ***men*** were 45% from a health worker, 44% from their wives, and 37% from CHVs. It is important to note that in the intervention area, the CHVs role was to refer the women to the government health facility for further FP information and services and may account for the high proportion of women who reported government facility as major source of HTSP/FP information and services.

Benefits of knowing about timing and spacing of pregnancies

Some benefits of HTSP, cited by men or as we phrase it, "seeing it from a man's perspective" showed more than half of the men (55%) indicating that HTSP ***"****allows men time to emotionally and financially prepare for the birth of a child"*, followed by 48% who said *"provides an action that men can take to safeguard the health and wellbeing of their partners and children"* and 44% indicating - *"involves men in making decisions about family planning, child spacing, and the health of the family."* Men's views have implication on how future programs can work with men to improve the health of women and children.

Critical Milestone 2: Increase in health provider counselling and knowledge of accurate of HTSP Messages and skills to provide family planning methods

The goal of MOMENT was to increase knowledge, understanding of HTSP, and increase voluntary use of modern methods of FP by couples. Thirty-two health workers interviewed had an average of 82% knowledge of more than three of the four HTSP messages.
In anticipation of a rise in demand of family planning services we had to ensure availability and access to services.

45 nurses working in 30 Level Two (Dispensary), and eight Health Centres, were trained to provide Implants. The nurses also received training in counselling on the different modern methods of FP.

To achieve Critical Milestone 4, Critical Milestone 2 had to be in place.

Critical Milestone 3: Family Planning Use

Contraceptive prevalence is a key indicator measured during the baseline and endline surveys. Among the 724 women interviewed, 6.5% (n=47) were pregnant. Of the 677 non-pregnant women, 30.4% (206/677) were not using any form of contraception and 69.5% (471/677) were using a form of contraception.

A significant percentage increase of 40.4% was recorded from baseline (49.5%) compared to endline (69.5%), exceeding the project target of 3% increase from baseline.

During the baseline 44.4% and 27.3% of women were using injectables, and implants respectively. By endline 51.4% of women were using implants compared to 30.8% on injectables. The shift and increase in use of implants is likely because it is a long acting reversible and less invasive contraceptive method able to be administered by nurses in health centers/dispensaries. The percentage increase in implants use from baseline to endline was 88.2%.

Family Planning Use	Women with children aged 0-59 months		Women with children aged 0-23 months	
	n=677	%	n=417	%
Using FP	471	69.5	262	62.8
Not using FP	206	30.4	155	37.2

Future Fertility Intentions
Currently pregnant women: Of the women who were pregnant at the time of the endline survey, 35% (16) wanted to become pregnant when they got pregnant, 37% (17) wanted to wait one or more years and 28% (14) did not want any more children. In the latter two groups of women, we did not determine if there was an "unmet need for contraception," which is an area for future program consideration.

Non-Pregnant women: Of the women who were not pregnant at the time of the endline survey 35% (237/677) wanted to become pregnant during their last pregnancy, 32.8% (222) wanted to wait one or more years and 27.5% (186) did not want any more children. A third (67%) of the women who "did not want to become pregnant/did not want any more children" were using a method of FP.

Critical Milestone 4: Increase in availability and access to family planning services at public/private health facilities

MOMENT's target was to operate in only 20 facilities but expanded its target upon request from the Siaya County Ministry of Health.

The project expanded its operations to 32 facilities where new contraceptive methods were added. These were implants and IUDs and which accounted for 43.8% and 28.1% respectively, of the contraceptive method mix.

Implants became the leading contraceptive choice of women. The preference for implants as noted under Critical Milestone #3, is consistent in achieving Critical Milestone 4.

Critical Milestone 4 could only be achieved because Critical Milestone 2, trained providers were in place.

Critical Milestones 5, 6, and 7: Community Engagement and Influence

During the implementation period, the MOMENT project supported dialogue and quarterly meetings with Faith leaders, Male champions, and CVA groups where HTSP/FP issues were discussed and shared with community to garner support for HTSP and use of FP for improved maternal and child health.

MOMENT also used different social behaviour change communication strategies to communicate accurate knowledge and service options of HTSP and FP in the communities, all to create demand and meet demand for women and couples who seek and access family planning services to achieve timing and spacing of pregnancies. Our achievements:

1. *Community Health Volunteers (CHVs):* MOMENT trained all 517 CHVs in Alego-Usonga sub-county in HTSP and counselling and to deliver the HTSP and FP message to households as part of their day-to-day duties. CHVs proved to be a good source of information and referral as stated above. Of the women surveyed 44.2% discussed family planning with a health worker and CHV in the preceding 12 months.

2. *Faith Leaders:* 136 (target was 100) faith leaders received training in how to message HTSP/FP in their congregations. This was achieved through a World Vision Channels of Hope training methodology. When faith leaders understood the importance and impact of timing and spacing of pregnancies on maternal and child health, they delivered HTSP messages to their congregations and promoted support from male spouses. Results showed that 6,086 women went to a health facility to seek HTSP, FP, or MCH services because they were referred there by a faith leader. From this number, 3,847 women

decided to use a method of contraception, which shows that more than half the women referred by a faith leader opted to use a modern method of family planning. MOMENT target was to train 100 faith leaders.

3. *Citizen Voice and Action (CVA):* is World Vision's social accountability approach, a local level advocacy and governance methodology that aims to improve essential services (like health and education) by improving the relationship between communities and government. MOMENT formed three CVA teams, one in each sub-division of Alego-Usonga. Thirty-nine (39) CVA meetings were held with community leaders, the community and health providers. Through this approach, community groups were trained and engaged to sensitise citizens about the expected government services and to work with the MoH to assure the services are implemented.

CHAPTER 1: INTRODUCTION

1.1: Background

The Mobilizing for Improved Maternal and New-Born Health through Birth Spacing and Advocacy project (MOMENT) was a three year (July 2013 to July 2016) project whose goal was to contribute in improving maternal, neonatal and child health (MNCH) by creating county and local enabling environments for service provision and use in Alego Usonga sub County. The project was funded by the World Vision US, and the Bill and Melinda Gates Foundation and implemented in collaboration with World Vision Kenya, Siaya County Government, and the Ministry of Health (MoH) as a key partner. The main key outcome area of the MOMENT project was to strengthen community awareness and civic action for improved service delivery and use of health timing and spacing of pregnancy/Family planning (HTSP/FP) services.

1.2: Family planning landscape in Kenya

The latest Kenya Demographic and Health Survey (KDHS)[1] findings indicate that overall contraceptive prevalence has increased to 58%, while use of modern methods of FP was 53% in 2014. Injectable is the most common method, used by 26% of married women, followed by implants (10%), and pills (8%). An additional 5% use a traditional method. Family planning use is higher among sexually active unmarried women, at 61%. Among married women, modern method use increases with education. Almost 60% of married women with secondary or higher education are currently using a modern method compared to only 15% of women with no education. The total fertility rate (TFR) is 3.9 births per woman. The TFR in rural areas is 4.5 and is significantly higher than the rate in urban areas (3.1 births per woman). Percentage of women using FP in Kenya varies by county as shown in Figure 1.

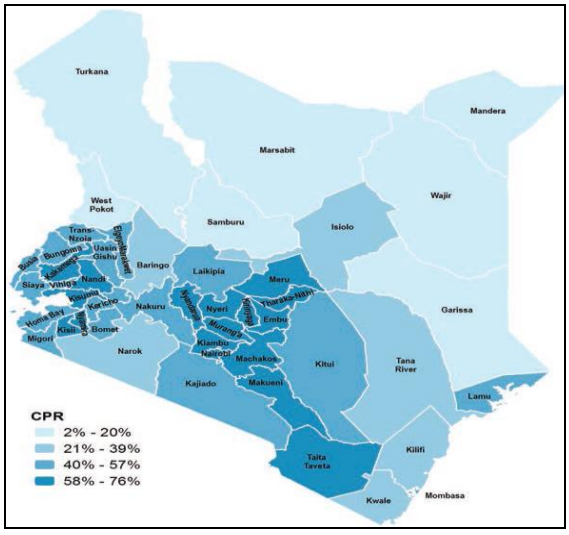


Figure 1: Use of Family planning in Kenya by County

1. Kenya Demographic and Health Survey, 2014

1.3: Project implementation areas and context

The MOMENT project was implemented in Siaya County, Kenya. The county is one of the six counties in the Nyanza region. It covers 2,530km² and is bordered by Busia County to the north, Vihiga and Kakamega counties to the north east, Kisumu County to the south east, Homa Bay County across the winam gulf to the south and Lake Victoria to the west. The county has a total area of 3,535 km^2 out of which 2,059 km^2 is arable. The county is divided into six administrative sub-counties namely; Gem, Ugunja, Ugenya, Siaya/Alego Usonga, Bondo, and Rarieda. Alego Usonga sub-county where the MOMENT project was being implemented, is the largest covering an area of 605.8 km^2 and has the most locations (Table 1.1), while Ugunja sub-county is the smallest covering an area of 201 $km^{2.}$ Alego Usonga sub County is divided into three administrative divisions namely, Karemo, Boro, and Uranga divisions respectively. Boro is the smallest covering an area of 180.1sq km.

Table 1: 1: Alego Usonga administrative units and sizes

Division	Area (sq. km)	Population	Density	Location
Karemo	235.1	78,994	336	4
Boro	180.1	48,627	270	3
Uranga	183.4	42,732	233	3
Total	**598.6**	**170,353**	**839**	**10**

Source: Siaya County Development Profile (2013)

Alego Usonga sub County has approximately 170,000 people, with the population of children below the age of 1 year being estimated at 3.6%, while the one for children under five years are estimated to be 18% of the total population. Additionally, women of reproductive age who are 15- 49 years are estimated to comprise 24%, while youths and adolescents 15-24 years comprise 21% of the total population (*Source: Siaya County Development Profile (2013)).*

.

According to the Ministry of Health's (MoH) Siaya County Health fact sheet[1], the county has a contraceptive prevalence rate of 51%, which is lower than the national average (53.2%). Being a rural/urban area, Alego Usonga sub-county experiences various forms of vulnerabilities including child abuse, labor, and destitution, poverty, high HIV and AIDS prevalence, crime related violence, food insecurity, poor sanitation/housing, disasters (floods) and governance issues. Fertility is an issue in the Sub County, making MNCH/FP one form of vulnerability, because of this high infant and maternal death are experience.

Siaya County Health Profile at a Glance

INDICATOR	County 2012	County (Current)[3]	Kenya (Current)[3]
POPULATION[2]			
1 Total	924,704	984,069	45,108,414
2 Male	437,651	465,748	22,422,667
3 Female	487,053	518,321	22,685,747
4 Under Age 5	160,899	171,228	6,936,691
5 Under Age 1	34,214	36,411	1,425,787
NUTRITION			
6 Underweight (weight for age) (%)	12.6[3]	7.8[4]	11.0[4]
7 Stunted (height for age) (%)	3.2[3]	24.7[4]	26.0[4]
CHILD HEALTH			
8 Children (12–23 months) immunised (%)	77.7[5] (fully immunised)	72.5[4]	67.5[4]
MATERNAL HEALTH			
9 Births delivered at a health facility (%)	57.3[6]	69.6[4]	61.2[4]
10 Contraceptive prevalence (%)	45.1[7]	51.0[4]	53.2[4]

[1] https://www.healthpolicyproject.com/pubs/291/Siaya%20County-FINAL.pdf

The end line survey provides a road map for MOMENT project scale up.

1.4: MOMENT project activities

The MOMENT project came in to complement the MoH's efforts, and it is aligned to World Vision Kenya (Financial Year 2013-2015) strategic objective three, that seek to improve the health and nutrition status of children under five, pregnant and lactating mothers within communities in Kenya by 2015 and the current FY16-20 WVK strategy

1.4.1: MOMENT Project Critical milestones

Below is a summary of the key MOMENT project critical milestones (CMs).

Table 1: 2: Critical milestones for the MOMENT project

Critical milestones		Baseline	Target
CM 1	20% increase in community knowledge /awareness of accurate HTSP/FP messages	40%	60%
CM 2	20% increase of service provider knowledge/awareness of accurate HTSP/FP messages and appropriate counselling for modern FP methods	27.7%	47.7%
CM 3	3% increase in new FP acceptors, and FP users per contraceptive method at project public and private HTSP/FP service provision sites	CPR: 50.1%, mCPR: 49.2%	53 % (3% increase in women using a modern method of FP)
CM 4	3% increase in number of public and private HTSP/FP service provision sites that provide modern contraceptive methods	45 facilities in Siaya sub-county	20 facilities to increase FP method mix. (14) Government, (2) Mission, (2) NGO run clinics and (2) Private Clinics.
CM 5	Two local level champions (faith leaders, opinion leaders, civic leaders, influencers) publicly advocating for HTSP/FP per year	**0**	**6**
CM 6	One local-level program finding included in national media and/or advocacy bulletin per year	**0**	**3**
CM 7	Four documented community and service provider discussions per year	**0**	**12**

1.4.2: MOMENT project strategies

The MOMENT project utilised different strategies to increase knowledge, information and services on HTSP and FP. These include World Vision's Channels of Hope (COH) and Citizen Voice and Action (CVA) approaches.

Demand Creation & Social Behaviour Change Communication:

Social and Behaviour Change Communication (SBCC) is a health-promotion strategy that evolved from Information, Education, and Communication approaches (IEC) to address contextual factors that prevented people from improving their health behaviours. The Health Communication Capacity Collaborative Initiative defines SBCC as the use of communication to change behaviours, including service utilization, by positively influencing knowledge, attitudes and social norms. It goes on to say that "SBCC coordinates messaging across a variety of communication channels to reach multiple levels of society…"[1]. MOMENT used different SBCC strategies to communicate accurate knowledge of HTSP and FP in the communities and to create demand to seek and access family planning services to aid the achieving of timing and spacing of pregnancies.

Channels of Hope (COH)

The Channels of Hope (CoH)[2] an approach for HTSP/FP information and services demand creation relates to CM 1, which is to increase knowledge of HTSP, CM 3, which is to increase in new FP acceptors, continuing FP users, and FP users per contraceptive method, and CM 5, which is to build capacity of local level champions (faith leaders) publicly advocating for HTSP/FP in the project area. CoH is an interactive, facilitated process to create a safe space for faith leaders and faith communities to learn, share and debate. World Vision recognises that faith leaders are uniquely placed to protect the rights and meet the needs of the most vulnerable in their communities. They have profoundly deep, trusted relationships and links with their communities and often dictate which behaviors are prescribed or prohibited. In this approach, CoH directly aimed to address faith leaders' misconceptions about family planning issues, thereby empowering faith leaders to transform their thinking and the thinking of others in their communities.

Health systems strengthening

This relates to CM 2, which is to increase of service provider knowledge/awareness of accurate HTSP/FP messages and appropriate counselling for modern FP methods and CM 4, which is to increase number of public and private HTSP/FP service provision sites that provide modern contraceptive methods in the MOMENT project area. The project aimed to leverage on existing community infrastructure such as community health units. Capacity building of nurses/health providers and community health volunteers on HTSP/FP counselling and skills enhancement to enable them to provide selective contraceptives was a priority in order to meet demand.

Citizen Voice and Action (CVA)

Citizen Voice and Action (CVA) was geared to influence all seven critical milestones in the project area. Citizen Voice and Action (CVA) is a local level advocacy and governance

[1] *http://ccp.jhu.edu/social-behavior-change-communication/*

[2] World vision International. CHANNELS OF HOPE Igniting a movement to transform communities. http://www.wvi.org/sites/default/files/CoH%20Igniting%20a%20Movement.FINAL_.pdf

methodology that aims to improve essential services (like health and education) by improving the relationship between communities and government[1]. Using CVA, the MOMENT project aimed to enhance community participation in maternal and child health services through improving the availability of HTSP/FP services and commodities. Through this approach, the project targeted to educate citizens about their right to health and social services and train them to work with the MoH to assure these services a made available, accessible and of high quality.

1.5: Project beneficiaries

The main project beneficiaries in the MOMENT project are Women of reproductive age, spouses/ partners, men, children under 5 years, adolescents and youths, families, community.

1.6: Evaluation Rationale

The three-year MOMENT project in Alego Usonga sub County, which started in July 2013 came to an end in July 2016. The overall project goal was to contribute in improving maternal, neonatal and child health by creating county and local enabling environments for MNCH service provision and use in Alego Usonga sub County.

The purpose of this end term evaluation is thus to find out if the outlined project outcomes have been achieved, activities implemented and how they have contributed to achieving the overall project goal. The evaluation will seek to generate data that will provide evidence on the effectiveness of the interventions/ activities executed within the project design and place this data in a broader context. We envisage that the evidence generated from the evaluation will contribute in three ways: to learn and exchange knowledge between the implementing partners, to build the capacity of the project staff and other implementers e.g. the ministry of health, and to generate evidence that may be used to improve future project implementation.

The endline evaluation also intends to provide evidence on the impact of the project interventions based performance of the critical milestones. In addition, it is anticipated that the MOMENT project implementing partners, including the MoH will refer to the results for future service improvement.

1.7: Evaluation Questions

a) What is the level of community knowledge/awareness of accurate HTSP/FP messages in Alego Usonga sub County following the three-year MOMENT project implementation?
b) Do service providers and community health volunteers have the capacity and skills to provide counseling on FP/ HTSP in Alego Usonga sub County following the three year MOMENT project implementation?
c) What is the percentage increase and trends in new FP acceptors, continuing FP users, and FP users per contraceptive method at project public and private HTSP/FP service provision sites in Alego Usonga sub County following the three-year MOMENT project implementation?
d) What is the level of in coverage and availability of public and private HTSP/FP services for modern contraceptive methods in Alego Usonga sub County following the three year MOMENT project implementation?

[1] World Vision International. 2012. Citizen Voice and Action. An effective local level advocacy approach to increase local government accountability. http://www.wvi.org/sites/default/files/Citizen_Voice_and_Action_PM.pdf

e) What is the role of religious leaders, opinion leaders, civic leaders, and other influences as local level champions and advocates for HTSP/FP in Alego Usonga sub County following the three-year MOMENT project implementation?
f) What is the perception and attitude of the community on their participation and involvement in HTSP/FP in Alego Usonga sub County following the three-year MOMENT project implementation?
g) What are the barriers and opportunities for community, health facility and health system towards provision and uptake of HTSP/FP in Alego Usonga sub County following the three year MOMENT project implementation
h) What policies, strategies and guidelines exist on HTSP/FP services in Alego Usonga sub County following the three-year MOMENT project implementation and what gaps exist?
i) To what extent has the project contributed to health system strengthening and sustainability? (What is the likelihood that benefits will continue?)

1.8: Evaluation Objectives

1.8.1 General objective

The general objective of the end line evaluation is to examine knowledge, attitudes and coverage of HTSP/FP following a three-year implementation of the MOMENT project in Alego Usonga sub County, Kenya.

1.8.2 Specific Objectives

1) To determine the level of HTSP / FP use in Alego Usonga sub-county following the three-year MOMENT project implementation
2) To assess the level in coverage and availability of public and private services for HTSP/FP Alego Usonga sub County following the three-year MOMENT project implementation?
3) To assess the knowledge/ awareness on HTSP / FP among women and men in Alego Usonga sub-county following the three-year MOMENT project implementation
4) To assess the capacity and skills of service care providers to provide counselling on FP/ HTSP in Alego Usonga sub-county following the three-year MOMENT project implementation
5) To establish the number of new users for various contraceptive methods for women of reproductive in Alego Usonga sub-county following the three-year MOMENT project implementation
6) To explore community, facility and health system barriers and opportunities for provision and uptake of HTSP/FP following the three-year MOMENT project implementation
7) To explore the role of religious leaders, opinion leaders, civic leaders, and other influences as local level champions and advocates for HTSP/FP in Alego Usonga sub County following the three-year MOMENT project implementation?
8) To review policies, strategies and guidelines for HTSP/FP provision and use and identify gaps in Alego Usonga sub-county following the three-year MOMENT project implementation

Arising from the above, to identify the effective strategies, best practices and learning/ key lessons in the project implementation towards providing specific, actionable, and practical recommendations for future project improvement.

CHAPTER 2: EVALUATION METHODOLOGY

2.1: Evaluation scope and area

The evaluation was conducted in August 2016, within the MOMENT project, implemented in Alego Usonga sub County, in Siaya County. The evaluation targeted direct project beneficiaries, comprising of households with women of reproductive age (15-49) and those with children under 5 years of age, and men of reproductive age (18-54).

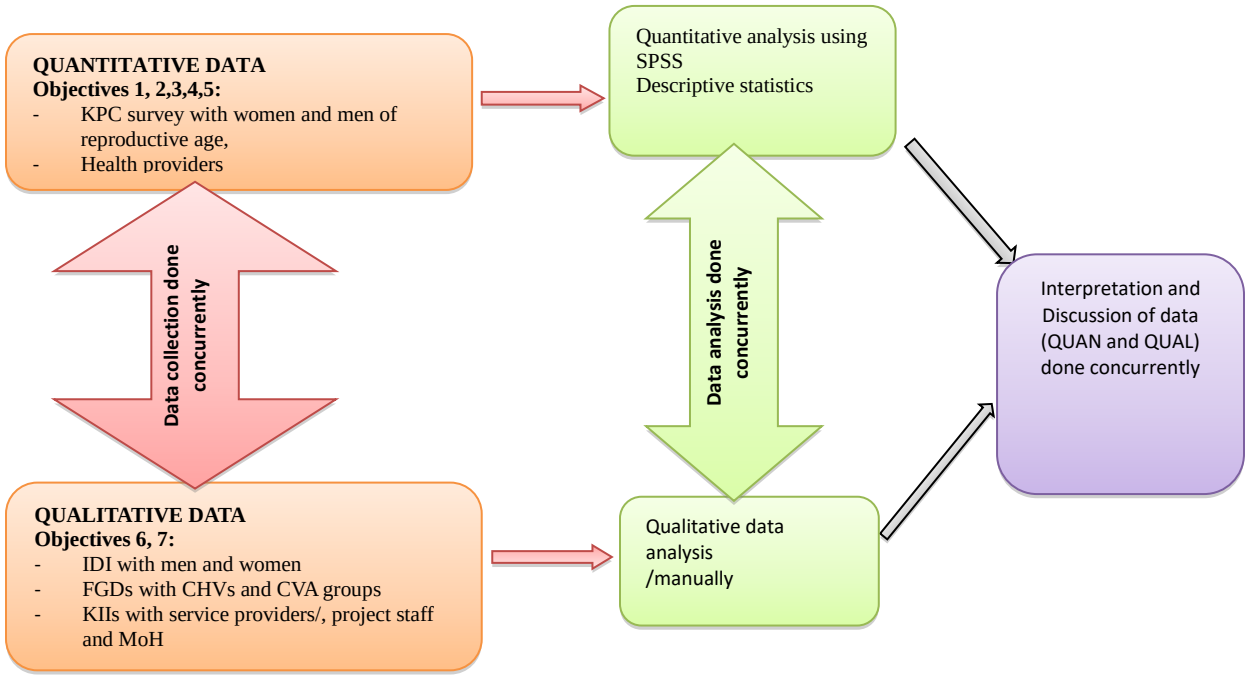
Of note is the deliberate analysis of women with children 0-59 and 0-23 months, because we wanted to find out whether there was a difference in levels of knowledge of HTSP and FP use in these two groups; particularly in the women with children under 24 months whom we deem are the cohort that really needs to understand spacing of pregnancies.

Other key project stakeholders included in this evaluation are FP/HTSP service providers, including community health volunteers, faith leaders, project staff and ministry of health officials, and other community advocacy groups.

2.2: Evaluation design

The evaluation adopted a cross sectional survey, with concurrent explanatory mixed methods data collection approaches[1]. This entailed employing both qualitative and quantitative data collection methods in a single study[2]. Figure 2 summarises the evaluation design.

Figure 2: MOMENT project evaluation design



[1] Creswell JW, Planoclark VJ, Hanson WE: *A handbook of mixed methods in social and behavioral research*. California: Sage publications Inc; 2003
Ozawa & Pongpirul. 10 best resources on ... mixed methods research in health systems. Health Policy Plan (2013)
[2]. Ozawa & Pongpirul. 10 best resources on ... mixed methods research in health systems. Health Policy Plan (2013)

2.3: Sample size determination and sampling procedures

2.3.1: Sample size determination

2.3.2: Sample size for quantitative study

For the household survey the sample size for the study site Alego Usonga Sub County was based on the sampling frame, (the number of households in the sub county with women aged 15-49 years with children aged under five) in each of the selected clusters where the project is being implemented. The formula by fisher et al 1998, for determining sample size for cross sectional studies were applied to compute the sample size for quantitative data.

$$n = \frac{(Z_{\alpha/2})^2 p(1-p)}{d^2} * \delta$$

Where: n = Minimum required sample size,
p = estimated population proportion for specific indicator: 0.51 (proportion of women using FP in Siaya County (KDHS 2014)
d = desired precision: 0.05,
α = Level of significance: 0.05,
$Z_{\alpha/2}$ = standard normal deviate corresponding to 95% confidence level: 1.96, and
δ= design effect: 2.

$$n = \frac{1.96^2 \times 0.51\ (1-0.51)}{0.05^2} \times 2$$

$$= 768$$

This yields a sample size of 768 respondents. Additionally, a subsample of men comprising 30% (240) of this were to be interviewed for the men Knowledge on FP/H

2.3.3: Sampling

The evaluation used a two-stage random sampling technique to select the villages (clusters). The first stage involved a random selection of desired number sub-locations from the list of all sub locations within the intervention area. The second stage involved determination of specified number of villages per sub-location within a selected sub-location using probability proportional to size approach. The calculated numbers of villages per sub-location were then randomly selected from a list of all the villages in each of the sub-locations. A total of 40 sub-locations were selected in the first stage. From the 40 sub-locations, 72 villages in total were randomly selected spread across Alego Usonga sub County. From each of the 72 selected villages, 10 households (HHs) were randomly selected, targeting a woman aged 15-49 years and with a child aged below five years of age. Additionally, 30% of these household targeted men aged 18-54 years.

Table 2.1 shows the selected sub locations in Alego Usonga sub County, from which the sampled households were selected.

Table 2: 1: Distribution of selected villages in Alego Usonga sub County

Division	Location	Sub-location	Number of villages	Households
Boro	Central Alego	KadengeRatuoro	1	10
		KakumKombewa	1	10
		Kochieng' A	1	10
		Kochieng' B	1	10
		Koyeyo	2	20
		Obambo	2	20
		Ojwand A	2	20
		Ojwand B	1	10
	North Alego	Hono	4	40
		Komolo	2	20
		Nyalgunga	2	20
		Nyamila	1	10
Karemo	East	Bar_Agulu	2	20
		Mur_Ngiya	2	20
		Olwa	1	10
		Ulafu	1	10
	South East	Bar_Olengo	1	10
		Bar_Osimbo	1	10
		Barding	1	10
		Mur_Malanga	2	20
		Nyajuok	2	20
		NyangomaKogelo	2	20
		Pap_Oriang	2	20
		Randago	1	10
		Umala	1	10
	Township	Karapul	5	50
		Mulaha	4	40
Uranga	Usonga	Kabura_Uhui	1	10
		Nyadorera A	1	10
		Nyadorera B	4	40
		Sigoma_Uranga	2	20
		Sumba	1	10
	West Alego	Gangu	2	20
		KalkadaUradi	1	10
		KaugagiHawinga	2	20
		KaugagiUdenda	2	20
		Kodiere	2	20
		KomenyaKalaka	2	20
		KomenyaKowala	2	20

2.4: Data collection

The evaluation adopted a cross-sectional mixed methods study design, involving both quantitative and qualitative data collection approaches. All interview tools were drafted in English, then translated into Dholuo the local dialect, and pre-tested before it was used.

Quantitative data: Entailed collection of primary data by interviewing women of reproductive age with children below five years of age, and a subsample of men in the same population. The MCHIP KPC tool was adapted for use. knowledge and understanding of FP and HTSP; source of FP commodities and supplies; access to FP services; and FP use, reason for non-use, intention for future use of contraceptives. A health provider's assessment tool and a facility capacity assessment checklist were also used.

Table 2: 2: Sample for quantitative study

	Women	Men	Provider knowledge	Facility assessment
Sample size	724	220	31	32

Qualitative data: This entailed conducting key informant interviews with community representatives and health workers, as well as in-depth interviews and focus group discussions with men and women in the community.

Table 2: 3: Sample for qualitative study

	IDIs		FGD		IDIs/KIIs		Total
	Women	Men	CHVs	CVAs	FP Providers	Faith Leaders	
Numbers	2	2	4	3	3	5	

Both the women and men tools were loaded in the open data kit (ODK) software data structure installed in electronic tablets. The ODK was programmed to minimise errors in data capture. The evaluation team members did a review on a daily basis to guarantee data. Daily reporting meetings were held in the mornings to plan for the day activities and address any data gaps and quality concerns. During the fieldwork, the evaluation team accompanied the interviewers and supervised the data collection process and ensured the correct sampling procedures were adhered to. Continued evaluation and correction of the processes and quality were rectified on a continuous basis as the survey progressed. The ODK data was transferred to a central server at WV Kenya servers on a daily basis.

Qualitative data collection entailed conducting qualitative interviews with various targeted community members and groups, as well as key informants. These were women, men, faith leaders, health providers, community health volunteers (CHVs), and Citizen Voice and Action (CVA) groups. Additionally, key informant interviews were conducted with the MOMENT project stakeholders, who were directly involved in the project implementation and for their knowledge of the project and the target communities. These included MoH representatives at the County level, health workers, and World Vision Kenya project staff. The information was used to validate the likelihood that MOMENT project had contributed to statistical change identified through survey and data analysis. Qualified qualitative data collection moderators were used to

moderate the discussion. Electronic voice recorders were used to capture the proceedings of the discussions, which were later transcribed.

2.5: Recruitment and training of data collection teams

A total of 35 research assistants were recruited by the WVK to be involved in the MOMENT data collection. Prior to the data collection exercise, the team was taken through a three days training and a one-day pre-test of the data collection tools. The training covered the end term evaluation and MOMENT objectives, the processes of data collection, an in-depth review of the data collection tools, identification of eligible households and administration of the questionnaire. Emphasis was on the importance of care and attention to detail in interviewing and recording responses.

2.6: Data Management

All the quantitative data at the central server was merged together in a single excel file. The data was then transferred to statistical package for social sciences (SPSS) version 20. Further cleaning and logical checks were performed to check for consistencies on the data set prior to analysis. The Statistical Package for Social Sciences (SPSS) version 20 was used to analyse quantitative data. Qualitative data was first transcribed from the tape recorders and typed verbatim. The transcribed scripts were translated to English. These were analysed manually in line with the themes and objectives of the end term evaluation.

2.7: Ethical considerations

Informed consent was obtained from all subjects prior to their participation in the evaluation. The informed consent highlighted the purpose of the study, risk and benefits of participating in the evaluation and detailed observance of confidentiality of data collected. In addition, strict adherence to World Visions Child Protection Policy was observed during the entire assignment. The consultants and all the enumerators each signed a copy of Plan Child Protection Policy. Data in this evaluation was collected in a variety of ways including tablet, written forms, tape recorder, session notes, and transcripts. Survey data was posted daily to a central online database. This data is now stored in electronic form securely at the WV offices and accessible to the evaluation team only.

2.8: Evaluation limitations

- The four key HTSP messages was the basis of the baseline and endline surveys. However, different evaluation tools were used in each and therefore only the 4 key HTSP messages, FP use and Contraceptive Prevalence Rate (CPR) can be directly compared. At baseline the MCHIP KPC had not been developed and so the project team crafted their questions to provide them responses to develop targeted interventions. In Year-2 the MCHIP KPC had been developed with emphasis on HTSP and so this was used for the endline survey, in order to capture a broader perspective, show how the project had evolved, and highlight new learnings and lessons learned.
- The household survey has been based on self-reporting, which is subjective and often based on how an individual remembers something, and which may give rise to recall bias. Some of the selected tools produced a score based on multiple questions to reduce this bias; however, it cannot be fully avoided.

CHAPTER 3: RESULTS AND DISCUSSION

3.1: Survey coverage

The quantitative survey was conducted at household level among 724 women with children ages 0-59 months and 0-23 months and 220 men, as well as at facility level with 32 service providers. For the quantitative study, a total of 49 interviews were conducted. These include in-depth interviews (IDIs) with 11 women and 13 men; key informant interviews (KIIs) with 7 service providers and 8 faith leaders; 2 with World Vision programme staff and 1 Ministry of health representative. Additionally, focus group discussions (FGDs) were conducted with 4 groups of community health volunteers (CHVs) and 3 Citizen Voice and Action (CVA) groups.

3.2: Demographic characteristics study respondents

The finding on women characteristic show that majority (46.1%) were aged between 25-34 years, followed by (32.3%) in the 18-24 (youth) age category. The mean age for the women was 27.65 years (SD. 6.4), ranging from 16 to 48 years. For men, majority (46.1%) were aged 18-24 years (youth), followed by (30.7%) the 25-34-age category. The mean age for the men was 35.11 years (SD. 7.9), ranging from 16 to 48 years.

On marital status, majority of the respondents were married. This applied for both the women (87.2%) and men (94.4). There were however slightly more married men than women. In terms of religion, a huge majority were Protestant and Catholic Christians, comprising nearly 90% of the study population.

In terms of education level, nearly half of the women had attained primary as the highest level of education compared to 5.9% for the men. Nearly half of the men had attained only pre-primary as the highest level of education.

In terms of occupation, the most prominent was self-employment, reported in 30% of the women and 46% of the men. Fishing was reported in 25.8% of the women and 32.7% of the men. Table 3.1 shows the distribution of demographic characteristic of the study respondents.

Table 3: 1: Demographic characteristics of the women and men

Variable	Characteristic	Women		Men	
		n = 724	%	n=220	%
Age	Below 18	36	5.0	15	7.0
	18 to 24 years	234	32.3	99	46.0
	25 to 34 years	334	46.1	66	30.7
	35 to 44 years	114	15.7	35	16.3
	45 to 54 years	6	.8	15	7.0
Marital Status	Never Married/Single	70	9.7	9	4.2
	Married	631	87.2	203	94.4
	Separated	5	0.7	2	.9
	Widowed	18	2.5	1	.5
Religion	Christian Catholic	164	22.7	62	28.8
	Christian protestants	462	63.8	129	60.0
	Muslim	46	6.4	9	4.2
	Traditional religion	52	7.2	15	6.9
Education	None	17	2.3	2	0.9
	Informal	62	8.6	50	22.7
	Preschool (nursery)	160	22.1	99	45.0
	Primary complete	369	51.0	13	5.9
	Post primary (Vocational)	89	12.3	8	3.6
	Secondary complete	27	3.7	6	2.7
	Postsecondary	-	-	32	14.5
	University	-	-	4	1.8
Occupation	Student	19	2.6	1	.5
	Employed	24	3.3	14	6.4
	Self employed	220	30.8	93	42.3
	Casual worker	17	2.3	28	12.7
	Domestic help	39	5.4	5	2.3
	Fishing	187	25.8	72	32.7
	Farmer	205	28.3	2	.9
	None	13	1.8	5	2.3

3.3: Critical Milestone 1 (CM 1): Increase in community knowledge/awareness of accurate HTSP messages and FP methods

The largest percentage increases from baseline to endline in knowledge of the HTSP messages was in the "Too Young" and "Too Old" messages, shown as 48% and 38% respectively.

The project focused on education/sensitization efforts with the aim of raising awareness about HTSP/FP methods, address myths and misconceptions about family planning commodities, encourage HTSP/FP services among women of reproductive age, and highlight HTSP/FP commodities and services available at public and private facilities around the target communities. The findings show outcome areas arising from increased community knowledge/awareness of FP methods, benefits and accurate HTSP/FP messages.

3.3.1: Knowledge of HTSP and benefits of practicing HTSP among women

Healthy Timing and Spacing of Pregnancy (HTSP) is an intervention to help women and families delay or space their pregnancies, to achieve the healthiest outcomes for women, newborns, infants and children, within the context of free and informed choice**,** taking into account fertility intentions and desired family size. The 4-Key HTSP messages used in MOMENT are:

Box 2: Four key messages on healthy timing and spacing of pregnancies

- ✓ Delay pregnancy until you are at least 18 years old (Too Young)
- ✓ Limit pregnancies to a mother's healthiest years, ages 18 to 34 (Too Old)
- ✓ Wait until your child is at least 2 years old before trying for another pregnancy (Too Close)
- ✓ Wait 6 months after a miscarriage or abortion, before trying for another pregnancy (Too Soon).

3.3.1.1: *Knowledge of delaying pregnancy until age of 18 years - Delay pregnancy until you are at least 18 years old - "Too Young" among women*

The messaging "Too Young" is about timing of pregnancies for young girls/women. The recommendation is to wait until 18 years or older to get pregnant in order to reduce risks of pregnancy complications and to provide the girl child with opportunity to complete basic education. The results show that about 77% of the women had knowledge of delaying pregnancy until a girl is 18 years old (Table 3.2).

Knowledge of the benefits of delaying pregnancy until age of 18 years:

75% of respondents could name at least one benefit for delaying pregnancy until you are at least 18 years old. The key benefit mentioned was "woman is at lower risk of gestational diabetes" (53.3%). The benefit "enables girls to finish school" was only mentioned by only 8% of the women as shown in Table 3.2. This will require further follow up by the MoH and Siaya County social services if they aspire to have a balanced population by age quintiles.

Table 3: 2: Knowledge and benefits of delaying pregnancy until 18 years – "Too Young"

Are there any benefits of delaying a pregnancy until the age of 18 years	Women with children aged 0-59 months		Women with children aged 0-23 months	
	n=724	%	n=417	%
Yes	560	77.3	323	77.5
No/ Don't Know	164	22.6	94	22.5
Benefits of delaying a pregnancy until the age of 18 years	**n=724***	**%**	**n=417***	**%**
Woman at lower risk of pre-eclampsia	63	8.7	40	9.6
Woman at lower risk of high blood Pressure	120	16.6	71	17.0
New-born less likely to be born prematurely	73	10.1	48	11.5
New-born less likely born with LBW	64	8.8	45	10.8
New-born less likely to have birth defects	40	5.5	25	6.0
Girl can finish school (through secondary)	58	8.0	33	7.9
Women's body is prepared to bear a child	75	10.4	45	10.8
Woman at lower risk of gestational diabetes	386	53.3	221	53.0
For overall good health of the mother	11	1.5	7	1.7
Good for overall health of the child	8	1.1	3	0.7
Mature enough	58	8.0	31	7.4
Benefits of delaying a pregnancy until the age of 18 years	**n=724***	**%**	**n=417***	**%**
None	176	24.3	103	24.7
At least one benefit	548	75.4	314	75.3
At least two benefits	270	37.3	163	39.1
At least three benefits	103	14.2	69	16.5
Four and above benefits	24	3.3	16	3.8

Note: n=denominator for each variable

3.3.1.2: *Knowledge among women on increased health risks associated with a woman becoming pregnant when she is over the age of 35 years - Limit pregnancies to a mother's healthiest years, ages 18 to 34 ("Too old")*

The results show that a third (39%) of women with children 0-59 and 0-23 months, know the "Too Old" message and could mention at least one increased risk associated with advanced age pregnancies. The most prominent health risks were "maternal death" (22%) and "high blood pressure" (19%), as shown in Table 3.3.

Table 3: 3: Knowledge on health risk associated with a woman becoming pregnant when over the age of 35 years: "Too old"

Are there health risks associated with a woman becoming pregnant when over 35 years	Women with children aged 0-59 months		Women with children aged 0-23 months	
	n=724	%	n=417	%
Yes	285	39.3	166	39.8
No/ Don't Know	439	60.7	251	60.2
Health risks associated with a woman becoming pregnant when over 35 years	**n=724***	**%**	**n=417***	**%**
Maternal death	162	22.3	93	22.3
High blood pressure	144	19.9	78	18.7
Gestational diabetes	64	8.8	35	8.4
Miscarriage	39	5.3	27	6.8
Chromosomal abnormalities/ Down's syndrome	59	8.1	26	6.2
Stillbirths.	37	5.1	21	5.0
New-born deaths	8	1.1	5	1.2
Number of health problems mentioned by women	**n=724***	**%**	**n=417***	**%**
None	467	64.5	269	64.5
At least one problem	257	35.5	148	35.5
At least two problems	155	21.4	86	20.6
At least three problems	64	8.8	33	7.9
Four and above problems	22	3.0	10	2.4

Note: n=denominator for each variable

Box 3: Births before the age of 18 years and over 35 years

Survey data show about 45% of the women surveyed gave birth before the age of 18 years. The results show that Siaya County and the MoH may need to emphasise girl's education and prevention of teen pregnancy. Clearly the Key HTSP message – Too Young in Siaya County needs to continue for a healthy younger population.

Box 2: Births before the age of 18 years, over 35 years and high parity

Births before the age of 18 years and over 35 years	Women with children aged 0-59 months		Women with children aged 0-23 months	
	n = 724*	%	n = 417*	%
Births before the age of 18 years	336	46.4	188	45.1
Births in women over the age of 35 years	102	14.1	35	6.0
Mothers with 4 children or more	303	41.8	136	32.6

Note: n=denominator for each variable

3.3.1.3: *Knowledge of adequate birth spacing - Wait until your child is at least 2 years old before trying for another pregnancy - "Too Close" and benefits among women*

The results show that 46.8% of women with children aged 0-59 months and 80.3% of women with children 0-23 months had knowledge on ideal birth spacing - that a mother should wait at least 24 months after she gives birth before attempting to become pregnant again (Table 3.4).

Knowledge of benefits of adequate birth spacing

83.5% of mothers with children 0-23 months, and 83% of mothers of children under 5 years had knowledge of at least one benefit of adequate spacing. Only about 20% of the women knew more than three benefits of adequate birth spacing. The most prominent benefit was "new-born has more time to breastfeed" (60%), followed by "fewer maternal deaths" (22%), and "women is at lower risk of anemia" (17.9%), as seen in Table 3.4.

Table 3: 4: Knowledge and Benefits of adequate birth spacing: "Too Close"

Ideal time to wait after giving birth	Women with children aged 0-59 months		Women with children aged 0-23 months	
	n=724	%	n=417	%
Below 2 years	263	36.3	14	3.4
Above two years	339	46.8	335	80.3
Don't Know	122	16.9	68	16.3
Benefits of adequate birth spacing	**n=724***	**%**	**n=417***	**%**
Fewer maternal deaths	162	22.4	88	21.1
Woman at lower risk for anaemia	130	17.9	66	15.8
Lower risk for miscarriage/abortion	78	10.8	37	8.9
Fewer stillbirths	43	5.9	25	6.0
Fewer new-born/infant/child deaths	62	8.6	36	8.6
New born less likely to be born prematurely	55	7.6	37	8.9
New-born less likely to be born with lbw	46	6.4	29	6.9
New-born Less Likely to be malnourished	75	10.4	47	11.3
New-born has more time to breastfeed	437	60.4	254	60.9
Babies grow up bigger, stronger and healthier	107	14.8	63	15.1
Benefits of birth spacing	**n=724***	**%**	**n=417***	**%**
None	123	17.0	69	16.5
At least one benefit	601	83.0	348	83.5
At least two benefits	358	49.4	204	48.9
At least three benefits	152	21.0	89	21.3
Four and above benefits	57	7.9	30	7.2

Note: n=denominator for each variable

3.3.1.4: *Knowledge of waiting at least 6 months after an abortion or miscarriage before attempting another pregnancy, "Too Soon"*

Although 61% of mothers with children 0-59 months and 44% of mothers with children under -2, mentioned that they know to wait after an abortion before trying to get pregnant again, only 8.4% and 6.7 % respectively, could mention "wait at least 6 months after a miscarriage or an abortion before attempting another pregnancy", per the HTSP message (Table 3.5). This result

may tell us to re-think and have a dialogue with mother's on how to effectively deliver the "Too Soon" message.

Knowledge of benefits of waiting at least 6 months after an abortion or miscarriage before attempting another pregnancy:

The most prominent benefit mentioned by women were "mother less likely to die", (15.9%), "woman at lower risk of anemia" (15.5%), and "lower risk for miscarriage" (13.3%). Only 38.5% and 12% knew at least one or more than three benefits respectively, for waiting at least 6 months after a miscarriage or abortion before attempting to become pregnant (Table 3.5).

Table 3: 5 Knowledge on ideal time to wait after having a miscarriage or induced abortion before attempting to become pregnant again "Too Soon"

Is there an ideal time to wait after having a miscarriage or induced abortion before attempting to become pregnant again?	Women with children aged 0-59 months		Women with children aged 0-23 months	
	n=724	%	n=417	%
Yes	442	61.04	183	43.9
No/ Don't Know	282	39.95	234	56.1
Ideal time	**n=724***	**%**	**n=417***	**%**
Below 6 months	328	45.3	131	31.4
At least 6 months	61	8.4	28	6.7
No/Don't Know/No response	335	46.3	258	61.9

Benefits of waiting after spontaneous or induced abortion before attempting to become pregnant again	Women with children aged 0-59 months		Women with children aged 0-23 months	
	n=724*	%	n=417*	%
Mother less likely to die	115	15.9	60	14.4
Woman at lower risk of anemia (reduced blood)	112	15.5	53	12.7
Lower risk for miscarriage / abortion	96	13.3	50	12.0
Fewer still births	59	8.1	38	9.1
Fewer newborn / infant child deaths	50	6.9	33	7.9
Newborn less likely to be born prematurely	50	6.9	26	6.2
Newborn less likely to be born with LBW	23	3.2	12	2.9
Newborn less likely to grow stunted / underweight	28	3.9	19	4.6
Benefits of waiting after spontaneous or induced abortion before attempting to become pregnant again	**n=724***	**%**	**n=417***	**%**
None	445	61.5	269	64.5
At least one benefit	279	38.5	148	35.5
At least two benefits	193	26.7	103	24.7
At least three benefits	87	12	51	12.2
Four and above benefits	22	3	12	2.9

Note: n=denominator for each variable

3.3.1.5: Knowledge of problems that may occur when a woman has too many children

The results show that 66.4% of women with children 0-23 months, and 66.7 % of women of children under 5 years had knowledge of increased risk associated with high parity for women (i.e. more than 4 children). The most prominent problem mentioned by women was "financial burden/ poverty", reported in 19.5% of women, followed by "less likely for children to be educated" (17.1%), and "maternal deaths" (12.7%), as shown in Table 3.6.

Implications for counselling –

1. discussion with Siaya MoH is recommended whether financial benefits should be included in counselling of women and couples.
2. In Siaya, men are mostly heads of households. Finances are usually held by the man. The data from men, Table 3.6 also cites financial burden when a woman has too many children. This suggests to purposefully include men in dialogue about family planning programs so that they understand and support planning their families.

Table 3: 6: Knowledge on problems that may occur when a woman becomes pregnant when she has more than four children: "Too many"

Are there problems that may occur when a woman becomes pregnant when she has more than four children	Women with children aged 0-59 months		Women with children aged 0-23 months	
	n=724	%	n=417	%
Yes	250	34.5	140	33.6
No/ Don't know	474	65.5	277	66.4
Problems that may occur when a woman becomes pregnant when she has more than four children	**n=724***	**%**	**n=417***	**%**
Maternal anaemia	56	7.7	27	6.5
Maternal deaths	92	12.7	50	12.0
Still births	28	3.9	12	2.9
Financial burden/ poverty	141	19.5	80	19.2
Less likely for children to be educated	124	17.1	64	15.3
Body weakens	8	1.1	5	1.2
Problems that may occur when a woman becomes pregnant when she has more than four children	**n=724***	**%**	**n=417***	**%**
None	483	66.7	281	67.4
At least one problem	241	33.3	136	32.6
At least two problems	150	20.7	78	18.7
At least three problems	41	5.7	16	3.8
Four and above problems	14	1.9	6	1.4

Note: n=denominator for each variable

3.3.2: Knowledge of HTSP and its benefits among men

The project targeted men and focused on educating them as they are often the decision makers of women's ability and freedom to seek health services.

3.3.2.1 Knowledge and benefits of adequate birth spacing among men *(HTSP message: wait at least 24 months after a mother gives birth before attempting to become pregnant again, "Too Close").*

The findings show that 46% of men had knowledge of adequate spacing. With regard to the specific benefits of waiting at least 2 years after a mother gives birth before attempting to become pregnant again, 67.9% of men mentioned, "babies grow up bigger, stronger and healthier" followed by 27% who said "fewer maternal deaths." Of note, men are not aware that one benefit of spacing births by at least 24 months is to give the child more months to breastfeed.

Other benefits of HTSP, cited by men or as we phrase it "seeing it from a man's perspective" showed more than half of the men (55%) indicating that HTSP ***"****allows men time to emotionally and financially prepare for the birth of a child"*, followed by 47% who said *"provides an action that men can take to safeguard the health and wellbeing of their partners and children,"* and 44% indicating - *"involves men in making decisions about family planning, child spacing, and the health of the family."* Almost all 215 men interviewed (98%) named 1-2 benefits of practicing timing and spacing. The data suggests that men – can and would like to be engaged in the planning for their families, Table 3.7.

Table 3: 7: Knowledge and benefits of adequate birth spacing among men

Is there ideal time to wait after giving birth	**Men**	
	n=215	**%**
Below 2 years	71	33
Above two years	98	46
Don't know	46	21.4
Benefits of waiting at least 24 months after giving birth before attempting to become pregnant again	**n=215**	**%**
Fewer maternal deaths	58	26.9
Woman at lower risk for anaemia	41	19.0
Lower risk for miscarriage/abortion	32	14.9
Fewer stillbirths, new-born/infant/child deaths	48	22.3
New born less likely to be born prematurely/low birth weight	56	26.0
New-born less likely to malnourished	44	20.5
New-born has more time to breastfeed	0	0
Babies grow up bigger, stronger and healthier	146	67.9
Other Benefits of HTSP - "Seeing it from a man's Perspective"	**n=215***	**%**
Provides an action that men can take to safeguard the health and wellbeing of their partners and children	101	46.9
Involves men in making decisions about family planning, child spacing, and the health of the family	94	43.7
Allows men time to emotionally and financially prepare for the birth of a child	117	54.4

Wife may find more time to be with him, which may contribute to a better relationship	45	20.9
Number of Benefits of HTSP Mentioned by Men	**n=215***	**%**
None	5	2.3
At least one benefit	210	97.7
At least two benefits	210	97.7
At least three benefits	48	22.3
More than three benefits	12	5.6

Note: n=denominator for each variable

3.3.2.2: Knowledge on health problems that may occur when a woman becomes pregnant when she is over the age of 35 years among men, "Too Old"

The findings show that 35.3% of men had knowledge that there are health problems that may occur when a woman becomes pregnant when she is over the age of 35 years, corresponding to the key HTSP message of "too old". Additionally, 34% of men had knowledge of at least one increased risk associated with advanced age pregnancies. The most prominent risk was "maternal death", mentioned by 1.7% of men Table 3.8.

Table 3: 8: Health problems that may occur when a woman when too old

Are there Health problems that may occur when a woman becomes pregnant when over the age of 35 years	**Men**	
	N=215	**%**
Yes	76	35.3
No/ Don't Know	139	64.7
Problems that may occur when a woman becomes pregnant when she is over the age of 35 years	**n=215***	**%**
Maternal death	38	17.7
High blood pressure	28	13.0
Gestational diabetes	5	2.3
Miscarriage	29	13.5
Chromosomal abnormalities/ Down's syndrome	16	7.4
Stillbirths	16	7.4
New-born deaths	11	5.1
Problems that may occur when a woman becomes pregnant when she is over the age of 35 years	**n=215***	**%**
None	142	66.0
At least one	73	34.0
At least two	47	21.9
At least three	21	9.8

Note: n=denominator for each variable

3.3.2.3: Knowledge among men - of problems that may occur when a woman becomes pregnant when she has too many children - more than four children: "

Only 33.5% of the men knew that there were problems that may occur when a woman becomes pregnant when she has more than four children. The most prominent problem was "financial burden/ poverty" (20.5%), followed by "less likely for children to be educated", (18.6%). Consistently, only 31.2% knew of at least one problem and only 20.5% knew of at least two problems that may occur when a woman becomes pregnant when she has more than four children as shown in Table 3.9.

Table 3: 9: Problems that may occur when a woman becomes pregnant when she has more than four children

Are there problems that may occur when a woman becomes pregnant when she has more than four children	**Men**	
	n=215	**%**
Yes	72	33.5
No/ Don't Know	143	66.5
Any problem Problems that may occur when a woman becomes pregnant when she has more than four children	**n=215***	**%**
Maternal anaemia	16	7.4
Maternal deaths	27	12.6
Still births	7	3.3
Financial burden/ poverty	44	20.5
Less likely for children to be educated	40	18.6
Problems that may occur when a woman becomes pregnant when she has more than four children	**n=215***	**%**
None	148	68.8
At least one	67	31.2
At least two	44	20.5
At least three	18	8.4
More than three	4	1.9

Note: n=denominator for each variable

3.3.2.4 Qualitative data on knowledge of HTSP and benefits among men: Despite the low awareness on all the four HTSP messages and benefits, qualitative data from groups of men seemed to highlight the importance of HTSP and the benefits of HTSP, as expressed below:

> *HTSP is having an easy time to take your children to school and not feeling the weight at home* ***[IDI_Man_01]***
>
> *Family planning and birth spacing is having the number of children that you can take care of and that you give enough spacing* ***[IDI_Man_02]***
>
> *The benefits - she is the only one to feel it, but through my support, she will have an easy time. Many who don't use family planning might find a child is sitting, the other is walking so if she wants to go somewhere, she has to carry two of them…and its hard.* ***[IDI_Man_01]***

There are benefits, when the child has grown and has stopped breast feeding, the mothers body becomes healthy, the child is also healthy, when a woman is breast feeding there is a lot of stress and confusion and she cannot be healthy. Is hard to take care of the child well when is breast feeding and expectant at the same time. When she does spacing, you can take care of herself and the child well. ***[IDI_Man_02]***

3.3.3 Family Planning Methods: Knowledge

3.3.3.1: Knowledge of FP methods among women

Knowledge of FP methods relates to the acceptability of, and access to FP and birth spacing. Individuals and couples are more likely to use FP if there are a variety of methods available, both modern and traditional.

Generally, knowledge of FP methods was very high among women in the MOMENT implementation area. About 98% of women knew of at least one modern family planning method. Over two thirds (67.3%) knew of more than three modern FP methods.

With regards to knowledge of specific modern FP methods, injection (92.4%) was highest known, followed by implants (83.4%), injections (82.5%), male condom (63.4%), and IUD (54.8%). Despite the high level of FP knowledge, that of permanent methods was very low. Only about 8% of the women mentioned female sterilization, while only 5% mentioned vasectomy.

Knowledge of FP methods among women with children 0-23 months shows a similar pattern. Table 3.10 shows the distribution of knowledge on FP methods among women.

Table 3: 10: Knowledge of family planning methods among women

Knowledge of FP methods	**Women with children aged 0-59 months**		**Women with children aged 0-23 months**	
	n=724*	**%**	**n=417***	**%**
Female Sterilisation	58	8.0	33	7.9
Vasectomy	40	5.5	23	5.5
IUD	397	54.8	218	52.3
Implants	604	83.4	343	82.3
Injection	669	92.4	379	90.9
Pill	597	82.5	341	81.8
Male condom	459	63.4	267	64
Female condom	219	30.2	121	29
Lactation Amenorrhea Method (LAM)	20	2.8	10	2.4
Standard Days Method (SDM)	55	7.6	28	6.7
Emergency pill	84	11.6	44	10.6
Knowledge of any modern FP	**n=724***	**%**	**n=417***	**%**

methods				
None	12	1.7	8	1.9
At least one method	712	98.3	409	98.1
At least two methods	690	95.3	397	95.2
At least three methods	621	85.8	351	84.2
More than three methods	487	67.3	276	66.2

Note: n=denominator for each variable

3.3.3.2: Knowledge of FP methods among men

Generally, knowledge of FP methods was very high among men of reproductive age in the MOMENT implementation area. A large majority (90.2%) of men knew of at least one modern FP method and 50 percent mentioned at least three methods. This is remarkable given the low levels of education for men, with only 5% completing primary school.

With regards to knowledge of specific modern FP methods among the men, the highest known was male condom (72.1%), yet this ranked fourth among women, 63.4. This was followed by pills (55.8%), injection (47.9%) and implants (40.5%). Despite the level of high FP knowledge, that of permanent methods was very low. Only 5.6% of the men mentioned female sterilization. In the case of male sterilization/ vasectomy, only 6% of men knew of the method. The low knowledge of male sterilization may be driven by perceptions around vasectomy. Table 3.11 shows the distribution of knowledge of FP methods among men.

Table 3: 11: Distribution of knowledge of FP methods among men.

Modern FP methods	Men	
	n=215*	%
Female Sterilisation	12	5.6
Vasectomy	13	6.0
IUD	47	21.9
Implants	87	40.5
Injection	103	47.9
Pill	120	55.8
Male condom	155	72.1
Female condom	4	1.9
Lactation Amenorrhea Method (LAM)	12	5.6
Standard Days Method (SDM)	4	1.9
Emergency pill	11	5.1
Knowledge on FP methods	**n=215***	**%**
None	21	9.8
At least one modern FP method	194	90.2
At least two modern FP methods	156	72.6
At least three modern FP methods	107	49.8
More than three modern FP methods	56	26.0

Note: n=denominator for each variable

3.3.4: Exposure or source of the 4-Key HTSP messages and family planning services reported by women and men

3.3.4.1 Exposure to key HTSP messages: The source of exposure through hearing or seeing family planning services and HTSP messages was relevant in order to know the most effective medium of delivering messages. The findings show that the medium that worked best for delivering HTSP messages for ***women*** was at the health facility (63.7%), followed by radio (42.3%), and CHVs (34%). Exposure to key HTSP messages and FP services for ***men*** were almost equally from a health worker (45%), and their wives (44%), and then from CHVs (37%), as seen in Table 3. 12.

Table 3: 12: Source – where HTSP messages were heard or seen by women and men

Where women heard or saw key HTSP message	**n=724***	**%**
TV	45	6.2
Radio	306	42.3
Messages on clothing: Lessos, T-shirts, Boda Boda jackets etc.)	77	10.6
Billboards/ Hoardings	11	1.5
Newspaper Articles	7	1.0
Print material - Posters, Banners, Brochures	65	9.0
Street Plays/Shows	6	0.8
CHVs	246	34.0
CHEW	62	8.6
Peer educator	52	7.2
Doctor	32	4.4
Nurse	105	14.5
Pharmacy / medical store	15	2.1
Hospital / Health Centre/ Dispensary	461	63.7
Private Clinics	5	0.7
Formal Learning Institutions (School, colleges	20	2.8
Men / Husbands	6	0.8
Church leaders, CHATS & members	16	2.2
Friends	64	8.8
Men's source of HTSP message	**n=215***	%
Health Facility worker (Nurse, clinician, doctor)	97	45.1
Community Health Volunteer/ Community based distributor	80	37.2
Faith leaders	6	2.8
Community leaders	24	11.2
Traditional healers/TBAs	1	0.5
Media (radio, TV, Billboard)	22	10.2
Wife	95	44.2
NGOs	4	1.9
Relatives/friends	10	4.7

Note: n=denominator for each variable

3.3.4.2 Qualitative data from the voices of various respondents also acknowledge health service providers and CHVs the main source of FP information and services.

I heard about Family planning at the hospital when I took my wife to deliver [IDI_Man_01]

I heard about family planning in the year 2014, when I started receiving information on family planning after my last delivery, then I started spacing, spacing after the teachings in the clinic, I later used Implants to give a space of three years, previously I used to give birth yearly and after the other child stopped breast feeding, I would have another. [IDI_Woman_01]

I heard about FP from the hospital when I had gone to deliver my first baby [IDI_Woman_02]

3.3.4.3 Where women go to for FP services

Increasing use of modern methods of family planning requires user knowledge of where to obtain them from.

Figure 3: An empowered Service provider conducting HTSP/FP counseling session

The proportion of women who knew of a place where you can obtain information and a method of family planning was generally high, reported in over 80% of the women. The major source of information on family planning was the government facility (63.7%), followed by community health volunteers (CHV) **(**47.5%**),** and mobile clinic (44%) - Table 3.13. Of note is that MOMENT, a community-based intervention, confirms the role of CHVs and mobile clinics as a source to obtain FP services and information is very evident at 92%. It is also important to note that in the intervention area, the CHVs role was to refer the women to the government health facility for further FP information and services. Perhaps, this also accounts for the high proportion of women who reported government facility as major source of FP information and services and also exposure to the messages.

In addition, the percentage of women who reported discussing family planning with a health worker in the 12 months preceding the survey was 44.2%. Consistent with the findings on source of FP information and services, community health volunteers (29%) and service providers (23%) were the most prominent (Table 3.13)

Women get information from the community health workers working in their villages, and also when they come here we have the pamphlets on the wall...These flipcharts, we have the books for those who can read…..and we also have some small pamphlets that sometimes we just issue them with to go and read at home then they can decide. So, those are the sources they get information from [KII_FP Provider_02]

Table 3: 13: Women's kknowledge of where to obtain FP information and services

Know of a place where you can obtain a method of family planning	Women with children aged 0-59 months		Women with children aged 0-23 months	
	n=724*	%	n=417*	%
Yes	633	87.4	374	89.7
No	91	12.6	43	10.3
FP information and services	**n=724***	**%**	**n=417***	**%**
Government facility	461	63.7	254	60.9
Mobile clinic	318	43.9	187	44.8
Community Health volunteer	344	47.5	209	50.1
Faith Leader	17	2.3	11	2.6
Community based distributor	71	9.8	31	7.4
CHEW	7	1.0	5	1.2
Private hospital/clinic	87	12.0	48	11.5
Pharmacy	38	5.2	22	5.3
Relatives/friends	6	0.8	3	0.7
Impact (NGO)	2	0.3	0	

Discussed FP with a health worker and community mobilizer last 12 months	Women with children aged 0-59 months		Women with children aged 0-23 months	
	n=724	%	n=417	%
Yes	320	44.2	187	44.8
No	404	55.8	230	55.2
Who did you discuss family planning with	**n=724***	**%**	**n=417***	**%**
Community Health Volunteers/ Peer Educator	211	29.1	129	30.9
Nurse, Clinical officer, Doctor, CHEW	170	23.5	97	23.3
Relative/Friend	20	2.8	10	2.4
Faith leader	3	0.4	1	0.2

Note: n=denominator for each variable

3.4 Critical Milestone 2 (CM 2): Increase in service provider knowledge/awareness of accurate HTSP/FP messages, appropriate counselling and skills to provide modern methods of Family Planning.

3.4.1: Provider knowledge on HTSP/FP

A total of 32 providers were interviewed for the provider survey, 75% (24) were registered nursing officers, 15.6% (5) were enrolled nurses, and the remaining three were 2,6.3% clinical officers and 1,3.1% a medical doctor, Table 3.14.

Among those interviewed, 78% had been trained on HTSP/FP and counselling skills. 96% had heard about HTSP, knowledge of three or more HTSP messages was 72% and knowledge of at least one HTSP message was 90%, Table 3.15.

***Opportunities cited to integrate knowledge on HTSP*:** The providers also mentioned that to increase coverage of the HTSP message we need to: (Table 3.15).

1. *Build capacity of providers:* Train service providers in HTSP (69%) and develop training modules, guidelines, and policies in HTSP, and how to achieve HTSP (63%) through use of modern methods of family planning, which includes natural methods.
2. *Promote integrated services:* at the following clinic services: post abortion, postnatal/postpartum, antenatal, child welfare. Outreach and at public health and community events/barrazas.

3.4.2 Training nurses to provide long acting reversible contraceptives (LARC)

Project monitoring data show 45 nurses from 30 Level Two (Dispensary) and eight Health Centres, were trained to provide Implants and IUDS, which are LARCs (long acting reversible contraception). The nurses were also trained in counselling on the different modern methods of FP. This activity was geared to increase access to more FP choices including LARCs for women in underserved areas.
In addition, three health centres received support to carry out outreach and health promotions in hard to reach areas and three other health centres provided services targeted at adolescents.

The project also facilitated unpacking/synthesizing of reproductive health policy documents and standards for health sector service delivery on HTSP/FP (Child Survival & Development Strategy, National Reproductive health policy) and disseminated them during annual community, sub county Forums.

Table 3: 14: Health Worker Knowledge, Benefits and Opportunities on HTSP

Trained/sensitized on the concept of healthy timing and spacing of pregnancy	**n=32**	**%**
Yes	25	78.1
No/Not sure/Not directly	7	21.9
Heard about HTSP/FP	**n=32**	**%**
Yes	31	96.9
No	1	3.1
Knowledge of 4 key HTSP/FP messages	n=32*	%
Too Young: Delay pregnancy until you are at least 18 years	27	84.4
Too Old: Limit pregnancies to a mother's healthiest years (ages 18 to 35).	27	84.4
Too close: Wait until your baby is at least 2	25	78.1
Too soon: It is best to wait at least 6 months after an abortion	26	81.3
Number of HTSP messages identified	n=32*	%
None	3	9.4
At least one	29	90.6

Two	27	84.4
Three and more	23	71.9
What are three benefits of practicing HTSP	**n=31**	**%**
Better nutritional status (for child and/or mother)	24	77.4
Lower incidence of anaemia (for child and/or mother)	10	32.3
Less pregnancy complications / better chance of survival for child	15	48.4
Lower incidence of childhood diseases / reduce infant deaths	11	35.5
Body returns to pre-pregnancy state/ better mental health/peace of mind	21	67.7
Reduces heavy financial burden	25	80.6
Number of benefits mentioned of practicing HTSP	n=32*	%
None	2	6.3
At least one benefit	30	93.8
Two benefits	28	87.5
Three benefits	21	65.6
More than three benefits	12	37.5
Opportunities to include HTSP education and interventions	n=32*	%
Postpartum care visit	26	81.3
Antenatal care visit	20	62.5
Post abortion care visit	20	62.5
Child welfare clinic/ immunisation	26	81.3
Outpatient	18	56.3
Church meeting	10	31.3
Women's group meeting	9	28.1
Outreach clinic	19	59.4
Public health events/community gatherings	20	62.5
Opportunities/Strategies that can be used to integrate HTSP to ongoing MCH programs	n=32*	%
Advocacy among program managers and leaders	16	50.0
Develop training modules, guidelines and policies in HTSP	20	62.5
Training of service providers on HTSP	22	68.8
Supportive supervision and mentoring on HTSP	19	59.4
Improve HTSP and FP coverage to hard-to-reach areas	19	59.4
Encourage partnership in delivery of HTSP across County for better MCH outcomes	17	53.1

Note: n=denominator for each variable

3.5: Critical Milestone 3 (CM 3): Increase in new FP acceptors and continuing users per contraceptive method at public / private HTSP/FP service sites

3.5.1 Family Planning / Contraceptive Use:

Among the 724 women interviewed, 6.5% (n=47) were pregnant.
Of the 677 non-pregnant women, 30.4% (206/677) were not using any form of contraception and 69.5% (471/677) were using a form of contraception, which is the Contraceptive Prevalence Rate (CPR)1 (Table 3.16).

The baseline survey yielded a CPR of 49.5%, and a mCPR of 49%. The project target was to increase the CPR by 3% by end of project.

With an endline, CPR and mCPR at 69.5% and 68.9% respectively, MOMENT clearly exceeded its 3% target by a percentage point increase of 40.4%, which is a major achievement.

A shift and increase in use of LARCs is also seen and is consistent with findings on method mix (Section 3.6, Table 3. 17), where Implants (51.4%) and Injectables (30.8%) were new methods of FP added to 32 facilities and hence increase method choice for women. Of note, the baseline percentages were: Implants was 27.3, Injectables (44%), and IUDs (5.7%), the endline data assumes some women switched to Implants with a duration of 3-5 years offered by the Kenya MoH.

Notable is the low use of condom as per the data. With high rates of HIV infection in Siaya County, partner use of condoms should be encouraged where deemed necessary.

Table 3: 15: Family Planning use among women at time of survey

Family Planning Use & CPR	Women with children aged 0-59 months		Women with children aged 0-23 months	
	n=677	%	n=417	%
Using FP	471	69.5	262	62.8
Not using FP	206	30.4	155	37.2
Modern CPR	**Women with children aged 0-59 months**		**Women with children aged 0-23 months**	
	n= 677	%	n=417	%
	467	68.9	262	62.8
Methods currently used by women	**Women with children aged 0-59 months**		**Women with children aged 0-23 months**	
	n=471*	%	n=262*	%
Female sterilization	5	1.1	1	0.4
IUDs	27	5.7	17	6.5
Injectable	145	30.8	86	32.8

[1] Contraceptive Prevalence Rate (CPR) - the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a particular point in time (PMA2020).

Implants	242	51.4	132	50.4
Pills	24	5.1	10	3.8
Condoms	17	3.6	10	3.8
LAM	2	0.4	2	0.8
Standard Days Method/ cycle beads	5	1.1	4	1.5
Other traditional methods (natural, withdrawal)	4	0.8	2	0.8

Note: n=denominator for each variable

While the CPR was 63% - almost two-thirds of mothers with children 0-23 this is notable given that recent mothers have a greater need to initiate contraception within the first two years to ensure healthy spacing. Education and information efforts by the community and providers to encourage timing and spacing of pregnancies needs to continue.

Contraceptive prevalence rate of 69.5% in the MOMENT project implementation area is impressively higher than the Siaya County rate of 51%. This is also higher compared to the Kenya Demographic and Health Survey (KDHS, 2014)[1] where findings indicate contraceptive prevalence for any methods was 58%. These finding highlight a major achievement for the MOMENT project.

3.5.1.1 Non-use of family planning methods by women: Reasons for non-use were not asked of the 206 women and on hindsight we should have done so to get a sense of unmet need, however a third (29.6%, n=61) of the women had used injectables, implants, and pills in the past 6 months preceding the survey. The two main reasons for stopping use of their FP methods were: health concerns/fear of side effects (50%) and wanted to become pregnant (17%).

3.6: Critical Milestone 4 (CM 4): Increase in number of public and private HTSP/FP service provision sites that provide modern contraceptive methods

Family planning method mix is the percent distribution of contraceptive users (or alternatively, of acceptors) by method. A broad method mix suggests that the population has access to a range of different contraceptive methods. [2] There are 45 facilities in Alego-Usonga sub-county. MOMENT's target was to work in 20 facilities currently not providing LARCs and to increase the number of facilities that could do so by 4%.

3.6.1: New FP methods added to health facilities – Method Mix

MOMENT was instrumental in adding new modern methods of FP to 32 of 45 health facilities in the project area, exceeding its target. MOMENT realized a method mix increase by 71%. LARCs – a more effective method of contraception saw the most increase – Implants were added to 14/32 facilities (43.8%) and 28.1% (9/32) added IUD.

[1] Kenya Demographic and Health Survey, 2014.
[2] https://www.measureevaluation.org/prh/rh_indicators/specific/fp/method-mix

MOMENT strategy in targeting these facilities was a mapping out of the most accessed/used health facilities in Alego Usonga project area and then collaborated with Siaya MoH to provide skills training and supportive supervision to nurses who were trained in dispensaries and health centres Table 3.16.

Table 3: 16: New FP methods added to the facility services during MOMENT

FP methods added to the facility services after MOMENT	n=32	%
Female sterilization	2	6.3
Male sterilization	3	9.4
IUD	9	28.1
Injectable	5	15.6
Implants	14	43.8
Pill	4	12.5
Male condom	5	15.6
Female condom	4	12.5
Lactational amenorrhea method	6	18.8
Standard Days Method	6	18.8
Emergency Pill	4	12.5

3.6.2 Case Study – HTSP message branding and Training of Nurses in Mulaha Dispensary increase access to different contraceptive methods

Figure 4: A health facility before and after branding with 4-Key HTSP messages

Another strategy MOMENT used to achieve its goal to increase the number of facilities that can provide family planning services was to brand health facilities with the 4-HTSP messages (Figure 4). In addition, nurses (who played a key role), were trained to counsel, provide quality FP services, and to forecast for FP so that there is always supply of contraceptives to meet demand.

As stated by one provider: *There is now no day that we run short of an FP method. In fact, since World Vision came to work with us, we are always having a continuous supply of the different type of methods. So, the methods are always there, when the women come, each method is always there that they can choose and receive it. The FP methods are provided on a daily basis from Monday to Friday and any staff on duty can counsel on family planning.* [KII_FP Provider_02]

Figure 5, the Mulaha Dispensary FP uptake data (2011-2015) - Note the steep decline in injection and pills during the period and the significant increase in Implants and IUCD/IUD, after nurses received refresher training and supportive supervision.

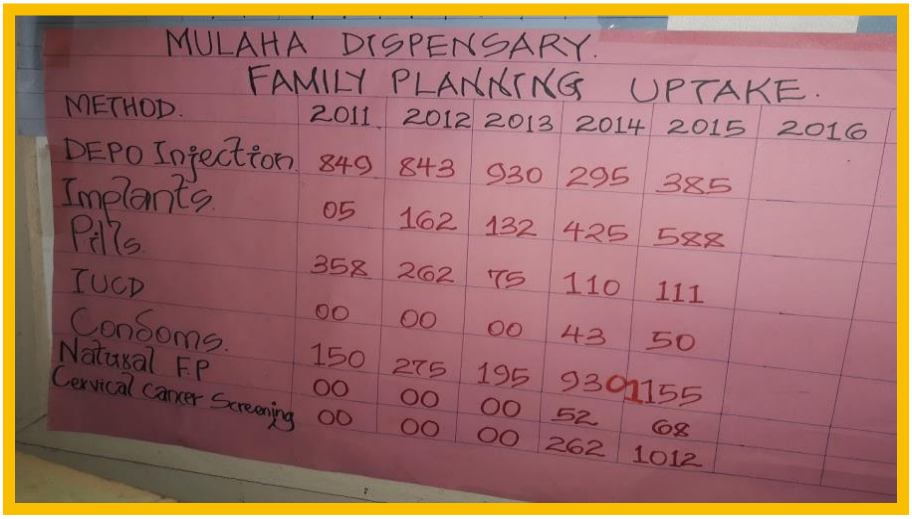


Figure 5: : Mulaha Dispensary, a MOMENT implementation showing impressive shifts in FP use

From a provider: Initially people were so much afraid of long term family planning methods but nowadays at least you find you don't have to do so much talking because of the HTSP messaging in the communities and at health facilities. They themselves they can ask for it, that is an advantage... so the knowledge is being widespread and at least with the referral that the CHVs are giving on where to seek more information, they are able to know that if I go to that facility I can be assisted. [KII_FP Provider_01]

3.7: Critical Milestone 5 (CM 5): Two local level champions (faith leaders, opinion leaders, civic leaders, influencers) publicly advocating for HTSP/FP per target project area per year

3.7.1: Faith leaders advocating for HTSP through the Channels of Hope approach and Congregation Hope Action Teams

World Vision recognises that faith leaders are uniquely placed, have profoundly deep, trusted relationships and links with their congregations, communities, and can influence changes in attitudes and behaviors. MOMENT project used the Channels of Hope (CoH) approach to directly address faith leaders' misconceptions about family planning issues, thereby empowering faith leaders to transform their thinking and the thinking of others in their communities. Various narratives from faith leaders in this study demonstrate how the Channels of Hope (CoH) aapproach provided a safe space for faith leaders and faith communities to learn, share and debate about HTSP and FP in the MOMENT implementation area. It started with a series of training and workshops being held with faith leaders and faith community members in order to catalyse faith leaders into action, through providing factual information and scriptural reflection to attitudes and actions that promote HTSP.

During the MOMENT implementation period, 136 faith leaders (target was 100) and 64 Congregational Hope Action Teams (CHATS) were formed and received training in CoH and follow up trainings. Each CHAT has an average membership of eight people. A total of 648 church community members received training. Forming CHATs was one key product from attending the COH training and a tangible way faith leaders adopted to show their support to help promote their followers and the community to seek MNCH services and adopt HTSP/FP services.

Figure 6: MOMENT project faith leaders putting knowledge into action sessions

Faith Leaders being trained to use Cycle Beads

Faith Leader speaking to a husband about FP

Thoughts from faith leaders:

1. My involvement in the Channel of Hope was through the trainings under the MOMENT project. I have been trained, I have information of how I can approach a person with information. I have so many people that I have taught on issues to do with healthy timing and birth spacing following the coming of MOMENT project First it was hard looking at my work as a pastor, this information was hard for us as pastors to take to the church members because the members believe in the pastor because pastors cannot say anything contrary to the word of God. Through MOMENT we were informed that the Bible says in Genesis that we give birth in the world and not houses, through this knowledge, it made it easy for me to approach the church members to know the benefits of family planning looking at the struggles that they had (Faith leader_02)

2. ...from the CoH training have changed me and one of the ways that am using to change my community is, when I do my sermons in church I slot in time to speak about healthy timing and spacing and we have groups in church, we have a group in church called congregation hope action team that was the first thing I did after the training I formed that group in the church which contains six people. That group when they were also trained after we had come back within our church they also helped me to reach out to the community to talk about healthy timing and spacing. (Faith leader_03)

3.7.1.1 Referrals to health facility for FP service made my Faith Leaders

When faith leaders understood the importance and impact of timing and spacing of pregnancies on maternal and child health, they delivered HTSP messages to their congregations and promoted support from male spouses. Results showed that 6,086 women went to a health facility to seek HTSP, FP, or MNCH services because they were referred there by a faith leader, and more than half (3,847) of the women decided to use a method of contraception. In addition, 24% of all the women referred by a faith leader opted to use Implants, a LARC. Table 3.17.

Table 3: 17: Contraceptive Uptake by Women Referred by Faith Leaders (2014-2016)

	Method	Alego-Usonga sub-county			Total
		Uranga	Boro	Karemo	
Women referred by Religious Leader who went to a Health Facility		1643	1869	2574	**6086**
The number of women who were acceptors by method they chose	Injectable	359	455	330	**1144**
	Pills	248	120	194	**562**
	Implant	338	417	732	**1487**
	Condoms	159	213	127	**499**
	IUCD	20	77	35	**132**
	BTL	3	10	10	**23**

	Total	**1127**	**1292**	**1428**	**3847**

Additional responses from faith leaders:

My experience with the Channels of Hope that as a pastor and a faith leader I was one of the fortunate ones that was trained by World Vision, I can say as a person it has benefited me and as a faith leader who had different perspectives concerning healthy timing and spacing (Faith leader_01)

What really changed my thinking were the many workshops, the regular trainings, I met other pastors who had the same problems and the same trainings changed their thinking, sharing about the benefits of family planning (Faith leader_04)

… I think the Channels of Hope training is one of the trainings that will forever cherish because as a faith leader it opened my eyes to part of my responsibility which I initially did not think about and the trainings that we've undergone has really helped me to be able to understand and also to help members of my congregation on issues of maternal and child health and more especially on issues of healthy timing and spacing and because we interact with our congregation almost on daily basis, it has helped me to be able to help them to effectively also plan their families (Faith leader_05)

Figure 7: A MOMENT project CoH catalyzing workshop

We realized that God did say that we give birth and fill the earth, but if I look at the Bible there is nowhere that is written we give birth and fill our houses, therefore it means that everyone is in his own house, so filling the earth is not filling your house, you must have a limit in your house and a single person cannot fill the earth. We realized that filling the earth is for many but filling the house is for one person (Faith leader_02)

What I have learnt and has helped me is, I realized that if MOMENT could have been here early I could not have messed up to giving birth to six children and life is hard…., The training has helped me personally in church, the many negative cases I used to handle are no longer there, at home, the cases from neighbours are not there, the youth in church who were giving birth early, they now know the danger of giving birth early. MOMENT has helped me have a healthy church. (Faith leader_01)

I strongly feel I have a role to play in order to see that members of my congregation are healthy; both the mothers and the children are able to survive, the children are able to enjoy that cordial relationship with their parents until they are of age, until they shall have breast fed well before another one comes up and that will also give the families time to plan for this period and also to give birth to number of children they can easily support (Faith leader_01)

Before MOMENT came, we thought that most people who were using family planning, we saw them as prostitutes, as the Bible says that a man should give his wife what is expected and vice-versa, we saw them as people with a hidden agenda. We saw them as people who wanted no family. We thought a woman who gave birth to many children and fast was a wife with a good name unlike the one who did not. We never took such a person as a good person in our families. Even in Church it was not easy to take family planning issues to church because the Bible says that we should give birth and fill the earth, it was not easy. Now we look at pregnancy spacing and family planning differently (Faith leader_03)

I have a great responsibility, As a servant of God I have to talk about them, any time am in church, midweek meetings I have to speak, any time I go to the barazas I have to speak about it, I have a big network, the chiefs are my friends, D.O is my friend, any time they call me I have to speak. Any time I am in a national convention meeting having 78 churches I have to speak about MOMENT and healthy timing and spacing of pregnancy. (Faith leader_04)

3.7.1.2 What do Faith Leaders think about HTSP and use of FP?

MOMENT deliberately chose only five faith leaders to answer the questions in the table below. This was really to test whether faith leaders were willing to answer direct questions about their faith. Refer Table 3.18 for the questions and answers.

Table 3: 18: Attitudes and Thoughts from Faith Leaders on Faith, HTSP and FP

	Attitudes and Thoughts from Faith Leaders on HTSP and FP	Yes / Agree (n=5)	No/ Disagree (n=5)
1.	I believe that God provides for every child born on this earth and preventing pregnancy is going against God's law.	0	5
2.	Couples should have a baby only when they are physically, financially and, emotionally ready.	5	0
3.	Modern methods of contraception (condoms, IUD, oral contraceptive pills) should be promoted, as they are tools God has given us to promote healthy mothers and children.	4	1
4.	God has called us to have as many children as possible, therefore promoting family planning is a sin.	0	5
5.	Faith leaders should not talk about contraceptives with unmarried youth because our role is to promote abstinence before marriage.	1	4
6.	Girls should remain modest and innocent (virgins before marriage) so	2	3

	they should not be exposed to information about contraception.		
7.	Medical abortion becomes necessary when the pregnant woman's health is in grave danger.	0	5
8.	It does not matter how many children a rich man has so long as he can afford their upkeep.	0	5
9.	Early marriage and child bearing by girls (before a girl is 18 years) is good for upholding societal morals.	0	5
10.	As a husband and father, it is the duty of this man to ensure that his wife has enough time and rest before becoming pregnant & having another child.	5	0
11.	Women must obey their husbands' decision about whether or not to use any contraceptive method.	2	3
12.	As a faith leader, it is my duty to promote contraceptives for healthy timing and spacing of birth (so that women and girls can be healthy and girls can finish secondary school).	5	0
13.	I struggle between God's word that says all children are gifts and the use of family planning methods that prevents pregnancies.	0	5
14.	I feel comfortable telling my congregation / followers about natural methods compared to modern methods of FP (pill, condom, IUD, Implants etc.).	1	4
15.	Using scripture validation helped me as a faith leader to embrace planning families through understanding of HTSP and using contraceptives to achieve timing and spacing.	5	0
16.	COH is an approach that helped break my resistance to FP and use of FP.	5	0
17.	The healthiest time for a woman to be pregnant is between ages 18-34.	5	0
18.	Children whose birth dates are spaced between 3-5 years are more likely to be healthy and do well in school.	5	0
19.	It is healthy for girls to get pregnant for the first when they are teenagers.	3	2
20.	It is important for a woman to wait 6 month after a miscarriage before trying to get pregnant.	5	0
21.	Having many children is good for a mother's health.	0	5

3.8: Critical Milestone 6 and 7 (CM 6&7):

CM 6: One local-level program finding included in national media and/or advocacy bulletin per year per country

CM 7: Four documented community and service provider discussions per year

3.8.1: Strengthening and Building Community Capacity

3.8.1.1 Building community advocacy capacity through Citizen Voice and Action – a World Vision Social Accountability Approach

Citizen Voice and Action (CVA) is a local level advocacy and governance methodology that aims to improve essential services (like health and education) by improving the relationship between communities and government[1]. The MOMENT project contributed in developing community advocacy capacity through training of community groups on CVA methodology with focus on HTSP/FP, with the aim to improve social and policy environment for family planning services, and positive reproductive health behaviours The MOMENT project has supported dialogue and quarterly meetings with CVA and Community Health Committee groups where HTSP/FP issues are discussed and shared with community. In total, 39 CVA meetings were held (18 meeting held bi-annually and 21 during Community engagements). Through this approach, community groups were trained and engaged to sensitise citizens about the expected government services and train them to work with the MoH to assure the services are respected and implemented.

Figure 8: A MOMENT project CVA community engagement forum

This CVA group was established in the year 2013, a series of training were undertaken back in the year 2014 and it has been actually continuous, our main focus was to do advocacy majorly on health issues including family planning, so in the health sector what

[1] World Vision International. 2012. Citizen Voice and Action. An effective local level advocacy approach to increase local government accountability. http://www.wvi.org/sites/default/files/Citizen_Voice_and_Action_PM.pdf

we were looking for was how to link the clients with the health facility and how to bring on board the health practitioners, the nurses and the doctors to actually give the clients the nest services and to see how the clients could also access other services to other level at the health sector. So, we were linkages to the community and the facility. (CVA_P4_02)

We have been trained to sensitise the community about family planning. It has been there but we were not talking openly about it, people used to hear about family planning but we never saw it as anything important, they were just stories. MOMENT project re-invigorated family planning…and is when people started to take it seriously, after being talked to about with the benefits, explaining myths etc. (CVA_P6_02)

The MOMENT has made a lot of efforts to link the CVAs with the health department and they have supported the CVAs on their own in activities, through training and also in terms of providing transport where necessary, world vision has really done a lot to sustain the CVA movement though MOMENT (CVA_P7_01)

As a CVA team, we have had an opportunity to share with the top-level decision makers within the health sectors or community and discuss issues that affect health services within most the sub county, of which most of them are corrected…the other day we requested a fence to be built around the dispensary to protect patients and nurse from thugs, and it was done by the local assembly ….and functional. That is one way we have done as CVA team in the MOMENT project (CVA_P4_03)

We now see that providers are polite and welcoming. We as CVAs have trained the patients on what services to expect, and that those who are supposed to attend to them are to do so with respect. In case anything happens, which is good they can speak out. Before they used to be shy even if they are slapped or abused. Even the radios can report and a person can even use a phone to record. The providers have to know it's their work to serve you well and are very keen not to harass anyone. (CVA_P8_01)

The CVA effort of the MOMENT project has also contributed in enhancing community participation in maternal and child health services. Various voices from representatives from three CVA groups reflect how they worked through several cycles of accountability improvements based on their observations of shortfalls at health centres and the services. Health facilities staffs were engaged in assessment of utilization and quality HTSP/FP services for identification and addressing barriers to demand, access, quality and with political environment for enhanced provision of high-quality HTSP/FP services. This was done through in partnership with the Ministry of Health, the Community Health Committees, Community Units through joint monitoring exercise in health facilities that has provided critical information and data for improvement of the reproductive health services and allocation of more resources to health by both government and other partners for increased access to family planning commodities to mothers and health interventions for children under the age of five:

We have had meetings with facility in charges to discuss charter and service delivery; through the in charges we have raised our concerns to improve services. Two, in the public participation, we have been raising facility concerns to be included in the budget. Three, we have been having

meetings with the MoH team to discuss issues touching on policies. Four, we have had our own meetings as CVAs, through our voices, there is motivation of the CHVs to improve their work. We have been raising at various levels to bring help to the community this is after the knowledge we received on how to improve our relationships with the service providers. CVA has made us manage to penetrate the facilities to know what is missing and what should be there. (CVA_P9_03)

We are working on advocacy, we visit facilities to check on how they are working, in case there are issues from the community, we go there to confirm because we cannot push for what we are not sure of. We visit our facilities and checking on the service charter, we also confirm if they are adhering to what they have written. In short, we act as advocates for the community on ground (CVA_P2_01)

The CVA effort has also contributed to positive reproductive health behaviours as narrated below:

MOMENT has empowered us, previously, when girls gave birth they dropped out of school, but now they have access to HTSP information and services, and she can do a lot that she wanted to do including finishing school. We also know that when a woman gives birth to two or three by using family planning, she can do her businesses with ease because she does not have a child on her back. When a woman gives birth regularly her health deteriorates (CVA_P2_01)

Men are really contributing, previously believed that children were a sign of wealth, they felt you were only filling his toilet if you took time before giving birth. After teaching them, they are now supporting and are happy and having time with their children. When a child was born and the other was less than three years they wonder why this child is sitting on mother laps where I used to sit. If we space them a man can be happy together with the other children. The men are happy with family planning (CVA_P4_01)

Initially, family planning was seen as a woman's affair. The coming of MOMENT helped us see that planning a family involves both partners, the exercise is not wasted because the man and woman know what is going on and what should be done, they have understood the importance of participating rather that the woman hiding and taking pills in secret. This is what MOMENT has really done to expose men to be involved fully in family planning (CVA_P3_01)

First and foremost, we hold dialogues at community level, where we put it very clear, the benefits of family planning for timing and spacing pregnancies, the involvement of men, and the heavy load that a family could have not carried if family planning was not done. .... Men have realized that it is not what people perceive that when a woman goes for family planning then she is trying to avoiding something or to hide something, it is to bring sustainable livelihood, majority have changed (CVA_P2_05)

3.8.1.2: Strengthening community health units and community health volunteer's functionality

The MOMENT project contributed in strengthening community health units and CHV functionality through training of all 517 CHVs in the implementation area on FP/HTSP methods as expressed below:

The MOMENT project is all about healthy timing and spacing of pregnancies, so that is where we have key messages, of too early a lady should conceive at the age of 18…. We have too late at 34 years…. should be on the border line. Someone should not proceed after having reached 34 years. And there is even too soon, when someone conceives and there is a miscarriage it is good for her to wait for 6 months before conception. I have learnt the key messages because before we CHVs we used to go to the households but we never had something concrete to tell these people but after the training at least we had a message to tell them. So, the message made them have an attitude change [FGD, CHVs_01]

The MOMENT Project for the period of 3 years that it has been working in this area we have been linking up with it through different bodies for example we had this body of Male Champion identified - some few male people within the community and they trained them. So these champions were interacting with the community members that they were living with. They were advocating for male involvement on health matters and specifically matters of family planning so that both male and female do it as partners… couple decision [FGD, CHVs_02]

We also do referrals. We can refer mothers so they come and get implant, coils… even now we have some women that we will refer here to the clinic so they can get BTL (sterilization) services. [FGD, CHVs_02]

After organizing outreaches, then we teach them the advantages of family planning. They will see that when you have few children you will take care of them in a proper way, educate them, and even the one who has many children knows the burden…will have a heavy burden. So after knowing the benefit, then they take their time and come to the hospital and access the chosen method of family planning, so that is the benefit that we are seeing. [FGD, CHVs_02]

CHVs, their role is also to give health messages to the mothers at home and also in the facility… if they get them. In fact, during the health talks, you find that also the CHVs and the CHWs they usually help us in giving the health messages. Those are the things they do. And then after that, after giving the health messages they refer the clients to us for the method [KII_FP Provider_03]

3.9: Community Views on HTSP and Family Planning

3.9.1 Qualitative accounts of community misconceptions, fears and myths that may act as a barrier to FP use

The positive findings showing an increase in CPR and mCPR in the MOMENT implementation over the three years does not mean that myths, misconception and rumours around FP, which act a barrier toward FP use, do not exist in the MOMENT project implementation area. It clearly

shows that the MOMENT project was able to put appropriate measures in place to address existing fears, doubts, myths and misconceptions about the use of family planning methods, to facilitate an increase in CPR and mCPR from 50.1 at baseline to 69.5% at end line for CPR and 49% at baseline to 62.8% at end line for mCPR.

The qualitative findings below highlight some of the prevailing myths, misconception, and rumours around FP - barriers, myths, misconceptions, and fears from the community members themselves. Views of service providers are also highlighted below.

(i) From the community:

From the mother-in-law is the worst because they don't want to hear about family planning, if they hear they say it can't happen no dowry should be taken to your home because you are there to just leave the life of their son the same way, you should give birth to children that's when this should be done for it to be in the count [IDI-_Woman_02]

In family planning, there are some people who are afraid, they believe that if I use the family planning method, I will bleed and I don't want that, but for me, I didn't experience this... We hear that one cannot practice family planning – the one of hormones, the pills, while we are breast feeding, but I was told it is not true at the clinic, not sure if I was told the truth or was lied… [IDI_Woman_01]

They say that if you are using family planning you feel nauseated, you feel dizzy, when a man is aware and does not want her to use it and, when he realizes she uses it, there would be a fight between them [IDI_Woman_02]

(ii) *From a community health volunteer*:

I found 2 women discussing how pills has a metallic thing that is inbuilt so when it's taken orally, it goes to the stomach and causes lots of damage and that's how it destroys your system stopping you from having children....I therefore volunteered and donated a pill for demonstration we placed it in a glass of water so that they could observe it producing the metal and at last when they did not see it they agreed that it was rumours and swore in front of me never to accept such rumours again. [FGD, CHVs_02]

(iii)From providers:

Is the myths that they get out in the villages that maybe this method of family planning has got many side effects…things like bleeding a lot….and pain. Those are maybe some of the things that make them not to come for those methods. But if we get the opportunity they come to the facility we give them the health messages about how to manage side effect, they do away about the myths and then they come for the methods [KII_FP Provider_03]

Beliefs and myths will never cease, as much as we're trying to demystify them they are still there. So one of them is like Jadelle will disappear in your arm, CopperT will disappeared in the stomach, Depo will make menstrual blood collect in the stomach [KII_FP Provider_01]

Some are just myths. Some they say when you practice family planning you will give birth to a retarded child... But there is a myth that they believe that family planning brings problems to women. It brings problem, you can deliver abnormal child, like for coil they say you may deliver a child holding the coil, so many myths, it is just myths and misconceptions. [KII_FP Provider_02]

The community here believes that if you have many children, you will be recognized in the community. Some, they feel if their women practice family planning, she will be unfaithful, she will be having some men outside the marriage, because she will not be pregnant, so the husband will not know. In fact, men really believe that a woman who is practicing family planning is a prostitute. ***[KII_FP Provider_02]***

(iv) Men as perceived barriers to FP

The men do not allow us to go for family planning, we just go as women because we feel the weight on giving birth, the men don't feel the burden, but as female we feel it by giving birth every year, so as women see that we have a burden but the man does not want, so I went when I was going to the facility and was taught I decided but he does not want, when I gave birth to a child who is now in the middle class its time he is allowing me to go for family planning [IDI_Woman_01]

Still male involvement in family planning still is low depending with what these women say and how they hide... We have had issues of women being brought here and we're being ordered to remove the implants we have inserted in them [KII_FP Provider_01]
Sometimes a woman can come here, you talk with the lady she agrees, you even give her a method, when she goes home especially the long-term methods, the implant the husband will tell her that you will not sleep here. Go back and remove.... so they hide, choosing the injectable one, because the injectable one the husband will not know, you are just injected and she goes. So most of the people using the injectable ones, mostly are those ones whose husbands are not agreeing for them to practice family planning [KII_FP Provider_02]

(v) Religious beliefs perceived as barrier to FP

Various respondents' narrations are reflection on how religious beliefs and teachings influence use of FP:

Most of the religious leaders see family planning as a bad thing, they say that it's the killing of the unborn child, some people support and some do not, the main thing is that it is between the married, when they decide the Church cannot come in. [IDI_Man_01]

Religious leaders are the main people who are not supporting family planning, like the condoms, they say that this increases promiscuity, they have allowed us to use any other method but not condoms and injections, they allow an agreement among the married. They don't support condoms and injections believing it increases promiscuity because the school going children are using them and this makes them to become prostitutes. ***[***IDI_Man_02]

Religious leaders are also the worst because they don't even want to hear about family planning, they say the Bible is written that people should give birth to fill the earth, this is what they preach [IDI_Woman_02]

The religious leaders, I think the Catholics, the Catholics they still have a problem with family planning. Because they believe God said you should deliver and multiply, why should you refuse God's…from what God has given you. So, like the Catholics they still have that stigma they don't like family planning. But natural they admit is good, but artificial they don't like. ... Roho religion also they have their own myth that family planning should never be practiced, it will make the women be sick, it interferes with their ovulation, they can deliver children who are mentally handicapped, something like that…so more information and education needed [KII_FP Provider_02]

3.9.2: Who, What, Where, Why and How - Targeting different groups of people to increase support for HTSP and use of modern methods of FP

3.9.2.1 The Men Say "Involve & Engage Men in FP issues: Of the 215 men interviewed, 71% were of the opinion that they supported their wives to use contraceptives, Table 3.19. Men were of the view that if services and programs deliberately included them, then they – the men would be more supportive.

Table 3: 19: Men's Views - Involvement in family planning

In your opinion, are men involved in family planning issues	**n=215**	**%**
Yes	152	70.7
No/ Don't know	63	29.3
Ways men's involvement enhance utilization of FP	**n=215***	**%**
To support contraceptive use	89	41.4
To share responsibility for contraception	62	28.8
To increase men's understanding of reproductive health issues	69	32.1

Note: n=denominator for each variable

Qualitative interviews also yielded agreement from the groups:

By sitting together and discussing and choosing the best method together... after she has explained to me why has wants a method because the weight if ours both, what she is doing should benefit us both and if I see it will benefit us both after telling me, I will support[IDI_Man_02]

Figure 9: HTSP/FP couple counseling session in Karemo

3.9.2.2: The community & Provider say "Involve Men at every stage"

For a woman to use a method first she must discuss and agree with the husband if not there will be a problem, you might think she is cheating on you, you might be newly married and the wife starts using these things either going for injections or taking pills, you might also think she is cheating and does not want to stay with me, this is when the difficulties come [IDI_Man_02]

Yes, they missed something small, it is their responsibility to give information on family planning and they only teach the women at the facility and not in the community and you know men don't take children to the facility, if they could have been sensitizing the community, the men could have been having the information not only for those who go to the facility. [IDI_Man_02]

Let's say informing women about FP together with their husbands because most of them don't want to escort their wives to the hospital, and men do not want to hear about hospitals and that their wives have gone to the facility for any reason, how then can they be reached and taught together with their wives? Using the CHVs and male champions was very good…. [IDI-_Woman_02]

Figure 10: Group session for HTSP male champions in Karemo

In my opinion since people still don't understand family planning, what should be done especially for men to support family planning is just teaching them. Even the ones who have started using them, they should be given knowledge and they will understand, its only information [IDI_Man_02]

I could be a woman who wants her husband to know more… maybe in cases he will not refuse if he knows the importance…., they are misbehaving more so on family planning because they don't know the importance and have no information, how can they be reached to get informed on family planning. [IDI_Woman_02]

So, if it can be ok then the catholic religious leaders should be brought on board also. So that they can know and teach the believers in their church so that at the end of the day….. because all these things are done jointly so that there can be a success. [FGD, CHVs_02]

Men as I told you earlier getting men is very difficult, getting them to come for family planning is very difficult, but the ones we get a lot mostly are the one coming to ask about the condom method. Apart from that we have never gotten any…none has ever asked about vasectomy, its only condom, family planning method that the men ask for and we give them. [KII_FP Provider_03]

3.9.2.3 Men say they need to be educated on HTSP/FP: Table 3.20 shows men reporting "Lack of accurate information" (55%) and "men's misunderstanding of correct use" (36%) of family planning as a major barrier to supporting use.

Table 3: 20: Reasons why men are perceived as barriers to use of FP

Barriers to men's use of FP	n=215*	%
Lack of accurate information	118	54.9
Provider bias against male method	33	15.3
Lack of access to services	27	12.6
Lack of provider training	33	15.3
Men's misunderstanding of correct use	77	35.8
Limited range of male methods	31	14.4

Note: n=denominator for each variable

3.9.2.4 Men suggest strategies to reach men: One-third (35%) of men interviewed indicated the best way to reach them was through media, workplace events came in second at 31% followed by sports events (26%), Table 3.21 Media outreach for men implies the cultural sensitivity that surrounds knowledge and use of contraceptives or family planning methods.

Table 3: 21: Activities/ methods that can be used to reach out to men

Activities/ methods that can be used to reach out to men	n= 215*	%
Stand-alone clinics for men	49	22.8
Separate hours/entrances for men	26	12.1
Integrated services	35	16.3

Male counsellors	51	23.7
Sports events	56	26.0
Workplace events	66	30.7
Media	75	34.9

Note: n=denominator for each variable

3.9.2.5 Improve access to facilities that provide FP services, or explore other ways of bringing services closer to the community e.g. through outreach

If the facilities could be brought nearer and increased in number, then the nurses who are doing family planning will be increased and can reach the women wherever they are [IDI_Woman_02]

We only encourage the partners, the MoH to make sure that we have the supplies, because it will be very bad if a client comes and misses a method. But something good, the clients have never missed a method, because MOMENT helped with training on commodities, so they (clients) have…. So just to continue making the facilities to have the different methods that can be given to the client. [KII_FP Provider_02]

Address incentives for CHVs, including supportive supervision, feedback,

After training, or even the visits with MOMENT Project was very minimal that you find that sometimes no one comes to follow up to see if you are on the right course or something like that. So it is proper that after the training by any particular organization, they should come and visit their trainees so as to ensure that during the training…. are they doing what we trained them on….. [FGD, CHVs_02]

There has to be something like feedback, like when they trained us, they just left us even without a reporting tool that we would have used to report, so you don't know whether the NGO had collapsed or is it still there. And also, feedback, you know someone should tell you are working well or you are not working well… at this point you should do such and such a thing [FGD, CHVs_02]

This can motivate us to work better and because it has taken long since training we need a refresher training (gives an example-like if you are told they are coming to the field tomorrow and you are required there you are likely to have forgotten some key issues [FGD, CHVs_03]

They need to do supervision, supportive supervision. We realised they only required reports when we went for their meetings but during ground work, they were not there. [FGD, CHVs_03]

Use Positive peer couples or women to tell their story

HTSP and FP…It is helping the men because they have enough time with their wives, their families, they can provide for the children, you cannot find child a crying here and there.... you are healthy, life becomes good for the children because they are getting enough food and attention they want so they could leave the house saying they are tired. [IDI_Woman_02]

Some women express a positive change on perceptions towards FP use as narrated below:
The community used to say a lot of bad things about FP, now they can't because FP is helping us, all the clinic that we go to, even in the small facilities you will find family planning teachings, anyone who might dispute family planning maybe he was born yesterday because we have seen that family planning has no problem. [IDI_Woman_01]

I made a decision that I will not be pregnant every year, I had a lot to do and not just sitting to give birth yearly. I decided to do some spacing to do my businesses, I can also run back home to do a few things and if I leave them they are safe because the people are responsible [IDI-_Woman_02]

3.10 New Learnings from MOMENT

This section details lessons learned that are outside the Critical Milestones of MOMENT, but highlight new and important learnings that are critical for future maternal and child health programming with Siaya County.

3.10.1: Future fertility intentions

Currently pregnant women: Of the women who were pregnant at the time of the endline survey, 35% (16) wanted to become pregnant when they got pregnant, 37% (17) wanted to wait one or more years and 28% (14) did not want any more children. In the latter two groups of women, we did not determine if there was an "unmet need for contraception," which is an area for future program consideration.

Non-Pregnant women: Of the women who were not pregnant at the time of the endline survey 35% (237/677) wanted to become pregnant during their last pregnancy, 32.8% (222) wanted to wait one or more years and 27.5% (186) did not want any more children. A third (67%), of the women who "did not want to become pregnant/did not want any more children" were using a method of FP Table 3.22.

Table 3: 22: Pregnancy intention for currently pregnant and last pregnancy for non-pregnant

	Currently pregnant		Last pregnancy	
Pregnancy intention	**n=47***	**%**	**n=677***	**%**
Wanted to become pregnant then	16	34.8	237	35.0
Wanted to wait at one or more years	17	37.0	222	32.8
Did not want to become pregnant / any more children	14	28.3	186	27.5
Don't Know	-	-	32	4.7

Note: n=denominator for each variable

Of the 677 women who were not pregnant at the time of the survey, but had a most recent child,

- 237 "want to become pregnant again". Of this number 77.6% (184/237) have their most recent child under 24 months, 19.8% had a child between 25-36 months and 2.5% couldn't specify the age of their youngest child.

- 222 wanted to "wait at least one or more years" Of the 222 women, 83.3% (185/222) have their most recent child under 24 months, 12.2% between 25-36 months and 4.5% couldn't specify the age of their youngest child.
- Of the 186 women who "did not want to become pregnant/did not want any more children," 67% were using a method of FP.

3.10.2 Effective medium for reaching community with information, education and health services

- Data from the endline survey showed that in addition to CHVs and health workers, outreach and radio were major outlets that the community received information, education and health services. MOMENT did not use radio as outlet for communication due to limited project resources. However, the fact that radio was a viable means of communication is important information for the Siaya County Government and Health Services. Something is being done right!

- In addition, men's knowledge showed impressive knowledge gain and from Table 3.21, men need to be targeted with accurate information on timing & spacing of pregnancy and support for MCH care.

3.10.3: Family planning messages received at MNCH services

In the six months preceding the survey, 54% (390/724) of mothers with children under 59 months reported receiving information, messages, or referrals on a contraceptive method during one or more of the following service sites: antenatal care; delivery; postnatal care; child immunization. Postnatal visits ranked highest (23.9%) as service point for receiving FP information as reported by women with children under 59 months. A similar pattern is seen for women with children under 24 months (37.4%) and maybe an important service place to integrate FP counseling and service provision Table 3.23

Table 3: 23: Family planning information or messages received last six months by women

MCH Services	Women with children aged 0-59 months		Women with children aged 0-23 months	
	n=390*	%	n=230*	%
Received FP information or messages during any ANC visits	52	13.3	45	19.6
After delivery/ pre-discharge	24	6.2	23	10.0
Received FP information, referrals, or services during postnatal visits	93	23.9	86	37.4
Received FP information, referrals, or services during immunization	38	9.7	32	13.9

Note: n=denominator for each variable

A major relevance of integrating family planning with other MNCH services is that because women's risk of pregnancy increases a few weeks after delivery, multiple opportunities to speak about timing and spacing of pregnancies during the postpartum / postnatal period are particularly

important[1]. For future improvement in health for the mother and child, opportunities to integrate MNCH and FP services is highly recommended.

Narrations of women users and service providers also provide evidence that family planning information and services was being provided to women during other MNCH visits, during the MOMENT project implementation period:

- ✓ *Most of the time when I went to the facility when even taking my child, I hear them teach but it was not happening before, the try looking for women to talk to about family planning* [IDI_Woman_02]
- ✓ *My role with MCH, targeting those mothers more so mothers who come for immunization, I give them information on family planning and identify those who can qualify for family planning and give them what they want from their own decisions after telling them what we have* [KII_FP Provider_01]
- ✓ *If a mother delivers, ok we will tell her about the different types of family planning methods that we offer in the facility. If she is a mother who wants to start FP immediately, then she can use the IUD, which can be inserted immediately after birth. But if she is not ready at that time you tell her the options, the benefits, and the best time for her to start on family planning which will be six weeks when she will be coming back to bring the child to the clinic to come to the post-natal clinic, so that's also the right time that she will also start the family planning…. methods that she wants.* [KII_FP Provider_02]

3.10.4: Sexual and reproductive health discussions with adolescents in and out of school

In Alego Usonga sub-county, the mean age of sexual debut for girls is 15.3, and the average age for a first birth is 16.5 years. HIV prevalence is 17.8 percent. This is corroborated by MOMENT baseline findings.

The MOMENT project partnered with the Ministry of Education (MoE) to cover 60 schools, and trained 68 peer educators in the MoE Life Skills Curriculum on the topics: sexual and reproductive health (SRH), complete your education, human development, prevention of teen pregnancies and HIV/AIDS, values and behaviours, relationships, drug abuse, and suicide. The MoE data indicate teen pregnancy caused 100 drop-outs in 2013, and 90 in 2014 and only 15 of these girls returned to school after delivery. Over the project period peer educators reached 3,900 girls and 1,580 boys aged 10-15, collaborated with 145 teachers, and 400 parents to provide information on life skills.

MOMENT also reached out of school adolescents by training eight nurses working in four health centers to provide youth-friendly services. The project furnished the health centers with: a television and DVD player, pool tables, posters on HTSP, and family planning brochures and other publications. In addition, 47 peer educators were attached to health centers and were trained in skills to enable them to hold daily counseling sessions that reached 200 youth weekly. Discussions focused on **S**afer sex practices, **A**ccess to information, **V**oluntary counseling and testing and **E**mpowerment - **SAVE**.

[1] FHI 360/PROGRESS. Postpartum Family Planning: New Research Findings and Program Implications. 2012b. Available from: http://www.fhi360.org/sites/default/files/media/documents/Postpartum%20Family%20Planning.pdf

CHAPTER 4: SUMMARY OF CRITICAL MILESTONES AND IMPLICATIONS FOR FUTURE PROGRAMS

4.1: Summary

4.1.1 Demographic characteristics of study respondents

- At endline the mean age for the women was 27.65 years (SD. 6.4), ranging from 16 to 48 years, similar to the baseline age of 28 years. For men, the majority (46.1%) were aged 18-24 years, with a mean age of 35.11 years (SD. 7.9), ranging from 16 to 48 years compared to the baseline age of 37.0 years.
- In the two surveys the majority of women (79.0% baseline, 87.2% endline) and men (90.4% at baseline, 94.4% endline) were married.
- Major religious affiliation in Alego-Usonga is Protestant and Catholic.
- Birth before 18, Births after 35 years**:** Survey data show percentage of women who gave birth before the age of 18 years was about 46%, while that of women who gave birth over the age of 35 years was 14.1%. Baseline data also showed 32.8% of births occurred before the age of 18 (16.9 years).

Implication for Future Programs:

- The results highlight the need for Siaya County and the MoH to continue to emphasise the following messages on:
    - "Too Young" - to bring to bear the importance of girl's education to enable them complete secondary education, to develop strategies to prevent teen pregnancy, and to institutionalize the "Too Young" message as part of CHV house-to-house messaging and health worker's information sharing with girls, women, and the community.

4.1.2 Critical Milestones – Achievements and Implication for Future Programs:

Critical Milestones 1: Community knowledge of the 4-HTSP messages and Implications for Future Programs *(Refer Table 4.1):*

Knowledge increase of HTSP messages

1. "Too Young": By endline the percentage point increase in knowledge of the "Too Young" message was 25.2% (52.1% baseline, 77.3% endline) for women with children under 0-59 months. It is an important result and an opportunity for Siaya County health, education and community development authorities to message and help families support girls to stay in school and delay early childbearing.

2. "Too Old": The percentage point increase from baseline was 10.8% (28.5% baseline, 39.3% endline) among women with children under 0-59 months. The level of knowledge in the group with children 0-23 months were almost the same.

3. "Too Close": Knowledge of the spacing message was 80.3% among mothers with children 0-23 months. Though we do not have a baseline, it is an important finding that they understand the importance and benefits of spacing pregnancies, especially as 60% of the women indicated the new-born will have more time to breastfeed (Table 3.4). However, the percentage increase stayed the same among mothers with children 0-59 months and has implications for further investigation.

4. "Too Soon": Although knowledge of this message showed 61% among mothers with children 0-59 months and 44% of mothers with children under-2, only 8.4% and 6.7 % respectively, could categorically mention "wait at least 6 months after a miscarriage before attempting another pregnancy", per the HTSP message (Table 3.5). The majority (45%) responded "below 6 months". This result may suggest a re-think of how to effectively deliver the message to all mothers and women.

Male Involvement: Faith leaders, Men

136 faith leaders and 120 men received training in HTSP/FP and served as champions of the message with communities.

When faith leaders understood the importance and impact of timing and spacing of pregnancies on maternal and child health, they delivered HTSP messages to their congregations, influenced other faith leaders to support HTSP, and promoted support from male spouses. Project data showed that 6,086 women went to a health facility to seek HTSP, FP, or MNCH services because they were referred there by a faith leader. From this number, more than half of the women referred (3,847) decided to use a method of contraception. Forty-two per cent (42%) of these women also chose a longer acting and permanent method of contraception (Table 3.18).

Critical Milestone 2: Increase in health workers' knowledge of the 4-HTSP messages and skills to provide family planning services - *Implication for Future Programs (Table 4.1):*

1. Thirty-two (32) health workers were interviewed and among them, 78% had been trained on HTSP/FP and counselling skills. 96% had heard about HTSP, 72% knew of three or more HTSP messages and 90% knew of at least one HTSP message. More staff at (32) had better knowledge that the 12 interviewed at baseline.

2. In anticipation of a rise in demand of family planning services we had to ensure availability and access to services.
    a. Forty-five (45) nurses working in 30 Level-Two (Dispensary) and eight Health Centres, were trained to provide Implants. The nurses received training in counselling on the different modern methods of FP.

3. Implants became the leading contraceptive choice of women.

To achieve Critical Milestone 4, Critical Milestone 2 had to be in place.

Table 4. 1: Critical Milestone 1 and 2 - Community and Health Provider Knowledge

Critical milestones (CM)		Baseline	Target
CM 1	20% increase (from baseline) in community knowledge/awareness of accurate HTSP/FP messages *(of each message)*	40%	60%
CM 2	20% increase (from baseline) of service provider knowledge/awareness of accurate HTSP/FP messages and appropriate counselling for modern FP methods	27.7%	47.7%

Result: Knowledge of accurate HTSP messages – Critical Milestone 1 & 2					
Percent distribution of women with children 0-59 and 0-23 months				**Service provider (nurses) knowledge/awareness of accurate HTSP/FP messages**	
Indicator	**Baseline**	**Endline**		**Baseline n=12**	**Endline N=32**
	0-59 months N=607	0-59 months N=724	0-23 N=417		
Too Young: Delay the first pregnancy until a girl is at least 18 years old	52.1	77.3	77.5	8.3	84.4
Too Old: Limit pregnancies to a mother's healthiest years, ages 18 to 34	28.5	39.3	39.8	33.3	84.4
Too Close: Wait until your child is at least 2 years old before trying for another pregnancy	46	46.8	80.3	41.7	78.1
Too Soon: Wait at least 6 months before trying for another pregnancy after a miscarriage	31.6	8.4 (61% have heard)	6.7 (44% have heard)	16.7	81.3

Critical Milestone 3: Family planning / Contraceptive Use *(Refer Table 4.1)*

Contraceptive prevalence is a key indicator measured during the baseline and endline surveys. Among the 724 women interviewed, 6.5% (n=47) were pregnant. Of the 677 non-pregnant women, 30.4% (206/677) were not using any form of contraception and 69.5% (471/677) were using a form of contraception.

A significant percentage increase of 40.4% was recorded from baseline (49.5%) compared to endline (69.5%), exceeding project targets.

During the baseline 44.4% and 27.3% of women were using injectables and implants respectively. By endline 51.4% of women were using implants compared to 30.8% on injectables. The shift and increase in use of implants is likely because it is a long acting

reversible and less invasive contraceptive method able to be administered by nurses in health centers/dispensaries. The percentage increase in implants use from baseline to endline was 88.2%.

Table 4. 2: Contraceptive Use

Critical milestones (CM)		Baseline	Target	Endline
CM 3	3% increase (from baseline) in new FP users	CPR: 50.1% mCPR: 49.2%	53 %	CPR: 69.5% mCPR 68.9%
	Contraceptive methods			
	Implant	27.3		51.82
	Injectables	44.4		31.05
	IUD	4.6		5.78

Critical Milestone 4: Increase in number of health facilities providing contraceptives *(Refer Table 4.2)*

1. MOMENT set out to work in only 20 facilities but expanded its target upon request from the Siaya County Ministry of Health.
    a. Thirty-two (32) government facilities added implants to their contraceptive method mix.

2. The preference for implants as noted under Critical Milestone #3, is consistent in achieving Critical Milestone 4. Of the 32 facilities where new contraceptive methods were added during MOMENT, implants and IUDs accounted for 43.8% and 28.1% respectively.

Critical Milestone 4 could only be achieved because Critical Milestone 2 was in place.

Table 4. 3: Increase in number of health facilities providing contraceptives

Critical milestones (CM)		Baseline	Target	Endline
CM 4	3% increase in number of public and private HTSP/FP service provision sites that provide modern contraceptive methods	45 facilities in Siaya sub-county	20 facilities to increase FP method mix. (14) Government, (2) Mission, (2) NGO run clinics and (2) Private Clinics.	32 (30 Level-2 (Dispensary) and 2 Health Centres

Critical Milestone 5: Two local level champions (faith leaders, opinion leaders, civic leaders, influencers) publicly advocating for HTSP/FP per year.

Project Target: 6.

Achievement: MOMENT exceeded the number of champions publicly advocating for HTSP/FP as described below. Refer Annex 1 for attachments:

a) During the 3-year project, 136 faith leaders received training in Channels of Hope. During their Sunday sermons, about 100 faith leaders talk about HTSP and family

planning as a good strategy to improve maternal and child health (Annex 1a-Sermon Guide). They willingly share their change stories with visitors.

b) In October 2014, a group of faith leaders came together to support HTSP and family planning. The story was reported in the Daily Standard, October 10, 2014 (Annex 1b-Standard clipping).
c) Citizens Voices for Action groups and faith leaders developed a budget proposal to increase funding for MNCH and HTSP in Siaya County. They presented it in April-May, 2015 to the County as a budget memorandum for the 2015 financial year.
d) In September 2015, two faith leaders and a husband and wife who had been exposed to HTSP participated in the Africa Global Missions Health Conference held in Nairobi. The purpose of the faith leaders was to share the experience gained after going through the Channels of Hope training, forming Congregation Hope Action Teams (CHAT) that advocate for HTSP/FP as an important factor for MNCH and the family. The couple also shared how they changed their attitudes towards seeking health services Annex 1c Excerpt from conference report).

Critical Milestone 6: One local-level program finding included in national media and/or advocacy bulletin per year.

Project Target: 3

Achievement: MOMENT's met this target, listed below: Refer Annex 2 for attachments:

a) In October 2014, a group of faith leaders came together to support HTSP and family planning. The story was reported in the Daily Standard, October 10, 2014 (Annex 1b-Standard clipping).
b) MOMENT participated and supported a national advocacy meeting and engagement with the First Ladies who are influential in informing policy change/review at county and national level. The goal was to influence policy around MNCH and budgeting for MNCH services (Annex 2a-Bevalyn Kedogo and First lady of Kenya interacting, 2015)
c) January 2016: Kenya received an award at the International Conference on Family Planning (ICFP) in Bali. WV Kenya MOMENT project is a partner recognized as contributing to this award. The MOMENT presentation at ICFP was on *Healthy Timing & Spacing of Pregnancy messages reinvigorates Family Planning in Siaya.*
    a. **http://www.standardmedia.co.ke/health/article/2000180026/global-forum-in-mexico-seeks-to-take-stock-of-maternal-child-health-gains.**

Critical Milestone 7: Four documented community and service provider discussions per year.

Project Target: 12

Achievement: MOMENT exceeded the number community and service provider discussions.

a) MOMENT trained three CVA groups to represent each of the three sub-divisions in Alego-Usonga sub-county-Boro, Uranga and Karemo. CVA teams per sub-division held

three meetings each year with health providers (12 meetings in total), to discuss how the community could help improve provider care. Refer Box 2 for an example of what the CVA and community achieved.

> Box 4: Excerpt from MOMENT case study: "The road to healthier families"
> Overcoming bureaucracy can sometimes be a matter of life and death. In June 2014 CVA volunteers investigated a "rampant" increase in maternal and child deaths in Nyamila town. They learned that the community's sole maternity clinic stopped night-time delivery services after thugs attacked its evening security guard. The guard survived, but the area's expectant mothers faced tragic risks and turned away from the clinic. It is reported that one pregnant woman delivered twins on the side of the road. Neither of the twins survived. "She wept so bitterly recalling that had she not been sent back home, her children would have survived," says one CVA volunteer. The CVA volunteers convened community leaders and clinic staff to brainstorm a solution for increased security of staff and the need for a solid fence to be constructed around the clinic boundaries. Funds were mobilized by the area Member of Assembly, and the clinic was secured, and the clinic records show that births have increased by 30 per cent between 2014 and 2016 – *CVA Volunteer, MOMENT Project.*

b) 27 additional meetings were held between CVA teams, the community and service providers in each division bi-annually. Refer Box 3 for an example of a meeting centred on ensuring availability and quality of services both from the patient and provider's point of view.

> Box 5: Excerpt from MOMENT case study: "The road to healthier families"
> 'CVA volunteers are also adept at eradicating red tape.' In December 2014, when they learned that a new health dispensary built to serve 6,500 people remained unopened due to lack of a perimeter fence and construction of staff quarters, CVA advocates in the Mur Ngiya area in Alego-Usonga acted. They organized the local chief, dispensary staff, community health workers, and Ministry of Health officials to sort out the issue. Public funds had been allocated for the fence and the quarters, but somehow the money had not been dispersed. The CVA volunteers inspired collaboration. and several weeks later, the construction was completed and the clinic ready to open its doors" – *MOMENT Program Manager, Siaya Bevalyn Kedogo, 2016.*

c) One key systemic issue was the lack of CHWs to carry out community-based distribution of FP methods because of frequent stock outs. MOMENT worked with the County referral hospital to improve family planning forecasting at lower level facilities. This item is an ongoing health systems issue that needs to be constantly monitored by the County Hospital.

Quote from a CVA Volunteer:
"As a CVA team, we have had an opportunity to share with the top-level decision makers within the health sectors or community and discuss issues that affect health services within most the sub-county, of which most of them are corrected…" (CVA_P4_03).

Summary of the Learning Agenda:

1. Male involvement and engagement using their voices,
2. Faith & Religious Leaders: Male and female engagement – Though the current majority of faith leaders are men, in recent times we have seen an increased number in females as faith leaders. If this is considered, it may change the gender dynamics.
3. Benefits of knowing – the MOMENT project demonstrated their theory of change: understanding from knowledge gained and benefits to be had. This is a good return on investment – achieving HTSP through use of modern methods of family planning.
4. Future fertility intentions:
    a. target unmet need for contraception,
    b. target the 'Too Old" and "Too Close" messages in a different way to achieve greater impact,
5. Integrated MNCH and FP clinics should be a strategy of the MoH to increase access to services.
6. Radio was a viable means of communication – this is important information for the Siaya County Government and Health Services. Something is being done right!
7. Adolescent programming should be a priority in Siaya County.

July 2017 - Recommendations from stakeholders

Participants: A cross-section of stakeholders including all six sub-county RH coordinators who are key to FP/RH programming in Siaya County, faith leaders, Catholic nuns, CHV and CVA representation, nurses from both private and government health facilities, staff from local NGOs/INGOs, and adolescent peer educators.

The dissemination of MOMENT came one-year after the project closed and yet stakeholders (and the CHMT above) are still energized by MOMENT as one project that affected the whole county. The group participated with enthusiasm and a discussion followed with suggestions for improvement in another project.

Key recommendations from the group were:
HTSP messages*:*

1. Re-crafting of the "Too Old" and "Too Close" messaging because the increase in knowledge was not as high as the "Too Young" and "Too Soon" HTSP messages.
2. Better translation of 4-HTSP messages into local language
3. More education and information emphasis on HTSP benefits and negative consequences of not practicing
4. Need to develop messages focused on the economic and health benefits of limiting births, as this was prominently recognised as a benefit of HTSP in this evaluation

Questions to ponder - Do we need to change the wording of the "Too Old" and "Too Close" message? Do we consider cultural dimensions and effect on responses during interviewing e.g. a woman may say "I need to bear the children in my healthiest years…like the HTSP message, but this may not include 2-3-year recommended gap "Too Close", and women with higher education may/will have their children after 35.

CVA, faith leader and engaging men and fathers

These strategies were reemphasized as very good and needs to be continued and taken up by MoH due to the socio-cultural context.

1. Strategies need to be scaled to cover Siaya County.
2. Capacity building for CVA groups, faith leaders and CHVs to ensure that they continue to perform the advocacy and community sensitization roles, including helping clarify community expectations and identify HTSP and FP service sites and delivery gaps so that the gains made by the MOMENT project are sustainable and not lost.
3. Feedback mechanism to community should be explored so that CVA participation in budget making process and achievements can be relayed back to show that community recommendations were reflected.
4. Need to address incentives for CHVs, including supportive supervision, feedback.

In exploring approaches that involve faith leaders and men, considerations to have each village have a HTSP/FP male champion would be ideal, reflecting on the view that men can be agents of positive change, acknowledging the fundamental role men play in supporting women's reproductive health and in transforming the social roles that constrain reproductive health and rights.

Discontinuation of contraceptives

1. *FP side effects and role of health care providers:* Nurses were concerned that continuation of use of a particular method of contraception by women was a challenge. This is supported by data from this evaluation. Discontinuing use of FP methods due to health concerns/fear of side effects was high among women.
2. This raises the need to actively address the issue of side effects of FP methods.
3. Nurses and other healthcare providers need to provide better counseling and encourage revisits to the provider if women experience side effects. This is because nurses have a critical role in dispelling the myths, misconceptions and can accurately explain the side effects. A client who is well prepared and well informed on side effects is at a better place to handle the side effects and return to the clinic for re-evaluation if the provider includes this aspect during counseling.
4. Modify nurses FP training to include point #3.
5. If possible inlcude discontinuation of FP use M&E plan in future projects as part of FP use and evaluation.

MoH has revised FP monitoring forms to capture women who discontinued use. For future projects, M&E plan should inlcude discontinuation indicators and ensure MoH standardized interpretation and referencing during measuring of project progress and at end of the project evaluation.

Annexes

Annex 1a: **SCRIPTURAL MESSAGE VALIDATION**

Scriptural message validation was a follow-up meeting held by Church Leaders (May 2014).

Questions discussed and on HTSP-FP and supported with biblical quotations:

1. Birth Spacing/Family Planning - whose plan?

- It is both God and man

Scriptures

- Genesis 4:1-2, 25 – Adam had Cain and Abel. Seth was born only after Abel had been killed by his brother.
- Genesis 9: 7 – Be fruitful and multiply (Genesis 9: 7, And as for you, be fruitful and multiply; Bring forth abundantly in the earth and multiply in it."). Which means someone must plan before a child is expected.
- Noah had 3 sons, Genesis 6:8-10
- Abraham had 2 sons. Ishmael and Isaac. Ishmael was not in God's plan. Isaac was the child in God's plan. They had a spacing of 14 years. God intended Abraham to have 1 child.
- God allows man to plan, Luke 14:28-29

2. Does Family Planning encourage promiscuity? No

- Immorality was there even before the modern family planning message. Genesis 6.
- An adulterous person will engage in adultery whether he/she does or does not use modern family planning methods.

Scriptures

Gal 5:19-21, Jeremiah 17:9, Mark 7:14-15, Genesis 38:14-15, I Corinthians 6:12-20

3. How can we practice birth spacing?

- The couple should agree that they want to practice birth spacing
- The couple should agree on the number of children they want.
- The couple should agree on the best Family Planning method they want to use and consult with a health worker at a health facility.

Scriptures (agreeing together)

Amos 3:3, Isaiah 1:8, Luke 14:28-29, Genesis 38:8-10, I Samuel 1:24, Genesis 21:18

Reported by

Josephine Philip, religious leader trained on COH MNCH.

Annex 1b. Newspaper/Daily Standard – Faith leaders, October 2014.

Religious Leaders - Standard New.pdf

Annex 1c: Excerpt from the Africa Global Missions Conference, 2015.

Participants 2015 Africa GM Conf.pdf

Annex 2:

Annex 2a: Bevalyn Kedogo and First lady of Kenya interacting, 2015

1st lady Kenya and MOMENT project ma