AACES COMPLETION REPORT:
EAST AFRICA MATERNAL NEWBORN CHILD HEALTH PROJECT
(EAMNeCH)

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Project outline

The East Africa Maternal Newborn Child Health project (EAMNeCH) was implemented in four health-vulnerable contexts in the County of Kilifi in Kenya, Kitgum District in Uganda, Gicumbi District in Rwanda and Kilindi District in Tanzania. It aimed to improve maternal, newborn and child survival by boosting the quality, supply, and community demand for health services; promoting the adoption of positive health, hygiene and nutrition practices for mothers and children; and contributing to a more favourable policy environment across the region. These aims have been achieved by working with marginalised people, strengthening health systems, encouraging behaviour change, building community advocacy and influencing policy. This $8.9M project was funded by the Department of Foreign Affairs and Trade (DFAT) under the Australia Africa Community Engagement Scheme (AACES) from July 2011 through to June 2016.

The EAMNeCH Theory of Change (ToC), which focused on implementing the World Vision (WV) health strategy, was essential in delivering these positive health outcomes. The ToC comprised elements of health systems strengthening at both facility and community levels to deliver key health interventions (see Key Results section), behaviour change via community groups for better health and nutrition and facilitating local level advocacy with a view to influence policy. This was done by implementing key WV models such as *timed and targeted counselling* (ttC), where community health workers (CHWs) delivered key health messages to households, making it easier to seek health services and improve their health, nutrition and hygiene. Community groups such as parent support groups (PSGs), nutrition counselling groups (NCGs), village child based nutrition centres and mother to mother support groups reinforced behaviour change. WV utilised Citizen Voice and Action (CVA), a local level advocacy methodology, where community and duty bearers were able to prioritise key services and work together for their delivery. WV worked directly with government, including chairing technical working groups to ensure that government policies and programs were informed by practices on the ground and included the marginalised experience. Over the life of the project, more emphasis was placed on the integration of food security for improved nutrition, by both producing food and income. Due to the interlinked nature of ill-health and its social determinants, the project sought to improve the voice of marginalised people to ensure improved access to health services; particularly those in remote communities, women and, as the program developed, this also included people with a disability (PWD).

The EAMNeCH project took a learning approach, building on existing strengths and partnered with a variety of organisations to ensure more sustainable change. Key partners included government, for long-term scalability and ownership, as well as local and national non-government organisation. As the program developed, WV worked directly with AACES NGOs and the private sector. Learning and adapting were critical elements of the program, with deliberate intention to utilise learning from practice as well as incorporate evidence based information. The monitoring and evaluation (M&E) systems were utilised to reflect on practice and feed back into programming, making adjustments as required. During the lifetime of the project, the M&E systems were also utilised to better communicate and tell the story of change as a result of the project.
The annual planning process was a positive enabler of reflection and review, allowing some changes and developments to the program ToC. This included the adoption of emerging and evidence-based models. These included the Village based Child Nutrition Centres (VCNCs) in Rwanda, as a local solution to malnutrition (see Innovation section) and “Helping Babies Breathe” methodology in Uganda, to address the high rates of newborn death. Modifications were also made by working closely with Partners and incorporating their priorities such as implementing Baby Friendly Health-

facility Initiative (BFHI) with the Ministry of Health in Uganda. Communities also played a role in influencing the ToC. This saw the inclusion of sanitation and hygiene programming in Rwanda, originally not included in the ToC, but demanded for by families when they saw the importance for health. The ToC always had a strong component of sustainability, and this was built upon with further input on livelihood approaches, income generating activities, community-level banking and working with private sector to build more resilient communities. Informing the Australian public on African development issues, under the third objective of the AACES program, ceased in 2014 due to direction by DFAT.

Key results (Project performance against Theory of Change)

Improved health, nutrition and hygiene outcomes

Central to the EAMNeCH ToC was the delivery of key health message to families. These were based on empirical evidence of applying WV's health strategy "7 -11", a package of seven intervention for mothers and eleven interventions for children, whose application reduced the prevalence of stunting, wasting and underweight and improve health.

The program employed 12 health indicators, as there is strong existing evidence that change in these indicators can lead to reduction in maternal and child mortality.

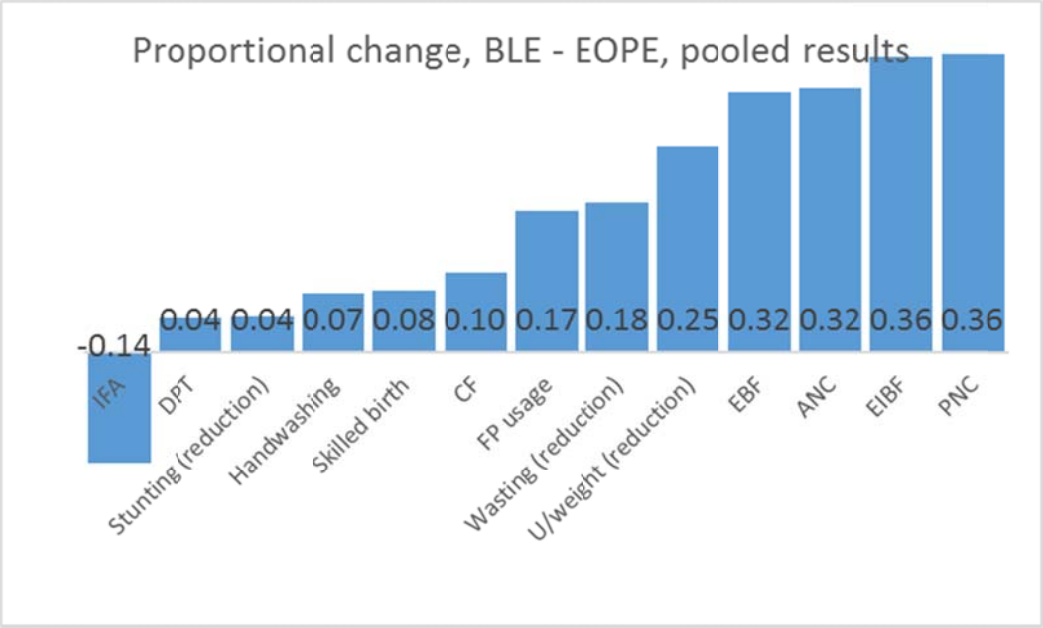
Nutrition for pregnant and lactating mothers is enhanced by iron folate supplements (IFA) which reduce anaemia and increase chances of survival for both mother and child. It is known that family planning (FP usage), ante-natal care (ANC), skilled birth attendance (Skilled birth) and early initiation of breastfeeding (EIBF) will save children's lives, and that ANC will also decrease the likelihood of perinatal/postnatal maternal mortality. Post-natal care (PNC) protects mother and child within the first 28 days, when according to WHO, around 45% of all under-five deaths currently occur. After this, survival is enhanced by immunisation (in particular the universally available DPT immunisation), by good hygiene including handwashing with soap, and by appropriate feeding practices: exclusive breastfeeding (EBF) to six months, and balanced complementary feeding (CF) afterwards. Stunting prevalence is an indicator of long-term under-nutrition, often starting in gestation, while wasting and underweight indicate more immediate and reversible conditions, sometimes linked to seasonal food insecurity (see Figure below).

The end of project evaluation used a pooled analysis that made a comparison between baseline and end-line values for key health indicators across the four countries, which revealed positive change in all but one indicator. This concludes that the EAMNeCH program achieved its goal of improving maternal, newborn and child health in selected districts in Kenya, Rwanda, Tanzania and Uganda.

The analysis concluded that the significant increase in the utilisation of ANC and PNC was a result that could be linked to stronger health systems and better quality service, as well as to the influence of the CHWs on pregnant women. The early initiation of breastfeeding increased by over one third, indicating that quality care and advice for mothers giving birth in health facilities, or with the assistance of trained birth attendants, has improved. Exclusive breastfeeding also increased by 13 percentage points, meaning that over 20% more women are now aware of and acting on sound nutritional advice.
Rates of complementary feeding, hand washing and DPT immunisation have all increased, but as baseline levels on these were already high, not in significant proportions. DPT immunisation was nearly universal in these locations and hand washing in children was also much higher than the national average. Anthropometric indicators; stunting, wasting and underweight – did not exhibit major levels of change but show signs of slow reversal. The evaluation highlighted the concerning result of a decrease in women accessing IFA. Project staff have reviewed this finding and consider that this is related to competing government priorities and resulting stock-outs of drugs (see Issues and Risks section).

Over the life of the program, WV reached over 150,000 direct and indirect beneficiaries, exceeding the target of the program of 106,250. According to monitoring data:

59,798 children appropriately vaccinated in first 12 months of life (3 doses of DPT)
52,682 additional women accessing a family planning method
32,144 additional births attended by a skilled birth attendant
32,443 people with increased knowledge of hygiene practices



37,539 additional people with greater access to basic sanitation

6,416 households provided with farming resources to increase family food security

Stronger Health Systems

- *At Facility level*

Across all four countries, WV strengthened health facilities by building the capacity of 606 facility-based health workers. This included training in basic emergency obstetric care, infant and young child feeding (IYCF), long-term family planning methods, infection prevention and control, "helping babies breathe" methodology to improve the survival of newborns and mainstreaming disability in MNCH programs. In Rwanda, WV worked with nurses in informing women about the benefit of family planning and in removing their existing prejudices around different options of contraception. This observed an increase in community satisfaction and increased take-up of contraceptive methods.

WV provided equipment and supplies based on the introduction of a systematic health facility assessment, prioritising inputs that would encourage mothers to attend for skilled birth and the survival of newborns, including delivery beds and emergency resuscitation equipment.

Additionally, health management information systems were improved through review of health indicators in technical working groups, the provision of data collection tools and equipment such as computers, registers and the training of staff, including the records officers, for more recording of accurate and consistent data. In turn, clinical staff were also trained on data management. This ensured that they then had an increased understanding and could utilise the data collected, which resulted in better resource management including re-ordering of drug stocks. The innovation of mobile health (mHealth) systems for CHWs and health facility staff was established in all four countries. In Kenya, CHWs registered all pregnant women and were then able to monitor, make referrals and report in real-time to health facilities. Health facilities were then able to use mass SMS to send messages to these registered mothers on scheduled ANC visits and outreach services, encouraging attendance and compliance. This Jami Smart platform was developed through a private-public partnership, involving government, the telecommunications company *Safaricom* and a consortium of NGOs. In Uganda, WV set priorities to improve delivery and post-natal services in health facilities. This was done by applying the criteria of the Baby Friendly Health-facility Initiative (BFHI)[1] throughout all of the 21 health facilities of the district. WV worked closely with the Ministry of Health through the Health Unit Management Committees and built the skills of 75 health workers (see Value for Money section for more information). On completion of the project, five health facilities are now fully BFHI certified, four are partially certified and the remaining have commenced the certification process. This has contributed to strong improvements in health sector performance where in 2011 Kitgum District was ranked 62 out of 112 districts in Uganda, it is now ranked 28.

- *At Community level*

Central to the ToC of the program, was the development and utilisation of CHWs. Over the life of the program, 897 CHWs were trained and worked with communities. Through the application of the ttC model, WV contributed to improving the community health system and ensuring key health messages reached women and their families, including their husband or partner, in remote communities that previously had low consultation with health professionals.

[1] BFHI is a global model developed by the World Health Organization and UNICEF aimed at creating health care environments that support breastfeeding as a norm and promoting optimal Infant and Young Child Feeding (IYCF).

WV took a systematic, measurable approach to strengthening the community systems utilising the Community Health Worker Assessment Improvement Matrix (CHW-AIM) tool[2]. This tool was used to assess community health programs based on a set of 15 programmatic elements moving beyond training to elements of retention, sustainability and government ownership. In all four countries, an initial assessment was undertaken and an improvement plan was then put in place with clear roles and activities of all stakeholders present at the assessment workshop. This process also contributed to improving ownership and partnering between stakeholders. Repeated exercises took place in Uganda, Kenya and Tanzania. These findings have been presented at the Global Maternal New Born Health Conference in Mexico City (see section on conferences). By the third year of the project, the CHW program was rated functional in all four countries.

WV partnered with governments to support CHWs in a variety of ways including in recruitment, CHW kits, training, data collection and quality of visits. In Kenya and Rwanda, CHWs are now providing family planning services to women and their partners in their own homes. In Uganda, Community health committees are now able to monitor the performance of CHWs, providing mentoring and coaching. This has seen an increase in the number of children under-2 being visited by CHWs - increasing from 392 to 682 by the final year of the project.

In Tanzania, WV presented the results of the CHW role enhancement such as the increased uptake of health services in health facilities. In response, the government has introduced a one year certificate course for CHWs and commenced discussions on integrating the role into the government health employee structure.

In Kenya, after advocacy at the national level, the CHW-AIM tool has been adopted and contextualised by the Ministry of Health as part of their CHW policy. This tool is now fully incorporated in the current Government of Kenya *Community Health Strategy* document, which has been drafted and undergone piloting in some regions of the country.

Behaviour change for improved nutrition and hygiene

The formation of community groups to support behaviour change was important for individuals to make better choices around nutrition and hygiene, but also to empower more vulnerable individuals, including women and PWDs.

In Uganda, 79 PSGs were formed to mobilise women and their husbands/partners to increase their utilisation of MNCH services. These groups were formed to deliberately involve men in MNCH, and were made up of 13 couples supervised by a CHW. They would meet monthly to discuss issues that parents may be experiencing and collectively set up income generating activities and kitchen gardens for food at household level. A study with Ugandan Christian University (see publications section), saw improved utilisation of health services in communities where PSGs were operating compared to areas where mothers-only groups were operating.

The mother to mother support groups of Kenya have ensured mothers learn from each other, contributing to an increased number of exclusively breastfed infants (from 22% to 66%).

In Tanzania, 15 NCGs were formed with 300 members (250 women, 50 males) and were trained on how to prepare nutrient dense food from locally available materials as a way of reducing malnutrition in the community. They have continued to operate in the community and went further, making household visits to give health education to mothers on the importance of infant and young child nutrition, which is often the time when children start to show signs of malnutrition. These groups identified malnourished children and referred them for early intervention. The Tanzanian project evaluation showed that the project halved rates of underweight (30% to 14%) and wasting (6.8% to 3%).

[2] A proven tool adopted from USAID's health care project.

Integration of Food Security and livelihoods for improved nutrition (including private sector engagement)

WV also deliberately leveraged support groups to improve the integration of food security for improved nutrition; both for the production of food and income.

The NCGs in Tanzania described above, were also trained on kitchen garden farming for food diversification, and then entrepreneurial skills to pursue business opportunities in the private sector. They were also encouraged to work together in a farming cooperative. Two of the groups went on to register with the government as a formal savings group. By the completion of the project, they had the ability to source loans directly from local banks as well as from local government, including a loan to establish a greenhouse for further food production.

In Uganda, the PSGs have been instrumental, not only in mobilisation of mothers and caregivers for increased utilization of MNCH services, but for increased household income. This was done through the utilisation of a business enterprise approach, initially through agricultural production and then the marketing of these goods.

In Kenya, WV used a value chain approach for agricultural production to improve income and nutrition. WV worked with the Ministry of Agriculture through their Agricultural Sector Development Program, and signed an agreement with *Equator Kenya*, a food processing business, who market African birds' eye chilli internationally. Equator Kenya has sourced its produce from 255 members (245 women, 10 men) from the Kilifi community cooperatives, with sales in excess of USD$10,000. This is the first cash crop from the area in two decades. WV has continued to support community groups in Kenya by providing 427 people (375 women and 52 men) access to smart farming technologies including use of drip irrigation to continue crop production during dry periods. In addition, WV supported 2,800 farmers with farming inputs including drought tolerant seeds and had their first successful harvest in three years despite a low annual rainfall. The farmers reported increased yield and being able to prolong their crop storage due to better preservation methods and equipment. As a result, the income of members of farming cooperatives rose and children in these households have stayed at school longer. Over 90% of women who took part in the Kenyan farming project went on to operate kitchen gardens, and they reported a change in their ability to diversify their diet and sell the surplus for income.

Building community advocacy and policy change

WV utilised the CVA model as a local level advocacy methodology for social accountability. This brought together government with community, to identify and fill gaps in the healthcare system and structures. The process involved training CVA working groups/teams on the government (health) services and standards e.g. numbers of health facilities and staff per population. Thereafter the duty bearers themselves were trained on the same standards. Engagement of the duty bearers and the citizens took place via a community gathering to find ways to deliver prioritised services.

CVA groups in Kenya used the CVA model to identify a number of shortfalls in health centres and services, including the release of government funds to improve infrastructure at health facilities. After evidence from the Kilifi CVA representative and discussions with the county, funds of USD$75,000 were redistributed and put towards the completion of the Jilla health facility, whose construction had been stagnated for more than a decade. A further USD$154,000 in 2015 and USD$538,000 in 2016 were redistributed for the completion of all stalled health facility infrastructure projects.

Rwanda's CVA negotiation resulted in a new health post being built in a remote area that previously had not had health infrastructure. This process saw improved dialogue and joint planning between community and government, facilitating and expediting this construction.

In Tanzania, two health facilities were constructed due to local advocacy efforts, with an additional four health facilities undergoing construction by the end of the project.
Uganda's advocacy efforts centred on the resourcing of health staff, with six midwives and four nurses employed after community monitoring showed gaps in the quality of care being delivered due to staff shortages.

Gender and women's empowerment

All four countries worked with (traditionally male-dominated) structures of governance to increase the participation and status of women. WV worked with community structures to continue to develop and include women in leadership and planning roles. In addition, the program facilitated women's opportunity to participate, communicate and increase their income. WV also deliberately involved men in programming, especially in issues pertaining to MNCH, which had traditionally been seen as a women-only domain.
In Kenya, by the end of the project, two of the seven community units responsible for managing the CHWs and the health services at community level, were chaired by women. The Palkumi women's group is an example of positive change, where women are now undertaking community banking, goat rearing and growth of high value crops such as chilli.
Women do not traditionally hold leadership positions in this Masai community. In an effort to change this, the Tanzania project worked towards achieving the government's policy guidelines to encourage women to actively participate in matters of governance, stating that over a third of all committee members should be women. This goal was exceeded in the 20 committees that WV worked with, with 35% of women membership. WV also encouraged women to take part in the Citizens Hearings in Tanga, a local health accountability forum. This then linked into a global process where a local woman from the CVA group, travelled to Geneva to present their results. She was then elected as Ward councillor in the October 2015 general elections, the first woman publicly elected in the area. The Kilinidi area saw an increase in men accompanying their wives to health services such as ANC and delivery.
In Rwanda, WV developed a strategy to involve husbands and partners more in MNCH issues, by connecting them with health centre staff to orient them on reproductive health messages. 142 men attended trainings and then went on to hold community awareness events, government curriculum "Parents Evenings" and household visits which reached an increasingly supportive male audience. As a result, both men and women reported an increased sharing of responsibility for family planning and support to attend ANC/PNC services. Additionally, women also reported more harmonious relationships and fewer family conflicts.
PSGs in Uganda were utilised throughout the project to more fully involve both men and women. This has increased women's awareness of their leadership skills, with some groups being led by women. As a result of the business enterprises being managed equally (whether they are women or men), both men and women have begun to handle and control income at household level with relative equality. Members also reported that men now took more interest in care of children with the result of improved, more harmonious relationships between men and women. In addition, at the completion of the project, all water management committees had over 40% women members, in line with government policy.

Disability Inclusive programming

Disability programming was an area for learning for WV going into this program. As a result of the AACES workshop (June 2012) and then seeking other resources, the four countries have all approached inclusive programming by deliberately including PWDs in the project – in line with the principle "nothing about us, without us". Within the contexts of the four countries, PWDs faced

challenges accessing healthcare resulting in poor treatment. This was not only due to visibility and transport, but also related to attitudes and discrimination from health providers.

In Kenya, WV supported the Ministry of Social Services within Kilifi County to conduct a disability situational analysis in 2012. These findings were disseminated with the Ministry of Health and government disability guidelines to raise awareness on the situation and what rights and services were available to PWDs. This increased knowledge of the PWDs, led to the formation of the Kilifi Disability Network, whose objective was to enhance access to services and resources for PWDs in the County. The Disability Network has reached approximately 1000 PWDs who have been registered, assessed and referred for further services. The network members have since been involved in budget planning processes with the county government and received USD$100,000 for their prioritisation for improved services.

WV built a partnership with the Rwandan National Council of Persons with Disabilities at the national level. This partnership was cascaded down from the district to the local level. CVA facilitators took up disability inclusion as a community campaign, leading to the creation of local PWD associations and increased employment and esteem among PWDs. 300 CHWs were trained on disability inclusion and PWDs reported that issues around access and uptake of health services have been resolved, with services now on par with the rest of the community.

In Tanzania, WV gave support to Disabled People's Organisations (DPO) and to quarterly government disability planning meetings, that led to better inclusion of PWDs in income generations groups and community input into disability friendly design of public buildings. There was a reported increase in PWDs accessing healthcare, with one health facility seeing a rise from 3 PWDs in 2010 to 35 in 2015.

The Ugandan project involved a local DPO from inception, with them participating in the baseline and in the M&E of the program. As a result, the project ensured that PWDs accessed services; especially by bringing services closer to the people through the monthly integrated outreaches by health facility staff and CHWs.

Innovation

Innovative practice was encouraged in the program through the AACES program approach, which was also reinforced with the valuing of principles of learning and partnering.

In Kenya, WV used some innovative practices to improve data collection, especially incorporating data from local communities that are often excluded. WV formed Bamba Voices which is a GIS (Geographic information system) mapping and SMS reporting system. This continuous process collects and analyses crowd sourced data from the community in the form of interactive maps[3]. The community was able to feed in information and also to act on information that was shared through this forum, as well as ensure the further dissemination of information through public forums. This was particularly useful as an approach to encourage youth to be involved and was undertaken as part of the Innovation Fund in partnership with Actionaid.[4]

VCNCs, which emerged as an unintended outcome of the program, are a hybrid community kitchen and day care centre for children under five. The innovation began in 2012, to address the high rates of child malnutrition and promote child protection. The centre runs every day staffed by volunteer mothers or caregivers from within the community. Children receive free nutritious meals (provided solely by the community) and childcare incorporating elements of early childhood education, which ensures children are safe while their parents work. The evaluation reported that rates of stunting are slowly falling from 48% to 46%, with Munini village confirming that rates of

[3] The online maps can be accessed via www.openstreetmap.org/bamba and https://www.arcgis.com/home/webmap/viewer.html?webmap=1d88a686d8fe4860a81e41ff7df046c3

[4] https://www.youtube.com/watch?v=0G4xITIoSQg

underweight was now 0%. In addition, the VCNCs also provide a platform for community education such as demonstrations on handwashing, cooking of nutritious recipes and social cohesion with the sharing of resources such as food to benefit all children. At the completion of the project, 18 VCNCs now function on a daily basis with over 650 children benefiting from the service. In terms of scale-up, local faith based and community organisations (72 members) were trained to facilitate the expansion of the model into other districts. This model is also being scaled up in WV program areas throughout Rwanda and Eastern Africa regional programs.

The project team in Tanzania deliberately included PWDs in all groups, including CVA groups. This meant that PWDs were then able to access income generation and community banking initiatives and to reiterate their experience and the need for improved disability friendly public services, including health services. WV is now replicating this approach in a number of other programs globally. Another innovative practice was the Kilindi MNCH Cup; a football tournament which continued throughout the project. It succeed in attracting men, who during the tournament were able to discuss a range of MNCH topics including family planning, nutrition, sanitation and hygiene. Rates of handwashing increased from 65% to 85%.

As stated previously, the PSGs in Uganda contributed to more positive health behaviours, compared to other communities that had mother-only support groups, in addition to improved benefits for livelihoods and improved gender relations. This model facilitated the involvement of men in an area that previously had been seen as not their domain, with positive results. WV will continue to replicate this approach in other programs globally, including Timor-Leste.

Value for money

The program never aimed to take a straight cost versus beneficiary approach, but considered the more complex, social value approach of the program when considering value for money (VfM). This included elements of increased capabilities and self-worth, empowerment and participation of marginalised people, social cohesion and collaboration, and the engagement of responsible governments and communities. VfM was inherent in the ToC, with a focus on social change and empowerment, as well as acting with other partners (in particular the Ministry of Health) to improve health services for sustainable change. There was a focus on policy and government accountability, especially the expectation of government to take up the improved CHW model, to expand the benefits beyond the life and geographic boundaries of the project. Measuring VfM was a learning opportunity for WV during the AACES program. The mid-term review undertook a social return on investment (SROI) study of the program. It revealed a positive finding in that, by the completion of the project, for every $1 invested, there would be $2.40 of benefit. It was decided not to repeat the SROI methodology due to the high level of resources required and instead, the end of project evaluation used a case-study methodology, which included programming costs, to demonstrate social value in key activities. The results showed that costs were relatively low when compared to impact; especially with regards to improved health and nutrition, and the increased capacity of governments and systems to sustain the work and benefits of the program.

An example of VfM is the implementation of the WHO/UNICEF BFHI in Kitgum, Uganda to improve MNCH services. This evidence-based model targeted the 1.4 million preventable deaths per year that are connected to poor infant feeding and aimed to create healthcare environments where breastfeeding is the norm and IYCF is promoted. Through the strong partnership with the MoH, WV researched the current practices of health workers in 21 health facilities and put in place plans to address the gaps that were found. A key finding was that 54% of health workers did not know how to support mothers to initiate breastfeeding, so infants were potentially missing out on receiving colostrum which is very important for their immunity. WV set up networks for mentoring and coaching health workers to build interest and knowledge in nutrition; supported health facilities to set up mothers groups for ongoing nutrition support; they developed IEC materials for

staff and community members on good nutrition and set up resuscitation corners to improve survival of newborns on delivery. The result was that 75 health staff were mentored through the networks and by the end of the project Kitgum is now ranked 28 out of 112 districts, increasing from a rank of 62. Five facilities have achieved full baby-friendly certification, with four more partially certified and the remaining 12 commencing on the certification process.[5]

The program team estimated that approximately USD$45,000 was invested into BFHI. WV supported across the spectrum of health centres in Uganda from Health Centres II – IV and saw particular value in providing support to Health Centre II, which are community-based centres. The cost to invest in these centres was low (estimated $569 per centre), but by including them in this program, they have seen community referral processes improve and better collaboration between centres, CHWs and community campaigns for IYCF.

Sustainability

Sustainability was also inherent in the ToC of the program, with the ownership of the program by communities and government integral to its foundation. From the outset, WV mobilised local community groups and government to work together with minimal WV involvement. The main models that were utilised, such as ttC, CVA and livelihood groups, were designed to be linked to existing systems and structures so that they became institutional community resources. The end of project evaluation found evidence of its occurrence and concluded that sustainable change is likely.

Particular effort has gone into the sustainability of CHW programs. Focus has been on strengthening the existing health system, with areas of work such as the CHW-AIM (see section on health system strengthening), that has improved the system to support CHWs and has been scaled up by the Kenyan government. The use of the CHW-AIM tool has also been replicated or shared in other WV programs, including Papua New Guinea and the Solomon Islands, to improve their government health programs.

Retention of CHWs is an ongoing issue for most health programs, especially as most are volunteers and are poorly resourced. In Kenya, the project team experienced high CHW turnover that was costly to the program and a threat to sustainability. As a result, WV developed an innovative livelihoods empowerment strategy which included working with the private sector, where female CHWs formed an income generating group to rear goats. The group has gone on to be registered with the local government and to other entrepreneurial investments. Since these groups have commenced, no CHW has dropped out of the health program, as they value this source of income and the benefits of working together in the group. This model has improved food security for around 300 CHW households and demonstrated a management tool for the government for CHW programs, who are interested in replicating the approach. A similar approach was taken across the remaining three countries, before the close of the project. WV is also replicating this approach of ensuring CHWs are incorporated into livelihood programs, in other programs globally.

WV has utilised the EAMNeCH ToC as a benchmark for future integrated health programs. Additional MNCH grants have been funded by other donors based on the EAMNeCH ToC[6]. The success recorded by this project has stimulated conversations amongst the respective WV leadership in the four countries with a view to looking at ways of ensuring replication. The learning from this project has been widely shared in the East Africa region, southern Africa region and through WV's global health community of practice.

[5] http://youtu.be/L8F3WbqrmKc

[6] KOICA MNCH grant of Uganda, AMURU MNCH project of Uganda, Mwatate EU funded project of Kenya

Partnerships formed

The project was governed by the AACES partnership principles particularly collaboration, mutual respect, learning and flexibility at all levels. The programs ToC emphasis on partnership to bring around sustainable change, also created efficient and mutually accountable relationships.
Partnership was observed and exhibited at different levels:

- *Partnership with Government*

The main partner across the four countries was the Ministry of Health, but WV also worked with Ministry of Agriculture and Ministry of Social Services. These relationships operated at national level through to local level, covering programming, strategy and policy. The project teams also worked closely with local government in planning, budgeting and implementation of key services.

- *Partnership with other AACES partners*

WV signed the AACES Partnership Agreement and actively participated at, and contributed to, the biannual AACES events (reflection meetings, thematic workshops, field trips, program steering committee meetings) which all served to reinforce the spirit of learning and collaboration which was a key highlight of the program. During these meetings, agencies were able to share experiences and tools with other partners. For example, all four countries utilised the 24 hour time use tool for gender analysis after the November 2013 thematic workshop with the findings providing an impetus to discuss gender relations pertaining to power issues at the community level. WV was also able to share the CVA and CHW-AIM tools and experience with Anglican Overseas Aid, who utilised them in their own programming.
WV in Kenya worked jointly with ActionAid Kenya to implement the Innovation Fund, with a focus on youth which extended the scope of the program in a positive way, leveraging ActionAid's expertise in working with youth. WV will continue to work with Plan after the life of the project to continue to coordinate the Kilifi County Disability Network, to improve services to PWDs.
Tanzania has enjoyed a vibrant partnership amongst the five AACES NGOs (CARITAS, Marie Stopes, Wateraid, CARE and WV). The five organisations come together during the launch of the first AACES annual report and have been able to raise issues at a national level relating to water and sanitation as a block. WV has continued to work with Marie Stopes, by linking CHWs to their family planning services and Wateraid provided technical sanitation advice.

- *Partnership with other organizations*

The encouragement to partner at the AACES level, encouraged partnership at the field level. All four countries deliberately sought to partner with Disabled People's Organisations for inclusive programming, which was a new approach for WV. All countries worked with appropriate NGOs for programming or policy influence, to minimise duplication and enhance scope. In Tanzania the involvement with the White Ribbon Alliance was integral to connecting different layers of influence to raise the profile of women and children's health in Kilindi District. World Vision leveraged its strengths in community approaches including working with faith based organisations, who can act as gatekeepers but will continue to work in communities at the grassroots level once the program has closed. For example, the Anglican Church of Gicumbi has been instrumental in replicating the VCNC model in Rwanda and has plans to continue to support replication in other areas of Rwanda.

The emphasis on learning encouraged WV to partner with academic institutions including Kenyan Methodist University and Uganda Christian University (see publications section).
Overall, these partnerships have been positive, however, stakeholders (including staff) acknowledge that the process itself involves costs, and that networking and liaison is time consuming and needs to be properly resourced. In the majority of cases, these partnerships led to greater efficiencies and adherence to deadlines. In some other cases, including Uganda's

experience (which was highlighted in the mid-term review), the partnership with the Ministry of Health slowed progress and resulted in more time being allocated for implementation and impact in the second half of the project.

Lessons learned – what worked, what didn't work, ways to improve

Partnership model

The AACES partnership principles and model for designing and managing the program enabled greater impact. A collaborative approach to the design of the program, involving Australian NGOs and our African partners and DFAT, resulted in stronger ownership of the program. DFAT encouraged a ToC approach which had not been utilised by WV in East Africa previously and significantly benefitted the design process. The team focused on higher level outcomes and how best to achieve these - breaking away from less flexible processes more focused on needs and outputs. WV National Offices appreciated this approach, and has committed to applying this methodology in other relevant design processes in the future. The partnership approach flowed to all levels of the program and was embedded in the WV ToC (as described in the section above) and is considered a strength of the program.

The AACES partnership took time to develop, with relationships being formed and common ground and purpose identified. Coming together during peer review activities, learning (including field trips) and management events helped to resource and build this partnership.

Learning

Continuous learning encouraged WV to be innovative in programming, resulting in a number of key interventions including: the focus on gender equity with the inclusion of men in MNCH issues, integrating disability inclusion, community responses to malnutrition such as the VCNCs and, in particular, the application of the integrated model of ttC with CVA to improve health outcomes.

As the program developed, the integration of food security and livelihoods for improved nutrition presented opportunities for more learning, including village banks, farming cooperatives, including women in economic development groups and linking to the private sector. The results were positive in Kenya. However, the results were not consistent and food availability and affordability remains an issue to be addressed throughout the four countries. Teenage pregnancy grew as a challenge during the program and despite some innovations such as youth groups, this remains an issue for WV and communities.

The emphasis on strong M&E, regular reflection, sharing of practices and tools gave the program scope and opportunity to respond and improve. Learning and partnership were embodied in the second objective of the AACES program, enabling this work to be budgeted, valued and reported on.

Flexibility

The AACES Steering Committee gave a flexible mechanism for the management of the program and resulted in a shared responsibility for program outcomes. The committee was able to make decisions on implementation, reporting, strategy and governance. WV was also able to leverage on these 6 monthly meetings with the timing of field visits, project level learning events and capacity building opportunities for staff.

The annual planning and budgeting process was a strength of the program. This process created a mechanism where the project teams could revise the ToC, utilise their learning and apply this to programming in a user friendly way, instead of prohibitive bureaucracy, which resulted in stronger ownership and relevance for project teams and stakeholders.

Objective 3

Despite co-hosting a successful photographic exhibition "Motherhood Matters" with Anglican Overseas Aid (2014), informing the Australian public on African development issues was problematic. This was due to DFAT concerns of potential for fundraising and lobbying with stringent compliance requirements. This created some tension, as the staff within WV with expertise to hold such events sit in the advocacy and fundraising units.

Australian political landscape

Change in the Australian political climate created uncertainty and ultimately budget cuts for the program. The change of focus in the aid program away from Africa and arguably the sector of MNCH, was disempowering for the program, leading to the reality that despite great results, the program would not be continued.

Issues & risks summary (including changes in operational environment / context)

Political instability and security

Across the lifetime of the program, despite elections being held in every country, the security context remained relatively stable. There were some episodes of political instability in Uganda (2015), Kenya (2013) and Tanzania (2013. There were also disease outbreaks including malaria and nodding disease in Uganda (2013). However, with appropriate scheduling and support from local government, implementation was able to continue with minimal disruption.

Competing government priorities

The success of the program created a high demand for health services. Despite the focus on strengthening the health system and close partnership with government, supply of health services through the existing system could not always be met; demonstrated through stock outs of drugs and erratic supply of family planning services experienced throughout the program. The emphasis on government partnership to strengthen the health system was embedded in the program ToC; it added complexity but saw positive change. However, government commitment requires ongoing monitoring. Communities will continue to utilise the empowerment they gained during this program and models such as CVA to protect what has been achieved, but this remains an ongoing risk once no further programming is funded.

Challenges of a Devolved Health System

In Kenya, the devolution of governance including in the health system had some negative impacts on health service delivery such as delays in budgets, uncertain responsibility and reporting lines. The building of partnerships with local and district government helped to mediate the situation and the CVA working groups raised issues directly with the duty bearers for more sustainable outcomes.

Publications – list & links

"*Influence of Maternal Health Education Delivered Through Community Health Referral Project on Antenatal Care Attendance: A Focus on Mirihini and Midoina Communities of Kilifi County, Kenya*" authored by Janet Mukoshi Shibonje, Wanja Mwaura-Tenambergen , Susan Njuguna was published in the International Journal of Scientific and Research Publications (http://www.ijsrp.org/research-journal-0516.php May 2016, Volume 6, Issue 5 publication under ISSN 2250-3153)

"*Investigating Associations between Parent Support Groups and Integrated Outreach Services for Maternal and Infant Survival: Experiences from a Project in Northern Uganda*" authored by Gloria K. Seruwagi, Richard Muhumuza, Geoffrey Babughirana, Anita Komukama and Andrew Tumuhameho was published in Journal of Advances in Medical and Pharmaceutical Sciences on science domain international (http://sciencedomain.org/issue/1196)

Conferences – list & links to materials

WV presented at five international conferences from 2013 and 2015.
At the 2015 Global Maternal Newborn Health conference in Mexico City, WV gave an oral presentation relating to the use of the CHW-AIM tool in the program "*Supporting community health worker systems to improve the care of mothers and newborns in 3 countries in East Africa" (https://www.globalmnh2015.org/project-tag/track-6/)*

At the 2014 Amref Health Africa International Conference In Nairobi Kenya, WV made a poster presentation on "How verbal autopsy training of CHVs and CHEWS in Kilifi district changed community awareness of newborn vulnerability and what community ownership, mobilisation and actions aimed at newborn survivals were implemented as a result" (abstracts2014ahaic@amref.org)

WV presented a poster at the 2015 Integrated Nutrition Conference in Nairobi on the topic "*Village-based Child Nutrition Centers in rural Gicumbi*"
(http://www.eposters.net/search/all/1/village-based-child-nutrition-center-in-rural-gicumbi)

"*Combining local level advocacy with strengthening community health systems to improve quality of maternity care in four East African countries*" was the topic for the poster presentation by WV at the 2013 Third International Confederation of Midwives (ICM) Africa Regional conference which took place in Nairobi, Kenya. (http://www.amrnkenya.org/index.php/icm-2013-congress/call-for-abstracts)

At the 2015 3rd FANUS conference in Arusha, Tanzania, WV gave an oral presentation on the topic "Contribution of Nutrition Working Groups in Improving Community Nutrition Systems".

Other key documentation– list & links

In line with the AACES approach to learning, WV was keen to document the learning from this program. The link below presents a snapshot in Tanzania of the work relating to the three sectors or MNCH, food security and sanitation and hygiene in Kilindi District;
https://vimeo.com/user7210506/review/185403355/5083592b5c

From Kenya the videos have documented CHW programming
https://www.youtube.com/watch?v=kCkJ7T94uy4
Linking nutrition and livelihood was a key feature of the Kenya project, as shown in this video
https://www.youtube.com/watch?v=FiDnp1IAynM

Conclusion & Recommendations

The EAMNeCH program has been successful; achieving its goal of improved health and nutrition for mothers and children, benefitting more than 150,000 direct and indirect beneficiaries**.** The program has had sustainable impact; ensuring stronger health systems at both facility and community level and nearly 900 CHWs working in communities. Communities are more empowered and connected; they now have more confidence and tools to continue working with government and duty bearers to monitor the services they know are necessary for improved lives.
Based on the success and lessons learned from WV's program, we make the following recommendations.

DFAT:

Poor health and nutrition continues in communities were DFAT works. CHWs have been found to be integral in improving the health and nutrition of communities, as links to community health systems are integral for sustainable health. Ways need to be found to continue increasing CHWs numbers and skills globally.
The partnership model for implementing and managing the AACES program has added value and improved impact. This approach, which has enabled more flexibility, learning and co-ownership, needs to be replicated in other DFAT programs globally and should be shared with other donor agencies.
The partnering and learning platform that was encouraged and properly resourced (and budgeted) through Objective 2, contributed to increased impact and should be replicated in DFAT programs globally.
Flexible practices such as annual plans and budgets creates a mechanism for the review of ToCs and application of learning, and should be replicated in other DFAT programs globally.

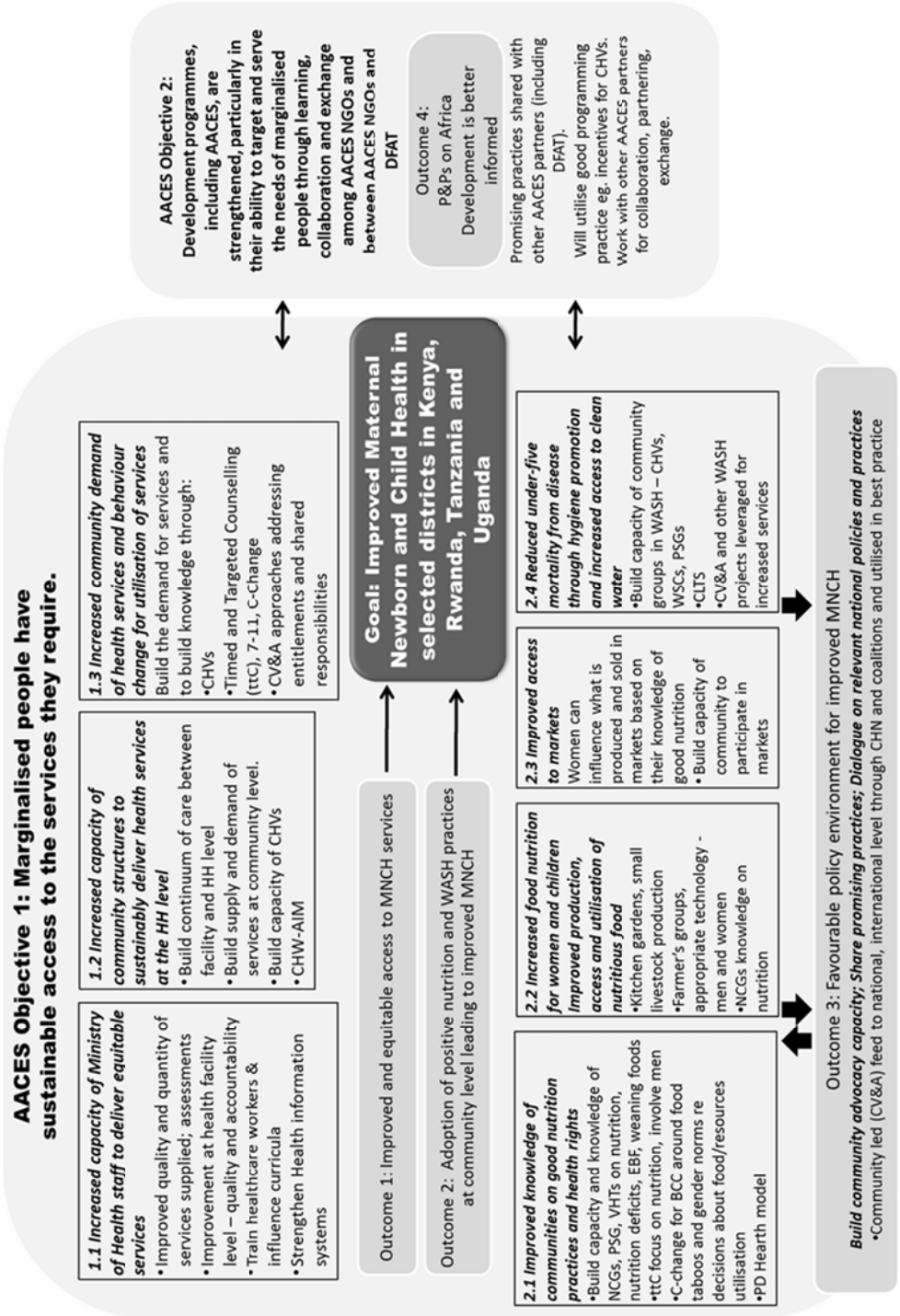
World Vision:

CHWs have been found to be integral in improving the health and nutrition of communities, as links to community health systems are integral for sustainable health. WV needs to continue to keep them central in all health and nutrition programming, to increase their numbers and skills.
The integrated approach of MNCH, food security and WASH in this program, in all four countries, resulted in positive outcomes. The integration of CVA with ttC models has particular benefits and should be included in all health and nutrition programming designs.
WV should continue to work with communities and governments to support integrated health and nutrition models such as VCNCs in Rwanda and NCGs in Tanzania, for potential scale-up.
The integration of health and livelihoods, including the private sector and food security for improved nutrition showed some positive results; this requires additional attention in other programming.
The partnering and learning platform that was encouraged and properly resourced (and budgeted) through Objective 2, contributed to increased impact and should be replicated in WVs programs globally.

Annexes:

A. **Five year summary financial report (External File)**
B. **AACES indicator matrix (External Excel File)**
C. **EAMNeCH Theory of Change**
D. **Detailed map of locations**
E. **List of Acronyms**

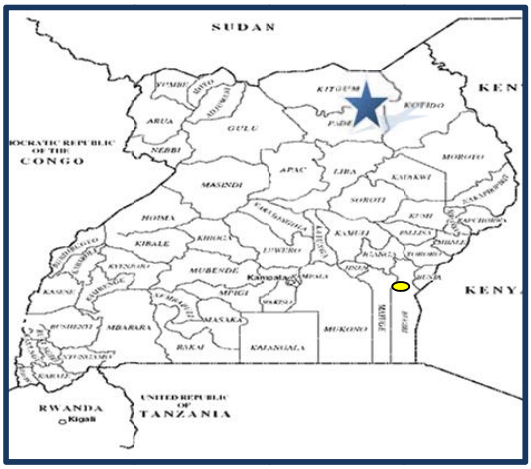
C. EAMNeCH Theory of Change



D. Detailed Map of locations

EAMNeCH
World Vision Rwanda
Gicumbi District

EAMNeCH
World Vision Uganda
Kitgum District



EAMNeCH
World Vision Kenya
Kilifi District

EAMNeCH
World Vision Tanzania
Kilindi District

E. List of Acronyms

AACES	Australia Africa Community Engagement Scheme
ADP	Area Development Programme
AMREF	African Medical and Research Foundation
ANC	Ante-natal care
BFHI	Baby Friendly Hospital Initiative
CHVW/CHV	Community Health Workers/Volunteers/Village Health Team
CHW-AIM	Community health worker assessment improvement matrix
CLTS	Community Led Total Sanitation
CVA	Citizen, Voice and Action
DFAT	Department of Foreign Affairs and Trade
DHIS	District health information system
DPO	Disabled People's Organisation
DPT	Diphtheria Pertussis Tetanus vaccine
EAMNeCH	East Africa Maternal New born and Child
EBF	Exclusive Breast Feeding
ECCD	Early Childhood Care and Development
EIBF	Early Initiation of Breastfeeding
EMNOC	Emergency Management of Neonatal and Obstetric Care
FBO	Faith Based Organisation
GMP	Growth Monitoring and Promotion
HBB/HBB+	Helping Babies Breathe Plus
HH	Household
HIS	Health Information Systems
HTSP	Healthy Timing and Spacing of pregnancy
IMCI	Integrated Management of Childhood Illness
IYCF	Infant and Young child Feeding
M&E	Monitoring and Evaluation
MCH	Maternal Child Health
MDG	Millennium Development Goals
mHealth	Mobile for health
MNCH	Maternal New born and Child Health
MoH, MoA	Ministry of Health, Ministry of Agriculture
NCG	Nutrition Care Groups
NGOs	Non-Governmental Organisation
PNC	Post Natal Care
PSG	Parent Support Group
PWD	People With Disabilities
SROI	Social Return on Investment
TBA	Traditional Birth Attendant

ttC	Timed and Targeted Counselling
ToC	Theory of Change
TOR	Terms of Reference
ToT/F	Training of Trainers/Facilitators
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
VICOBA	Village Community Bank
VCNC	Village based Child Nutrition Centre
VCT	Voluntary Counselling and Testing
VfM	Value for Money
VHTs	Village Health Teams/Community Health Volunteers
VSLA	Village savings and loan association
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
WV	World Vision