Monitoring the Outcomes of Orphans and Vulnerable Children Programs in Kenya

Findings from a 2018 Survey of Recently Enrolled Beneficiaries

MWENDO Project

September 2019

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ABBREVIATIONS

APHIAplus	AIDS, Population and Health Integrated Assistance Program, Western Kenya
ART	antiretroviral therapy
ARV	antiretroviral
CHV	community health volunteer
CI	confidence interval
CRS	Catholic Relief Services
ESI	essential survey indicator
KNBS	Kenya National Bureau of Statistics
LIP	local implementing partner
MER	Monitoring, Evaluation and Reporting
MUAC	mid-upper arm circumference
MWENDO	Making Well-Informed Efforts to Nurture Disadvantaged Orphans & Vulnerable Children
OVC	orphans and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

This report presents findings from a cross-sectional study of beneficiary households receiving services from Making Well-Informed Efforts to Nurture Disadvantaged Orphans & Vulnerable Children (MWENDO) in western Kenya, in areas not served by the AIDS, Population and Health Integrated Assistance Program, Western Kenya, known as APHIAplus, in 2016. MWENDO is a five-year project funded by the United States Agency for International Development (USAID) and implemented by Catholic Relief Services (CRS) that provides an umbrella of services to orphans and vulnerable children (OVC). Beneficiaries included in this study started receiving services from MWENDO in the past two years, and were not among the households that participated in a similar survey Round 1 conducted in 2016. This study was undertaken by MEASURE Evaluation—a project funded by USAID and the United States President's Emergency Plan for AIDS Relief (PEPFAR)—at the request of PEPFAR and the USAID Kenya mission. This 2018 cross-sectional study was designed to meet PEPFAR's reporting requirements, which involves the collection of data for nine PEPFAR monitoring, evaluation and reporting (MER) OVC essential survey indicators (ESIs). Two additional indicators were included: OVC_KE1, to measure the proportion of children (ages 0–17 years) living with HIV who are taking antiretroviral (ARV) drugs; and OVC_KE2, to measure the proportion of households able to access money to pay for expected household expenses. This was a cross-sectional study of 99 beneficiary households, randomly selected from a list of beneficiary households in the study areas.

The report presents results for the nine ESIs and the two supplemental indicators. The results, which are summarized in Table 1, provide a snapshot of the well-being of recently (in the past two years) enrolled beneficiaries served by the MWENDO project in 2018, and fulfilled the PEPFAR reporting requirements. Although the survey was not designed to assess the effectiveness of the MWENDO OVC project, it is useful for identifying potential needs and program gaps. It complements a panel study of MWENDO OVC beneficiaries, available at the following link: https://www.measureevaluation.org/resources/publications/tr-19-342/

Results related to health were positive. No child was identified as malnourished. Caregivers reported knowing the HIV status of nearly all children in their care., and almost all children living with HIV were on antiretroviral therapy (ART). However, 12.7 percent of children (mostly younger than five years) were too ill to participate in daily activities in the two weeks preceding the survey. As for education, the results revealed high rates of school enrollment and progression, with some room for improvement. About two-thirds of caregivers were able to access money to pay for expected and unexpected expenses.

Our findings point to potential program gaps and future areas of focus. Gaps in well-being of beneficiaries that were identified are the widespread acceptance of harsh physical punishment of children at home and at school, and the low proportion of children with a verified birth certificate.

Table 1. Summary of PEPFAR MER OVC ESI results for MWENDO

OVC MER ESIs	n/N	Percent (95% confidence Interval [CI])
OVC_HIVST: Percent of children (aged 0–17 years) whose primary caregiver knows the child's HIV status	351/386	90.9 (87.6–93.4)
OVC_NUT: Percent of children (aged 6–59 months) who are undernourished (MUAC < 125 mm)	0/53	0.0
OVC_SICK: Percent of children (aged 0–17 years) too sick to participate in daily activities	49/386	12.7 (9.7–16.4)
OVC_BCERT: Percent of children (aged 0–17 years) who have a verified birth certificate	156/386	40.4 (35.6–45.4)
OVC_SCHATT: Percent of children (aged 5–17 years) regularly attending school	277/330	83.9 (79.5–87.5)
OVC_PRGS: Percent of children (aged 5–17 years) who progressed in school during the last year	301/315	96.5 (92.6–97.4)
OVC_STIM: Percent of children < 5 years of age who recently engaged in stimulating activities with any household member over 15 years	40/56	71.4 (57.9–82.0)
OVC_CP: Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control of children in the home or at school	74/99	74.7 (65.1–82.4)
OVC_MONEY: Percent of households able to access money to pay for unexpected household expenses (among households that experienced an unexpected expense in the last 12 months)	48/77	62.3 (50.8–72.6)
OVC_KE1: Percent of children (aged 0–17 years) living with HIV who are taking ARV drugs	19/20	95.0 (67.7–99.4)
OVC_KE2: Percent of households able to access money to pay for expected household expenses	63/99	63.6 (53.6–72.6)

These findings have several programmatic implications:

1. MWENDO should continue to reinforce its existing household economic strengthening strategies.

2. MWENDO should put additional focus on community-level activities, in addition to household-level ones, to change attitudes about harsh physical punishment.
3. Health and legal status indicators, such as children having verified birth certificates, suggest room for additional improvement. Closer collaboration with government departments, additional sensitization of community health volunteers (CHVs), and increased data use are recommended.

INTRODUCTION

The United States President's Emergency Plan for AIDS Relief is committed to supporting OVC in countries around the world as part of its global effort to assist children affected by the HIV epidemic. Given PEPFAR's considerable investment in OVC programs, in 2014, PEPFAR introduced the Monitoring, Evaluation and Reporting MER ESIs to help track changes over time in the well-being of OVC project beneficiaries and their households. These outcome indicators reflect internationally-accepted developmental milestones and ways that OVC programs gain from, and contribute to, broader HIV and child protection responses. PEPFAR encourages the collection of data on these indicators every two years (MEASURE Evaluation, 2014).

This report presents findings from a cross-sectional survey conducted among a selection of beneficiaries of the MWENDO project in western Kenya, funded by PEPFAR/Kenya. The study focused on households that had become project beneficiaries in the two years preceding the study. The report provides a snapshot of the status of the MER ESIs among beneficiaries at that time. The findings are intended to help the MWENDO project better understand the well-being of its beneficiaries in 2018, and to support the project, the PEPFAR OVC team, and other program decision makers and stakeholders, including those from the Government of Kenya, to take evidence-informed actions to improve OVC program strategy, resource allocation, and implementation. The study supplements a panel study that provides a similar snapshot of MWENDO beneficiaries in 2016, who were interviewed again in 2018. Monitoring the Outcomes of Orphans and Vulnerable Children Programs in Kenya: Findings from 2016–2018 Panel Data is available at the following link: https://www.measureevaluation.org/resources/publications/tr-19-342/

The MWENDO Project

The MWENDO project is implemented by Catholic Relief Services (CRS)/Kenya and is funded by PEPFAR. MWENDO's holistic, child-focused, and family-centered approach sees child well-being as nested in household well-being, community resilience, and support. That is, interventions are at the community and household levels, but focus on the needs of children. Specifically, the project strengthens the HIV and social support system from the household to the national level, and across systems and sectors, with a specific focus on protection, household economic strengthening, health and HIV, and the intersections among them (CRS, n.d.)

MWENDO has three sub-purposes (CRS, n.d.):

1. *Increased access to health and social services for OVC and their families.* Through social and behavioral change initiatives, the project works at the community level to increase knowledge about child protection and HIV, reduce HIV-related stigma and discrimination, and transform communities to become advocates for vulnerable children and their families.
2. *Strengthened capacity of households and communities to protect and care for OVC*, by helping households meet basic needs and grow their resources to improve their economic security. MWENDO facilitates household access to social safety-net programs, financial services, and financial education.
3. *Improved child welfare and protection structures and systems for effective responses.* This involves capacity building for local implementing partners (LIPs) and the Department of Children Services in organizational effectiveness, and using a management information system to collect and use data to strengthen case management, target referrals, and inform advocacy.

The MWENDO project reported nearly 300,000 individual beneficiaries receiving services in August 2018, among nearly 150,000 households. The LIPs work with CHVs, who play lead roles in assessing household needs through monthly visits. MWENDO uses a case management approach to providing services, and vulnerability is assessed through a Case Plan Achievement Readiness Assessment and use of the Household Vulnerability and Prioritization Tool (Bunkers, & Ventimiglia 2017). The CHVs are also the primary service providers to registered OVC and their households.

Study Objectives

The conceptual model used to define the MER ESIs assumes that the set of interventions delivered to members of households enrolled in MWENDO-supported activities should lead to improved well-being of children under age 18 in the households, as measured by the OVC ESIs (Settergren, Faye, Beguy, 2018). The purpose of this study was to obtain a snapshot of the well-being of OVC beneficiaries and their households, who were served by the MWENDO project at the time of data collection, and who have become project beneficiaries in the two years preceding the survey. The study aimed to support evidence-informed strategy, programming, and resource allocation by Kenyan stakeholders, and contribute to a global PEPFAR-wide evidence base on the effectiveness of PEPFAR OVC programming. Specifically, the objectives of the study were to:

- Obtain a snapshot of children's health, nutrition, education, legal rights, and early childhood development. The indicators used for this assessment, by domain, were:
    - Health: percent of children too sick to participate in daily activities.
    - Nutrition: percent of under-five children who are undernourished.
    - Education: percent of children regularly attending school, and percent of children who progressed in school during the last year.
    - Legal rights: percent of children who have a birth certificate.
    - Early childhood development: percent of under-five children who recently engaged in stimulating activities.
- Assess caregiver attitudes about harsh physical punishment.
- Assess OVC households' economic resilience (i.e., percent of households able to access money to pay for unexpected household expenses).
- Assess additional indicators of interest to Kenyan stakeholders: percent of children living with HIV who are taking antiretroviral ARV drugs; percent of households able to access money to pay for expected household expenses.
- Propose recommendations for improving MWENDO project activities and other PEPFAR OVC programs in Kenya, based on the results of this study and of the panel study of MWENDO beneficiaries.

METHODS

This cross-sectional survey was done independently from Round 2 of the MWENDO panel study, which was undertaken at the same time in 2018. Respondents were caregivers in households served by the MWENDO project through three LIPs (Kwosp, Green Zone, and Devlink). These LIPs did not work with APHIAplus in 2016, and were therefore not included in the panel study, which sampled households that were receiving services from APHIAplus at the time, interviewing them in 2016 and again in 2018. A total of 120 households were randomly selected from a list of all households served by the three LIPs, proportional to LIP size (60 from Devlink and 30 each from the other two LIPs). Of these, caregivers from 99 households were successfully interviewed.

Survey Indicators and Questionnaire

The survey collected data for measuring the nine PEPFAR OVC MER ESIs, which were vetted and selected in 2014 by the global PEPFAR OVC program and strategic information technical leaders (MEASURE Evaluation, 2014). They applied several criteria in their selection, including relevance in the various countries where PEPFAR provides OVC program support, and representation of factors amenable to change over a two-year period. All selection criteria and the indicator reference sheets that define the indicators can be found in the MEASURE Evaluation guidance developed for the surveys (MEASURE Evaluation, 2014). Two supplemental indicators were added (OVC_KE1 and OVC_KE2), chosen by the Kenyan PEPFAR team before the first round of data collection in 2016 (Settergren, Faye, & Beguy, 2018). Table 2 lists the 11 indicators.

Table 2. PEPFAR OVC MER ESIs and two supplemental indicators

Indicator reference	Type	Indicator
OVC_SICK	ESI	Percent of children (aged 0–17 years) too sick to participate in daily activities
OVC_HIVST	ESI	Percent of children (aged 0–17 years) whose primary caregiver knows the child's HIV status
OVC_NUT	ESI	Percent of children (aged 6–59 months) who are undernourished
OVC_STIM	ESI	Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age
OVC_BCERT	ESI	Percent of children (aged 0–17 years) who have a verified birth certificate
OVC_SCHATT	ESI	Percent of children (aged 5–17 years) regularly attending school
OVC_PRGS	ESI	Percent of children (aged 5–17 years) who progressed in school during the last year
OVC_CP	ESI	Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control of children in the home or at school
OVC_MONEY	ESI	Percent of households able to access money to pay for unexpected household expenses

Indicator reference	Type	Indicator
OVC_KE1	Supplemental	Percent of children (aged 0–17 years) living with HIV who are taking ARV drugs
OVC_KE2	Supplemental	Percent of households able to access money to pay for expected household expenses

Interviews were conducted with caregivers using a standardized questionnaire previously developed by MEASURE Evaluation for the PEPFAR OVC Technical Working Group specifically for the purpose of collecting data for the MER OVC ESIs. The survey questionnaire consisted of three interviews: (1) caregiver; (2) child ages 0–4 years; and (3) child ages 5–17 years, inclusive. The survey team made only minor modifications to the standardized questionnaire to adapt it to the Kenyan context. Specifically, questions were added to measure the two supplemental indicators, and the names of the local OVC project partners were inserted into questions that referenced the MWENDO project. The questionnaire was translated into Kiswahili, Luhya, and Luo, the primary languages spoken among the project beneficiaries. Minor changes were made to the translations following pilot testing to enhance the clarity of the translations. The English version of the questionnaire is provided in Appendix A.

Ethics Review and Compliance for the Surveys

Institutional review board approval was granted by the AMREF Health Africa Ethics and Scientific Review Committee, Kenya, and the Health Media Lab, United States.. All study activities adhered strictly to United States, Kenya, and international research ethics guidelines, including the Code of Federal Regulations, part 45CFR46, and the Council for International Organizations of Medical Sciences. Participation in the study was completely voluntary, based on a consent form. Interviews were undertaken in the caregivers' homes, in areas where the conversation could not be observed or overheard by persons outside the household and where interruptions could be minimized. Maintaining the privacy and confidentiality of respondents was paramount.

Fieldwork

MEASURE Evaluation worked closely with the African Population and Health Research Center to implement the survey. Data collection was conducted between October 29 and November 17, 2018, by a team of trained data collectors comprising a field coordinator, two field supervisors, and eight field interviewers. The team worked with MWENDO's LIPs to locate the selected households with the help of the CHVs assigned by the LIP to support the household. The CHVs or other LIP staff accompanied the data collection team to the household and facilitated introductions. However, they left the household before the field interviewer started the consent process for the interviews to maintain confidentiality and avoid coercion to participate.

Informed consent was sought by field interviewers from all participating OVC caregivers before they were interviewed. All participating caregivers were adults ages 18 years and above. They were asked to consent to their own participation and to provide assent for mid-upper arm circumference (MUAC) measurement of children ages 6–59 months in their care. Respondents who consented to participate signed a soft copy of the informed-consent form on a password-protected Android tablet and a hard-copy duplicate informed consent form, which was left with them.

Responses from survey participants were captured electronically on password-protected Android tablets preprogrammed with the survey questionnaire using the SurveyCTO software. The electronic data

capture tool mirrored the paper questionnaire, which is attached in Appendix A, and presented one question per screen. Instructions were included in the tool to guide the interviewers and to facilitate the interview flow. Skip logic was built in and error messages and caution notices were triggered when faulty or out-of-range data were entered to alert the field interviewers to correct any errors at the point of data collection. Caregivers were interviewed in a quiet and private location out of earshot of others, including children and other family members. MUAC measurements of children ages 6–59 months were obtained in the presence of their caregivers. At least three attempts were made to conduct interviews with caregivers who were temporarily absent from the household at the time of the first visit to their households.

The field team met after each day's work to review experiences of the day and to plan for the following day. All completed interviews were reviewed daily by the field supervisors, and any errors encountered were referred back to the field interviewers for correction before the data were approved for transmission to the African Population and Health Research Center database server. Daily checks were done on the data based on a predesigned data cleaning script in Stata 15 that included checks for structure, uniqueness, and external consistency of key identifiers; completeness of the data; acceptable data; and unexpected data. An inconsistency report from the database was then generated and shared with the field team daily. Immediate action/correction (e.g., reinterview; revisit to households for confirmation) was undertaken accordingly by the field teams to correct the inconsistency before the data were resubmitted.

Data Processing and Data Analysis

Once the data collection was completed, additional checks were done on the full data file. Only minimal edits were required because real-time data cleaning was continually conducted during data collection. On completion of the checks, a clean version of the data was saved for analysis. The analytical files included data dictionaries with variable labels, value labels, and other standard specifications. Detailed metadata reports were also generated using Nesstar software. Because missing data were minimal, no data imputation was needed.

To assess the status of OVC beneficiary households/children, we used data collected on all children (zero to four years and 5–17 years of age) under the care of the primary caregivers. Data analysis was performed using Stata 15. The ESIs were derived as specified in the MEASURE Evaluation guidance document (MEASURE Evaluation, 2014). Confidence intervals (95%) for the indicator estimates were calculated.

Response Rate

A total of 99 households were successfully interviewed from among the 120 households sampled for the study. This represents an overall response rate of 82.5 percent. The response rate varied across the three sampled LIPs, with Green Zone and KWOSP having a lower response rates, at 66.7 percent and 70.0 percent respectively, compared with 96.7 percent for Devlink beneficiaries. Table 3 presents the overall sample and sample coverage by different categories, and the reasons for non-response.

Table 3. Household response rates

LIP	Number of households sampled	Caregivers interviewed	Could not be located	Caregivers not traced	No longer being visited by LIP	Response rate (%)
Kwosp	30	21	9	0	**0**	**70.0%**
Green Zone	30	20	3	2	**5**	**66.7%**
Devlink	60	58	2	0	**0**	**96.7%**
Total	**120**	**99**	**14**	**2**	**5**	**82.5%**
Household sample coverage						
Households in the survey sample (selected for interview from the project listing)						120
Sample households (or caregivers) unknown to the LIP, assigned CHV, or local guide						2
Sample household no longer being visited by the LIP						5
Caregivers in sample households reported to be temporarily away from the household for extended period						4
Caregivers residing at sampled household but could not be located for an interview after three attempts						10
Caregivers who refused an interview						0
Sample households with no resident children under age 18						0
Households with successfully completed interviews						99
Survey household response rate						**82.5%** **99/120**

A total of 99 caregivers were interviewed about themselves and the children under their care ages zero to four years (n=56) and 5–17 years (n=330), as shown in Table 4.

Table 4. Completed interviews

Sample information	Number
Number of caregiver interviews completed	99
Number of child interviews for ages 0–4 years completed	56
Number of child interviews for ages 5–17 years completed	330
Total number of child interviews completed	386
Percentage of child interviews completed among eligible children in the household	100%
Average number of completed child interviews per household	3.9
Percentage of children listed by caregivers who were registered with the project	88.1%

RESULTS

Background Characteristics of Respondents

Caregivers

The majority of the 99 caregivers who were successfully interviewed were female (89.9%) (Table 5). The majority of the caregivers were in the age group 31 to 50 years (56.6%), followed by the 18 to 30 year age group (24.2%), whereas persons age 51 years or more represented 19.2 percent of the caregivers who were interviewed. There was no caregiver below 18 years. Details of the caregiver age distribution are given in Table 5.

Table 5. Age distribution of primary caregivers

Age (years)	n / N	% (95% CI)
Female caregivers		
<18	-	-
18–30	22/89	24.7 (16.7–34.9)
31–50	52/89	58.4 (47.8–68.3)
51+	15/89	16.9 (10.3–26.3)
All females	**89/99**	**89.9 (82.1–94.5)**
Male caregivers		
<18	-	-
18–30	2 (10)	20.0 (4.6–56.6)
31–50	4(10)	40.0 (14.7–72.0)
51+	4(10)	40.0 (14.7–72.0)
All males	**10 (99)**	**10.1 (5.5–17.9)**
Both sexes		
<18	-	**-**
18–30	24 / 99	24.2 (16.7–33.8)
31–50	56 / 99	56.6 (46.5–66.1)
51+	19 / 99	19.2 (12.5–28.3)
All ages	**99 / 99**	**100.0**

Children

Table 6 presents the distribution of children represented in the survey, by sex and age. Overall, a total of 386 children were represented in the survey by the caregivers who were interviewed. Female children were the majority (52.3%) compared with 47.7 percent male children. Children ages 10–14 years were the largest proportion (38.1%) of all children sampled, whereas the least represented age group was zero to four years, at only 14.5 percent.

Table 6. Age distribution of children, by sex

Child's age (years)	n / N	% (95% CI)
Females		
0–4	27/202	13.4 (9.3–18.8)
0–5 months	1/202	0.5 (0.1–3.5)
6–11 months	2/202	1.0 (0.2–3.9)
12–23 months	6/202	3.0 (1.3–6.5)
2–4 years	18/202	8.9 (5.7–13.7)
5–9	56/202	27.7 (22.0–34.3)
10–14	82/202	40.6 (34.0–47.5)
15–17	37/202	18.3 (13.5–24.3)
All female children (0–17)	202 /386	52.3 (47.3–57.3)
Males		
0–4	29/184	15.8 (11.2–21.8)
0–5 months	2/184	1.1 (0.3–4.3)
6–11 months	4/184	2.2 (0.8–5.7)
12–23 months	3/184	1.6 (0.5–5.0)
2–4 years	20/184	10.9 (7.1–16.3)
5–9	47/184	25.5 (19.7–32.4)
10–14	65/184	35.3 (28.7–42.5)
15–17	43/184	23.4 (17.8–30.1)
All male children (0–17)	184 /386	47.7 (42.7–52.7)
Both sexes		
0–4	56/386	14.5 (11.3–18.4)
0–5 months	3/386	0.8 (0.2–2.4)
6–11 months	6/386	1.6 (0.7–3.4)
12–23 months	9/386	2.3 (1.2–4.4)
2–4 years	38/386	9.8 (7.2–13.3)
5–9	103/386	26.7 (22.5–31.3)
10–14	147/386	38.1 (33.4–43.1)
15–17	80/386	20.7 (17.0–25.1)
All ages	386 /386	100.0

OVC Services Received

Caregivers were asked whether they had personally ever participated in project activities or received services from a MWENDO LIP in their community. They were also asked whether they had participated in or received these services from the MWENDO project in the six months preceding the survey. The results are provided in Table 7. Although all households were registered with the project, only 75.8 percent of the caregivers reported ever participating in or receiving services, and only 69.7 percent reported that they had participated in or received services from the project in the past six months.

Table 7. Number and percentage of caregivers who personally received services or participated in activities from the OVC implementing organization

Caregivers)	n / N	% (95% CI)
Female caregivers		
Ever received services	66/89	74.2 (63.9–82.3)
Received services in the past six months	60/89	67.4 (56.8–76.5)
Male caregivers		
Ever received services	9/10	90.0 (49.8–98.8)
Received services in the past six months	9/10	90.0 (49.8–98.8)
Both sexes		
Ever received services	75/99	75.8 (66.2–83.3)
Received services in the past six months	69/99	69.7 (59.8–-78.1)

Caregivers were asked a similar set of questions for each of the children in their care. These results are given in Table 8. Among children ages 0–4 years represented in the survey, only 17.9 percent were reported to have ever received services from the project, whereas for children ages 5–17 years, 56.4 percent of them had ever received services. However, 17.9 percent of children ages zero to four years had received services in the six months preceding the survey. Of all children ages 5–17 years in the study, 48.8 percent were reported to have received services during the same period.

Table 8. Caregivers' reports of children's OVC project participation or receipt of OVC project services

Age (years)	n / N	% (95% CI)
Females		
Ever received services		
0–4	3/27	11.1 (0.0–23.0)
5–17	114/175	65.1 (58.1–72.2)
Received services in the last 6 months		
0–4	3/27	11.1 (0–23.0)
5–17	100/175	57.1 (49.8–64.5)
Males		
Ever received services		
0–4	7/29	24.1 (8.6–39.7)
5–17	72/155	46.5 (38.6–54.3)
Received services in the last 6 months		
0–4	7/29	24.1 (8.6–39.7)
5–17	61/155	39.4 (31.7–47.0)
Both sexes		
Ever received services		
0–4	10/56	17.9 (7.8–27.9)
5–17	186/330	56.4 (51.0–61.7)
Received services in the last 6 months		
0–4	10/56	17.9 (7.8–27.9)
5–17	161/330	48.8 (43.4–54.2)

Caregivers' Reports of the Types of Services Received Through the MWENDO Project in the Past Six Months

Caregivers who reported participating in or receiving services in the past six months before the survey were asked whether they had received each of the ten types of services provided by the MWENDO project. Caregiver reports of the types of services they had received in the past six months are shown in Table 9. Education and HIV testing and counseling were the most reported services, at 44.4 percent and 40.4 percent, respectively. Legal and social protection was the least reported service, at 12.1 percent, whereas shelter was not reported as having been received by any household in the past six months before the survey.

Table 9. Caregivers' reports of the types of services received through the MWENDO project in the past six months

Type of services	n / N	% (95% CI)
Psychosocial counselling	36 / 99	36.4 (27.4–46.4)
Health or nutrition	25 / 99	25.3 (17.6–34.9)
Education	44 /99	44.4 (34.8–54.5)
Shelter	0 /99	0.0
Household economic strengthening	26 /99	26.3 (18.4–36.0)
Legal and social protection	12 /99	12.1 (6.9–20.3)
HIV testing and counseling	40/99	40.4 (30.6–50.7)
Referral to ART	19/99	19.2 (12.0–28.3)
Support for disclosing HIV status	21/99	21.2 (13.6–30.6)
Referral to GBV services	6/99	6.1 (2.3–12.7)

PEPFAR MER OVC Essential Survey Indicators

Results for the survey indicators were disaggregated by sex and age following PEPFAR's MER requirements. For each indicator, the numerator (*n*), denominator (*N*), indicator estimate (%), and 95% confidence intervals (lower and upper limits) are provided in table format. Because this was a random sample, we did not adjust for sample design. Findings are organized by the dimensions of OVC well-being that were measured.

Health

OVC_SICK: Percent of children (aged 0–17 years) too sick to participate in daily activities

Caregivers were asked whether the children in their care had been too sick to participate in daily activities at any time in the two weeks before the survey. The results are presented in Table 10. Caregivers reported that 12.7 percent of all children represented in the survey were too sick to participate in daily activities. By age category, children ages 0–4 years had the highest proportion (19.6%) of those who were too sick to participate in daily activities, followed by children ages 15–7 years (13.8%). Children ages 5–9 years and those ages 10–14 years had the least proportions of sick children, at 11.7 percent and 10.2 percent, respectively.

Table 10. Percentage of children too sick to participate in daily activities

Child's age (years)	n / N	% (95% CI)
Females		
0–4	6 /27	22.2 (10.2–41.9
5–9	7 /56	12.5 (6.0–24.2)
10–14	7 / 82	8.5 (4.1–16.9)
15–17	8 /37	21.6 (11.1–37.9)
All female children (0–17)	28/202)	13.9 (9.7–19.4)
Males		

Child's age (years)	n / N	% (95% CI)
0–4	5/29	17.2 (7.2–35.8)
5–9	5/47	10.6 (4.4–23.4)
10–14	8/65	12.3 (6.2–22.9)
15–17	3/43	7 (2.2–19.8)
All male children (0–17)	21/184	11.4 (7.5–16.9)
Both sexes		
0–4	11/56	19.6 (11.0–32.3)
5–9	12/103	11.7 (6.7–19.5)
10–14	15/147	10.2 (6.2–16.3)
15–17	11/80	13.8 (7.7–23.3)
All ages	49 /386	12.7 (9.7–16.4)

OVC_HIVST: Percent of children (aged 0–17 years) whose primary caregiver knows the child's HIV status

Caregivers reported that they knew the HIV status of the majority of the children in their care (90.9%). However, the majority of the children whose HIV status was known were more likely to be five years of age or older, with only 78.6 percent of children younger than five years having their HIV status known by the caregivers. No difference between female and male children was observed. These results are summarized in Table 11.

Table 11. Percentage of children whose primary caregiver knows the child's HIV status

Age (years)	n / N	% (95% CI)
0–4	19/27	70.4 (50.5–84.7)
5–9	52/56	92.9 (82.3–97.3)
10–14	77/ 82	93.9 (86.1–97.5)
15–17	36/37	97.3 (82.7–99.6)
All female children (0–17)	**184/202**	**91.1 (86.3–94.3)**
0–4	25 29	86.2 (68.0–94.8)
5–9	43/47	91.5 (79.2–96.8)
10–14	60/65	92.3 (82.7–96.8)
15–17	39/43	90.7 (77.4–96.5)
All male children (0–17)	**167/184**	**90.8 (85.6–94.2)**
0–4	**44/56**	**78.6 (65.8–87.5)**
5–9	95/103	92.2 (85.2–96.1)
10–14	137/147	93.2 (87.8–96.3)
15–17	75/80	93.8 (85.7–97.4)
All ages	**351/386**	**90.9 (87.6–93.4)**

OVC_S2B: Percent of children (aged 0–17 years) living with HIV who are taking ARV drugs

A total of 12 girls and eight boys were known to be living with HIV: 5.7 percent of the children ages 0–17 whose caregivers knew their HIV status. Among children whom the caregiver reported knowing their HIV status, 95 percent were reported to be on ART, with 100 percent of the males taking ARVs compared with 91.7 percent of the females (Table 12). Notably, of all children under five years who were reported to be living with HIV, none was reported to be on ARVs. Table 12 summarizes these results.

Table 12. Percentage of children living with HIV who are taking ARV drugs

Age (years)	n / N	% (95% CI)
Females		
0–4	N.A	N.A
5–9	4/5	80(22.6–98.2)
10–14	5/5	100.0
15–17	2/2	100.0
All female children (0–17)	**11/12**	**91.7 (52.9–99.1)**
Males		
0–4	N.A	N.A
5–9	2/2	100.0
10–14	3/	100.0
15–17	3/(3	100.0
All male children (0–17)	**8/8**	**100.0**
Both sexes		
0–4	**N.A**	**N.A**
5–9	6/7	85.7 (34.3–98.6)
10–14	8/8	100.0
15–17	5/5	100.0
All ages	**19/20**	**95.0 (67.7–99.4)**

Nutrition

OVC_NUT: Percent of children (aged 6–59 months) who are undernourished

In accordance with PEPFAR's MER OVC ESI guidance, a child was considered undernourished if her/his MUAC measurement fell below 125 mm. Data from the survey indicated that no child ages 6–59 months was undernourished at the time of the survey. Table 13 presents these findings.

Table 13. Percentage of children ages 6–59 months who are undernourished

Child's age (years)	n / N	% (95% CI)
Females		
6–11 months	0/2	0.0
12–59 months	0/24	0.0
All female children (6–59 months)	0/26	0.0
Males		
6–11 months	0/4	0.0
12–59 months	0/23	0.0
All male children (6–59 months)	0/27	0.0
Both sexes		
6–11 months	0/53	0.0
12–59 months	0/53	0.0
All children 6-59 months	0/53	0.0

Early Childhood Development

OVC_STIM: Percent of children < 5 years of age who recently engaged in stimulating activities with any household member over 15 years of age

Caregivers were asked whether the children younger than five years in their care had engaged in stimulating activities in the past three days with either the caregiver or any member of the household over 15 years of age. Stimulating activities that were asked about included reading books, looking at the pictures in the books, telling stories, singing songs or lullabies, playing with the child, or naming, counting, or drawing things. Caregivers reported that nearly three-quarters of all children under age five (71.4%) had engaged in at least one of these types of stimulating activities in the past three days, as shown in Table 14. A higher proportion of male children (79.3%) were engaged in stimulating activities compared with females (63.0%), but the difference was not statistically significant (p<0.1). Singing songs or lullabies and playing were the most frequently reported activities.

Table 14. Percentage of children under five years of age who recently engaged in stimulating activities with any household member over 15 years of age

Type of stimulating activities	n / N	% (95% CI)
Activity	**n / N**	**% (95% CI)**
Females		
Read or looked at picture books	10/27	37.0 (20.7–57.0)
Told stories	12/27	44.4 (26.6–63.8)
Sang songs or lullabies	16/27	59.3 (39.5–76.4)
Engaged in play	16/27	59.3 (39.5–76.4)
Named, counted, or drew things	8/27	29.6 (15.1–49.9)
One or more of these activities	**17/27**	**63.0 (43.0–79.3)**
Males		
Read or looked at picture books	12/29	41.4 (24.7–60.4)

Type of stimulating activities	n / N	% (95% CI)
Told stories	14/29	48.3 (30.4–66.6)
Sang songs or lullabies	18/29	62.1 (42.8–78.1)
Engaged in play	18/29	62.1 (42.8–78.1)
Named, counted, or drew things	11/29	37.9 (21.9–57.2)
One or more of these activities	**23/29**	**79.3 (60.1–90.7)**
Both sexes		
Read or looked at picture books	22/56	39.3 (27.1–52.9)
Told stories	26/56	46.4 (33.5–59.8)
Sang songs or lullabies	34/56	60.7 (47.1–72.9)
Engaged in play	34(56	60.7 (47.1–72.9)
Named, counted, or drew things	19/56	33.9 (22.5–47.6)
One or more of these activities	**40/56**	**71.4 (57.9–82.0)**

Pre-Primary School Attendance

In Kenya, early childhood education or preschool begins as early as age two and children typically begin primary education at age six. Although indicators on pre-primary school are not part of the OVC ESIs, the survey questionnaire asked about education among children ages 2–5 years. The results are given in Table 15. Caregivers reported that 58.9 percent of children ages 2–5 were enrolled in preschool. 44.6 percent of these children were reported to be regularly attending school (i.e., did not miss any school days in the week preceding the survey). Of all the children who were in school the year preceding the survey, 95.0 percent were reported to have progressed to the next level or grade from that in which they were in the previous year.

Table 15. Percentage of children ages 2–5 years who were enrolled, regularly attended, and progressed in preschool

Child's age (years)	n / N	% (95% CI)
Females		
Enrolled	16/27	59.3 (39.5–76.4)
Regularly attending school	11/27	40.7 (23.6–60.5)
Progressed in school (among 3- to 5-year-olds enrolled the previous year)	10/10	100.0
Males		
Enrolled	17/29	58.6 (39.6–75.3)
Regularly attending school	14/29	48.3 (30.4–66.6)
Progressed in school (among 3- to 5-year-olds enrolled the previous year)	9/10	90 (46.8–98.9)
Both sexes		
Enrolled	33/56	58.9 (45.3–71.3)
Regularly attending school	25/56	44.6 (31.9–58.1)

Progressed in school (among 3- to 5-year-olds enrolled the previous year)	19/20	95.0 (67.7–99.4)

Legal Rights

OVC_BCERT: Percent of children (aged 0–17 years) who have a verified birth certificate

Caregivers were asked whether the children in their care had birth certificates, and if they reported that a child had a birth certificate, they were asked to show the certificate to the interviewer. Only 40.4 percent of the children had a verified birth certificate (Table 16). The likelihood of having a verified birth certificate increases with age.

Table 16. Percentage of children (ages 0–17 years) who have a verified birth certificate

Child's age (years)	n / N	% (95% CI)
Females		
0–4	4/27	14.8 (5.5–34.0)
5–9	20/56	35.7 (24.2–49.1)
10–14	38/82	46.3 (35.8–57.2)
15–17	21/37	56.8 (40.4–71.8)
All female children (0–17)	83/202	41.1 (34.5–48.0)
Males		
0–4	8/29	27.6 (14.2–46.7)
5–9	13/47	27.7 (16.7–42.2)
10–14	28/65	43.1 (31.5–55.4)
15–17	24/43	55.8 (40.7–69.9)
All male children (0–17)	73/184	39.7 (32.8–47.0)
Both sexes		
0–4	12/56	21.4 (12.5–34.2)
5–9	33/103	32.0 (23.7–41.7)
10–14	66/147	44.9 (37.0–53.1)
15–17	45/80	56.3 (45.2–66.8)
All ages	156/386	40.4 (35.6–45.4)

Education

OVC_SCHATT: Percent of children (aged 5–17 years) regularly attending school

Overall, caregivers reported that the majority (97.3%) of the children ages 5–17 years in their care were enrolled in school (98.3% of females and 96.1% of males). The difference between the sexes was not significant. However, only 83.9 percent of the children were reported to be attending school regularly,

that is, enrolled in school and did not miss any days in the school week preceding the interview. The proportion of children regularly attending school was higher for females (85.7%) compared with males (81.9%). This results are shown in Tables 17a and 17b. Table 17a shows the OVC_SCHATT indicator and Table 17b shows the supplemental information.. In Kenya, children typically begin primary education at age six and secondary education at age 14.

Table 17a. Percentage of children regularly attending school, by age

Child's age (years)	n / N	% (95% CI)
Females		
5–9	47/56	83.9 (71.7–91.5)
10–14	72/82	87.8 (78.7–93.4)
15–17	31/37	83.8 (68.0–92.6)
Females 5-17	150/175	85.7 (79.7–90.2)
Both sexes		
5–9	80/103	77.7 (68.5–84.7)
10–14	128/147	87.1 (80.6–91.6)
15–17	69/80	86.3 (76.7–92.3)
All ages 5–17	277/330	83.9 (79.5–87.5)
Males		
5–9	33/47	70.2 (55.6–81.6)
10–14	56/65	86.2 (75.3–92.7)
15–17	38/43	88.4 (74.7–95.1)
Males 5–17	127/155	81.9 (75.0–87.3)

Table 17b. Percentage of children regularly attending school, by school level

Child's age (years)	n / N	% (95% CI)
Age groups according to school levels		
6–13 (primary)	67/87	77.0 (66.9–84.7)
14–17 (secondary)	52/59	88.1 (77.0–94.3)
All male children (6–17)	119/146	81.5 (74.3–87.0)
Age groups according to school levels		
6–13 (primary)	104/117	88.9 (81.7–93.4)
14–17 (secondary)	40/49	81.6 (68.1–90.2)
All female children (6–17)	144/166	86.7 (80.6–91.1)
Age groups according to school levels		
6–13 (primary)	171/204	83.8 (78.1–88.3)
14–17 (secondary)	92/108	85.2 (77.1–90.8)
All ages 6–17	263/312	84.3 (79.8–87.9)

OVC_PRGS: Percent of children (aged 5–17 years) who progressed in school during the last year

Of all children reported to be enrolled in the year preceding the survey, caregivers were asked about their current school level or grade to identify how many progressed from one grade level to the next. Overall, 96.5 percent of the children ages 5–17 were reported to have progressed in school (Table 18). Looking at age groups defined according to school levels, school progression was similar for both primary (96.5%) and secondary grades (96.2%), respectively. By sex, 95.8 percent of male children progressed to the next grade level compared with 95.4 percent of the females. Table 18 below presents a summary of school progression in the past one year, by children and school level.

Table 18. Percentage of children aged 5–17 years who progressed in school during the past year

Child's age (years)	n / N	(95% CI)
Females		
5–9	50/54	92.6 (81.7–97.2)
10–14	79/81	97.5 (90.5–99.4)
15–17	35/37	94.6 (80.4–98.7)
Females 5–17	**164/172**	**95.4 (90.9–97.7)**
Age groups according to school levels		
6–13 (primary)	**112/116**	**96.6 (91.1–98.7)**
14–17 (secondary)	47/49	95.9 (84.8–99.0)
All female children (6–17)	**159/165**	**96.4 (92.1–98.4)**
Males		
5–9	37/39	94.9 (81.3–98.7)
10–14	61/64	95.3 (86.3–98.5)
15–17	39/40	97.5 (83.8–99.7)
Males 5–17	**137/143**	**95.8 (90.9–98.1)**
Age groups according to school levels		
6–13 (primary)	80/83	96.4 (89.3–98.8)
14–17 (secondary)	53/55	96.4 (86.4–99.1)
All male children (6–17)	**133/138**	**96.4 (91.5–98.5)**
Both sexes		
5–9	87/93	93.6 (86.3–97.1)
10–14	140/145	96.6 (91.9–98.6)
15–17	74/77	96.1 (88.5–98.8)
All ages 5–17	**301/315**	**96.5 (92.6–97.4)**
Age groups according to school levels		
6–13 (primary)	192/199	96.5 (92.8–98.3)
14–17 (secondary)	100/268	96.2 (90.1–98.6)
All ages 6–17	**292/303**	**96.4 (93.5–98.0)**

Attitudes about Child Punishment

OVC_CP: Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control of children in the home or at school

When asked whether hitting or beating a child is always or sometimes an appropriate means of discipline or control in the home or at school, 74.7 percent of caregivers were in agreement. Caregivers in the age category 31 to 50 years were more likely to affirm harsh child punishment as a way of disciplining the child, whereas older caregivers (51 years and older) were the least likely to affirm harsh punishment, although the age differences were not statistically significant. There were no statistically significant differences between male and female caregivers. Table 19 summarizes the findings.

Table 19. Percentage of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control of children in the home or school

Age of caregiver	n / N	% (95% CI)
Females		
<18	-	-
18–30	16/22	72.7 (50.2–87.6)
31–50	41/52	78.9 (65.4–88.0)
51+	10/15	66.7 (39.4–86.0)
All females	**67/89**	**75.3 (65.1–83.3)**
Males		
<18	-	-
18–30	1/2	50.0 (1.9–98.1)
31–50	4/4	100.0
51+	2/4	50.0 (1.9–98.1)
All males	**7/10**	**70.0 (35.5–90.8)**
Both sexes		
<18	-	-
18–30	17/(24)	70.8 (49.4–85.8)
31–50	45/(56)	80.4 (67.6–88.9)
51+	12/(19)	63.2 (39.4–81.9)
All ages	**74/(99)**	**74.7 (65.1–82.4)**

Household Economic Well-Being and Resilience

OVC_KE2: Percent of households able to access money to pay for expected household expenses

Caregivers were asked whether their households were able to access money to pay for expected household expenses in the past 12 months. Results are provided in Table 20. Overall, 63.6 percent of all households in the study reported that they were able to pay for expected household expenses.

Table 19. Percentage of households able to access money to pay for expected household expenses.

Sex of caregiver	n / N	% (95% CI)
Females	56/89	62.9 (52.3–72.4)
Males	7/10	70.0 (35.5–90.8)
All caregivers	63/99	63.6 (53.6–72.6)

OVC_MONEY: Percent of households able to access money to pay for unexpected household expenses

Caregivers were also asked whether their households encountered any unexpected expenditures in the past 12 months and whether they were able to access money to pay for the unexpected expenditures. Nearly 78 percent (77.8%) of the caregivers reported that their households had experienced an unexpected household expense, such as a house repair or urgent medical treatment, in the past 12 months (Table 21). Of all the households that reported experiencing unexpected household expenditure, 62.3 percent were able to access money to pay for the unexpected household expenses. The ability to access money to pay for the unexpected household expenditures did not differ significantly by sex of the caregiver (62.3% for females and 62.5% for males). Table 21 summarizes the findings.

Table 20. Percentage of households able to access money to pay for unexpected household expenses

Sex of caregiver	n / N	% (95% CI)
Females	69/89	77.5 (67.5–85.1)
Males	8/10	80.0 (43.4–95.4)
All caregivers	77/99	77.8 (68.4–85.0)
Households able to access money to pay for unexpected expenses (among those experiencing an unexpected expense)		
Sex of caregiver	**n / N**	**% (95% CI)**
Females	43/69	62.3 (50.1–73.1)
Males	5/8	62.5 (26.0–88.8)
All caregivers	48/77	62.3 (50.8–72.6)

DISCUSSION

This cross-sectional study involved an outcome monitoring survey conducted in 2018 with households that were not part of the MWENDO project beneficiaries who participated in the first survey round conducted for the project in 2016. The findings represent child and household well-being at that time, and reflect the project's performance on the various dimensions of child and household well-being for beneficiary households served by the MWENDO project in 2018, who had enrolled in the project in the two years preceding the survey.

Although all 99 households who were successfully interviewed in the study were listed by MWENDO project as beneficiaries, only 75.8 percent of the respondents reported that they had personally ever received services from the project; about 70 percent reported receiving services in the past six months. That not all caregivers reported having ever received a service from the project may be explained by the fact that intangible services may not be considered by respondents to be services. For example, the project may consider an informational conversation to be a service, whereas respondents do not consider it as such, because it is not as tangible as receiving financial assistance. Also, the question posed to the respondent was phrased as "have you ever *personally* received services?" Because some services are directed to the child rather than to the caregiver, some caregivers may not have considered child services as personal services and, therefore, did not report them. It is also possible that respondents modified their responses in expectation of receiving additional services. However, we do not think this would have significantly impacted the results because the CHVs working with the respondents were not present during the interview, and it was made clear to the respondents during the informed consent process that participation and survey responses would not affect services received in any way.

When asked about specific services received in the past six months, education and HIV testing and counseling were the most likely services to be reported, at 44.4 percent and 40.4 percent, respectively, followed by psychosocial counseling (36.4%), household economic strengthening (26.3%), health or nutrition (25.3%), and support for disclosing HIV status (21.2%). Legal protection (12.1%) was the least likely service to be mentioned as received by the caregivers. Consistent with the expectation that MWENDO would no longer provide shelter as a service, no respondent reported receiving shelter as a service in the past six months preceding the date of the interview. MWENDO should consider comparing these responses to the identified household and OVC needs to better tease out why some caregivers may not have reported all the services they had received.

Regarding **children's health**, 12.7 percent of all children were reported to be too sick to participate in daily activities at some point during the two weeks before the survey. The highest proportion of children too sick to participate in daily activities were in the age group zero to four years. This finding compares very positively with the 2016 survey, which showed the proportion of children too sick to participate in daily activities at 31.4 percent (Settergren, Faye, Beguy, 2018). Although it is possible that these children came into the program healthier, it may also indicate that the MWENDO project's activities targeting the health of children may be having a positive impact. The caregivers reported knowing the HIV status of most of the children in their care. However, there is still need for more efforts to be made by the project to ensure that caregivers know the HIV status of all children living in their households. This is critical because the knowledge of HIV status helps the caregivers link those found to be positive with relevant healthcare services.

Our findings show that severe **malnutrition** is not a problem among these MWENDO beneficiaries. Data on MUAC measurements of OVC ages 6–59 months indicate that no child was found to be

undernourished. Although this finding is positive, it should be considered with caution because of the small sample size. However, the MWENDO panel study and national surveys also show very low rates of severe malnutrition among young children in counties included in this survey (Kenya National Bureau of Statistics [KNBS] and ICF International, 2015).

About three-quarters of the young children participated in one or more of the stimulating activities listed with a caregiver or any other member of the household 15 years or older. This gap in engaging with young children in stimulating activities should be deliberately addressed by the project because it is a critical component of early childhood development. The most commonly reported activities were singing and playing, at 60.7 percent each, with the other activities falling below 50 percent.

Preschool enrollment for children ages 2–5 years was shown to be 58.9 percent. Only 44.6 percent regularly attended school. School enrollment during the survey period may have been partly affected by a misunderstanding of the new (2017) Ministry of Education policy, which states: "The overall goal is to enhance access to quality relevant pre-primary education services to all children aged 4-5" (Republic of Kenya, Ministry of Education, 2017, p. 20). Some preschools may have refused to enroll children younger than four years despite the fact that the policy does not expressly state so, suggesting that the rate could have been higher if not for the policy. The findings on preschool attendance rates are consistent with historical figures from national surveys (World Bank, 2016).

Data from the study show that OVC beneficiaries are doing fairly well with respect to **education,** with 97 percent of children ages 5–17 years reported as enrolled in school. However, only 84 percent of children were attending school regularly (i.e., did not miss any school days in the week preceding the survey). Because our findings show only a snapshot of OVC well-being at one point in time, these findings cannot be attributed to MWENDO because children may have been healthier coming into the program. However, there is no reason to think that the population enrolling in the project between 2016 and 2018 is different from children enrolled earlier, and if this is the case, then the high attendance rates may be a reflection of the MWENDO project, either directly (through activities aimed at improved school attendance), or indirectly, by improving the health of children and the economic well-being of the beneficiary households.

Under **child protection**, MWENDO facilitates caregivers to have children in their care acquire a birth certificate as part of legal protection. Our findings show that only 40.44 percent of all children ages 0–17 years had a verified birth certificate. MWENDO works closely with the government to facilitate access to birth certificates through mobilization, assistance to households with registration forms and procedures, and payment of registration fees. Although our findings are consistent with low estimates from national surveys (KNBS and ICF international, 2015), more effort should be made by the project to help increase the proportion of children with verifiable birth certificates, especially for younger children.

The survey found that about three-quarters of caregivers agreed that hitting or beating a child is always or sometimes an appropriate means of discipline or control in the home or at school. Acceptance of violence against children may reflect cultural norms that condone violence, in general. Moreover, public debate around the lack of student discipline in schools as a result of recent spates of school strikes and cases of children reportedly burning their schools (BBC News, 2016) may have limited the influence of the project on caregivers' attitudes about harsh punishment as a way of disciplining children in school and at home. The 2014 Kenya Demographic and Health Survey found that physical violence against women and children was more prevalent in Western and Nyanza regions compared with other parts of the country (KNBS and ICF International, 2015). This finding suggests the need for MWENDO to increase efforts to reduce **harsh physical punishment** against OVC.

Data from the survey show that 63.6 percent of the households were able to access money to pay for expected household expenses. Among the households that reported ever experiencing unexpected household expenditures in the 12 months before the survey, 62.3 percent were able to access money to meet those expenses. Over one-quarter of the respondents said that they had received economic strengthening support from MWENDO. This finding may partially reflect MWENDO's focus on addressing **household economic resilience** by promoting entrepreneurial training and linking their beneficiaries to sources of support for startups for income generating activities, and linking them to savings and loan organizations as a way of promoting their economic independence.

Limitations of the Study

There are several limitations of the survey that should be considered when interpreting these results. They are:

1. Because the study was cross-sectional, it does not show progress over time.
2. Data on children were reported by the caregiver, not the child, and therefore may be subject to inaccuracies and bias as to the child's actual well-being.
3. The association of the survey team with the LIP during fieldwork (for the purpose of locating beneficiary households) may have influenced the caregivers' responses; however, CHVs were not present during the interview and without the assistance of the partner, the field teams would not have been able to locate the households and, likely, as "outsiders," would have faced refusals for interviews.
4. The survey was designed for the purposes of outcome monitoring only, and the methodology does not allow for attribution of the results directly to the MWENDO project. Moreover, the results from this survey cannot be generalized to populations outside this project beneficiary subpopulation, given that the sample was selected from among a select group of project beneficiaries.

Despite these limitations, our findings provide a snapshot of this subset of MWENDO beneficiaries and insights on the program's successes and gaps, which are useful for the MWENDO project and for other OVC projects in Kenya.

RECOMMENDATIONS

Our findings have clear programmatic implications for MWENDO and for other OVC programs in Kenya.

1. The project performance on two indicators, attitudes about corporal punishment and engagement with young children in stimulating activities, appeared to be low. Therefore, the project needs to focus extra efforts on the activities related to these indicators, as follows:
    a. Given the cultural norms that favor violence in the family, there is a need for activities at the community level to encourage change. For example, MWENDO could design community sensitization activities that address the dangers associated with corporal punishment and tackle related norms and attitudes.
    b. Sensitize CHVs to the importance of discussing child participation in stimulating activities with caregivers, giving the issue more emphasis in their communications with caregivers.
    c. Design opportunities for young child stimulating activities at the community level, such as creating play areas at health facilities and other public venues.
2. Health, education, and legal status indicators, although appearing good, still have gaps that can be narrowed by:
    a. Improving collaboration with relevant government agencies, such as the Department of Children Services and the Office of the Registrar of Births, to ensure that registration services are made conveniently available, to the extent possible. The project should also assist caregivers to navigate the requirements and documentation.
    b. Empowering the CHVs to be able to identify and refer sick children to necessary care. The project should also focus more on conducting HIV risk assessments and referring those most at-risk children to HIV testing to ensure that their status information is reliable and up to date.
    c. Increased internal data use to inform actions for households with children who have challenges with school progression. MWENDO should intensify its tracking and follow-up of the provision of appropriate services to its beneficiaries through evidence-based decision making.
3. Future ESI data collection efforts should consider modifying the questionnaire to ask respondents about services they received without including the word, "personally," and to identify additional reasons for the findings. For example, when children are reported to have missed school, they could be asked the reason for that, to better tease out what MWENDO could do to improve this indicator.

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APPENDIX A. QUESTIONNAIRES

IDENTIFICATION DATA

001	QUESTIONNAIRE IDENTIFICATION NUMBER	
002	COUNTY	
003	Subcounty	
005	WARD	
006	VILLAGE/TOWN	
007	TYPE OF LOCATION *Circle*	Urban 1 Rural 2
008	HOUSEHOLD NUMBER (from sampling list)	**[__ __]**

INTERVIEW RESULT

	VISIT 1	VISIT 2	VISIT 3
DATE (day/month/year)			
INTERVIEWER RESULTS			

Interview comment codes: 1–Interview completed; 2–Relocated/Changed address in the area; 3–Unavailable for extended period; 4–Out-migrated; 5–Not known in the community / Not traced; 6–Duplicate 7–Refused.

009	INTERVIEWER	A) CODE	B) NAME
010	DATE INTERVIEW COMPLETED (day/month/year)		

COMMENTS

Caregivers

First, I have a few questions about you and the children in your care.

No.	Question	Coding Category			Skip
1	**Record caregiver sex.**	Female 1 Male 2			
3	How old were you at your last birthday? **Do not leave blank. If unknown, ask respondent to estimate.**	[_____] years			
4	Have you personally ever received services or participated in activities from [insert name of OVC CBO]? By this, I mean have you ever been visited by a community worker, or have you ever participated in any activities organized by this organization such as a savings group or parenting program?	Yes 1 No 2 Don't know 8 No answer 9			**If No, DK, or No answer: 8**
5	How many months/years ago did you start receiving services or participating in activities from [insert name of CBO]?	[_____] months [_____] years Record 88 for Don't know; 99 for No answer			
6	Have you personally received services or participated in activities from [insert name of CBO] in the last 6 months?	Yes 1 No 2 Don't know 8 No answer 9			
7	What types of services have you or other members of your household received from [organization] in the past 6 months?	**Yes**	**No**	**Don't know**	**No answer**
	7.1 Health or nutrition	1	2	8	9
	7.2 Education	1	2	8	9
	7.3 Shelter	1	2	8	9
	7.4 Household economic strengthening	1	2	8	9
	7.5 Legal and social protection	1	2	8	9
	7.6 Psychosocial counselling	1	2	8	9
	7.7 HIV testing and counseling	1	2	8	9
	7.8 Referral to ART	1	2	8	9
	7.9 Support for disclosing HIV status	1	2	8	9
	7.10 Referral to GBV services	1	2	8	9

No.	Question	Coding Category			Skip
8	Have you ever attended school?	Yes 1 No 2 Don't know 8 No answer 9			If No, DK, or No answer: 10
9	What is the highest level of school you attended?	Pre-primary/nursery/ECD . . .0 Primary . . . . . .1 Secondary . . . . . .2 College . . . . . .3 University . . . . . .4 Don't know . . . . . 8 No answer 9			
10	Do you think that hitting or beating a child is an appropriate means of discipline or control <u>in the home</u>?	Always an appropriate means of discipline . . . . . 1 Sometimes an appropriate means of discipline. . . . . 2 Rarely an appropriate means of discipline . . . . . 3 Never an appropriate means of discipline . . . . . 4 Don't know . . . . . 8 No answer 9			
11	Do you think that hitting or beating a child is an appropriate means of discipline or control <u>at school</u>?	Always an appropriate means of discipline . . . . . 1 Sometimes an appropriate means of discipline. . . . . 2 Rarely an appropriate means of discipline . . . . . 3 Never an appropriate means of discipline . . . . . 4 Don't know . . . . . 8 No answer 9			
12	I'm now going to read some statements and I'd like you to tell me if you agree, partially agree, or do not agree.	**Agree**	**Partially agree**	**Do not agree**	**No answer**
	12.1 Changing diapers or giving a bath to kids is only mother's/woman's responsibility.	1	2	3	9
	12.2 Feeding a child can be the father's responsibility	1	2	3	9
	12.3 Taking care of her home and family is only the woman's responsibility	1	2	3	9
	12.4 The husband should decide to buy the major household items.	1	2	3	9
	12.5 A man should have the final word about decisions in his home.	1	2	3	9

No.	Question	Coding Category			Skip
	12.6 A woman should obey her husband in all things.	1	2	3	9
	12.7 There are times when a woman deserves to be beaten.	1	2	3	9
	12.8 A woman should tolerate violence to keep her family together.	1	2	3	9
	12.9 If someone insults a man, he should defend his reputation with force if he has to.	1	2	3	9
	12.10 A man using violence against his wife is a private matter that shouldn't be discussed outside the couple	1	2	3	9
13	Do you own the house/dwelling where you live	Yes 1 No 2 Don't know 8 No answer 9			
14	Does your household have any of the following:	**Yes**	**No**	**Don't know**	**No answer**
	14.1 Electricity (connected to grid)	1	2	8	9
	14.2 Solar power	1	2	8	9
	14.3 Generator	1	2	8	9
	14.4 Other source of electricity	1	2	8	9
15	Has your household been able to cover <u>expected</u> household expenses in the last 12 months?	Yes 1 No 2 Don't know 8 No answer 9			
16	Did your household incur any <u>unexpected</u> household expenses, such as a house repair or urgent medical treatment, in the last 12 months?	Yes 1 No 2 Don't know 8 No answer 9			**If No, DK, or No answer: 18**
17	Was your household able to pay for these expenses?	Yes 1 No 2			
18a	Are there children in your care who used to receive services from [LIP name] but are no longer receiving services, since January 2018?	Yes 1 No 2 Don't know 8 No answer 9			**If No, DK, or No answer: 19**

No.	Question	Coding Category	Skip
18b	How many children in this household are no longer receiving services from [LIP name] since January 2018?	Number/__/ Don't know 98 No answer 99	**If No, DK, or No answer: 20**
19	Does this household still qualify to receive services from [LIP name]	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 19b** If Yes: 20
19a	Were you told that the household no longer qualifies for services from [LIP name]?	Yes 1 No 2 Don't know 8 No answer 9	
19b	When was the last time (or how many months ago) you or the children you care for received any service from [LIP name]	[_____] months [_____] years Record 88 for Don't know; 99 for No answer	
19c	Since that time, have you or any child from this household received any service or support from	Y/N Government services…… Other NGOs…… Churches/Mosques……..	
20	How many children ages 0–17 years are you responsible for?	[_____]	

Starting with the oldest, please tell me the first names and ages of the children you care for or for whom you are responsible. ***Make sure that the total number of children is the same as the response given to question 20 above.***

No.	First name	Age (years)	Questionnaire		Registered beneficiary of [organization's] OVC program
			0–4 years	5–17 years	Y/N
1	*Example.* Samuel	6	-	X	Y

Child Ages 0–4 years

I have a few questions about [insert child's name]. Check to make sure that the sampled child is present. You will need to take this child's mid–upper arm circumference.

No.	Question	Coding Category			Skip
1	Is [NAME] female or male?	Female 1 Male 2			
2	How old was [NAME] at her/his last birthday? **Do not leave blank. If unknown, ask caregiver to estimate. If the child is older than 4 at last birthday, use 5–17 years questionnaire. Proceed to next household/child on list.**	[_____] years			**If No, DK, or No answer: 4**
3	3.1 Does [NAME] have a birth certificate?	Yes 1 No 2 Don't know 8 No answer 9			**If No, DK, or No answer: 4**
	3.2 Could you please show me [NAME'S] birth certificate?	Seen/Confirmed 1 Not seen/Not confirmed 2			**If 1: 4**
	3.3 What is the reason you are unable to show it to me?	Can't locate it just now 1 Permanently missing/ destroyed 2 Someone else keeps it 3 Other reason (specify) 8			
4	In the past 3 days, did you or any household member over 15 years of age engage in any of the following activities with [NAME]: **Read out one at a time.**	**Yes**	**No**	**Don't know**	**No answer**
	4.1 Read books to or looked a picture books with [NAME]?	1	2	8	9
	4.2 Told stories to [NAME]?	1	2	8	9
	4.3 Sand songs to [NAME] or with [NAME] including lullabies?	1	2	8	9
	4.4 Played with [NAME]?	1	2	8	9
	4.5 Named, counted, or drew things with [NAME]?	1	2	8	9
5	Is [NAME] currently enrolled in school (Early Child Development)?	Yes 1 No 2 Don't know 8 No answer 9			**If No, DK, or No answer: 8**

No.	Question	Coding Category	Skip
6	During the last school week, did [NAME] miss any school days for any reason?	Yes 1 No 2 Don't know 8 No answer 9	
7	What ECD grade (or year) is [NAME] in now?	[___|___] Record 88 for Don't know; 99 for No answer	
8	Was [NAME] enrolled in school during the previous school year?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 10**
9	What ECD grade (or year) was [NAME] in during the previous school year?	[___|___] Record 88 for Don't know; 99 for No answer	
10	In the last 2 weeks, has [NAME] been too sick to participate in daily activities?	Yes 1 No 2 Don't know 8 No answer 9	
11	Has [NAME] ever received services or participated in activities from [insert name of CBO]? READ: For Example, referral to health services for the child, referral of the child for immunizations, referral of the child to HIV testing and counseling, referral for ART, counseling, payment of school fees, support for school supplies and materials, help to get child's birth certificate, water-treatment products, medicines, referral to social protection services, etc.	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 14**
12	How many months ago did [NAME] start receiving services or participating in activities from [insert name of CBO]?	[_____] months Record 88 for Don't know; 99 for No answer	
13	Has [NAME] received services or participated in activities from [*insert name of CBO*] in the last 6 months?	Yes 1 No 2 Don't know 8 No answer 9	

No.	Question	Coding Category	Skip
14	Has [NAME] ever been tested to see if he/she has the AIDS virus?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer:**
15	Do you know the results of [NAME's] test?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: end**
16	Did [NAME] test positive for the AIDS virus?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 20**
17	Is [NAME] currently taking antiretroviral (ARV) drugs?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 20**
18	When the last time [NAME] was took his/her ARV drugs?	Number of days ago: [___|___] 0=today 88=Don't know 99=No answer	
19	May I measure your child's mid–upper arm circumference? **Measure the child's mid–upper arm circumference using the MUAC tape and record measurement.**	[_____|_____].[_____|_____] cm Record 88.88 if permission not given 99.99 if child not present	

Child Ages 5–17 years

Age group	5–9 years	10–14 years	15–17 years

I have a few questions about [insert child's name].

No.	Question	Coding Category	SKIP
1	Is [NAME] female or male?	Female 1 Male 2	
2	How old was [NAME] at her last birthday? **Do not leave blank. If unknown, ask caregiver to estimate. If the child was less than 5 years old at last birthday, complete the 0- to 4-year-old form. If the child is 18 or older, stop the interview for this child.**	[___|___] years	
3	3.1 Does [NAME] have a birth certificate?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 4**
	3.2 Could you please show me [NAME'S] birth certificate?	Seen/Confirmed 1 Not seen/Not confirmed 2	**If 1: 4**
	3.3 What is the reason you are unable to show it to me?	Can't locate it just now 1 Permanently missing/ destroyed 2 Someone else keeps it 3 Other reason (specify) 8	
4	Is [NAME] currently enrolled in school?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 7**
5	During the last school week, did [NAME] miss any school days for any reason?	Yes 1 No 2 Don't know 8 No answer 9	
6	6.1 What education level is [NAME] currently attending?	Pre-primary/nursery/ECD 0 Primary 1 Post-primary training 2 Secondary 3 Post-secondary training 4 College 5 Vocational training 6 University 7 Don't know 8 No answer 9	

No.	Question	Coding Category	SKIP
	6.2 What school grade is [NAME] currently attending?	[___|___] Record 88 for Don't know; 99 for No answer	
7	Was [NAME] enrolled in school during the previous school year?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 9**
8	8.1 What education level did [NAME] attend during the previous school year?	Pre-primary/nursery/ECD 0 Primary 1 Post-primary training 2 Secondary 3 Post-secondary training 4 College 5 Vocational training 6 University 7 Don't know 8 No answer 9	
	8.2 What school grade did [NAME] attend during the previous school year?	[___|___] Record 88 for Don't know; 99 for No answer	
9	At any point in the last 2 weeks, has [NAME] been too sick to participate in daily activities?	Yes 1 No 2 Don't know 8 No answer 9	
10	FOR FEMALE CHILDREN, AGE 12+ 10.1 Has [NAME] ever been pregnant?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 11**
	10.2 How old was [NAME] when she first became pregnant?	[_____] months Record 88 for Don't know; 99 for No answer	
11	Has [NAME] ever received services or participated in activities from [insert name of CBO]? READ: For Example, referral to health services for the child, referral of the child for immunizations, referral of the child to HIV testing and counseling, referral for ART, counseling, payment of school fees, support for school supplies and materials, help to get child's birth certificate, water-treatment products, medicines, referral to social protection services, etc.	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: 14**

No.	Question	Coding Category	SKIP
12	How many months ago did [NAME] start receiving services or participating in activities from [insert name of CBO]?	[_____] months Record 88 for Don't know; 99 for No answer	
13	Has [NAME] received services or participated in activities from [*insert name of CBO*] in the last 6 months?	Yes 1 No 2 Don't know 8 No answer 9	
14	Has [NAME] ever been tested to see if he/she has the AIDS virus?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, or No answer: end**
15	Do you know the results of [NAME's] test?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, No answer: end**
16	Did [NAME] test positive for the AIDS virus?	Yes 1 No 2 Don't know 8 No answer 9	**If No, DK, No answer: end**
17	Does [NAME] know that s/he tested positive for the AIDS virus?	Yes 1 No 2 Don't know 8 No answer 9	
18	Is [NAME] currently taking antiretroviral (ARV) drugs?	Yes 1 No 2 Don't know 8 No answer 9	
19	When the last time [NAME] was took his/her ARV drugs?	Number of days ago: [___|___] 0=today 88=Don't know 99=No answer	

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