PROGRAM REPORT

NOVEMBER 2021

Mother to Mother Project in Kilifi - Kenya

Shionogi

Submitted as part of Access Accelerated

Access Observatory

Contents

Program Description

Program Overview

1 Program Name

Mother to Mother Project in Kilifi, Kenya

2 Diseases program aims to address

- Other NCDs (maternal and children disease)

3 Beneficiary population

- Children (under 5yrs)
- Women of reproductive ages 15-64
- Genders: All genders
- Special populations: Rural populations

4 Countries

- Kenya

5 Program start date

March 4, 2020

6 Anticipated program completion date

March 3, 2023

7 Contact person

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8 Program summary

The concept of Mother to Mother SHIONOGI Project derives from the vision to support vitality of mothers and children globally. Mother to Mother SHIONOGI project aims to foster self-sustainability and contribute to the reduction of maternal and child mortality by increasing access to healthcare, improving quality of healthcare, providing education and advocacy activities.

This program strengthens cooperation between the government communication efforts to the community, in accordance with the efforts of the "Baby Friendly Community Initiative" by exposing the community to educational content regarding breastfeeding, inoculation of micronutrients and balanced diets.

This program also help community health volunteers(CHVs) form saving and loan groups so that they can use lamp some of money to start a new business or cover unplanned expenditures. This is expected to improve the sustainability of rigorous participation by CHVs.

The program plans to conduct a variety of trainings. These include knowledge and technology training for medical professionals, basic maternal and child health and nutrition knowledge training for CHVs, trainings for Community health committee to guide and support CHVs, agricultural support for adaptation to climate change and introduction of drought-resistant crops strategies. In addition, to improve healthcare and nutrition education, this program also sets out to support community health works to establish peer support groups to enhance peer education. For example, we establish school health clubs where children can learn hand washing and hygiene behaviors. A further training activity of this program includes the data management training for the staff of the Ministry of Health and health facilities to improve the quality of data.

Program Overview

8 Program summary cont.

Further, this program implements growth monitoring and promotion sessions, where nutritional status of the children is evaluated, and support, treatment and follow-up provided for malnourished children. Given the high prevalence of malaria in the region of interest, CHVs are also instructed to diagnose malaria and provide treatment if necessary. The program further provides mobile clinics in areas located far from the health facility.

The program collects a baseline in the first year, an interim evaluation in the second year and a final evaluation in the third year to evaluate the improvement of indicators for maternal and child health. In addition, staff from the Health Bureau and higher hospitals visit lower hospitals on a regular basis as "Supportive Supervision" to help solve problems.

Program Strategies & Activities

9 Strategies and activities

Strategy 1: Community Awareness and Linkage to Care

ACTIVITY	DESCRIPTION
Communication	We strengthen cooperation between the government communication efforts to the community, in accordance with the "Baby Friendly Community Initiative" set by the Ministry of Health of Kenya. We conduct awareness-raising activities regarding breastfeeding, provision of micronutrients and balanced diets according to government-led maternal and child health awareness campaign "Malezi Bora". We also conduct awareness-raising activities on nutrition to all ages including mothers and children according to the "Kilifi County Nutrition Action Plan 2019-2023" adapted by government of Kilifi County. This area has a high prevalence of malaria. CHVs instruct residents to prevent malaria and to take a simple diagnosis and medication if they are suspected of being infected.
Funding	We carry out the saving and loan group activities for 60 CHVs. It is a scheme that allows them to save and receive a lamp some of money at the end of cycle. Since CHVs are voluntary activities, they are encouraged to start a new business or pay for their children's tuition by using the savings from this activity.

Strategy 2: Health Service Strengthening

ACTIVITY	DESCRIPTION
Planning	We carry out a baseline survey in the first year, an interim evaluation in the second year, and a final evaluation in the third year to evaluate the improvement of indicators regarding maternal and child health. Achievement of outcomes and goals are evaluated by KPI.
Training	We support community health workers (CHWs) to establish or strengthen peer support groups to enhance peer education of healthcare and nutrition. We train and strengthen the established Advocacy group on advocacy relating to health issues in the community. We establish a school health club with the aim of spreading it throughout the community by allowing children to learn hand washing and hygiene behaviors and practice at home. We carry out knowledge and technology training for medical professionals. CHVs and Community Health Extension Workers (CHEWs), who are responsible for community health, will be trained in basic knowledge of maternal and child health and nutrition. Training to the Community Health Committee to guide and support CHVs. We also work on nutrition improvement through agricultural support such as adaptation to climate change and the introduction of drought-resistant crops. We carry out the data management training to data managers of the Ministry of Health and staff who handle data at health facilities to improve the quality of data.

Program Strategies & Activities

Strategy 2: Health Service Strengthening, Cont.

ACTIVITY	DESCRIPTION
Infrastructure	We plan to extend three healthcare facilities. We build and expand obstetric wards, outpatient and clinical laboratories, construct lodgings for health professionals, and provide equipments required for antenatal and postnatal examinations and obstetric and neonatal care. We install rainwater storage tanks and use pumps to make water available in the clinic or deliver water from the water supply to the clinic. We extend pipelines from healthcare facilities to neighboring villages. We construct a sanitation facility in the community.
Management	Staff from the Health Bureau and higher hospitals visit lower hospitals on a regular basis to help solve problems as "Supportive Supervision".

Strategy 3: Health Service Delivery

ACTIVITY	DESCRIPTION
Screening	We check the nutritional status of the children through Growth Monitoring and Promotion sessions, support the malnourished children to receive treatment at the health facility and follow up with the prefecture until they return to the proper weight.
Treatment	We provide monthly mobile clinics in areas far from the health facility.

10 Strategy by country

STRATEGY	COUNTRY
Community Awareness and Linkage to Care	Kenya
Health Service Strengthening	Kenya
Health Service Delivery	Kenya

Companies, Partners & Stakeholders

11 Company roles

COMPANY	ROLE
Shionogi	Shionogi established "Mother to Mother SHIONOGI Project in Kilifi" to reduce the high maternal mortality rate in Kenya. The project is donated from Shionogi and its employees. Shionogi aims to provide sustainability and together with implementing partner 'World Vision', we identify the needs of the people to constantly ensure the improvement and progress of the project, at the same time to seek for possible collaboration to further expand this project. Healthcare facility in the targeted areas were reconstructed to provide better healthcare services.

12 Funding and implementing partners

PARTNER	ROLE/URL	SECTOR
World Vision Japan and World Vision Kenya	Through the World Vision's network, we are able to contact and directly confirm the needs of the target area and implement our programs. WVJ oversees the project. WVK manages and coordinates health programs and regional development programs in its locations of operation. WVJ and WVK provide the report to Shionogi to track the improvement and progress of the project in the target area. http://www.wvi.org/	Voluntary

13 Funding and implementing partners by country

PARTNER	COUNTRY
World Vision Japan and World Vision Kenya	Kenya

14 Stakeholders

STAKEHOLDER	DESCRIPTION OF ENGAGEMENT	REQUESTED OR RECEIVED
World Vision Japan and World Vision Kenya	Ministry of Health, County Government Company engaged with the local government to obtain necessary approval for the reconstruction of healthcare facility. In addition, government also supports in supplying medicines such as supplement and vaccination for children used in mobile clinic.	Infrastructure: No Human Resources: Yes Funding: No Monitoring or Oversight: Yes Other resource: Yes
Non-governmental Organization	World Vision Kenya Support the program in assessing target population needs, designing and implementing interventions, as well as providing periodic reports to Shinogi.	Infrastructure: Yes Human Resources: Yes Funding: Yes Monitoring or Oversight: Yes Other resource: Yes

Companies, Partners & Stakeholders

14 Stakeholders

STAKEHOLDER	DESCRIPTION OF ENGAGEMENT	REQUESTED OR RECEIVED
Government	Ministry of Health, County Government. We engaged with the local government to obtain necessary approval for the reconstruction of healthcare facility. In addition, government also supports in supplying medicines such as supplement and vaccination for children used in mobile clinic.	Infrastructure: No Human Resources: Yes Funding: No Monitoring or Oversight: Yes Other resource: Yes
Non-governmental Organization	World Vision Kenya – support the program in assessing target population needs, designing and implementing interventions, as well as providing periodic reports to Shionogi.	Infrastructure: Yes Human Resources: Yes Funding: Yes Monitoring or Oversight: Yes Other resource: Yes
Faith-based Organization	We asked for the leader of a local religion to cooperate in education community.	Infrastructure: No Human Resources: No Funding: No Monitoring or Oversight: No Other resource: Yes
Local Hospitals/Health Facilities	Health care professionals are sent from public health facilities to our dispensary.	Infrastructure: No Human Resources: Yes Funding: No Monitoring or Oversight: No Other resource: No
Other	We collaborate with CHV group for the education of the community. CHV is a member of the local community he/she is selected to serve in. As defined by the Government policy (Kenya Community Health Policy 2020 - 2030), the group of CHV is called Community Health Unit, and it plays a key role in primary health care at community level and is acknowledged as the gateway to achieving UHC. The main duties of the CHV are 1) to deliver key health messages to households, 2) to guide community on health improvement and disease prevention, 3) to refer cases to respective link facilities, and 4) to promote care seeking behaviors, among others.	N/A

Local Context, Equity & Sustainability

15 Local health needs addressed by program

Most health indicators in the region covered by the Mother to Mother Project in Kilifi – Kenya are below the national average in Kenya. Access to essential health services for women and children is also low, with only 44.1 and 23.3% of women attending at least four antenatal care (ANC) visits and 77.5 and 15.4 % delivering at a health facility with a skilled birth attendant. The proportion of children in the 12-23 months after birth fully immunized is 75.0 and 50.3%, and prevalence of malaria, 22.9 and 35.7% in Bamba and Jaribuni, respectively. There is also 27.6% of high prevalence of diarrhea and 18.7% of limited access to improved water in Bamba.

In the Kenya Community Health Strategy 2020 - 2025, the Government of Kenya adopts the Community Health Approach, which provides the first level of health services through volunteers. However, there is a gap in numbers, knowledge and capacity of the volunteers.

To tackle these challenges, Mother to Mother Project, along with World Vision, puts our priority in enhancing education to mothers and community health workers, as well as improving accessibility to healthcare services. Through trainings, mothers developed their own 'mother to mother' group to enhance peer education on MNCH, and the health committees are now able to manage the health facility to improve its effectiveness in service delivery. Furthermore, to achieve our goal in proving self-sustainability in the area, we address other critical problems such as lack of water by supplying water tanks near the hospital, sanitation issues and support income generating activities.

a How needs were assessed

The survey which employed participatory methods of data collection such as HH (Household) survey, FGDs (Focus group discussion) and KII (Key informant interviews) were done, and meetings with community and local government were held to discuss issues as well. The project conducted the baseline survey from October to November 2020 to assess the needs in the community. The project team studied secondary data for the baseline survey through review of relevant documents such as population census and demographic survey. The team also conducted field data collection through household questionnaire (759 households), anthropometric survey (974 children aged 6 to 59 months), focus group discussions (8 groups), and key informant interviews (12 interviews of government officials and community leaders).

b Formal needs assessment conducted

Yes.

16 Social inequity addressed

[No response provided]

Local Context, Equity & Sustainability

17 Local policies, practices, and laws considered during program design

POLICY, PRACTICE, LAW	APPLICABLE TO PROGRAM	DESCRIPTION OF HOW IT WAS TAKEN INTO CONSIDERATION
National regulations	Yes	Kenya has health care guideline named "Community strategy implementation guideline" (Ministry of Health, Kenya 2007.3). However, the indicators of maternal and children's health are worse than those of Kenya.
Procurement procedures	Yes	Public regulations/guidelines and World Vision Kenya internal rules/guidelines.
Standard treatment guidelines	Yes	Same as above
Quality and safety requirements	Yes	Same as above
Remuneration scales and hiring practices	Yes	Same as above

18 How diversion of resources from other public health priorities is avoided.

We have only one program that focuses on improving health of maternal and child health in the target area. The program employs health volunteers to avoid diverting local human resources from other priorities.

19 Program provides health technologies (medical devices, medicines, and vaccines).

TYPE	COMMERCIAL NAME	INTERNATIONAL NON-PROPRIETARY NAME (INN)
Device	Equipment and supplies necessary for prenatal and postnatal examinations, obstetric care and newborn care services are provided at each clinic.	[No response provided]

20 Health technology(ies) are part of local standard treatment guidelines

Yes (Details are not currently available).

21 Health technology(ies) are covered by local health insurance schemes

No.

22 Program provides medicines listed on the National Essential Medicines List

No.

Local Context, Equity & Sustainability

23 Sustainability plan

In this project, we promote information-sharing in cooperation with the County Government, the Ministry of Health, the Ministry of Agriculture, Livestock, Fisheries and Education, Department of Children Services, UNICEF, the Kenya Red Cross Society, Anglican Development Services, and APHIA Pwani in order to strengthen health system management in the project areas.

Advocacy groups consisting of community residents who regularly have opportunities for dialogue with the government will be formed to discuss issues in the medical field and community issues. The groups also compile community opinions as recommendations and work with the government to improve services.

At the end of project, we will transfer health facilities to the Ministry of Health to support the continued provision of health services.

Additional Program Information

24 Additional program information

[No response provided]

a Potential conflict of interest discussed with government entity

No.

25 Access Accelerated Initiative participant

Yes

26 International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) membership

Yes

Resources

(1) Kenya Demographic and Health Survey 2014. Available at: https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf

(2) County Government of Kilifi. Kilifi County Integrated Development Plan 2018-2022 (2018). Available at: http://repository.kippra.or.ke:8080/xmlui/handle/123456789/181

Program Indicators

PROGRAM NAME

Mother to Mother Project

27 List of indicator data to be reported into Access Observatory database

INDICATOR	TYPE	STRATEGY	2020
1 Proportion of women who developed complications during delivery	Outcome	Health Service Strengthening	16.1%
2 Prevalence of stunting among children under 5 years of age	Outcome	Health Service Strengthening	28.9%
3 Prevalence of wasting among children under 5 years of age	Outcome	Health Service Strengthening	12.9%
4 Prevalence of diarrhea among children under 5 years of age	Outcome	Health Service Strengthening	19.6%
5 Number of patients visiting healthcare facilities	Outcome	Health Service Strengthening	15,394 people

INDICATOR

Proportion of women who developed complications during delivery

1

STRATEGY HEALTH SERVICE STRENGTHENING

	ITEM	DESCRIPTION
	Definition	[No response provided]
	Method of measurement	The proportion is calculated by the number of mothers who developed complications during delivery divided by the number of all respondents (759 people).
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The implementation partners, World Vision Kenya and World Vision Japan, outsource the survey of the indicators to an external consultant and report to Shionogi once a year. The primary data is collected through household questionnaire, anthropometric survey tool. The secondary data is obtained through review of relevant documents including government policy documents. To meet the key requirements of collecting anthropometric, mortality and caregiver household data of good quality, reliable and comparable integrity, the survey adopted commensurate probability sampling methods that captured such data for all the indicators concurrently. In determining a representative sample size for quantitative household data collection, the consultant adopted the Cochran Equation. The equation is also cited as the sample size formula for anthropometry in systematic random survey (SRS). The equation yields a representative sample for populations that are larger than 10,000. Using the equation, the sample size worked out to 800. The desired sample size was split evenly between Bamba and Jaribuni wards with each assigned equal half of 400. The focus area was Bamba and Jaribuni wards and the survey targeted 25 villages in Bamba and 25 villages in Jaribuni Ward. Households in these villages formed the primary sampling unit where 16 households formed a cluster in each of the villages and were drawn using a simple random sampling method.	Once per year

INDICATOR

Proportion of women who developed complications during delivery

1

STRATEGY HEALTH SERVICE STRENGTHENING

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
31 Data processing	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The implementation partners, World Vision Kenya and World Vision Japan, outsource the survey of the indicators to an external consultant and report to Shionogi once a year. The data is collected once a year by a consultant and the field evaluation team led by World Vision Kenya. The staff from World Vision Kenya join the field data collection and make sure that the data from households are appropriately collected. After the data is collected, it is verified by reviewing the evaluation report from the consultant. During the household survey, the data is collected by using a smartphone through computer-based questionnaire to minimize data entry errors. For the anthropometric data processing, it is done by using ENA (Emergency Nutrition Assessment) software. World Health Organization Growth Standards (WHO-GS) data cleaning and flagging procedures is used to identify outliers which would enable data cleaning as well as exclusion of discordant measurements from anthropometric analysis. The ENA software generates weight-for-height, height-for-age and weight-for age z scores to classify them into various nutritional status categories using WHO 2006 standards and cut-off points and exports to SPSS for further analysis.	Once per year
32 Data validation	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The implementation partners, World Vision Kenya visits the local team to verify the data collection and management procedures.	

33 Challenges in data collection and steps to address challenges

COVID-19 affects both the impact of health/hygiene behavior and field data collection obviously. The pandemic interferes with normal working arrangements for both the World Vision Kenya staff, the local Government staff and the consultant, which affect fieldwork activities. It also resulted in closure of school. Regarding the baseline survey, World Vision Kenya had conducted some interventions before the survey, and that could affect the result of the baseline figures as some of the respondents had been benefitted from the interventions by the time they were interviewed.

INDICATOR	2020
1 Proportion of women who developed complications during delivery	16.1%

Comments: The number of all respondents is 759.

INDICATOR

Prevalence of stunting among children under 5 years of age

2

STRATEGY HEALTH SERVICE STRENGTHENING

	ITEM	DESCRIPTION
	Definition	Prevalence of stunting among children under 5 years of age
	Method of measurement	The stunting of under-five children (974 children under 5 years of age staying in the selected household) is monitored by the height for age. Prevalence of stunting is the percentage of children under age 5 whose height for age is more than two standard deviations below the median.
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The implementation partners, World Vision Kenya and World Vision Japan, outsource the survey of the indicators to an external consultant and report to Shionogi once a year. The primary data is collected through household questionnaire, anthropometric survey tool. The secondary data is obtained through review of relevant documents including government policy documents. To meet the key requirements of collecting anthropometric, mortality and caregiver household data of good quality, reliable and comparable integrity, the survey adopted commensurate probability sampling methods that captured such data for all the indicators concurrently. In determining a representative sample size for quantitative household data collection, the consultant adopted the Cochran Equation. The equation is also cited as the sample size formula for anthropometry in systematic random survey (SRS). The equation yields a representative sample for populations that are larger than 10,000. Using the equation, the sample size worked out to 800. The desired sample size was split evenly between Bamba and Jaribuni wards with each assigned equal half of 400. The focus area was Bamba and Jaribuni wards and the survey targeted 25 villages in Bamba and 25 villages in Jaribuni Ward. Households in these villages formed the primary sampling unit where 16 households formed a cluster in each of the villages and were drawn using a simple random sampling method.	Once per year

INDICATOR

Prevalence of stunting among children under 5 years of age

2

STRATEGY HEALTH SERVICE STRENGTHENING

31 Data processing	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The implementation partners, World Vision Kenya and World Vision Japan, outsource the survey of the indicators to an external consultant and report to Shionogi once a year. The data is collected once a year by a consultant and the field evaluation team led by World Vision Kenya. The staff from World Vision Kenya join the field data collection and make sure that the data from households are appropriately collected. After the data is collected, it is verified by reviewing the evaluation report from the consultant. During the household survey, the data is collected by using a smartphone through computer-based questionnaire to minimize data entry errors. For the anthropometric data processing, it is done by using ENA (Emergency Nutrition Assessment) software. World Health Organization Growth Standards (WHO-GS) data cleaning and flagging procedures is used to identify outliers which would enable data cleaning as well as exclusion of discordant measurements from anthropometric analysis. The ENA software generates weight-for-height, height-for-age and weight-for age z scores to classify them into various nutritional status categories using WHO 2006 standards and cut-off points and exports to SPSS for further analysis.	Once per year
32 Data validation	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The implementation partners, World Vision Kenya visits the local team to verify the data collection and management procedures.	

33 Challenges in data collection and steps to address challenges

COVID-19 affects both the impact of health/hygiene behavior and field data collection obviously. The pandemic interferes with normal working arrangements for both the World Vision Kenya staff, the local Government staff and the consultant, which affect fieldwork activities. It also resulted in closure of school. Regarding the baseline survey, World Vision Kenya had conducted some interventions before the survey, and that could affect the result of the baseline figures as some of the respondents had been benefitted from the interventions by the time they were interviewed.

INDICATOR	2020
2 Prevalence of stunting among children under 5 years of age	28.9%

Comments: The number of all children to be measured is 974.

INDICATOR

Prevalence of wasting among children under 5 years of age

3

STRATEGY HEALTH SERVICE STRENGTHENING

	ITEM	DESCRIPTION
	Definition	[No response provided]
	Method of measurement	The wasting of under-five children (974 children under 5 years of age staying in the selected household) is monitored by the weight for height. Prevalence of wasting is the percentage of children under age 5 whose weight for height is more than two standard deviations below median.
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The implementation partners, World Vision Kenya and World Vision Japan, outsource the survey of the indicators to an external consultant and report to Shionogi once a year. The primary data is collected through household questionnaire, anthropometric survey tool. The secondary data is obtained through review of relevant documents including government policy documents. To meet the key requirements of collecting anthropometric, mortality and caregiver household data of good quality, reliable and comparable integrity, the survey adopted commensurate probability sampling methods that captured such data for all the indicators concurrently. In determining a representative sample size for quantitative household data collection, the consultant adopted the Cochran Equation. The equation is also cited as the sample size formula for anthropometry in systematic random survey (SRS). The equation yields a representative sample for populations that are larger than 10,000. Using the equation, the sample size worked out to 800. The desired sample size was split evenly between Bamba and Jaribuni wards with each assigned equal half of 400. The focus area was Bamba and Jaribuni wards and the survey targeted 25 villages in Bamba and 25 villages in Jaribuni Ward. Households in these villages formed the primary sampling unit where 16 households formed a cluster in each of the villages and were drawn using a simple random sampling method.	Once per year

INDICATOR

Prevalence of wasting among children under 5 years of age

3

STRATEGY HEALTH SERVICE STRENGTHENING

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
31 Data processing	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The implementation partners, World Vision Kenya and World Vision Japan, outsource the survey of the indicators to an external consultant and report to Shionogi once a year. The data is collected once a year by a consultant and the field evaluation team led by World Vision Kenya. The staff from World Vision Kenya join the field data collection and make sure that the data from households are appropriately collected. After the data is collected, it is verified by reviewing the evaluation report from the consultant. During the household survey, the data is collected by using a smartphone through computer-based questionnaire to minimize data entry errors. For the anthropometric data processing, it is done by using ENA (Emergency Nutrition Assessment) software. World Health Organization Growth Standards (WHO-GS) data cleaning and flagging procedures is used to identify outliers which would enable data cleaning as well as exclusion of discordant measurements from anthropometric analysis. The ENA software generates weight-for-height, height-for-age and weight-for age z scores to classify them into various nutritional status categories using WHO 2006 standards and cut-off points and exports to SPSS for further analysis.	Once per year
32 Data validation	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The implementation partners, World Vision Kenya visits the local team to verify the data collection and management procedures.	

33 Challenges in data collection and steps to address challenges

COVID-19 affects both the impact of health/hygiene behavior and field data collection obviously. The pandemic interferes with normal working arrangements for both the World Vision Kenya staff, the local Government staff and the consultant, which affect fieldwork activities. It also resulted in closure of school. Regarding the baseline survey, World Vision Kenya had conducted some interventions before the survey, and that could affect the result of the baseline figures as some of the respondents had been benefitted from the interventions by the time they were interviewed.

INDICATOR	2020
3 Prevalence of wasting among children under 5 years of age	12.9 %

Comments: The number of all children to be measured is 974.

INDICATOR

Prevalence of diarrhea among children under 5 years of age

4

STRATEGY HEALTH SERVICE STRENGTHENING

	ITEM	DESCRIPTION
	Definition	[No response provided]
	Method of measurement	Prevalence of diarrhea is monitored by a questionnaire to mothers "whether they had any under-five who suffered diarrhoea two weeks preceding the survey". (974 children under 5 years of age staying in the selected household)
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The implementation partners, World Vision Kenya and World Vision Japan, outsource the survey of the indicators to an external consultant and report to Shionogi once a year. The primary data is collected through household questionnaire, anthropometric survey tool. The secondary data is obtained through review of relevant documents including government policy documents. To meet the key requirements of collecting anthropometric, mortality and caregiver household data of good quality, reliable and comparable integrity, the survey adopted commensurate probability sampling methods that captured such data for all the indicators concurrently. In determining a representative sample size for quantitative household data collection, the consultant adopted the Cochran Equation. The equation is also cited as the sample size formula for anthropometry in systematic random survey (SRS). The equation yields a representative sample for populations that are larger than 10,000. Using the equation, the sample size worked out to 800. The desired sample size was split evenly between Bamba and Jaribuni wards with each assigned equal half of 400. The focus area was Bamba and Jaribuni wards and the survey targeted 25 villages in Bamba and 25 villages in Jaribuni Ward. Households in these villages formed the primary sampling unit where 16 households formed a cluster in each of the villages and were drawn using a simple random sampling method.	Once per year

INDICATOR

Prevalence of diarrhea among children under 5 years of age

4

STRATEGY HEALTH SERVICE STRENGTHENING

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
31 Data processing	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The implementation partners, World Vision Kenya and World Vision Japan, outsource the survey of the indicators to an external consultant and report to Shionogi once a year. The data is collected once a year by a consultant and the field evaluation team led by World Vision Kenya. The staff from World Vision Kenya join the field data collection and make sure that the data from households are appropriately collected. After the data is collected, it is verified by reviewing the evaluation report from the consultant. During the household survey, the data is collected by using a smartphone through computer-based questionnaire to minimize data entry errors. For the anthropometric data processing, it is done by using ENA (Emergency Nutrition Assessment) software. World Health Organization Growth Standards (WHO-GS) data cleaning and flagging procedures is used to identify outliers which would enable data cleaning as well as exclusion of discordant measurements from anthropometric analysis. The ENA software generates weight-for-height, height-for-age and weight-for age z scores to classify them into various nutritional status categories using WHO 2006 standards and cut-off points and exports to SPSS for further analysis.	Once per year
32 Data validation	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The implementation partners, World Vision Kenya visits the local team to verify the data collection and management procedures.	

33 Challenges in data collection and steps to address challenges

COVID-19 affects both the impact of health/hygiene behavior and field data collection obviously. The pandemic interferes with normal working arrangements for both the World Vision Kenya staff, the local Government staff and the consultant, which affect fieldwork activities. It also resulted in closure of school. Regarding the baseline survey, World Vision Kenya had conducted some interventions before the survey, and that could affect the result of the baseline figures as some of the respondents had been benefitted from the interventions by the time they were interviewed.

INDICATOR	2020
4 Prevalence of diarrhea among children under 5 years of age	19.6%

Comments: The number of all children to be measured is 974.

INDICATOR **Number of patients visiting healthcare facilities** 5

STRATEGY HEALTH SERVICE STRENGTHENING

	ITEM	DESCRIPTION
	Definition	[No response provided]
	Method of measurement	Number of patients are recorded in the clinic registry by doctors, health care providers and healthcare volunteers.
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	World Vision Japan (WVJ) and World Vision Kenya (WVK)	There is a registration and medical record form by Ministry of Health in Kenya which are required to be filled in. The health facility keeps a record of all the patients that received health services by using the form. Implementing partner, World Vision Kenya and World Vision Japan, visit the facility and collect the data of the number of patients from the health staff every month.	Every month
31	Data processing	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The number of patients is collected by the field staff of the implementing partner every month and recorded in a excel sheet.	Every month
32	Data validation	World Vision Japan (WVJ) and World Vision Kenya (WVK)	The implementation partners, World Vision Kenya visits the local team to verify the data collection and management procedures.	

33 Challenges in data collection and steps to address challenges

COVID-19 affects both the impact of health/hygiene behavior and field data collection obviously. The pandemic interferes with normal working arrangements for both the World Vision Kenya staff, the local Government staff and the consultant, which affect fieldwork activities. It also resulted in closure of school. Regarding the baseline survey, World Vision Kenya had conducted some interventions before the survey, and that could affect the result of the baseline figures as some of the respondents had been benefitted from the interventions by the time they were interviewed.

INDICATOR	2020
5 Number of patients visiting healthcare facilities	15,394 people

Comments:

Program Documents

Program Documents

1. Mother to Mother Project - Year 1 Completion Report. 30 June 2021.

Appendix

This program report is based on the information gathered from the Access Observatory questionnaire below.

Program Description

PROGRAM OVERVIEW

1 Program Name

2 Diseases program aims to address:

Please identify the disease(s) that your program aims to address (select all that apply).

3 Beneficiary population

Please identify the beneficiary population of this program (select all that apply).

4 Countries

Please select all countries that this program is being implemented in (select all that apply).

5 Program Start Date

6 Anticipated Program Completion Date

7 Contact person

On the public profile for this program, if you would like to display a contact person for this program, please list the name and email address here (i.e. someone from the public could email with questions about this program profile and data).

8 Program summary

Please provide a brief summary of your program including program objectives (e.g., the intended purposes and expected results of the program; if a pilot program, please note this). Please provide a URL, if available. Please limit replies to 750 words.

PROGRAM STRATEGIES & ACTIVITIES

9 Strategies and activities

Based on the BUSPH Taxonomy of Strategies, which strategy or strategies apply to your program (please select all that apply)?

10 Strategy by country

If you have registered one program for multiple countries, this question allows you to provide a bit more specificity about each country (e.g. some countries have different strategies, diseases, partners, etc.). Please complete these tables as applicable.
For each portion you have you selected from above (program strategies), please identify which country/countries these apply.

COMPANIES, PARTNERS AND STAKEHOLDERS

11 Company roles

Please identify all pharmaceutical companies, including yours, who are collaborating on this program:

What role does each company play in the implementation of your program?

12 Funding and implementing partners

Please identify all funding and implementing partners who are supporting the implementation of this program (Implementing partners is defined as either an associate government or non-government entity or agency that supplements the works of a larger organization or agency by helping to carry out institutional arrangements in line with the larger organization's goals and objectives.)

a. What role does each partner play in the implementation of your program? Please give background on the organization and describe the nature of the relationship between the organization and your company. Describe the local team's responsibilities
for the program, with reference to the program strategies and activities. (response required for each partner selected).

b. For each partner, please categorize them as either a Public Sector, Private Sector, or Voluntary Sector partner.

(Public Sector is defined as government; Private Sector is defined as A business unit established, owned, and operated by private individuals for profit, instead of by or for any government or its agencies. Generation and return of profit to its owners or shareholders is emphasized; Voluntary Sector is defined as Organizations whose purpose is to benefit and enrich society, often without profit as a motive and with little or no government intervention. Unlike the private sector where the generation and return of profit to its owners is emphasized, money raised or earned by an organization in the voluntary sector is usually invested back into the community or the organization itself (ex. Charities, foundations, advocacy groups etc.))

c. Please provide the URL to the partner organizations' webpages

13 Funding and implementing partners by country

If you have registered one program for multiple countries, this question allows you to provide a bit more specificity about each country (e.g., some countries have different strategies, diseases, partners, etc.). Please complete these tables as applicable. For each portion you have you selected from above (funding and implementing partners), please identify which country/countries these apply.

14 Stakeholders

Please describe how you have engaged with any of these local stakeholders in the planning and/or implementation of this program. (Stakeholders defined as individuals or entities who are involved in or affected by the execution or outcome of a project and may have influence and authority to dictate whether a project is a success or not (ex. Ministry of Health, NGO, Faith-based organization, etc.). Select all that apply.

- Government, please explain
- Non-Government Organization (NGO), please explain
- Faith-based organization, please explain
- Commercial sector, please explain
- Local hospitals/health facilities, please explain
- Local universities, please explain
- Other, please explain

LOCAL CONTEXT, EQUITY & SUSTAINABILITY

15 Local health needs addressed by program

Please describe how your program is responsive to local health needs and challenges (e.g., how you decided and worked together with local partners to determine that this program was appropriate for this context)?

a How were needs assessed

b Was a formal need assessment conducted

(Yes/No) If yes, please upload file or provide URL.

16 Social inequity addressed

Does your program aim to address social inequity in any way (if yes, please explain). (Inequity is defined as lack of fairness or justice. Sometime 'social disparities,' 'structural barriers' and 'oppression and discrimination' are used to describe the same phenomenon. In social sciences and public health social inequities refer to the systematic lack of fairness or justice related to gender, ethnicity, geographical location and religion. These unequal social relations and structures of power operate to produce experiences of inequitable health outcomes, treatment and access to care. Health and social programs are often designed with the aim to address the lack of fairness and adjust for these systematic failures of systems or policies.*)

*Reference: The definition was adapted from Ingram R et al. Social Inequities and Mental Health: A Scoping Review. Vancouver: Study for Gender Inequities and Mental Health, 2013.

17 Local policies, practices, and laws considered during program design

How have local policies, practices, and laws (e.g., infrastructure development regulations, education requirements, etc.) been taken into consideration when designing the program?

18 How diversion of resources from other public health priorities is avoided

Please explain how the program avoids diverting resources away from other public health priorities? (e.g. local human resources involved in program implementation diverted from other programs or activities).

19 Program provides health technologies

Does your program include health technologies (health technologies include medical devices, medicines, and vaccines developed to solve a health problem and improve quality of lives)? (Yes/No)

20 Health technology(ies) are part of local standard treatment guidelines

Are the health technology(ies) which are part of your program

part of local standard treatment guidelines? (Yes/No) If not, what was the local need for these technologies?

21 Health technologies are covered by local health insurance schemes

Does your program include health technologies that are covered by local health insurance schemes? (Yes/No) If not, what are the local needs for these technologies?

22 Program provides medicines listed on the National Essential Medicines List

Does your program include medicines that are listed on the National Essential Medicines List? (Yes/No) If not, what was the local need for these technologies?

23 Sustainability plan

If applicable, please describe how you have planned for sustainability of the implementation of your program (ex. Creating a transition plan from your company to the local government during the development of the program).

ADDITIONAL PROGRAM INFORMATION

24 Additional program information

Is there any additional information that you would like to add about your program that has not been collected in other sections of the form?

a Potential conflict of interest discussed with government entity

Have you discussed with governmental entity potential conflicts of interest between the social aims of your program and your business activities? (Yes/No) If yes, please provide more details and the name of the government entity.

25 Access Accelerated Initiative participant

Is this program part of the Access Accelerated Initiative? (Yes/No)

26 International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) membership

Is your company a member of the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA)? (Yes/No)

Program Indicators

INDICATOR DESCRIPTION

27 List of indicator data to be reported into Access Observatory database

For this program, activities, please select all inputs and impacts for which you plan to collect and report data into this database.

28 Data source

For this indicator, please select the data source(s) you will rely on.

29 Frequency of reporting

Indicate the frequency with which data for this indicator can be submitted to the Observatory.

30 Data collection

a. Responsible party: For this indicator, please indicate the party/parties responsible for data collection.

b. Data collection — Description: Please briefly describe the data source and collection procedure in detail.

c. Data collection — Frequency: For this indicator, please indicate the frequency of data collection.

31 Data processing

a. Responsible party: Please indicate all parties that conduct any processing of this data.

b. Data processing— Description: Please briefly describe all processing procedures the data go through. Be explicit in describing the procedures, who enacts them, and the frequency of processing.

c. Data processing — Frequency: What is the frequency with which this data is processed?

32 Data validation

Description: Describe the process (if any) your company uses to validate the quality of the data sent from the local team.

33 Challenges in data collection and steps to address challenges

Please indicate any challenges that you have in collecting data for this indicator and what you are doing to address those challenges.