



COMMUNITY HEALTH VOLUNTEERS' PROGRAM

VILLAGE HOPECORE
INTERNATIONAL
HOPE CHANGES EVERYTHING

EVALUATION REPORT



SEPTEMBER 2022

ACKNOWLEDGEMENT

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ABBREVIATIONS & ACRONYMS

ANC	Ante-Natal Care
BP	Blood Pressure
CHAs	Community Health Assistants
CHEWs	Community Health Extension Workers
CHOs	Community Health Officers
CHPs	Community Health Programs
CHVs	Community Health Volunteers
CHUs	Community Health Units
CIDP	County Integrated Development Plan
CMNC	Child, Maternal & Neonatal Care
CUs	Community Units
GOK	Government of Kenya
HIV/AIDS	Acquired Immunodeficiency Syndrome
HopeCore	Village HopeCore International
KHIS	Kenya Health Information System
M2M	Mother-to-Mother
MCH	Maternal Child Health
MMR	Mixed Methods Research
MOH	Ministry of Health
NCHVs	Neighbourhood Community Health Volunteers
ODF	Open Defecation Free
PHOs	Public Health Officers
SDGs	Sustainable Development Goals
SOPs	Standard Operating Procedures
SPSS	Statistical Package for Social Sciences
TB	Tuberculosis
TNC	Tharaka Nithi County
TOC	Theory of Change
WHO	World Health Organization



EXECUTIVE SUMMARY

Globally, the Community Health approach continues to receive much attention as an efficient way towards achieving better health care delivery; as well as addressing the heavy burden of disease, especially among the poor communities. The vision of Village HopeCore International (HopeCore) is aligned with the attainment of this goal as it focuses on creating empowered and healthy communities in Africa. In March 2022, HopeCore undertook an evaluation of the Community Health Volunteers (CHVs) program to measure its impact. The evaluation targeted 77,688 households, 749 CHVs, and 8 stakeholders in Mwimbi, Muthambi, Chuka, and Igambang'ombe Sub-Counties. The simple random sampling technique was employed to determine the desired sample size of 398 respondents. Primary data was gathered through the administration of questionnaires, field observations, and interviews with the respondents. Secondary data was gathered from community health records, survey reports, the Kenya Health Information System (KHIS), and a review of various CHVs program financial documents. The collected data was analyzed using excel software and the Statistical Package for Social Sciences (SPSS). The overall response rate for the evaluation was 104%, whereby 414 out of the 398 targeted respondents were interviewed. The findings established an impressive household beneficiary satisfaction of 78.5%, which puts HopeCore above par in terms of delivery of community health services. The CHVs' knowledge and level of influence in the community have improved by 15.90% due to engagement with HopeCore.

The key recommendations proposed for program improvement are:

1. Community health coordinator to devise new and better strategies for continuous improvement, especially on stakeholder engagement, tracking various health outcomes, and documentation of baseline data.
2. Community health coordinator to enhance the level of supervision and support offered to, CHVs, especially during household visits.
3. The finance manager to establish an accounting procedure that can adequately organize program financials with a clear matrix for tracking return on investment into the CHVs program, in addition to ensuring timely/consistent payment of CHVs monthly stipend.

INTRODUCTION

1.1 Village HopeCore International

Village HopeCore International (HopeCore) is a non-profit development organization working in Tharaka Nithi County (TNC) - Eastern Kenya. The organization's vision is to create empowered and healthy communities in Africa through the implementation of Health and Micro enterprise programs. Over the past two decades, HopeCore programs have expanded reaching six Sub-Counties of Tharaka County in Kenya as illustrated in Figure 1:

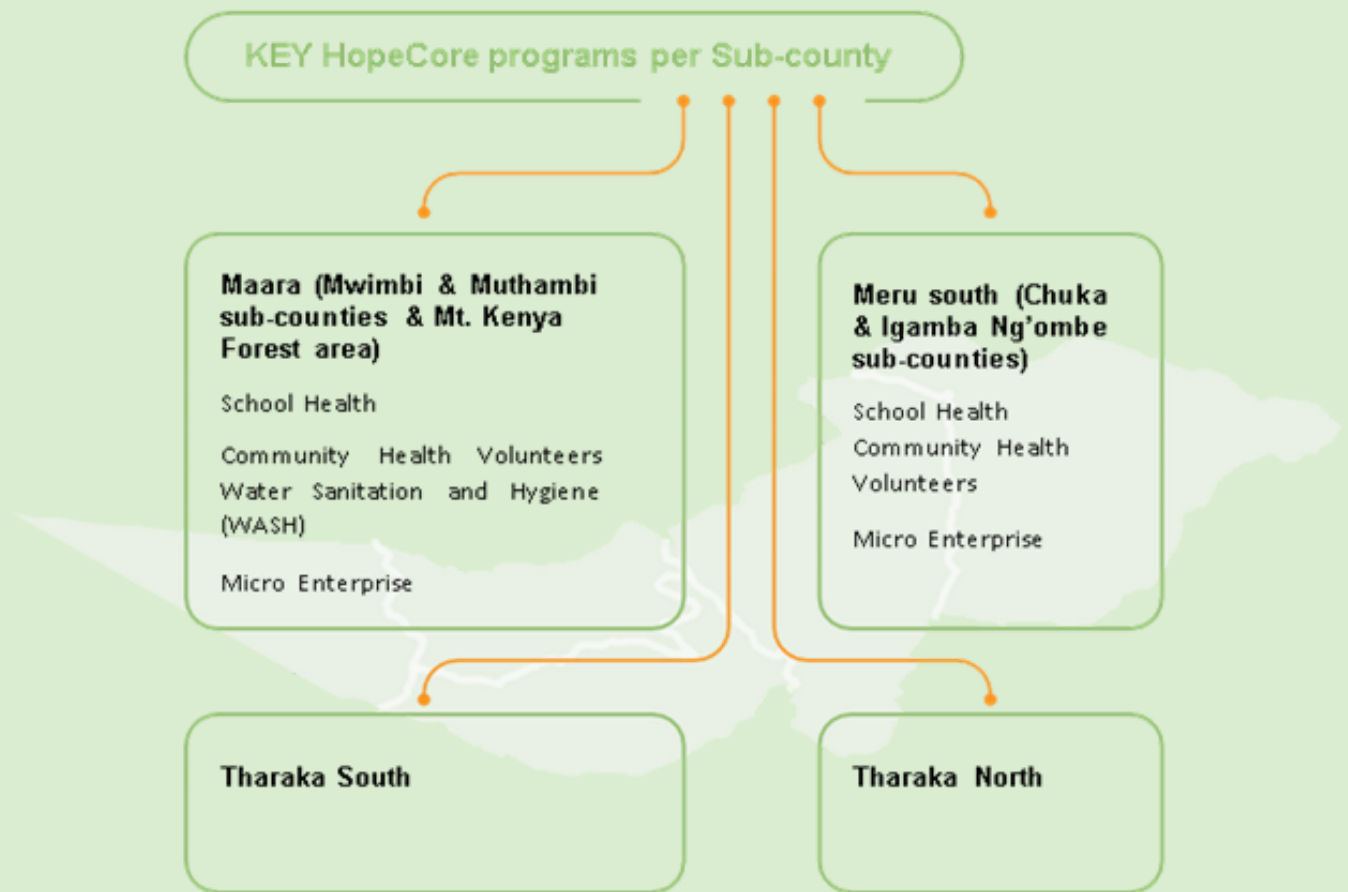


Figure 1: HopeCore area of coverage in Kenya

1.2 Background to the Community Health Programs (CHPs)

Community Health Programs (CHPs) have been recognized globally as an effective way of improving health care delivery, addressing the heavy burden of disease, and contributing to the health and socio-economic development. However, many resource-constrained communities have limited access to reliable healthcare services. Community Health Volunteers (CHVs) bridge the gap in disease burden by linking their communities to the formal healthcare system.

CHVs mainly live and work with the marginalized, resource-constrained, and underprivileged communities with inadequate access to quality healthcare. They offer health education, advocacy, and support to civilians to help them raise their lifestyles and link them with their appropriate healthcare options, as well as collect data and discuss health concerns with specific community members.

The CHVs program in Kenya dates back to the early 1970s when community-based health care projects in different parts of the country emerged. The National Health Sector Strategic Plan II formalized CHVs in their current structure, opening up the spaces for partners, donors, and other interested parties to start rolling out CHPs to different parts of the country.

An evaluation of community health services in Kenya (2018) showed that there were 6,087 Community Health Units (CHUs) out of an expected 10,375 CHUs, leaving a gap of 4,292 or 41% (**Kenya Community-Health-Policy-2020-2030**). The current coverage of community health services in Kenya is below 60%. Similarly, the population of CHVs stands at 86,025 out of an expected 103,783 CHVs, giving a gap of 17,763 (17%). HopeCore CHVs program is designed to narrow this gap by enhancing HopeCore's activities in TNC.

HopeCore's CHVs Program started in 2016 aimed at leveraging on CHVs to avail community health services to rural parts of TNC. At inception, only 30 women volunteers were enrolled in what was then called the 'Mother-to-Mother' (M2M) volunteer program. In 2018, the program transformed into the Neighbourhood Community Health Volunteers' (NCHVs) Program, with about 46 volunteers. Since 2018, the HopeCore CHVs program has grown to 80 CUs and 749 CHVs spread across 4 Sub-Counties of TNC. This phenomenal growth necessitates an evaluation of the CHVs program to measure the impact and the general health outcomes influenced by the program.

1.3 Purpose of the Evaluation

The purpose of the evaluation was to measure the impact of HopeCore's CHVs program from the year 2019 to 2021

1.4 Evaluation Questions

The evaluation sought to answer the following questions:

1. How effective is HopeCore's approach to engaging, training, and supervising community health volunteers?
2. To what extent is the CHVs program affecting health outcomes in the community?
3. To what extent do the outcomes of the program represent value for money?

1.5 Significance of the Evaluation

The findings will offer valuable insights into the achievements realized, the challenges faced, and the impact of the CHVs program on all the community health stakeholders. Additionally, the evaluation report will provide insights and recommendations on areas that need improvement; and inform HopeCore's ongoing approach to implementing the community health volunteer program, allowing for expansion in TNC.

1.6 Parameters to be Measured

The evaluation sought to measure the following key parameters:

Objective 1: How Effective is HopeCore's Approach to Engaging, Training, and Supervising Community Healthy Volunteers?

Q1: How has CHVs' knowledge changed?

Q2: What motivates CHVs to continue serving their communities?

Objective 2: To What Extent is the CHVs Program Affecting Health Outcomes in the Community?

Q3: How have morbidity and mortality rates changed?

Objective 3: To What Extent do the Outcomes of the Program Represent Value for Money?

Q4: How has the organization utilized its CHVs budget?

Q5: To what extent has the organization made use of resources and partnerships available as a cost-saving measure?

Q6. To what extent has the program produced or contributed to the intended outcomes in the short, medium and long-term?

Q7. For whom, in what ways and circumstances has the program produced unintended outcomes (positive and negative)?

Q8. To what extent can the changes be attributed to the program?

Q9. What were the particular features of the program and context that made a difference?

Q10. What was the influence of other factors on the program?

1.7 Evaluation Matrix

An evaluation matrix summarizes the key objectives of an evaluation, methods/techniques to be used in data collection, indicators, and data sources. Table 1.1 shows the evaluation matrix that was adopted:

Table 1.1: Evaluation Matrix

Evaluation Objective/ Question	Methods(s)	Instrument(s)	Measure(s)/ Indicator(s)	Data Source(s)
<i>Objective 1: How effective is HopeCore's approach to engaging, training, and supervising community health volunteers?</i>	-documents review -interviews -questionnaire administration -observation	-questionnaire -interview guides	-% coverage -# of topics trained -CHVs knowledge retention -competence levels -working conditions, socioeconomic status, materials, equipment, etc. -satisfaction levels (on the Likert scale)	-HopeCore reports -flipbooks -TNC health reports -support supervision checklists -pre and post-tests -survey reports
<i>Objective 2: To what extent is the CHV program affecting health outcomes in the community?</i>	-interviews -document review -questionnaire administration -observation	-interview guides questionnaire -interview guides	-attendance rate to ANC clinics -immunization rate -FP uptake rate -% usage of treated mosquito nets	-HopeCore annual reports -TNC reports -stakeholder feedback

Evaluation Objective/ Question	Methods(s)	Instrument(s)	Measure(s)/ Indicator(s)	Data Source(s)
			<ul style="list-style-type: none"> -% of households using treated water -% of households with functional latrines -% of households with functional handwashing stations -% of households with refuse disposal facility -% of villages declared ODF -# of community members referred (success rate-TB, ANC, immunization, and hypertension) -annual growth in the number of clients in the nearest link facilities -% coverage of unintended outcomes -# of circumstances in which unintended outcomes have occurred -special program features that made a significant difference -other factors that have influenced the program -% short-term outcome achievement -% medium-term outcome achievement -% long-term impact achievement 	<ul style="list-style-type: none"> -donor reports -clinic records -TNC health reports -MOH 514 -survey reports -KHIS data
<p><i>Objective 3: To what extent do the outcomes of the program represent value for money?</i></p>	<ul style="list-style-type: none"> -document review -questionnaire -interviews 	<ul style="list-style-type: none"> -document review checklist -interview guides -questionnaire 	<ul style="list-style-type: none"> -total budget allocation (annually) -budget absorption rate (annually) -stakeholder engagements & partnerships 	<ul style="list-style-type: none"> -finance records -Hopecore annual reports

Evaluation Objective/ Question	Methods(s)	Instrument(s)	Measure(s)/ Indicator(s)	Data Source(s)
			<ul style="list-style-type: none"> -growth rate in stakeholder engagements/ partnerships -the quality of stakeholder engagements -Standard Operating Procedures, Processes, and guidelines -level of adherence to the SOPs 	

LITERATURE REVIEW

2.1 Introduction

Community Health interventions have evolved in response to the emerging needs of the communities. A brief literature review on the general state of volunteerism and organization of the health delivery system in Kenya was conducted. The evaluators also analyzed the theory of change in the context of HopeCore CHVs' program.

2.2 State of Volunteerism in Kenya

Kenya recognizes volunteerism as a critical driver toward attaining its socio-economic goals, including Vision 2030 and the Millennium Development Goals. Volunteers derive certain benefits from their volunteering activities by acquiring skills, knowledge, motivation, and enhancement of their networks. HopeCore CHVs activities include conducting health education to the community, Maternal Child Health (MCH) activities, growth monitoring, malaria campaigns, referrals of sick persons to link facilities, identification of diabetic and other chronic cases, and collection of health data. The data collected by the CHVs helps to monitor, evaluate, and improve the program.

2.3 Organization of Health Delivery System in Kenya

The Government of Kenya identified the achievement of Universal Health Coverage (UHC) as one of its 4 priority agendas during the period 2018 - 22. Figure 2 and Table 2.1 illustrates the various levels of the Kenyan health delivery system and mortality targets, respectively:

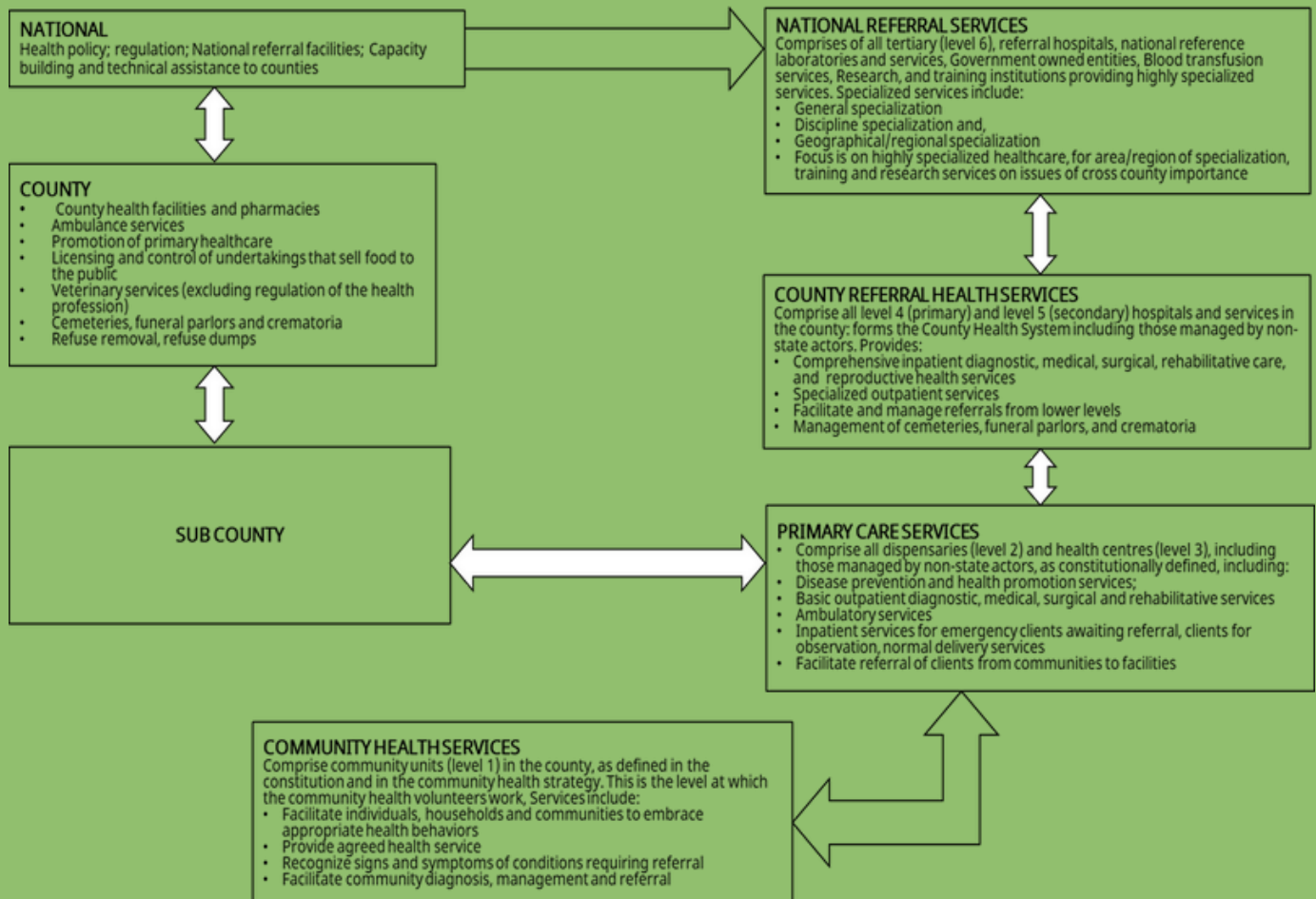


Figure 2: Organization of Health Delivery System in Kenya

Source: GOK, Kenya Health Policy 2014–2030

Table 2.1: Mortality Targets in Kenya:

	2010		2030 Targets	
	Absolute No. of Deaths	Deaths Per 1,000 Persons	Absolute No. of Deaths	Deaths Per 1,000 Persons
Total	420,000	10.6	290,000	5.4
Communicable conditions	270,000	6.8	140,000	2.6
Non-communicable conditions	110,000	2.8	110,000	2.0
Violence/injuries	40,000	1.0	40,000	0.7
Population estimates	38,500,000		54,150,000	

Source: Projections by Ministry of Health, Kenya

2.4 Our Community System

HopeCore’s CHVs program community system comprises the link health facilities, Community Health Assistants (CHAs), and the target household units. The CHAs supervise the CHVs in collaboration with HopeCore. A simplified version of HopeCore’s CHVs Program Community System is shown in Figure 3:

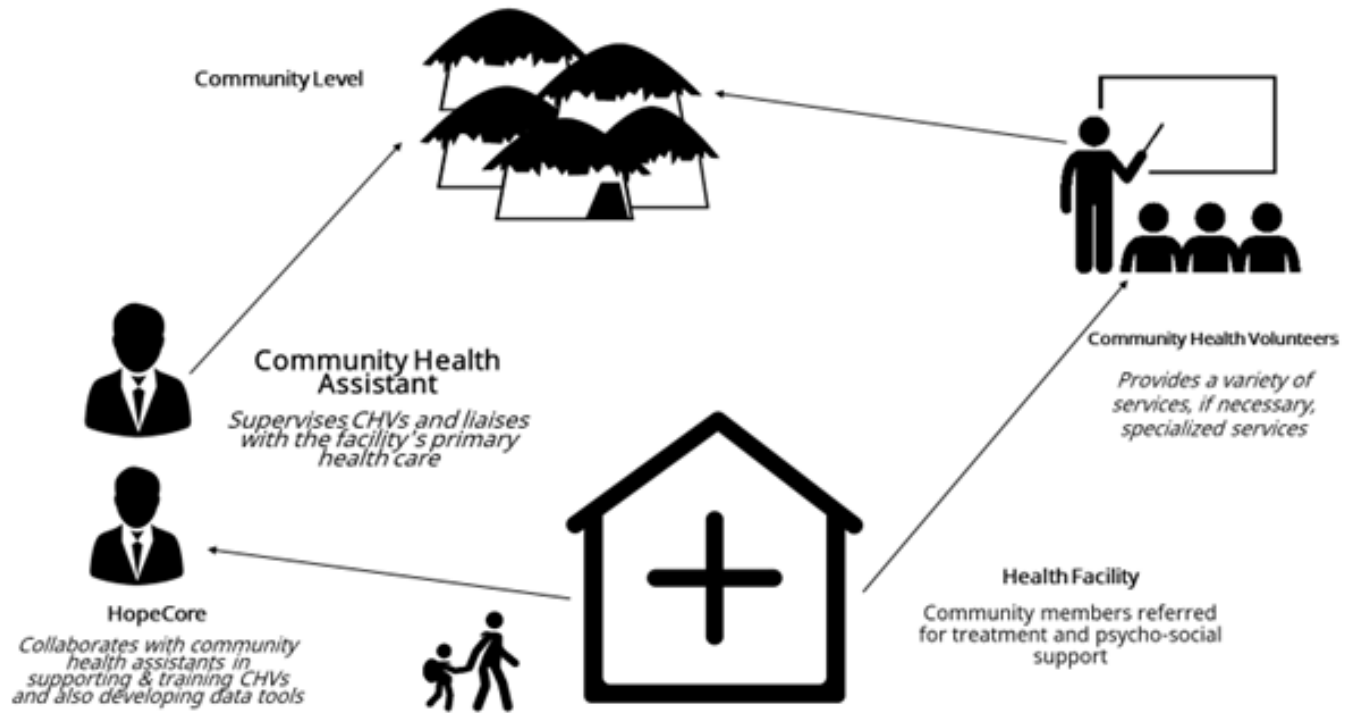


Figure 3: HopeCore CHVs Program Community System

2.5 Theory of Change

The theory of change describes how a program brings about specific long-term outcomes through a logical sequence of intermediate outcomes. The five main components of the theory are- Inputs, Activities, Outputs, Outcomes, and Impacts. In the context of HopeCore, the theory resonates very well with the modeling of the CHVs program as illustrated in Figure 4:

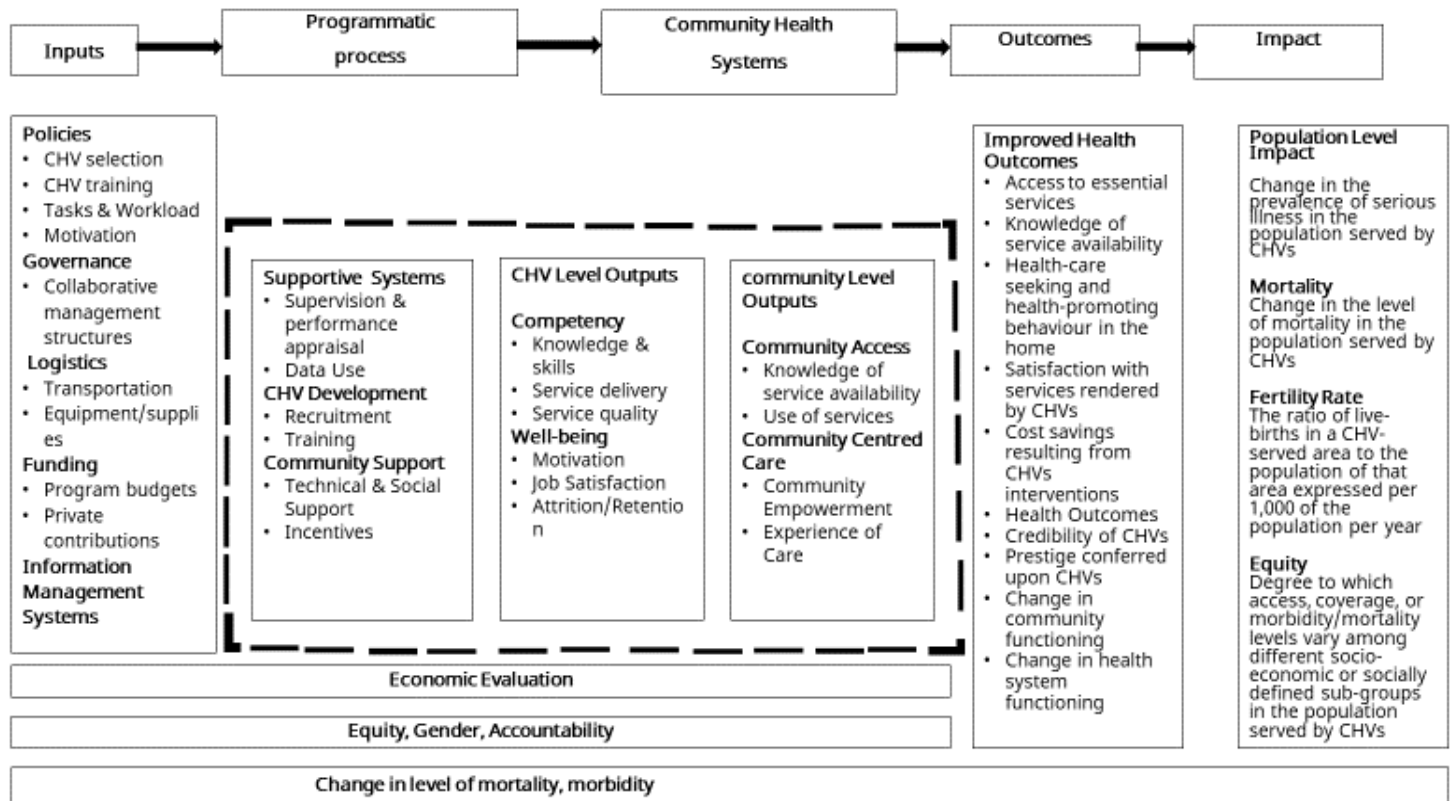


Figure 4: CHVs Impact Measurement Framework utilized for this evaluation

Source: Gichuki et al. (2020)

EVALUATION METHODOLOGY

3.1 Introduction

The evaluation adopted a unique methodology with a clearly defined target population, sampling design, sampling techniques, sampling frame, and sampling procedures. The methodology also encompassed a well-structured data collection and analysis process.

3.2 Target Population

The evaluation targeted 77, 688 households, 719 CHVs, and 8 stakeholders. Table 3.1 shows the sampling frame:

Table 3.1: Sampling Frame

Category	No. of CUs	Population	Sample
1. Community Health Volunteers (CHVs)			
Muthambi	13	114	10
Mwimbi	24	204	18
Chuka	24	231	5
Igambang'ombe	19	170	5
Sub Total	80	719	38
2. Households			
Sub Total		77,688	352
3. Stakeholders			
PHOs (1 per Sub-County)		4	4
CHEWs (1 per Sub-County)		4	4
Sub Total		8	8
Total		78,415	398

3.3 Sampling Design

The Mixed Methods Research (MMR) design was applied in the evaluation. This design was appropriate for this particular evaluation since it allowed the use of qualitative and quantitative data collection methods. Most of the data collected in the CHVs program is usually numerical, in this case, the quantitative data collection method was handy. Similarly, qualitative data collection methods were applied to get better insights, opinions, and feelings of target beneficiaries.

3.4 Sampling Techniques

The random sampling technique was used to determine the desired sample size across the 4 Sub-Counties, i.e., Muthambi, Mwimbi, Chuka, and Igambang'ombe. This technique eliminated bias and other sampling errors that could lead to skewed evaluation findings.

3.5 Sample Determination

In determining the sample size, the evaluation adopted the Taro Yamane (Yamane, 1973) formula with a 95% confidence level. The formula is:

$$n = \frac{N}{1 + N(e)^2}$$

n = sample size

N = population size

e = margin of error (%)

The evaluation targeted a population of 78,415 at a 95% confidence interval with a margin of error of 5%. The sample size, n, becomes:

$$n = (78,415) / \{1 + (78,415 \times 0.05 \times 0.05)\}$$

$$n = 397.97$$

The required sample size is therefore 398 respondents.

3.6 Sampling Frame and Sampling Procedures

As noted, the evaluation applied the simple random sampling technique to arrive at the desired sample size of 398 respondents across the 4 Sub-Counties. The sampling frame included the sampled households, active CHVs, and the other stakeholders as indicated in Table 3.1.

3.7 Data Collection Instrument

The data was collected using semi-structured questionnaire, interviews, observations, and document review. The questionnaire was designed in a manner that it could collect both quantitative and qualitative data. Quantitative data is vital in making statistical inferences and predictions about the target population.

3.8 Data Collection Procedures

3.9 Training of Evaluators

The evaluation engaged a team of 13 HopeCore staff as internal evaluators to assist in data collection. The evaluators were trained on the process of data collection. After the training, the evaluators started data collection as a team from the nearest Sub-Counties, i.e., Mwimbi, Muthambi, and later Chuka and Igambang'ombe.

3.10 Piloting

The data collection instrument was first administered to a purposively selected sample of 40 respondents of Ndunguri and Chogoria CUs to enhance its quality. Piloting helped identify ambiguous, incomplete, or incoherent questions, which were rectified before the actual data collection activity. The instrument was ready for administration after approval by HopeCore management.

3.11 Data Collection

Data was collected through the administration of the questionnaire. Interviews were also conducted to get in-depth information from the targeted respondents in the study area. The stakeholders were interviewed on specific days as per the evaluation work plan. Each evaluator was required to support the assigned respondents in filling out the questionnaire appropriately. To enhance the response rate, the questionnaire was administered and completed within the same day. The entire data collection exercise lasted for five days.

DATA ANALYSIS, PRESENTATION, AND INTERPRETATION

4.1 Introduction

After data collection, the other task involved data analysis, presentation, interpretation, and reporting.

4.2 Data Analysis

The collected data was inspected by the Monitoring & Evaluation (M&E) team for completeness and accuracy and then coded and analyzed using the Excel and SPSS software. The analysis output generated descriptive statistics such as frequencies, means, modes, and percentages. Qualitative data was analyzed using thematic analysis to establish trends and patterns in some parameters, such as behavior change amongst the beneficiaries over the years.

4.3 Response Rate

The evaluation sampled 398 respondents from a target population of 78,415 with an overall response rate of 104%. This indicates that the general approach to the evaluation was effective. Table 4.1 summarizes the response rate of the questionnaire from the four categories of respondents that were sampled:

Table 4.1: Response Rate

Category of respondents	Sample	Frequency	Percentage (%)
Households	352	370	105.0
CHVs	38	39	103.0
CHEWs	4	3	75.0
PHOs	4	2	50.0
Total	398	414	

n = 414

4.4 Demographic Data of Respondents

4.4.1 Highest Education Level

Education wise, most of the household respondents, 181 or 48.9% have attained primary school level of education. An average of 26 or 7.0% of household respondents have post-secondary education across the 4 Sub-Counties. Figure 5 summarizes this information:

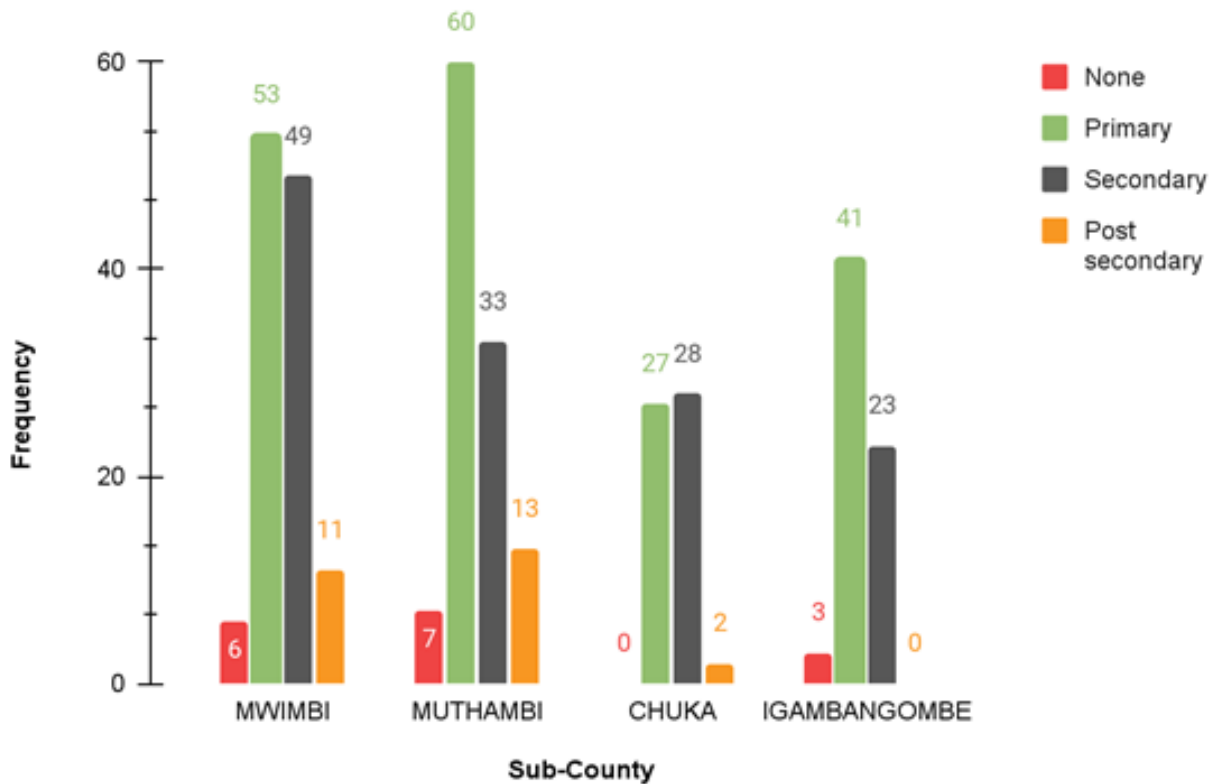


Figure 5: Highest Education Level of the Household Respondents (n = 370)

Unlike the households, all the CHVs have attained at least a primary level of education with 84.62% of them having at least secondary education. However, only Igambang’ombe satisfies the minimum secondary education requirement for recruitment into the CHVs program. The other 3 Sub-Counties have between 13% and 25% of their CHVs having a primary level of education as shown in Figure 6:

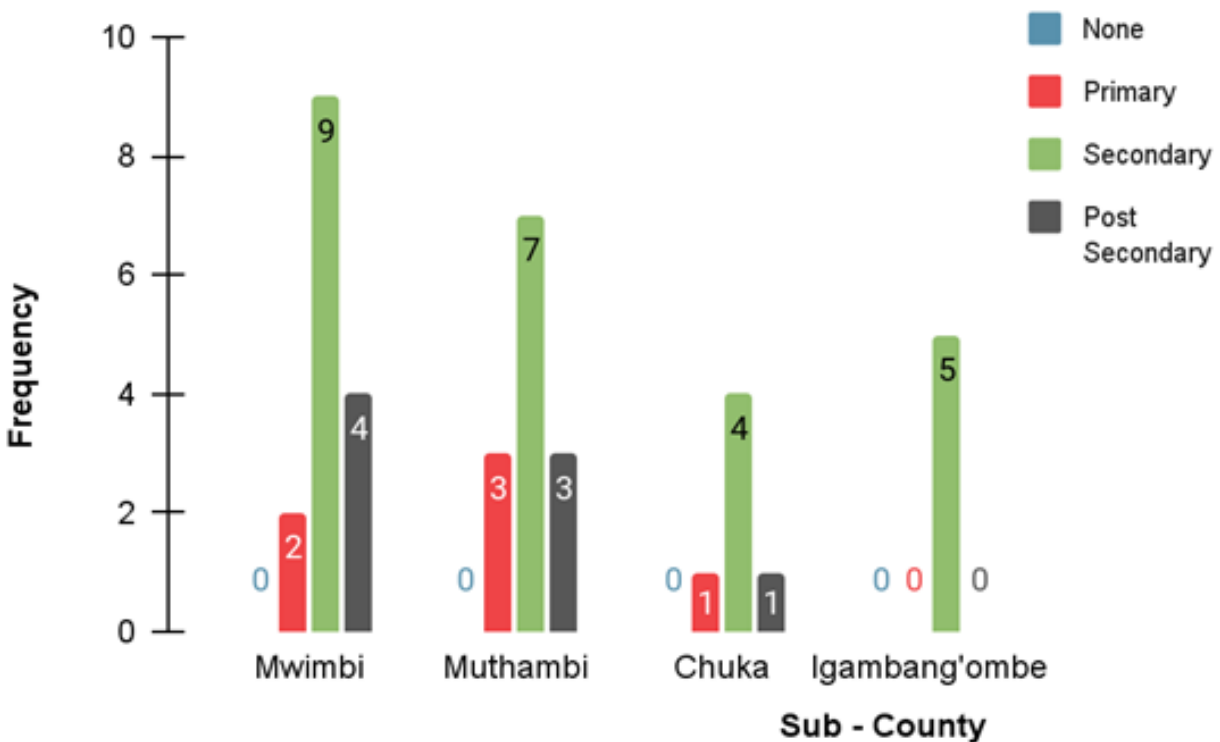


Figure 6: CHVS Highest Level of Education (n = 39)

NOTE: The education level for all the CHEWs/PHOs was above the secondary school level. In Kenya, the minimum education requirement for CHEWs/PHOs to be recruited by the government to serve in health facilities is at least post-secondary education.

Notably, Community Health Volunteers usually live and work in the local communities. Thus, they must meet some minimum age requirements, usually at least 18 years. The majority of the CHVs (64.1%) are aged above 45 years and only 12.8% of the CHVs are youth (aged below 36 years as shown in appendix 7). The CHVs we interviewed serve a total of 4296 households, with each CHV averaging 110 households.

4.5 Households' Knowledge about area CHV

HopeCore expects the CHVs to establish a mutual connection with the households they serve to deliver community health services effectively. The households were asked to state whether they knew their area CHV by responding to the question: *“Do you know your area CHV?”* The responses are summarized in Table 4.2:

Table 4.2: Households' Knowledge about their area CHV

Sub-County	YES		NO		Total	
	Freq.	Percentage (%)	Freq.	Percentage (%)	Freq.	Percentage (%)
Mwimbi	99	64.7	20	35.3	119	100
Muthambi	93	82.3	20	17.7	113	100
Chuka	44	78.6	12	21.4	56	100
Igambang'ombe	65	80.2	16	19.8	81	100
Total / Average	301	76.5	68	23.5	369	100

n = 369

The analysis in Table 4.2 shows that an average of 76.5% of the sampled households know their area CHV, an indication that most of the CHVs have visited the households within their villages over the last 3 months. Muthambi had the highest number of households who know their area CHV (82.3%) while Mwimbi was the least (64.7%).

4.6 CHVs' Visit to the Households

HopeCore CHVs are expected to conduct at least 20 monthly household visits in their coverage area. The households were required to state whether the CHV had visited them

over the last 3 months by answering the question, “Have you been visited by your area CHV over the last 3 months?” Table 4.3 shows this information:

Table 4.3: Have you been visited by Your area CHV over the last three months?

Sub-County	YES		NO		Total	
	Freq.	Percentage (%)	Freq.	Percentage (%)	Freq.	Percentage (%)
Mwimbi	77	64.7	42	35.3	119	100
Muthambi	77	68.1	36	31.9	113	100
Chuka	29	50.9	28	49.1	57	100
Igambang’ombe	51	63	30	37	81	100
Total	234	63.2	136	36.8	370	100

n = 234

From the analysis in Table 4.3, 63.2% of the household respondents agreed that they had been visited by the area CHV over the last 3 months.

4.7 Motivation to Partner with HopeCore

Various factors motivate people to work. During the evaluation, the CHVs were required to indicate the most important factor that motivates them to partner with HopeCore by responding to the question, “What motivates you to partner with HopeCore as CHVs?”. Table 4.4 summarizes the responses:

Table 4.4: Major Source of Motivation for CHVs to Partner with HopeCore

Source of Motivation	Freq.	Percentage (%)
Create impact in my community	30	76.9
Others	1	12.8
Earn a living	2	5.1

Lack of opportunities	1	2.6
Raise my social status	5	2.6
Total	39	100

n = 39

A majority (76.9%) of CHVs are motivated by creating an impact in the community.

4.8 CHVs Training, Knowledge, and Skills

HopeCore, through the CHVs program, undertakes regular CHVs training aiming to equip and empower the CHVs with health information they can eventually disseminate to the community. The evaluation, therefore, sought to measure the level of knowledge acquired by the CHVs and how confident they are to undertake their community work. Table 4.5 shows the average knowledge acquired by the CHVs across the 4 Sub-Counties focusing on 6 health campaigns that is, Water & Hygiene, Nutrition, Family Planning, Hypertension, Pneumonia & Tuberculosis (TB), and Child & Maternal Neonatal Care (CMNC):

Table 4.5: CHVs Training (Pre-test & Post-test Training)

Sub-County	Pre-Test Score (Average)	Post-Test Score (Average)	% Change (Average)
Igambang'ombe	59.6	67.7	8.1
Chuka	65.5	73.4	7.9
Mwimbi	68.9	76.2	7.3
Muthambi	68.7	72.8	4.1
Average	65.7	72.5	6.9

(n = 734, data for all CHVs was used in the analysis)

The analysis in Table 4.5 shows that all the 4 Sub-Counties recorded an average of 6.9% in terms of new knowledge acquisition for the 6 health campaigns. Igambang’ombe had the highest percentage of 8.1 with the lowest change being noted in Muthambi Sub-County (4.1%).

In addition, the analysis in Table 4.6 shows the results of knowledge uptake per health campaign across the 4 Sub-Counties:

Table 4.6: Knowledge Uptake per Health Campaign (4 Sub-Counties)

Health Campaign	Pre-Test	Post-Test	Change	% Change
Hypertension	39.7	56.6	16.9	42.6
Family Planning	59.0	69.7	10.7	18.2
Pneumonia & TB	59.4	66.8	7.5	12.6
Nutrition	74.0	83.1	9.2	12.4
CMNC	74.0	77.6	3.7	5.0
Water & Hygiene	71.6	75.0	3.4	4.7
Average	62.9	71.5	8.6	15.9

(n = 734, data for all CHVs was used in the analysis)

From this analysis, hypertension training registered the highest change in new knowledge (42.6%) whereas Water & Hygiene had the least change (4.7%). On average, there was 15.9% acquisition of new knowledge for all health campaigns.

Figure 7 shows a line graph on knowledge uptake per health campaign:

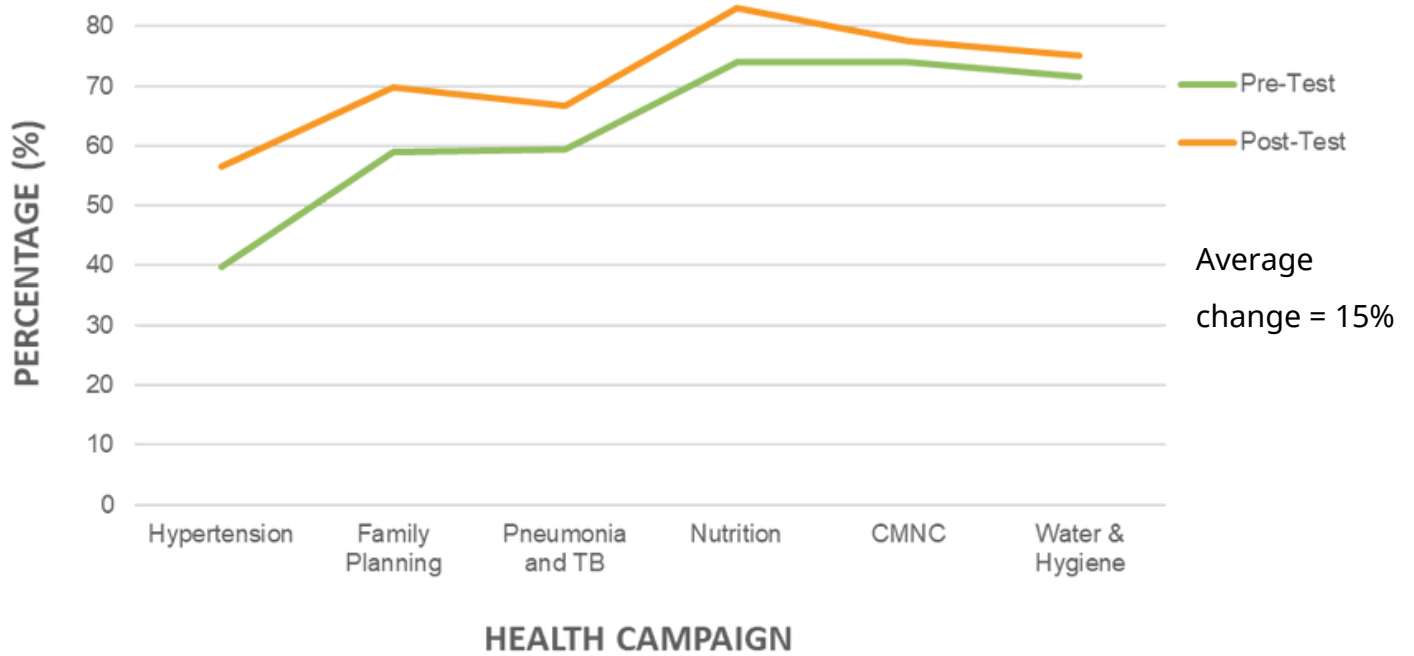


Figure 7: Knowledge uptake per health campaign

A paired samples T - test was performed using the SPSS software (version 26.0) to establish the statistical significance of the six health campaigns. Table 4.7 summarizes the paired samples T-Test SPSS output:

Table 4.7: Paired Samples T-Test Analysis in SPSS

Paired Samples Statistics								
		Mean	N	Std. Deviation	Std. Error Mean			
Pair 1	Pre-Test Scores	62.49	3921	30.745	0.491			
	Post-Test Scores	71.21	3921	30.948	0.494			

Paired Samples Correlations								
		N	Correlation	Sig.				
Pair 1	Pre-Test Scores & Post Test Scores	3921	0.359	0.000				

Paired Samples Test								
		Paired Differences				T	df	Sig. (2-tailed) (p-value)
		Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pair 1	Pre-Test Scores – Post-Test Scores	34.928	0.558	-9.809	-7.622	15.625	3921	0.000

The statistical analysis shows that there is a significant difference between the means (averages) of pre-test and post-test scores ($p < 0.05$). This implies that, on average, the CHVs have actually acquired some statistically verifiable knowledge after pre-test in each of the six health campaigns. When the CHVs were asked to rate their understanding on different health campaigns, these were the results:

Table 4.8: CHVs Knowledge after Training

Level of Knowledge / Understanding	Freq.	Percentage (%)
Excellent	21	53.8
Above Average	11	28.2
Average	7	18.0
Very Low	0	0
Low	0	0
Total	39	100.0

n = 39

This confirms that majority of the CHVs (82%) have above average knowledge about the health campaigns.

4.9 General Impact, Positive Health Outcomes, and Unintended Outcomes

Since its inception, the CHVs program has significantly impacted the community in terms of improved general living conditions and other positive health outcomes (intended and unintended).

4.9.1 Morbidity and Mortality Trends

The CHVs program focuses mainly on reducing morbidity and mortality rates in the community. The CHEWs and PHOs usually support the CHVs within various link facilities in TNC. A total of five CHEWs and PHOs were thus interviewed and asked to comment on morbidity and mortality trends in their respective link facilities (community & village) over the last two years (Increase or decrease). The analysis in Appendix 18 shows that there has been some decline in morbidity in various link facilities in TNC. However, the varied views of the CHEWs and PHOs could indicate that the change is minimal and perhaps unsustainable. Figure 8 shows mortality trends for inpatient deaths in TNC (2018 – 2021) based on data extracted from the Kenya Health Information System (KHIS). (More detailed analysis in appendix 17).

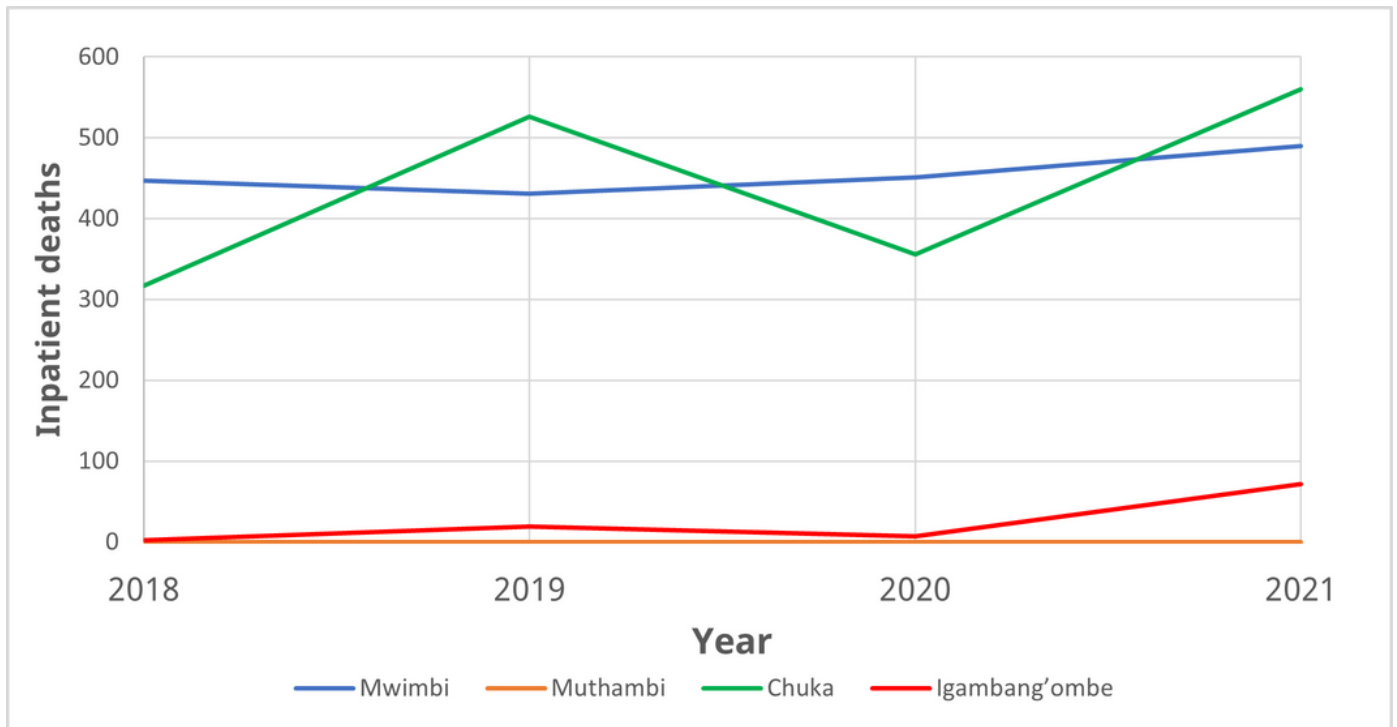


Figure 8: Mortality Trends in TNC (2018 - 2021)

An analysis of mortality trends for hypertension, typhoid, diabetes, diarrhea trends using data retrieved from KHIS for TNC is also shown in appendix 18. The results of the analysis further supports the comments by CHEWs and PHOs that there still seems to be an unstable trend in morbidity within the county especially for chronic illnesses such as hypertension, diabetes and pneumonia. However, typhoid and diarrhea incidences are stabilizing across the 4 Sub-Counties. HopeCore has invested largely in water and hygiene health campaigns through the CHVs program towards ensuring that the communities are free from water-borne diseases.

Further, HopeCore identifies immunizations as a critical step to reducing mortality and morbidity. The analysis in appendix 19 indicates the trends in terms of the number for children under 1 year in TNC (2018 - 2021) who have been fully immunized. But notably, there has been considerable growth in the number of fully immunized children in the four

of the six Sub-Counties. Chuka and Tharaka South Sub-Counties have registered the highest number of fully immunized children over the four years.

4.9.2 Household Respondents' Medical Expenditure

The household respondents were required to state the extent to which they agreed or disagreed with the statement, *"my medical expenses have declined in the past two years"*

Figure 9 shows the responses:

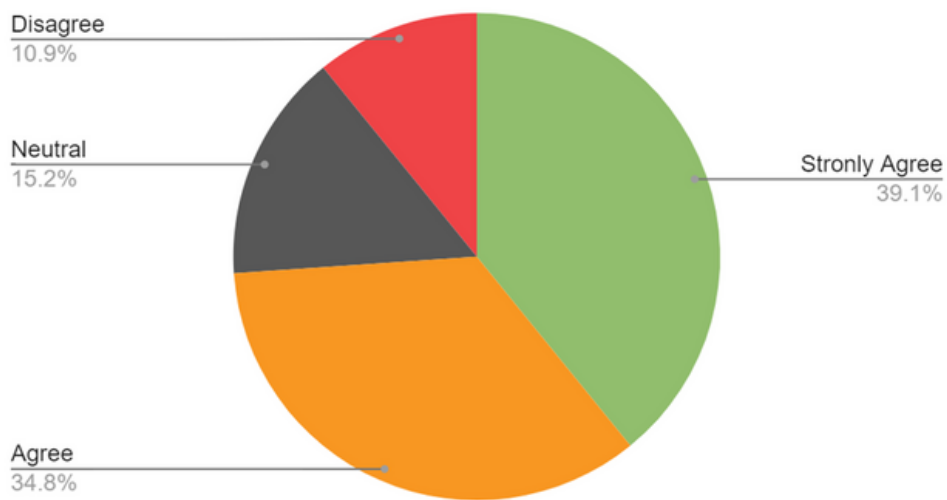


Figure 9: Household Medical Expenses Have Declined

n = 184

The analysis in Figure 9 indicates that 73.9% of the households were in agreement that their medical expenses have declined/dropped over the last two years.

4.9.3 Households with Up-to-Date Health Insurance

Health insurance is a key indicator of a community that is conscious about its healthcare. The households were required to indicate whether they have up-to-date insurance cover by responding to the question, *"Do you have up-to-date insurance cover?"* Table 4.9 summarizes the responses:

Table 4.9: Households with Up-to-Date Health Insurance

Sub-County	YES		NO		Total
	Freq.	Percentage (%)	Freq.	Percentage (%)	Freq.
Mwimbi	66	55.9	54	44.1	118
Muthambi	54	47.8	59	52.2	113
Chuka	29	50.9	28	49.1	57
Igambang'ombe	27	33.3	54	66.7	81
Total	176	47.7	193	52.3	369

n = 369

From the analysis in Table 4.9, more than half of the households (52.3%) lack up-to-date health insurance. The implication is that perhaps there is a need for additional education, sensitization, and support to the community towards health insurance coverage.

4.9.4 Positive Health Outcomes

The ultimate goal of the CHVs program is to create positive health outcomes in the community. The CHVs were therefore required to give their opinion on the extent to which they have contributed towards this goal by responding to the question, *"I have influenced many people in my community to adopt positive health outcomes"*. Table 4.10 shows the responses given:

Table 4.10: CHVs’ Level of Influence towards Adoption of Positive Health Outcome

Level of Agreement/Disagreement	Freq.	Percentage (%)
Strongly Agree	28	71.8
Agree	10	25.6
Neutral	1	2.6
Disagree	0	0
Strongly Disagree	0	0
Total	39	100.0

n = 39

A majority of CHVs (97.4%) believe in contributing to positive health outcomes in their community.

4.9.5 Major Health Practices adopted by Households

As noted above, the CHVs have continued influencing the community members to adopt different health practices. As such, the households were also required to state the major health practices they have adopted by responding to the question, *“Which major health practices have you adopted in the last two years?”* Table 4.11 summarizes the responses:

Table 4.11: Major Health Practices adopted by Households across the Sub-Counties

Major Health Practice	Igambang'ombe	Muthambi	Chuka	Mwimbi	Total	%
Hygiene & Sanitation	65	60	42	65	232	63.0
Timely Immunization of Under Fives	0	8	1	10	19	5.2
Adoption of Family Planning	1	6	2	2	11	3.0
Health Eating Habits	2	21	1	20	44	12.0
Others	0	5	1	8	14	3.8
None	13	13	10	12	48	13.0
Total	81	113	57	117	368	100.0

n = 368

Again, the analysis in Table 4.11 puts hygiene & sanitation at the top (63.0%) as the major health practice adopted by the households in the 4 Sub-Counties. Of the many topics the CHVs focus on, the majority of respondents felt as though that is where their largest impact lied in all Sub-Counties. Notably, the gap between hygiene & sanitation and other health practices is vast, calling for the reallocation of resources to strike a balance. Additionally, CHEWs and PHOs were asked this same question about CHVs and 100% strongly agreed.

However, adoption of family planning services comes last at 3.0%. There is therefore a need for sensitization in favor of the other health practices, especially family planning services for females in the reproductive age bracket (15 - 45 years).

4.9.6 General Living Conditions of Households

In order to measure the extent to which the living standards of the community had changed, the households were required to state the extent to which they agreed or disagreed with the statement “*The general living conditions in my household have significantly improved due to CHVs work*”. Table 4.12 Shows the responses:

Table 4.12: The General Living Conditions in my Household have Significantly Improved due to CHVs Work

Sub - County	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree		NA		Total
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq
Mwimbi	59	49.6	32	26.9	8	6.8	0	0	1	0.8	19	16	119
Muthambi	44	38.9	36	31.9	10	8.8	2	1.8	0	0	21	18.6	113
Chuka	24	42.1	17	29.8	1	1.8	0	0	0	0	15	26.3	57
Igambang’o mbe	31	38.3	32	39.5	3	3.7	0	0	0	0	15	18.5	81
Total	158		117		22		2		1		70		370

n = 370

The analysis in Table 4.12 shows that 275 or 74.3% of households in all Sub-Counties agreed that their general living conditions have improved significantly due to CHVs work. Additionally, most CHVs (more than 90%) agree that their work has created a huge impact on the community, specifically in the living conditions of these households.

4.9.7 Households' Influence on the Community

The CHVs program's impact is expected to spread beyond the target community. In order to measure this parameter, the household respondents were required to give their level of agreement / disagreement to the statement, “*I have influenced very many people outside*

my community and in my household to adopt positive health behaviors.” Table 4.13 shows the responses:

Table 4.13: I have Influenced Very Many People outside my Community and in my Household to adopt Positive Health Behaviors

Sub - County	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree		NA		Total
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq
Mwimbi	52	44.4	38	32.5	19	16.2	8	6.8	0	0	0	0	117
Muthambi	27	23.9	56	49.6	20	17.7	9	8.0	1	0.9	0	0	113
Chuka	17	31.5	25	46.3	9	16.7	3	5.6	0	0	0	0	54
Igambang'o mbe	25	30.9	35	43.2	14	17.3	7	8.6	0	0	0	0	81
Total	121		154		62		27		1		0		365

n = 365

According to the analysis in Table 4.13, at least 275 or 75.3% of the households agreed that they have influenced other people to adopt positive health behavior within and outside their communities in all the Sub-Counties.

4.9.8 Improvement of CHVs Social Status

Serving as a CHV largely involves living and interacting with many community members. With time, the CHVs gain some level of influence in their villages. In order to measure such influence, the CHVs were asked to comment on the extent to which their social status has improved / deteriorated through engagement with HopeCore by responding to the question “My social status has improved through my involvement in HopeCores CHVs program”. The analysis in the appendix 30 indicates that the social status of all the interviewed CHVs has improved as a result of involvement with HopeCore. In fact, at the point of data collection,

many CHVs confirmed how the community treated them with high regard as “*village doctors*” and change agents.

4.10 Feedback on Continuity of the CHVs Program

4.10.1 Households’ Feedback on Continuity of the Program

The CHVs program has been operational since 2014, offering different community health services. During the time of data collection, the households were required to give their views about the continuity of the program by responding to the question “*I want the CHVs program to continue.*” The responses were summarized in Table 4.14:

Table 4.14: I want the CHVs Program to Continue (Household Comments)

Sub - County	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree		NA		Total
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq
Mwimbi	70	58.8	25	21.0	4	3.4	1	0.8	0	0	19	16.0	119
Muthambi	56	50.5	34	30.6	3	2.7	0	0	0	0	18	16.2	111
Chuka	31	54.4	10	17.5	1	1.8	0	0	0	0	15	26.3	57
Igambang’o mbe	35	43.2	28	34.6	2	2.5	0	0	0	0	16	19.6	81
Total	192		154		10		1		0		68		368

n = 368

According to the analysis in Table 4.14, the majority of the households (289 or 78.5%) in the 4 Sub-Counties, would like the CHVs program to continue. This is perhaps an indicator that 78.5% of the households are satisfied with the CHVs program. At a slightly higher rate, all the CHVs (100%) would like the CHVs program to continue as indicated in Appendix 33. This indicates that the CHVs are convinced that the program is positively impacting the community.

4.11 Unintended Outcomes to the Community

The ultimate goal of the CHVs program is to promote positive health outcomes in the community. However, many other unintended changes have been reported in villages where the program operates. These include:

- The program has influenced CHVs to start welfare groups, mobilize savings, and construct houses for needy neighbors
- Some CHVs were inspired to attend the Street Business School (SBS) training under the Micro-Enterprise Programme. After the training, they received group funding to invest in various income-generating projects. The Funded CHVs groups include: *Kaare CHVs, Kariakomo CHVs, Mikuu CHVs, Thigaa CHVs, Kandungu CHVs, and Mutindwa CHVs*
- Reduction in domestic violence and alcoholism - some families who used to experience frequent fights and violence have been influenced by CHVs work to embrace peace and unity (as per household comments)
- Enhanced literacy levels in the community - in some cases, children who had dropped out of school have resumed learning after CHVs' intervention (household comments)

4.12 Extent to Which the Outcomes of the Program Represent Value for Money

The third objective of the evaluation was to establish the extent to which the program's outcomes represent value for money. Document analysis was performed to track the total CHVs program expenditure (2018 - 2021) versus the number of households visited each year. Table 4.15 summarizes the expenditure:

Table 4.15: Summary of annual Expenditure and Household Visits (2018 – 2021)

Year	Number of CHVs		Number of Households Visited	Estimated Annual Expenditure (KES)
	Jan	Dec		
2018	27	48	4,991	1,551,794.00
2019	48	206	49,216	8,035,916.00
2020	206	749	192,216	6,709,951.00
2021	749	749	138,346	9,779,672.00
Total			384,769	26,077,333.00

NOTE: *The major annual expenditure items in the analysis are: Field Allowance for CHVs, Staff Salaries (50%), Hypertension (BP Machines & Flipbooks), CHVs Bags, CHVs Feedback Meeting Stipends, CHVs Mobile Phones and T-shirts (see more details in Appendix 41). The county government primarily pays CHVs stipend.*

The analysis in Table 4.15 indicates that 384,769 household visits were conducted between 2018 and 2021. This translates to an average of 96,192 household visits annually. Notably, the highest number of household visits were conducted in 2020. That year, additional household campaigns/visits were mounted in response to COVID 19 pandemic. Comparatively, the total annual expenditure that has gone into supporting various CHVs program activities (2018 - 2021) stood at KES 26,077,333.00, translating to an average of KES 6,519,333.00 annually (excluding CHVs monthly stipend that is usually paid by TNC).

The average annual unit cost per household over the four years becomes; $26,077,333.00 / 384,769 = \text{KES } 67.77$ or **\$0.68** (excluding the CHVs monthly stipend that is usually paid by the county government). The corresponding annual unit cost per household is **KES 197.91** or **\$197.91** when the county government CHVs monthly stipend is factored in (more details on page 41).

DISCUSSION OF FINDINGS AND RECOMMENDATIONS

5.1 Introduction

In an attempt to link the results of the analysis to the objectives of the evaluation, a thorough discussion of findings was undertaken with a special focus on major program outcomes and beneficiary feedback. Relevant recommendations were then drawn for program improvement.

5.2 Discussion of Findings

5.2.1 Objective 1: How Effective is HopeCore's Approach to Engaging, Training, and Supervising Community Health Volunteers?

Effectiveness measures the extent to which an intervention produces the desired results. It measures the degree of attainment of the predetermined objectives. The evaluation sought to establish the effectiveness of HopeCore's approach to engaging, training and supervising CHVs. The guiding evaluation questions were:

Q1: How has CHVs' knowledge changed?

Q2: What motivates CHVs to act as CHVs in their community?

Q1. The Extent to which CHVs' Knowledge has Changed

The evaluation has confirmed that most CHVs have received pre-test and post-test training. On average, there was a 6.9% significant change in the new knowledge acquired by the CHVs between the two training sessions. Igambang'ombe Sub-County registered the most significant change at 8.1%. Muthambi Sub-County, on the other hand, had a minor change of 4.1%. Studies on community health in Kenya, for instance, (Kenga et al., 2018), **Knowledge, Attitudes and Practices of Community Health Volunteers, 2018**, have reported a 6.3% change in CHVs' knowledge between the initial and follow-up training.

There is, however, some disparity between pre and post-test scores for the six health campaign topics covered during the CHVs training. The six health topics were Hypertension, Pneumonia & TB, Water & Hygiene, Nutrition, Family Planning, and CMNC. On average, there was a 15.9% acquisition of new knowledge for all health campaigns. Hypertension recorded the most considerable improvement between pre and post-test scores of 42.6%, primarily because the CHVs had a relatively lower pre-existing knowledge of hypertension (39.7%) before the training compared to the other five health campaigns. However, there is a need to allocate more resources towards future hypertension campaigns since the average post-test score of 56.6% is still low compared to the other campaigns. But generally, the CHVs seem to have some considerable initial exposure to training/knowledge on Pneumonia & TB, Water & Hygiene, Nutrition, Family Planning, and CMNC.

The evaluation also demonstrated that most CHVs (82.0%) have at least above-average knowledge/understanding of their work and were very confident while executing the volunteer functions to the rural community they serve. This was further confirmed by comments from most CHEWs and PHOs (80%), who affirmed that CHVs' knowledge and skills have improved due to HopeCore's intervention.

Q2. CHVs' Major Source of Motivation as CHVs in their Community

The evaluation revealed that the most significant source of motivation for HopeCore CHVs is the drive to create impact in their communities at 76.9%. This is evident in how most CHVs (71.8%) confirmed that they had influenced many households to adopt different positive health outcomes. Typically, many CHVs are highly appreciated by the communities they serve and the affiliated organizations (local and global) that promote their value and rely on the services they offer to the community (Lee, 2020). However, their well-being must be considered to ensure the sustainability and continuity of service delivery.

5.2.2 Objective 2: To What Extent is the CHVs Program Affecting Health Outcomes in the Community?

The primary driver for community health interventions is to generate positive health outcomes. To this end, the evaluation intended to address two key questions:

Q3: How have health practices changed in the community?

Q4: How have morbidity and mortality rates changed?

Q3. The Extent to Which Health Practices Have Changed in the Community

From the evaluation findings, it was clear that most CHVs (77.4%) have influenced a significant part of the community towards the uptake of positive health practices. More than 75% of the households also reported influencing many people within and outside their community to adopt positive health behaviors. In fact, 63.2% of the households in the 4 Sub-Counties have adopted hygiene and sanitation practices as their major positive health behavior due to CHVs intervention. Similarly, healthy eating habits, timely immunization of under-fives and adoption of family planning services represent 12.0%, 5.2% and 3.0%, respectively.

It has been established that hygiene and sanitation is a growing concern in TNC. Indeed, over 87.7% of the communities residing in the county use pit latrines (Tharaka Nithi CIDP, 2018 -2022). This is perhaps why most of the CHVs' major area of influence in the community is skewed towards promoting hygiene and sanitation. Much emphasis is on ensuring every household has a functional latrine, proper refuse disposal facility, and a handwashing station. In the long - term, this would reduce the occurrence of water-borne diseases and the serial open defecation menace.

According to the PHOs and CHEWs, more community members have started seeking health services. The PHOs and CHEWs also stated that CHVs are increasing the number of referrals to link facilities. However, when reviewing data from the KHIS (Appendix 35), the referral counts do not indicate the same upward trend. The evaluation team believes this is due to inconsistent reporting and not an accurate representation of the number of referrals done by CHVs. Based on the qualitative data collected from PHOs and CHEWs, we believe that the CHVs are effecting change and acting as change agents in the community.

Indeed, CHVs are widely identified as enabling the development of national and Sub-National capacities for diagnosis, treatment, monitoring, and health promotion programs (Raven et al., 2020). The World Health Organization & United Nations Children’s Fund (2018) have recognized CHVs as vital agents in achieving universal health coverage and other positive health outcomes on the African continent. HopeCore’s investment towards this end thus seems to be in the right direction in line with United Nations’ Sustainable Development Goals (SDGs), particularly goal Number 3, which advocates for good health and well-being.

The findings further indicated that 73.9% of the households agreed that their medical expenses had declined over the last two years. 63.1% of the interviewed household respondents had spent less than KES 1,000 over the last three months. According to World Bank Per Capita Expenditure on Health, Kenya’s annual per capita expenditure on health was \$83.41(or KES 8,341) in 2019. This translates to KES 2,085.25 quarterly medical expenditure per household member. The average quarterly medical expenditure for 3 - 6 household members is thus expected to range between KES 6,255.75 and KES 12,511.50 per quarter. This implies that the average quarterly medical expenditure for majority of households in our CHVs program (of less than KES 1,000) is much lower than the national average. This is primarily due to timely and robust community health interventions through the CHVs program and affordable healthcare services in public facilities. Families with a history of chronic illnesses, however, have higher medical expenses.

In general, the CHVs program has contributed to a more significant extent towards the achievement of favorable health outcomes in the community. The findings demonstrate that 74.3% of the households agree that the program has improved their living standards. The CHEWs and PHOs also confirmed that the program positively impacts the community. Overall, the satisfaction level in the program is 100% for CHVs and 78.5% for the households. All of them would like the program to continue.

Q4. The Extent to Which Morbidity and Mortality Rates have Changed

Mortality refers to the number of deaths due to a specific illness or condition. In contrast, morbidity occurs when individuals suffer or are affected by a specific illness or condition. The evaluation findings revealed that changes in mortality and morbidity trends could be associated with HopeCore's intervention over the last four years (2018 - 2021). 40% of the CHEWs and PHOs reported a slight decrease in mortality with others (40%), noting that no data supports the trend. Morbidity in various link facilities within TNC declined marginally during this period. Comments provided by the CHEWs and PHOs indicated that there still seems to be an unstable trend in morbidity within the county, especially for chronic illnesses such as hypertension, diabetes, and pneumonia. The overall implication is that HopeCore should continue to invest in community health initiatives towards the reduction of both morbidity & mortality within TNC in order to reverse the trend.

5.2.3 Objective 3: To what Extent do the Program's Outcomes Represent Value for Money?

The evaluation findings revealed that the average annual expenditure for the CHVs program stands at KES 19,038,333.25 (this amount includes CHVs monthly stipend which is usually paid by the county government). The corresponding annual unit cost per household is currently **KES 197.91 (\$1.98)**. In Kenya, the average annual unit cost of implementing a community health program for a household in rural settings such as Tharaka Nithi County is estimated at between **KES 360 - KES 400, or \$3.6 - \$4** (Wafula et al., 2017: **Contextual variations in costs for a community health strategy in Kenya**).

This shows that the annual expenditure per household in our CHVs program is just **54.98%** of the expected national average of at least \$3.6 in Kenyan rural settings, implying that the current annual cost of the program is efficient. However, the exact economic returns from the financial investment made in the program might not be quantifiable. Globally, most CHPs yield a 10:1 Return On Investment (ROI), implying that, on average, for every \$1 investment in a CHP, a return of at least \$10 would be expected. In the Kenyan context, for every Kenya Shilling (KES) invested in Community Health, an economic return equivalent to 9.4 KES will be realized - **The Investment Case for Community Health in Kenya, MOH, 2018**. This implies that our CHVs program's average ROI is at least **KES 61.28 million** (excluding the expenditure on CHVs monthly stipend which is paid by the county government), or at least **KES 178.96 million** (including the expenditure on CHVs monthly stipend which is paid by the county government). Other non-quantitative benefits of investment in Community Health include; empowerment of youth and women, increased knowledge and capacity at the community level, and increased data pool on indicators not directly linked with health, such as school enrolment.

5.3 Summary of Major Findings

The evaluation established that:

- Household beneficiary satisfaction level in the program stands at 78.5%
- There was a 15.9% significant change in the new knowledge acquired by the CHVs across the six health campaigns. The highest knowledge gain was in Hypertension (42.6%), and the least in water & hygiene (4.7%). The average increase in knowledge for support supervision was 21.7%
- Majority of the CHVs (82.0%) have above-average knowledge/understanding of their work and are very confident while executing the volunteer functions to the rural community they serve
- Creation of impact in communities is the most important source of motivation for CHVs to partner with HopeCore at 76.9%

- Majority of the CHVs (71.8%) confirmed that they have influenced many households to adopt different positive health outcomes/behavior
- Most CHVs (77.4%) had influenced a larger part of the community to uptake positive health practices
- Majority of the households (75.3%) had influenced many people within and outside their community to adopt positive health behaviors. Indeed, 74.3% of the households agree that the program has improved their living standards
- Hygiene and sanitation were the most highly adopted health practice across all the 4 Sub-Counties by about 63.2% of the households through the influence of the CHVs
- 73.9% of the households confirmed that their medical expenses have declined/dropped over the last two years. 63.1% of the interviewed household respondents have spent less than KES 1,000 over the last three months
- The current average annual expenditure per household in the program is **KES 197.91** or **\$1.98**. This represents **54.98%** of the expected national average of at least \$3.6 in Kenyan rural settings
- There is low uptake of health insurance by the community (only 47.7% of households have up-to-date health insurance)

5.4 Conclusion

The overall objective of this evaluation was to measure the impact of the CHVs program on the community. Specifically, the evaluation intended to assess the effectiveness of HopeCore's approach to engaging, training and supervising CHVs, the extent to which the CHVs program affects health outcomes in the community, and the extent to which the outcomes of the program represent value for money. The evaluation findings have demonstrated that the program has generated a significant impact on the community, leading to an overall household satisfaction level of 78.5%. The level of stakeholder engagement is also fairly effective though there is room for further expansion to accommodate more stakeholders and generate a more significant impact in the future. The program has also been found to be very efficient in terms of resource use and allocation.

The average annual household expenditure is slightly a half of the recommended industry average, implying that there is room for serving more households even with the current program budget. It is, however, essential to note that some critical areas of improvement have been identified and put forward for action.

5.5 Major Areas of Improvement and Recommendations

5.5.1 Major Areas of Improvement

The major areas of improvement drawn from the evaluation findings include:

1. Demographic Data

- 29.9% of the CHVs are only educated upto primary school level (The Kenya Community Health policy guidelines require that CHVs have at least secondary school education level unless situations do not allow it)
- 36.8% of the households had not been visited by the area CHV over the last three months, and 23.5% of the household respondents do not know their area CHV

2. Objective 1: How effective is HopeCore's approach to engaging, training, and supervising community health volunteers?

- CHVs selective visits - some CHVs only visit households closer to their residence or where the reception is "good"
- No defined timelines for recruitment and replacement of CHVs who have dropped out of the program. The county government should adopt the 2021 CHVs Certification Guidelines developed by MOH to formalize CHVs recruitment, training and replacement
- Delayed and inconsistent payment of CHVs monthly stipend by Village HopeCore International
- No clearly updated database for CHVs profiles at the county level
- Most of the CHVs referrals are not adequately documented at the link facilities

3. Objective 2: To what extent is the CHVs program affecting health outcomes in the community?

- Low uptake of health insurance by the community (only 47.7% of households have up-to-date health insurance)

4. Objective 3: To what extent do the outcomes of the program represent value for money?

- Level of effort in the CHVs program by each CHO and program coordinator is not clearly defined
- An improvement is required on the CHVs program budgeting, tracking and financial reporting
- No verifiable Return on Investment (ROI) in the CHVs program

5.5.2 Recommendations

In order to enhance program improvement, the following recommendations are put forth for action:

Objective 1: How effective is HopeCore's approach to engaging, training, and supervising community health volunteers?

(Recommendations for the Community Health Program Coordinator)

1. Knowledge Improvement - devise new strategies for boosting new knowledge amongst the CHVs, for instance, simplification of some health topics like nutrition, continuous revision of flipbooks, and the inclusion of more questions in each test.

2. Stakeholder Engagement Plan / Matrix - develop a clear stakeholder engagement plan that outlines the scope of stakeholder engagement, their needs, interests, expectations, and how to manage each stakeholder.

- 3. Tracking CHVs Households Visits** - provide adequate support and close supervision to the CHVs during household visits to ensure that the CHVs do not selectively conduct the visits. Also, ensure that CHVs conduct all the recommended monthly, quarterly, and annual visits.
- 4. CHVs Service Charter** - develop a clearly defined CHVs service charter that explains the nature of engagement, including specific timelines.
- 5. CHVs Monthly Stipend** - Ensure timely and consistent payment of CHVs monthly stipend.
- 6. Updated CHVs Database** - work closely with the TNC government to develop an updated CHVs database. The database should be updated regularly to capture any necessary changes.
- 7. Documentation of CHVs Referrals** - the households should be constantly educated on the importance of carrying CHVs referral notes while visiting the nearest link facilities for medication.

Objective 2: To what extent is the CHVs program affecting health outcomes in the community?

(Recommendations for the Community Health Program Coordinator)

- 1. Baseline Data** - Strengthen our data collection process and record-keeping for the CHVs program. Make use of M&E tools i.e., KHIS, MOH & HopeCores M&E reports.
- 2. Uptake of Health Insurance** - invest more towards sensitization and promoting health insurance in the community.
- 3. Maintenance of Health Records** - encourage and support the households concerning the storage of health records.
- 4. Program Implementation Matrix** - develop a clear program implementation matrix with phases (sub-phases) that have clear deliverables, timelines, and budget.

Objective 3: To what extent do the outcomes of the program represent value for money?

(Recommendations for finance manager)

- 1. Level of Effort Planner** - formulate a level of effort planner that outlines the proportion (percentage) of time every CHO spends in CHVs work. The planner should be updated regularly as time demands.
- 2. Organization of Program Financials** - there is a need for a well-organized accounting procedure that promotes ease of retrieval and accessibility of CHVs program financials.
- 3. Return on Investment** - develop a framework for measuring and tracking return on investment in the CHVs program.

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APPENDICES

Appendix 1: Community Health Volunteers’ Questionnaire

The purpose of the evaluation is to assess the impact of HopeCore’s CHVs program

Part A: Demographics Data

Q1. Gender: Male [] Female []

Q2. Highest Education Level: None [] Primary [] Secondary [] Post-Secondary []

Q3. Age bracket: Less than 36 [] 36 - 45 [] 46 - 55 [] Above 55 []

Q4. Marital Status: Married [] Single [] Divorced [] Separated []

Widowed [] Other (Specify).....

Q5. sub-county.....Community Unit.....

Q6. No. of Villages served..... Households served (average).....

Part B: HopeCore’s Approach to Engaging, Training, and Supervising CHVs

Q7. What motivates you to partner with HopeCore as a CHV?

Create impact in my community [] Earn a living []

Raise my social status [] Lack of other opportunities []

Others (Specify).....

Q8. Rate your understanding of HopeCore CHVs’ work:

Very Low [] Low [] Average [] Above average [] Excellent []

Part C: CHV Program and Health Outcomes in the Community

Q7. i) Which major health practices have you influenced your community to carry out over the last 2 years?

Hygiene & sanitation (handwashing, use of latrines, refuse disposal []

Timely immunization of my under-fives [] Adoption of family planning []

Healthy eating habits [] others (list).....

ii) If none, please give reasons.....

.....

.....

Part D: CHV Program and General Impact to the Community

Indicate your level of Agreement or Disagreement with the following statements

5 - Strongly agree, 4 - Agree, 3 - Neutral, 2 - Disagree, 1 - Strongly disagree

Statement	5	4	3	2	1
I have influenced very many people outside my community to adopt positive health behaviour					
The general living conditions in my community have significantly improved due to CHVs' work					
My social status has improved through involvement in the HopeCore CHVs program					
I want the CHVs program to continue					

Appendix 2: Household’s Questionnaire

The purpose of the Evaluation is to assess the impact of HopeCore’s CHVs program

Part A: Demographics Data

Q1. Gender: Male [] Female []

Q2. Highest Education Level: None [] Primary [] Secondary [] Post-Secondary []

Q3. Age bracket: Less than 36 [] 36 - 45 [] 46 - 55 [] Above 55 []

Q4. Marital Status: Married [] Single [] Divorced [] Separated []

Widowed [] Other (Specify).....

Q5. sub-county.....Community Unit.....

Q6. Village.....

Q7. Number of household members: Less than 3 [] 3 - 6 [] More than 6 []

Part B: CHV Program and Health Outcomes in the Community

CU: Name of the area CHV:

Q8. i) Do you know your area CHV? Yes [] No []

ii) Have you been visited by the CHV over the last 3 months? Yes [] No []

Q9. i) Which major health practices have you adopted over the last 2 years?

Hygiene & sanitation (handwashing, use of latrines, refuse disposal) []

Timely immunization of my under-fives [] Adoption of family planning []

Healthy eating habits [] Sleeping under-treated net []

Others (list).....

ii) If none, please give reasons.....

iii) please indicate how you are likely to continue with the acquired health practices in the next 5 years?

Very likely [] likely [] Not Sure [] unlikely [] Very unlikely []

iv) Rate the extent to which the CHVs program has benefited you over the last 2 years: 5 - Very great extent [] 4 - Great extent [] 3 - Not sure [] 2 - Low extent [] 1 - Very low extent []

Part C: CHV Program and General Impact to the Community

Q10. Indicate your level of Agreement or Disagreement with the following Statements, where; 5 - Strongly agree, 4 - Agree, 3 - Neutral, 2 - Disagree, 1 - Strongly disagree

Statement	5	4	3	2	1
I have influenced very many people outside my community to adopt positive health behaviour					
The general health condition of my household has improved					
My medical expenses have declined in the past 2 years					
I want the CHVs to continue visiting my Household					

Q11. In the past 3 months, how much have you (as a household) spent on medication? Less than KES 1000 [] KES 1000- 2000 []

KES 2000 - 3000 [] Above KES 3000

Q12. Do you have an active NHIF cover? Yes [] No []

Appendix 3: CHEWs & PHOs Questionnaire

The purpose of the evaluation is to assess the impact of HopeCore’s CHVs program

Part A: Demographics Data

Q1. Gender: Male [] Female []

Q2. Highest Education Level: Secondary [] Post-Secondary []

Q3. sub-county.....Link Facility.....

Part B: CHV Program and Health Outcomes in the Community

Q4. i) Which major health practices have improved/changed in your community over the last 2 years?

Hygiene & sanitation (handwashing, use of latrines, refuse disposal) []

Timely immunization of my under-fives [] Adoption of family planning []

Healthy eating habits [] others (list).....

ii) If none, give reasons.....

Q5. Comment on morbidity and mortality trends in your village/community over the last 2 years (increase/decrease)

i) Morbidity.....

ii) Mortality.....

Part C: CHV Program and General Impact to the Community

Indicate your level of Agreement or Disagreement with the following statements

where; 5 - Strongly agree, 4 - Agree, 3 - Neutral, 2 - Disagree, 1 - Strongly disagree

Statement	5	4	3	2	1
More community members have started seeking health services through CHV referrals					
The CHVs program has contributed to positive health outcomes in the community					
I am proud to be associated with HopeCore CHV program					
CHVs' knowledge and skills have improved due to association with HopeCore					

Appendix 4: Highest Education Level of Household Respondents Per Sub-County

Sub-County	None (%)	Primary (%)	Secondary (%)	Post-Secondary (%)	Total
Mwimbi	5	44.5	41.2	9.3	100
Muthambi	6.2	53.1	29.2	11.5	100
Chuka	0	47.4	49.1	3.5	100
Igambang'ombe	4.5	61.2	34.3	0	100
Average	3.9	51.5	38.6	6.1	100

n = 370

Appendix 5: Highest Education Level of CHVs per Sub-County

Sub-County	None (%)	Primary (%)	Secondary (%)	Post-Secondary (%)	Total
Mwimbi	0	13.3	60	26.7	100
Muthambi	0	23.1	53.8	23.1	100

Chuka	0	16.7	66.6	16.7	100
Igambang'ombe	0	0	100	0	100
Average	0	13.3	70.1	16.6	100

n = 39

Appendix 6: Number of Household Members per Sub-County

Sub-County	Household size	Frequency	Percentage (%)
Mwimbi	Less than 3	30	25.2
	3 - 6	78	65.5
	More than 6	11	9.2
Subtotal		119	100
Muthambi	Less than 3	42	37.8
	3 - 6	61	54.9
	More than 6	8	7.2
Subtotal		111	100
Igambang'ombe	Less than 3	22	27.1
	3 - 6	51	62.9
	More than 6	8	9.8
Subtotal		81	100
Chuka	Less than 3	12	3.2
	3 - 6	38	66.6
	More than 6	7	12.2
Subtotal		57	100
Total		369	

Appendix 7: Age of the CHVs

Sub-County	Age Bracket (Years)	Frequency	Percentage (%)
Mwimbi	Less than 36	0	0
	36 - 45	5	33.3
	46 - 55	7	46.6
	Above 55	3	20
Subtotal		15	100
Muthambi	Less than 36	4	30.7
	36 - 45	3	23
	46 - 55	5	38.4
	Above 55	1	7.6
Subtotal		13	100
Igambang'ombe	Less than 36	1	20
	36 - 45	0	0
	46 - 55	4	80
	Above 55	0	0
Subtotal		5	100
Chuka	Less than 36	0	0
	36 - 45	1	16.7
	46 - 55	2	33.3
	Above 55	3	50
Subtotal		6	100
Total		39	100

n = 39

Appendix 8: Number of Villages Served by CHVs

Number of Villages Served	Frequency	Percentage (%)
1.	24	61.5
2.	12	30.8
3.	2	5.1
4.	1	2.6
5.	0	0
Total	39	100

n = 39

Appendix 9: Have you been Visited by your Area CHV over the Last Three Months?

Sub-County	YES		NO		Total	
	Freq.	(%)	Freq.	(%)	Freq.	(%)
Mwimbi	77	64.7	42	35.3	119	100
Muthambi	77	68.1	36	31.9	113	100
Chuka	29	50.9	28	49.1	57	100
Igambang'ombe	51	6.3	30	37	81	100
Total/Average	234	63.2	136	36.8	370	100

n = 234

Appendix 10: Knowledge Uptake per Health Campaign (4 Sub-Counties)

Health Campaign	Pre-test	Post-test	Change	% Change
Hypertension	39.72	56.63	16.9	42.57
Family Planning	58.95	69.67	10.7	18.18
Pneumonia & TB	59.35	66.82	7.47	12.59
Nutrition	73.95	83.12	9.17	12.40
CMNC	73.91	77.63	3.72	5.03
Water & Hygiene	71.63	74.99	3.36	4.69
Total/Average	62.90	71.50	8.55	15.90

n = 734, data for all CHVs was used in the analysis

Appendix 11: Paired Samples T-Test Analysis in SPSS

Paired Samples Statistics								
		Mean	N	Std.Dev.	Std Error Mean			
Pair 1	Pretest Scores	62.49	3921	30.745	0.491			
	Posttest Scores	71.21	3921	30.948	0.494			
Paired Samples Correlations								
		N	Correlation	Sig.				
Pair 1	Pre Test Scores & Post Test Scores	3921	0.359	0.000				
Paired Samples Test								
		Paired Differences				t	df	Sig. (2-tailed) (p-value)
		Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pair 1	Pre Test Scores - Post Test Scores	34.928	0.558	-9.809	-7.622	-15.625	3921	0.000

Appendix 12: CHVs Scores in Support Supervision (2021)

Sub-County	Household 1 (Average score)	Household 2 Average score)	Change	% Change
Igambang'ombe	13.6	17.1	3.5	25.7
Chuka	13.4	16.6	3.2	23.8
Mwimbi	14.3	17.1	2.8	19.5
Muthambi	14.6	17.2	2.6	17.8
Average	13.98	17	3	21.7

n = 734

Appendix 13: CHVs Knowledge Improvement

CHVs' knowledge and skills have improved due to their association with HopeCore	Freq.	Percentage (%)
Strongly Agree	4	80.0
Agree	1	20.0
Total	5	100.0

Appendix 14: CHEWs & PHOs Comments on Morbidity Trends (2018 - 2021)

Morbidity Trend	Freq.	Percentage (%)
Decrease	2	40.0
Increase	2	40.0
Static	1	20
Total	5	100.0

n = 5

Appendix 15: CHEWs & PHOs Comments on Mortality Trends (2018 - 2021)

Mortality Trend	Freq.	Percentage (%)
Slight decrease	2	40.0
No data / Updated records	2	40.0
Decrease	1	20.0
Total	5	100.0

n = 5

Appendix 16: MOH 711 Neo Natal Deaths 0 - 28 Days

Year/Sub-County	2018	2019	2020	2021	Average annual change % Change
Muthambi	0	1	0	2	2
Igambang'ombe	2	0	5	5	0.8
Tharaka North	4	2	1	4	0
Tharaka South	24	24	18	20	- 1
Chuka	45	42	33	33	- 3
Mwimbi	17	14	13	16	- 4

Appendix 17: Mortality Trends in Tharaka County (2018 - 2021)

Year/Sub-County	Nature of Death/Year	2018	2019	2020	2021	Total
Mwimbi	Inpatient deaths	447	431	452	490	1819
Muthambi	Inpatient deaths	0	0	0	0	0
Chuka	Inpatient deaths	317	526	356	560	1759
Igambang'ombe	Inpatient deaths	2	19	7	72	100

Source: Source: Extracted from Kenya Health Information System (KHIS)

The analysis indicates no major change in mortality trends across the 4 Sub Counties (2018 - 2021), considering population growth over this period.

Appendix 18: Morbidity Trends in Tharaka Nithi County (2018 - 2021)

	Nature of Death/Year	2018	2019	2020	2021	Total
Mwimbi	Hypertension	14470	13578	9417	10267	59208
	Diabetes	1397	2759	2610	2252	9688
	Diarrhoea	4177	6460	3071	2551	18836
	Typhoid	476	684	221	248	2351
	Pneumonia	3759	4326	2193	2262	14476
	Muthambi	Hypertension	5722	6984	5344	4941
Diabetes		876	1343	1009	1346	5163
Diarrhoea		2256	2180	1535	919	8516
Typhoid		122	175	119	64	569
Pneumonia		2282	1964	936	631	7119

Chuka	Hypertension	9749	15349	17878	25529	73414
	Diabetes	1673	3540	4954	6979	18588
	Diarrhoea	5152	5830	3540	3120	21459
	Typhoid	145	647	624	554	4859
	Pneumonia	6313	6273	4234	10284	32564
Igambang'ombe	Hypertension	2952	5054	5049	5027	18742
	Diabetes	171	788	828	1298	3124
	Diarrhoea	3021	3816	3296	1821	14162
	Typhoid	511	284	144	33	1701
	Pneumonia	3258	4955	4040	2016	15872
Total		69788	86989	71049	82142	356288

Source: Extracted from Kenya Health Information System (KHIS)

Appendix 19: Fully Immunized Children Under one Year in TNC

Year/Sub-County	2018	2019	2020	2021	Total
Igambang'ombe	754	821	1169	1104	3848
Mwimbi	1614	1342	1846	1991	6793
Chuka	1926	1876	2289	2204	8295
Tharaka North	1431	1256	1452	1554	5693
Muthambi	678	678	836	663	2855
Tharaka South	2038	2041	1932	2017	8028
Total	8441	8041	9524	9533	35512

Source: KHIS

Appendix 20: Households' Medical Expenditure Over the Last Three Months

Sub-County	Less than 1000		1000 - 2000		2001 - 3000		Above 3000		TOTAL
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.
Mwimbi	83	70.3	11	9.3	7	5.9	16	13.6	118
Muthambi	58	51.3	17	15	11	9.7	27	23.9	113
Chuka	34	59.6	5	8.8	6	10.5	12	21.1	57
Igambang'ombe	58	71.6	6	7.4	2	2.5	15	18.5	81
Total/Average	233	63.2	39	10.1	26	7.2	70	19.3	369

n= 369 , expenses are in KES

Appendix 21: Summary of Major Health practices Influenced by CHVs

Major Health Practice	Igambang'ombe	Muthambi	Chuka	Mwimbi	Total	%
Hygiene and Sanitation	5	5	2	12	24	63.2
Timely Immunization of under fives	0	2	1	2	5	13.2
Adoption of Family Planning	0	1	2	0	3	7.9
Health Eating Habits	0	2	0	1	3	7.9
Others	0	2	1	0	3	7.9
Total	5	12	6	15	38	100

n= 38, CHVs were required to select only one major health practice

Appendix 22: Mwimbi Sub - County

Major Health Practice	Freq.	Percentage (%)
Hygiene and Sanitation	12	80.0
Timely Immunization of under fives	2	13.3
Healthy eating habits	1	6.7
Adoption of Family Planning	0	0
Others	0	0
Total	15	100.0

n= 15,CHVs were required to select only one major health practice

Appendix 23: Muthambi Sub - County

Major Health Practice	Freq.	Percentage (%)
Hygiene and Sanitation	5	41.7
Timely Immunization of under fives	2	16.7
Others	2	16.7
Healthy eating habits	2	16.7
Adoption of Family Planning	1	8.2
Total	12	100.0

n= 12,CHVs were required to select only one major health practice

Appendix 24: Chuka Sub - County

Major Health Practice	Freq.	Percentage (%)
Adoption of Family planning	2	33.3
Hygiene and Sanitation	2	33.3
Timely Immunization of Under Fives	1	16.7
Others	1	16.7
Health Eating Habits	0	0
Total	6	100.0

n= 6, CHVs were required to select only one major health practice

Appendix 25: Igamba Sub-County

Major Health Practice	Freq.	Percentage (%)
Hygiene and sanitation	5	100
Adoption of family planning	0	0
Health Eating habits	0	0
Timely Immunization of Under Fives	0	0
Others	0	0
Total	5	100.0

(n = 5, CHVs were required to select only one major health practice)

Appendix 26: The CHVs Program has led to Positive Health Outcomes (Feedback by CHEWS / PHOs)

Level of Agreement / Disagreement	Freq.	Percentage (%)
Strongly Agree	5	100
Agree	0	0
Neutral	0	0
Disagree	0	0
Strongly disagree	0	0
Total	5	100.0

n = 5

Appendix 27: Major Health Practices that have Improved/ Changed over the last two years (according to the CHEWS & PHOs)

Major Health Practices that have improved	Freq.	Percentage (%)
Hygiene and sanitation (hand-washing of latrines, refuse disposal pit)	5	100
Adoption of family planning	0	0
Health Eating habits	0	0
Timely Immunization of Under Fives	0	0
None	0	0
Total	5	100.0

n = 5, the respondents were required to select only one response)

Appendix 28: More Community Members have started seeking health services through CHVs Referrals

Level of Agreement / Disagreement	Freq.	Percentage (%)
Strongly Agree	4	80
Disagree	1	20
Agree	0	0
Strongly disagree	0	0
Total	5	100.0

n = 5

Appendix 29: Iam Proud to be associated with HopeCore's CHV Program

Level of Agreement / Disagreement	Freq.	Percentage (%)
Strongly Agree	5	100
Disagree	0	0
Agree	0	0
Strongly disagree	0	0
Neutral	0	0
Total	5	100.0

n = 5

Appendix 30: My social status has improved through my involvement in HopeCore's CHVs Program

My social status has improved	Freq.	Percentage (%)
Strongly Agree	32	82.1
Agree	7	18.0
Neutral	0	0
Disagree	0	0
Strongly Disagree	0	0
Total	39	100.0

n = 5

Appendix 31: Extent to which the CHVs Program has Benefited the Community

Extent of Benefits	Freq.	Percentage (%)
Very great extent	154	41..6
Great extent	104	28.1
Not applicaple	71	19.2
Not sure	16	4.3
Low extent	7	1.9
Very low extent	2	0.5
Total	370	100.0

n = 5

Appendix 32: Impact of CHVs' Work on the Community (Comments by CHVs)

The general living-conditions in community have significantly improved due to CHVs work	Freq.	Percentage (%)
Strongly Agree	36	92.3
Agree	3	7.7
Neutral	0	0
Disagree	0	0
Strongly Disagree	0	0
Total	39	100.0

n = 39

Appendix 33: I want the CHVs Program to Continue (CHVs Comments)

I want the CHV program to continue	Freq.	Percentage (%)
Strongly Agree	37	94.9
Agree	2	5.1
Neutral	0	0
Disagree	0	0
Strongly Disagree	0	0
Total	39	100.0

n = 39

Appendix 34: CHVs Program Expenditure (2018 - 2021)

Year/Budget Item	2018	2019	2020	2021
Annual general Meeting	NA	114134	NA	63760
Bags	70200	NA	NA	749250
CHEW & CHA Monthly stipend	NA	NA	180340	181460
CHV Feedback Meeting stipend	141400	42000	424340	632540
CHV MCH Mobilization	250	6080	83500	101500
CHV lead communication Stipend	NA	NA	16800	295520
COVID transport	NA	NA	159080	18000
Entry Meeting	NA	NA	111280	22720
Field Allowance - CHVs	875229	5848390	3302684	4568629
Hypertension (BP machines & Flip-books)	NA	NA	376000	834700
Masks	NA	NA	50000	55500
Mobile phones	NA	683500	14000	315868
Photocopy	8640	107100	NA	4,696
Stipend (paid by the county government)	1368000	4572000	16128000	26964000
Transportation Costs	350475	146700	538863	NA
T- shirts	NA	95550	NA	305250
Staff Salaries (50%)	123600	992462	1453064	1630279
Total	2919794	12607916	22837951	36743672
Grand Total				75109333
Annual Average				18777333.25

Source: HopeCore Finance Department

NOTE: The figures are in KES, county government stipend are calculated based on the average number of CHVs in each particular year. Average number of CHVs: 2018 (38), 2019 (127), 2020 (448), 2021 (749).

Appendix 35: CHVs Referrals

Sub County	Disease / Year	Apr to Jun 2021	Jul to sept 2021	Oct to Dec 2021	Jan. to Mar.	Total
Chuka	HIV Testing	56	101	81	95	333
	Comprehensive Geriatric Services	93	93	110	102	398
	Family Planning Services (15 - 49)	336	263	499	580	1698
	ART defaulter	1	0	5	1	7
	Home Delivery referred for Postal Natal Care	3	1	9	1	14
	Immunization defaulter referred	0	1	1	2	4
	Children (6 - 59 months) referred for Vitamin A supplementation	2204	7	236	13	2460
	Children (0 - 11) referred for immunization	37	0	6	5	48
	Children with delayed developmental milestones referred	3	0	0	1	4
	HIV exposed infant defaulters referred	0	0	0	0	0
	Children <5 years TB of bacteriologically confirmed TB cases referred for IPT	0	0	4	1	14
	Pregnant women referred	115	104	116	96	431
	Presumptive TB contacts of bacteriologically confirmed TB cases referred	9	0	4	1	14
	Presumptive TB persons referred for diagnosis	17	3	15	11	46

Muthambi	HIV Testing	30	29	20	22	101
	Comprehensive Geriatric Services	121	98	52	73	344
	Family Planning Services (15 - 49)	136	86	78	124	424
	ART defaulter	2	1	0	2	5
	Home Delivery referred for Postal Natal Care	4	0	5	0	9
	Immunization defaulter referred	2	19	18	3	42
	Children (6 - 59 months) referred for Vitamin A supplementation	462	556	295	190	1503
	Children (0 - 11) referred for immunization	23	23	12	17	75
	Children with delayed developmental milestones referred	1	8	4	4	17
	HIV exposed infant defaulters referred	2	0	0	0	2
	Children <5 years TB of bacteriologically confirmed TB cases referred for IPT	2	3	0	0	5
	Pregnant women referred	70	63	50	59	242
	Presumptive TB contacts of bacteriologically confirmed TB cases referred	2	2	10	1	15
	Presumptive TB persons referred for diagnosis	49	26	11	21	107

Igambang' ombe	HIV Testing	154	92	183	69	498
	Comprehensive Geriatric Services	70	72	51	175	368
	Family Planning Services (15 - 49)	310	213	200	158	881
	ART defaulter	1	6	1	0	8
	Home Delivery referred for Postal Natal Care	6	8	1	4	19
	Immunization defaulter referred	144	9	8	32	193
	Children (6 - 59 months) referred for Vitamin A supplementation	941	148	209	158	1456
	Children (0 - 11) referred for immunization	134	56	80	43	313
	Children with delayed developmental milestones referred	7	2	2	5	16
	HIV exposed infant defaulters referred	1	1	1	0	3
	Children <5 years TB of bacteriologically confirmed TB cases referred for IPT	2	0	2	0	4
	Pregnant women referred	35	59	39	33	166
	Presumptive TB contacts of bacteriologically confirmed TB cases referred	4	8	31	1	44
	Presumptive TB persons referred for diagnosis	99	118	74	129	420



Mwimbi	HIV Testing	618	967	923	831	3339
	Comprehensive Geriatric Services	938	852	745	1001	3536
	Family Planning Services (15 - 49)	578	1119	732	525	2954
	ART defaulter	0	2	1	3	6
	Home Delivery referred for Postal Natal Care	1	1	1	3	5
	Immunization defaulter referred	5	2	4	13	24
	Children (6 - 59 months) referred for Vitamin A supplementation	2468	894	1284	287	4933
	Children (0 - 11) referred for immunization	67	56	60	114	297
	Children with delayed developmental milestones referred	1	2	7	3	13
	HIV exposed infant defaulters referred	0	0	0	0	1
	Children <5 years TB of bacteriologically confirmed TB cases referred for IPT	1	0	0	0	1
	Pregnant women referred	44	84	67	67	262
	Presumptive TB contacts of bacteriologically confirmed TB cases referred	0	0	0	0	0
	Presumptive TB persons referred for diagnosis	8	8	17	14	47

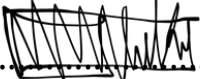
Tharaka North	HIV Testing	5	4	3	2	14
	Comprehensive Geriatric Services	6	12	10	16	44
	Family Planning Services (15 - 49)	980	619	442	910	2951
	ART defaulter	0	0	0	0	0
	Home Delivery referred for Postal Natal Care	16	30	1	10	57
	Immunization defaulter referred	6	1	0	1	8
	Children (6 - 59 months) referred for Vitamin A supplementation	520	78	606	15	1219
	Children (0 - 11) referred for immunization	26	17	5	0	40
	Children with delayed developmental milestones referred	3	1	0	0	4
	HIV exposed infant defaulters referred	0	0	0	0	0
	Children <5 years TB of bacteriologically confirmed TB cases referred for IPT	0	0	0	0	0
	Pregnant women referred	69	54	35	59	217
	Presumptive TB contacts of bacteriologically confirmed TB cases referred	0	0	0	2	2
	Presumptive TB persons referred for diagnosis	0	0	1	2	3



Tharaka South	HIV Testing	971	66	32	32	1101
	Comprehensive Geriatric Services	126	149	431	30	736
	Family Planning Services (15 - 49)	456	728	175	205	1564
	ART defaulter	10	19	13	20	62
	Home Delivery referred for Postal Natal Care	22	321	12	5	360
	Immunization defaulter referred	25	13	28	32	98
	Children (6 - 59 months) referred for Vitamin A supplementation	2365	227	402	139	3133
	Children (0 - 11) referred for immunization	45	68	63	41	217
	Children with delayed developmental milestones referred	2	5	1	4	12
	HIV exposed infant defaulters referred	2	0	4	5	11
	Children <5 years TB of bacteriologically confirmed TB cases referred for IPT	0	2	0	2	4
	Pregnant women referred	140	109	57	86	392
	Presumptive TB contacts of bacteriologically confirmed TB cases referred	4	7	5	4	20
	Presumptive TB persons referred for diagnosis	12	14	7	15	48
Total	16228	8810	8695	6730	40462	
Average	193	105	104	80	483	

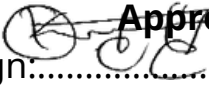
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SEPTEMBER 2022**