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MATERNAL, INFANT AND YOUNG CHILD NUTRITION (MIYCN)

Stakeholder Mapping and Landscape Analysis Report

September 2021

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CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS AND ABBREVIATIONS

A&Y	Adolescents and Youth
ACDI-VOCA	Agricultural Cooperative Development/International Volunteers in Overseas Cooperative Assistance
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
ASAL	Arid and Semi-Arid Land
ASRH	Adolescent Sexual Reproductive Health
BFCI	Baby-Friendly Community Initiative
BFHI	Baby-Friendly Hospital Initiative
CBO	Community-Based Organization
CCG	Community Care Group
CHAs	Community Health Assistants
CHEWs	Community Health Extension Workers
CHS	Community Health System
CHU	Community Health Unit
CHVs	Community Health Volunteers
CHWs	Community Health Workers
CMSG	Community Mother Support Groups
CNTF	County Nutrition Technical Forum
COVID-19	Coronavirus Disease 2019
CSB++	Super Cereal Plus
CSG	County Steering Group
EBF	Exclusive Breastfeeding
F75	Special Milk for Stabilization of Severe Malnutrition
F100	Special Milk for Catching Up Growth for Severe Malnutrition
FBO	Faith-Based Organization
FLM	Family-Led Mid-Upper Arm Circumference
FP	Family Planning
GAM	Global Acute Malnutrition
GM	Growth Monitoring
GMP	Growth Monitoring and Promotion
HCD	Human-Centered Design
HCWs	Health Care Workers
ICCM	Integrated Community Case Management
IEC	Integrated Education Curriculum
IGA	Income-Generating Activities
IMAM	Integrated Management of Acute Malnutrition
INGOs	International Nongovernmental Organization
IP	Implementing Partner
IYCF	Infant and Young Child Feeding
KABP	Knowledge, Attitudes, Beliefs, and Practices
KAP	Knowledge, Attitude, and Practice Surveys
KES	Kenyan Shilling
KHIS	Kenya Health Information System

KI	Key Informant
KII	Key Informant Interview
LASM	Landscape Analysis and Stakeholder Mapping
MAM	Moderate Acute Malnutrition
MCA	Male Change Agent
MCH	Maternal and Child Health
MCHN	Maternal and Child Health Nutrition
MIYCN	Maternal, Infant, and Young Child Nutrition
MMSG	Mother-to-Mother Support Groups
MoH	Ministry of Health
MSP	Multisectoral Platform
MUAC	Mid-Upper Arm Circumference
NICHE	Nutrition Improvement for Children through Cash and Health Education
NGO	Nongovernmental Organization
PAM	Persistent Acute Malnutrition
PLWs	Pregnant and Lactating Women
PNC	Post-natal Care
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RUSF	Ready-to-Use Supplementary Food
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SBC	Social Behavior Change
SBCC	Social Behavior Change Communication
SMART	Standardized Monitoring and Assessment of Relief and Transitions
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VSLAs	Village Savings and Loan Associations
WASH	Water and Sanitation Hygiene
WFP	World Food Program
WHO	World Health Organization

EXECUTIVE SUMMARY

Progress has been made in averting deaths associated with acute malnutrition in Samburu and Turkana Counties; however, global acute malnutrition (GAM) remains persistently high, and maternal, infant, and young child nutrition (MIYCN) practices are still suboptimal in the two counties. Optimal MIYCN practice and care are critical pathways to reducing persistent acute malnutrition (PAM). The purpose of the landscape analysis and stakeholder mapping (LASM) is twofold; (1) first, to identify programs, strategies, and approaches – including social behavioral change (SBC) – that would improve MIYCN; (2) second, to investigate design and implementation challenges of the existing strategies in improving MIYCN. This work also maps key stakeholders to understand who is doing what and where, with a view for the Project to identify areas of possible integration and layering. The LASM also helps to understand government priorities and current platforms to coordinate nutrition, specifically MIYCN programs, at different levels. Together with findings from other USAID Nawiri research studies, the LASM will inform MIYCN program codesign actions for the USAID Nawiri in Turkana and Samburu.

The LASM applied key informant interviews (KIIs) with county government staff, frontline workers, and development partners using a semi structured questionnaire to interview 28 key informants (KIs) in Samburu County. Of those 28 KIs, 16 were at the county level and 12 were at the community level. In Turkana County we interviewed 34 informants, of whom 20 were at the county level and 14 at the community level. We also reviewed secondary literature, including program reports, impact evaluation reports, and nutrition policy and program documents.

The programmatic implications of the findings on MIYCN programming of both Turkana and Samburu Counties and the USAID Nawiri Project are as follows:

1. **Coordination**: The counties engage partners and coordinate their nutrition work through the County Nutrition Technical Forum (CNTF), the multisectoral platform (MSP), and the County Steering Group (CSG) platforms to align with the county nutrition plans and programs, ensure complementarity of projects, and discuss progress and barriers to implementation.
2. **Targeting**: Counties' MIYCN programs and partner projects target a range of vulnerable groups including children under 5 years of age, adolescent girls/mothers, pregnant and lactating mothers, women of reproductive age, and children under 5 with acute malnutrition. There are several partners supporting the county Department of Health at all levels to strengthen policy, strategy, and implementation of MIYCN and integrated management of acute malnutrition (IMAM). However, there is duplication of work by partners in a few sub-counties.
3. **The Baby-Friendly Community Initiative (BFCI) is a promising community approach** adopted by both counties that primarily uses existing community health units (CHUs) and mother-to-mother support groups (MMSGs) targeting improvement of MIYCN and care practices. However, there is a need to address the low coverage of BFCI due to the high cost of training and implementation, limited integration at the community units, and lack of integration of data recording tools and reporting systems with those of the Kenya Health Information System (KHIS). **We recommend that Nawiri's MIYCN**

human-centered design (HCD) process investigate these issues and propose solutions by engaging key stakeholders. In addition, USAID Nawiri will need to engage the Nutrition Improvement for Children through Cash and Health Education (NICHE) in Turkana County.

4. **Findings of LASM show that IMAM and the recently introduced family-led mid-upper arm circumference (FLM) are effective platforms to promote MIYCN.** The counties and USAID Nawiri should review IMAM training packages, services, and monitoring tools to systematically and effectively integrate and promote MIYCN practices. The FLM through MMSGs approach has empowered mothers to screen their children for acute malnutrition and take control of their children's referral to IMAM services. It is another potential community contact point to promote MIYCN practices and health care for mothers/caregivers.
5. **Nawiri should use the counties' existing community health system (CHS) (health facilities and CHUs) and community groups, such as Care Groups and MMSGs, to scale up MIYCN interventions, services, and SBC** at the facility, community, and household/individual levels. Turkana County provides 3,000 KES to incentivize community health volunteers' (CHVs') health and nutrition work. However, the compensation is small for the workload they are asked to carry, which negatively affects community and household level MIYCN and health activities. There is a need to streamline their workload and to consider other modalities of incentives for CHWs, such as income-generating activities (IGAs) and nonmonetary incentives. In Samburu County, the county assembly recently passed the CHS strengthening bill, under which CHVs will be provided with a monthly stipend for facilitation of activities at the community unit level. However, to incentivize CHVs, partners introduced cash or IGA grant incentives to boost CHV's morale and improve performance. It has been effective, but it is not sustainable unless it is part of the county incentive system and fully supported by the county resources. **Nawiri's research on the CHS, including incentives for CHV performance, will provide information to address this challenge in collaboration with the county Department of Health.**
6. **Build on previous women's empowerment and household influencer work to improve gender dynamics as they relate to MIYCN.** There are best practices that influence women's adoption of MIYCN and health behaviors. Some successful practices include increasing their nutrition and gender-related knowledge and skills through MMSGs, increasing access to income through table banking and village savings and loans (VSLAs), and involving husbands and elderly women, especially mothers-in-law, in community nutrition and SBC programs. In addition, programs should involve morans[1] and male change agents (MCAs) in Samburu. Programs have been empowering adolescents using champions for girls' education and termination of early marriages. The counties, with USAID Nawiri, can scale up and streamline these best practices in community SBC programming for improving MIYCN and health optimal practices and care.

[1] The malezi bora program is an initiative implemented nationally as a strategy to accelerate the utilization of maternal and child health and nutrition (MCHN) services offered in county health facilities.

7. **Strengthen and scale up the existing approaches to community MIYCN's SBC.** There are effective SBC approaches and platforms, such as individual or group counseling and support by health workers, community health extension workers (CHEWs) and CHVs, community dialogue and mobilization through MMSGs and Community Care Groups, and reinforcing MIYCN and health behaviors and services using radio talk shows and Digi-Somo. The team recommends strengthening the combination of these community SBC strategies; and building skills of CHVs and mentor mothers in IYCN counseling, running group sessions, and using SBC materials to increase demand for health and nutrition services, and improve MIYCN practice and health care.

8. **Utilize effective MIYCN SBC materials and review those that need contextualization.** The existing SBC materials that improved MIYCN practices are pictorial and have context-specific messages and pictures that are easily understood by mothers/caregivers, communities, and CHVs. The materials include talking walls, ABS boards with key MIYCN messages, and shujaa booklets (father/baba, mother/mama, and girl/adolescent). However, there are also SBC materials—but the materials are not translated into Ng'aturkana, which is the local dialect, nor are they adapted to the lifestyle and sociocultural contexts of nomadic populations, and they do not consider livelihoods of different livelihood zones within the counties (e.g., fisheries or urban livelihood zones). The recommendation is to review these MIYCN SBC materials to adapt them to the cultural and livelihood contexts of nomadic populations and various livelihood zones. In addition, existing and new SBC materials must be translated into Ng'aturkana for easy dissemination by CHAs, CHVs, and mentor mothers, and to increase understanding of these issues among the communities, influencers, and caregivers.

9. **There is a need to increase investment in promising community-based nutrition-sensitive interventions.** In Samburu Central Subcounty, nutrition-sensitive interventions such as kitchen gardens, merry-go-round systems,[2] poultry production, and Healthy Baby Living Clubs help to increase consumption of orange-fleshed sweet potatoes, promote production and consumption of indigenous nutritious foods, introduce drought-resistant crops, and increase the presence of markets with nutritious foods that have contributed to improving MIYCN practices. USAID Nawiri is ideally positioned to support the counties to implement livelihood and market approaches and interventions to improve MIYCN practice and care.

10. **Strengthen and scale up program approaches to reach adolescents and promote adolescent nutrition. Current interventions are limited in coverage.** Promising approaches in both counties include having a separate adolescent MMSG or care model; older school adolescent clubs; radio talk shows; digital technologies like Ong'a integrated mobile outreaches and mobile apps; and bulk SMS implemented in Samburu East and Central Sub-counties. These measures have promoted nutrition messaging among the adolescent group. Another approach includes collaborating with church or religious youth

[2] Merry-go-round is an organization of women who collectively save money from their paychecks, and after some time, gift all the money to one of the women involved in the merry-go-round system. The goal is to provide each woman with the opportunity to access a large amount of money for their business or domestic use that they may otherwise have had to save months or years to accumulate. *Nkaingonisho* is the Samburu word for "brave." *Mama*, *Baba*, and *binti shujaa* are Swahili words for mother, father, adolescent girl, and brave, respectively.

groups. In Samburu County, the program identified adolescent and youth champions/binti shujaas and morans as role models[3] and held a "dialogue day" with mini-dialogues at the household level. Mama, Baba, and binti shujaa booklets are currently being used in a few locations in the two counties. However, these promising approaches and interventions have limited coverage and reach. Counties will benefit from scale-up of the context-specific interventions, approaches, platforms, and SBC materials to areas that have not been reached, while strengthening these measures in places that already have them.

11. **Involve adolescents in the design of approaches and feasible interventions that are responsive to their health and nutrition needs; include adolescent pregnant mothers in this effort.** There are limited experiences and programs or approaches in health facilities and communities that have tried to address MIYCN and adolescent sexual reproductive health (ASRH) issues of adolescents, specifically adolescent pregnant mothers. In addition, most of the SBC materials, such as Nkaingonisho/shujaa booklets for mothers (mama shujaa), fathers (baba shujaa), girls/adolescents (binti shujaa) are adapted from materials prepared for the general population or adult pregnant and lactating women, rather than considering specific needs and barriers to MIYCN and sociocultural contexts of adolescents, especially adolescent pregnant and lactating mothers. Other SBC materials are mainly focused on family planning and reproductive, maternal, neonatal, child, and adolescent health (FP/RMNCAH). To address these gaps, there is a need to design innovative and scalable interventions and approaches and develop SBC materials suitable to adolescents by proactively engaging adolescents, including pregnant and lactating ones, throughout the process. USAID Nawiri's HCD approach will facilitate involvement of adolescents in the design of interventions and approaches responsive to their needs and contexts for improving adolescent nutrition and health outcomes and appropriately supporting and counseling young adolescent mothers on feeding their young children.

The following areas need more investigation to develop locally appropriate and acceptable strategies and approaches.

1. **Strengthen current adaptations and try out innovative ways to mitigate shock/stress.** In both counties, the most common adaptation is shifting resources from existing program activities and raising new resources to respond to drought, floods and recently to COVID-19. There are some promising MIYCN program adaptations to shocks in Samburu that should be considered in future programming. For example, the county uses the intercommunity elders' meeting to discuss resource sharing during droughts and floods, and engages morans to respond to shocks. Partners could help the counties to identify additional MIYCN program adaptation strategies to mitigate droughts and other shocks—for example, the USAID Nawiri-supported FLM and modified IMAM community management around COVID-19.
2. **MIYCN programs and approaches need to be contextualized to different livelihood zones.** The LASM found limited efforts to adapt MIYCN and health programs' strategies

[3] The binti shujaa ("my sister's heroine") intervention is an innovative strategy to address the health needs of adolescent mothers and their children. The model uses peer-based and mentorship approaches and targets teen girls (15–19 years) who are either pregnant or have children under 24 months, to link them with health and socioeconomic services. Positive deviant teenage mothers/girls serve as champions to encourage and motivate others.

and interventions to different livelihood zones in Turkana. The county should challenge their departments and partners to avoid a "one size fits all" MIYCN approach, and push them to contextualize MIYCN strategies, programs, and SBC materials to respond to needs of each livelihood zone.

3. **Contextualize the SBC approach to different living environments.** Findings of the LASM point to the need to design and implement a simple and sustainable SBC approach that addresses the unique needs of mobile pastoralist communities and sub-counties commonly affected by conflict like Turkana South, East, and North. USAID Nawiri's MIYCN HCD process offers solutions to these challenges.

1. INTRODUCTION

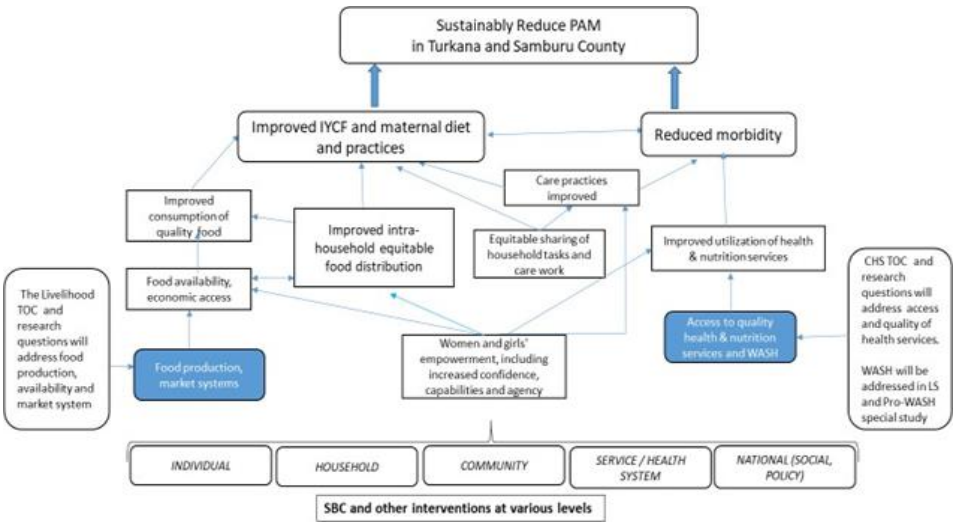
The United States Agency for International Development's (USAID) Nawiri is a 5-year project committed to sustainably reducing persistent acute malnutrition (PAM) in four counties in the arid and semi-arid regions (ASALs) of Kenya. A consortium led by Mercy Corps—in collaboration with Save the Children, RTI International, and other partners, including county government partners—is responsible for implementing USAID Nawiri in two counties: Samburu and Turkana. The project is working with local governments and other stakeholders to understand the drivers of acute malnutrition at a systems level to enable evidence-based programming to determine what works and how it works in these contexts. The ultimate goal is to use evidence generated to design contextually appropriate program interventions while promoting adoption of a systems approach to enhance sustainability of efforts.

Optimal maternal, infant, and young child nutrition (MIYCN) is the ultimate pathway to reducing persistent acute malnutrition (see MIYCN theory of change in Figure 1). Government and development partners have invested in programs to improve MIYCN, as seen in program strategies and approaches being implemented in Samburu and Turkana. Notably, great strides have been made to minimize mortalities associated with acute malnutrition, but global acute malnutrition (GAM) remains persistently higher than the World Health Organization (WHO) threshold of 15%. Although mothers appear to have good knowledge about optimal breastfeeding practices, there are insufficient data to conclude that they have adequate knowledge about optimal complementary feeding practices. There is ample evidence to show that both breastfeeding and complementary practices are suboptimal. This scenario is worrying, as it has a longer-term impact on the quality of life and economic growth of the two counties. The persistent nature of the GAM rates also points to a pertinent question for government and development partners: Children may respond to and survive the current strategies to reduce malnutrition, but are there different approaches that can be used in the health field to trigger future declines in GAM?

This landscape analysis evaluated existing strategies—how they are working, who among the partners are doing what, and where. This work also investigated the design and implementation challenges of the existing strategies and sought to collect ideas from key stakeholders on improving MIYCN programming and practices in the two counties.

The outcome of this landscape analysis will form the basis for designing multistakeholder sustainable solutions to improve MIYCN in Samburu and Turkana. The MIYCN theory of change guides the USAID Nawiri as it seeks to achieve these goals.

Figure 1. MIYCN Theory of Change



2. PURPOSE

Cognizant of the multiple factors that influence nutritional status outcomes, USAID Nawiri has adopted a multisectoral approach in evidence generation to inform co-creation of locally appropriate solutions to address key drivers of PAM, including MIYCN and behaviors around care of young children. The landscape and stakeholder analysis is one of USAID Nawiri's areas of inquiry for MIYCN, designed to enhance understanding the outreach, coverage, quality of past and current programs, and barriers and opportunities to improvement of MIYCN practices and behaviors. Findings lay out relevant policies at the national and county level, and document existing stakeholder activities, geographical locations, and scale of program activities. Through this analysis and mapping, USAID Nawiri will seek to learn from relevant activities being implemented by governments and partners. More specifically, the purpose of the landscape analysis and stakeholder mapping (LASM) included the following:

- Understanding the key barriers to and enablers of optimal MIYCN and care practices
- Mapping all the current strategies and program interventions targeting improvement of MIYCN, and extent of their adaptation to different livelihood zones and shocks/stresses
- Mapping current stakeholders' roles (what, where, when, how)
- Understanding government investment and priorities regarding MIYCN
- Mapping potential areas for integration, layering, and integration with existing and planned initiatives
- Understanding how current efforts are coordinated among development partners and government

3. METHODOLOGY

The LASM used qualitative methodologies, including key informant interviews (KIIs) using a semi structured questionnaire to obtain information and data from county departments of health, other relevant government ministries (agriculture, water, gender and social protection), UN agencies (UNICEF and World Food Program [WFP]), implementing partners including community-based organizations (CBOs), international nongovernmental organizations (INGOs), and faith-based organizations (FBOs). The KIIs also included Community Mother Support Group (CMSG) leaders (chair ladies, secretaries, and mentor mothers), frontline health workers such as community health volunteers (CHVs), community health assistants (CHAs), nutritionists, and other stakeholders involved in supporting MIYCN programs for the target population. In Samburu County, a total of 28 KIIs were conducted (16 KIIs at the county level and 12 KIIs at the community level). In Turkana County, 34 KIIs were conducted (20 KIIs at the county and 14 KIIs at the community level). The interviews were audio recorded.

The methodology also encompassed a review of secondary literature, including a review of program reports, impact evaluation reports, nutrition policy documents (County Nutrition Plan of Action, Community Health Strategy Policy 2020, etc.), MIYCN and nutrition assessment reports (SMART surveys or MIYCN knowledge, attitudes, beliefs and practices [KABP] surveys), and other relevant program documents and SBC materials, such as MIYCN counseling cards, familia bora pregnant and lactating women (PLWs) CHVs' guide, malezi bora job aids, and the Samburu CHV Key Message Guide. They have been used over the past 10 years or are currently being implemented in the counties. These MIYCN documents were obtained from the county Department of Health and implementing partners such as Afya Timiza, Feed the Children, International Rescue Committee, Save the Children, World Vision International, Kenya Red Cross, Palladium, FBOs (Catholic Diocese of Lodwar and Maralal), and other MIYCN programs.

During the data collection, the team ensured that targeted respondents and research assistants (data collectors) followed all COVID-19 public health mitigation measures to minimize community transmission. When training research assistants (RAs) to handle data collection at the field level, RAs and respondents maintained social distancing, wore masks, and used hand sanitizer. They were also encouraged to practice the safe disposal of used masks, gloves, and water bottles to maintain proper environmental sanitation and hygiene.

The audio recordings were carefully transcribed verbatim into a Microsoft Word document and coded and analyzed in NVIVO using thematic content analysis. A codebook was developed using deductive codes based on the interview guides. The team defined themes and subthemes to gather critical information that would clearly identify MIYCN strategies, challenges, adaptations, and SBC channels used.

4. FINDINGS OF THE LANDSCAPE ANALYSIS

4.1 TURKANA COUNTY

4.1.1 Key stakeholders and their support to counties

The county Ministry of Health (MoH), with support from partners, implementers, and monitors, integrated MIYCN services across 208 community health units (CHUs) and 148

health facilities targeting adolescent mothers, PLWs, and children less than 5 years of age. The MIYCN activities are implemented using the Baby-Friendly Community Initiative (BFCI) approach, where mothers, caregivers, men, and the community are engaged through CMSGs, community dialogue meetings, local chief baraza,[4] and community activities such as cooking demonstrations/competitions. Currently, there are five local organizations and INGOs (Concern Worldwide, Africare International, Feed the Children, Sapcone, and World Relief) supporting the implementation of MIYCN at the community and health facility level in Turkana Central, Kibish, Loima, and Turkana South Sub counties. The MIYCN activities supported by these partners included promotion of optimal breastfeeding and complementary feeding practices, BFCI, malezi bora program,[5] development and dissemination of MIYCN SBC materials using various approaches, in addition to complementary activities including agri-nutrition, provision of water and sanitation hygiene (WASH) amenities to improve hygiene and sanitation, and women's empowerment through supporting community support groups with cheap loans and income-generating activities (IGAs). There was no local or international partner supporting MIYCN activities in Turkana West Subcounty before USAID Nawiri.

The United Nations Children's Fund (UNICEF) and World Food Program (WFP) have also greatly supported local and international partners technically and financially to implement MIYCN activities and roll out other health-related approaches that complement MIYCN, such as family-led mid-upper arm circumference (MUAC), community-based management of acute malnutrition (CMAM), and integrated community case management (ICCM) in the county. In addition, UNICEF has provided anthropometric equipment (MUAC tapes, weighing scales, height boards), ready-to-use therapeutic food (RUTF), F75, F100, and vitamin A to health facilities to improve the quality of and access to treatment of severe acute malnutrition (SAM) services for children 6–59 months of age. WFP has continued to provide in-kind food assistance such as super cereal plus (CSB++) and ready-to-use supplementary food (RUSF) for supplementary feeding programs targeting PLWs and children 6–59 months with moderate acute malnutrition (MAM) at the health facility level; they also funded integrated outreach programs across the county in hard-to-reach areas.

The county Department of Health, with support from UNICEF, rolled out nutrition improvement through the NICHE program, which is designed to reach vulnerable households with nutrition-sensitive cash transfers to improve well-being in nutrition, child protection, and social protection. NICHE utilizes the county's community health strategy to deliver high-impact nutrition interventions for cash to beneficiaries through adoption of the BFCI approach to influence knowledge, attitudes, behaviors, and practice in health, child protection, and nutrition within households. NICHE will build the capacity of the county Department of Health, gender, and social protection, and communities to be resilient and responsive through integration of services for improvement of health and overall well-being of the community.[6]

4 A baraza is a public gathering held specifically to promote interaction among the people in the community and their leaders such as chiefs, politicians, etc.

[5] The malezi bora program is an initiative implemented nationally as a strategy to accelerate the utilization of maternal and child health and nutrition (MCHN) services offered in county health facilities.

[6] https://www.unicef.org/kenya/press-releases/innovative-cash-transfer-and-nutrition-programme-launched-reduce-child-poverty-five

The main stakeholder tasked with the implementation of maternal and child health nutrition (MCHN) services at the subcounty, ward, and village level is the county MoH. In collaboration with development partners, the MoH provided strategic leadership in the roll-out of various complementary approaches to MIYCN such as family-led mid-upper arm circumference (FLM) for community surveillance by caregivers, ICCM/CMAM for detection and treatment of childhood illnesses, integrated management of acute malnutrition (IMAM) surge for facility monitoring of malnutrition trends, and IMAM services for the reduction of PAM.

4.1.2 County/subcounty/community engagement in MIYCN projects/program development, implementation, coordination, and accountability

The county has established governance and coordination platforms from county to ward level to ensure that partners align with nutrition priorities of the county, monitor implementation, and ensure complementarity of projects. The county government has been at the forefront of developing and advocating for context-specific and feasible solutions to reduce acute malnutrition. This leadership and commitment is the main reason for several local and international partners working closely with the county on their effort to improve the nutrition status of the population's PLWs, adolescents, and children under 5 years of age. During KIIs, implementing partners shared the following:

"…There is a County Steering Group (CSG) meeting that I just mentioned, held every month, and sub-county meetings conducted by the National government, and we also attend them."

KII Implementing Partner

"…We use the established county structures right from the village level."

KII Implementing Partner

"We also work with the county government very closely because our nutrition programs were designed around CIDP."

KII Implementing Partner

The county coordinates nutrition activities, including MIYCN, through the monthly County Nutrition Technical Forum (CNTF). All stakeholders converge to discuss the progress and challenges of implementing various projects or programs supported by the county Department of Health, MoH, and development partners, including UN agencies and NGOs. Although it is not robust, partners from various sectors such as WASH, Health and Nutrition, Livelihoods, Gender-Based Violence, and Social Protection continue to meet monthly through the multisectoral platform (MSP) to discuss layering for effective utilization of resources for reduction of PAM. County Steering Committee (CSG) platforms provide meetings for representatives from the county government's various departments, including health and nutrition, as well as NGOs, for discussing challenges that affect the population, including health and nutrition, WASH, pending emergencies such as floods, drought, etc., and for advice on how to improve or mitigate a worsening situation.

Partners also mentioned the monthly community health system (CHS) meetings at the community unit. CHAs and CHVs participate, and have enabled CBOs and INGOs to monitor the implementation of MIYCN activities. The meetings provide an opportunity to

engage with these two key frontline health worker roles to understand their challenges, successes, and possible improvements to programming.

Additionally, the County Department of Health, MoH, and partners involved in the coordination and implementation of MIYCN and health-related interventions have conducted joint monitoring, support supervision, and nutrition assessments, such as Standardized Monitoring and Assessment of Relief and Transitions (SMART) and Knowledge, Attitudes, Behaviors, and Practices (KABP) surveys, to track the performance of nutrition indicators and understand gaps and challenges for advocacy.

4.1.3 Strategies and program interventions to improve MIYCN

The landscape analysis looked at strategies and interventions of previous and current programs/ projects implemented by key stakeholders designed to improve MIYCN outcomes in the county. Information gathered focused on program strengths, challenges, and adaptations to different contexts and target groups.

Strategies and Interventions

BFCI: With support from UNICEF and partners, the county has adopted BFCI for the implementation of MIYCN activities at the community units. BFCI is a community-based approach to promote, protect, and support breastfeeding, and promote optimal complementary feeding and maternal nutrition practices through the formation and training of CMSGs. It includes conducting home visits and uses referrals to link mothers with primary health care facilities. BFCI also includes feeding sick children, promoting hygiene and sanitation, early childhood stimulation, and referrals to and from maternal and child health (MCH) clinics. It has clearly defined guidance and tools for implementing and monitoring MIYCN at the community level.

BFCI has yielded great success by empowering women enrolled in various CMSGs to practice optimal breastfeeding, complementary feeding, and maternal nutrition behaviors.

"The BFCI is one of the approaches that help in terms of improving these MIYCN and care practices."

KII Implementing Partner

Challenges to BFCI: BFCI coverage is low because it is resource-intensive to train health providers and community workers and to operationalize its implementation. Only seven out of 208 CHUs currently implement BFCI. Therefore, its scalability has been limited, with a minimal nutrition budget from the county Department of Health. BFCI integration is better at the health facilities and to some degree at the community units. Moreover, it has been difficult to track key indicators and milestones and report BFCI, because its data recording tools systems are not integrated with Kenya's Health Information System (KHIS).

"BFCI is not integrated into District Health Information System (DHIS), which means it can only be found in hard copies. But other partners are working very hard to integrate so that at some point, you will be able to have BFCI reports in the DHIS."

KII Implementing Partner

"BFCI is the game-changer, but its problem is that BFCI is expensive, and the reports are not anchored in MOH reports."

KII Implementing Partner

Strengthened IMAM services linked with MIYCN: All the county MoH's health facilities have continued providing IMAM services to PLWs, adolescents, and children less than 5 years of age. The IMAM is also used as a platform to promote MIYCN practices and care. Complementing IMAM with MIYCN activities, such as vitamin A supplementation, deworming nutrition counseling and education, and iron folate supplementation has enabled the community to benefit from other high-impact nutrition interventions that promote optimal MIYCN practices such as WASH, vitamin A supplementation, deworming of children 12–59 months, fortification of local foods, nutrition counseling, and education.

Adoption of FLM: Mothers enrolled in mother-to-mother support groups (MMSGs) were linked to FLM activities to develop skills and knowledge on how to detect and refer children with malnutrition at the household level. The FLM approach has enabled mothers to conduct screening for acute malnutrition, seek IMAM services, and take control of their child's future. This approach can be leveraged to promote MIYCN, as evidenced by one KII partner.

"…Family MUAC is a very good intervention that helps a mother make timely health decisions by adopting health-seeking behaviors. The mother participates by monitoring and in the timely identification of malnutrition, can self-refer to a facility."

KII Implementing Partner

Involvement of community members and community-level approaches: Most strategies and interventions to improve MIYCN practices and prevent and treat acute malnutrition at the community level were designed to engage communities. Communities, health workers, partners, and local authorities have been involved in developing community-level interventions and approaches, hence contributing to sustainability and resilience. These interventions include the following.

Care group model: This behavior change model engages women in the community. Groups are made up of 10–15 mothers from the same neighborhood who meet monthly to share information on MIYCN good practices. The care group promoters disseminate information on MIYCN behaviors/practices to other mothers using a cascade model. Stakeholders have used MMSGs, one type of care group model, to change MIYCN practices of caregivers and households.

One key informant interview shared, "…Many other partners and many countries have used it. But what I like about this approach is that it has a wide coverage, the messages can help all community members, and it has a very good multiplier effect because of how it is designed."

Care group models were successfully used by Feed the Children to promote and support optimal MIYCN and care practices. This strategy enrolled community mother support groups, and resulted in building community ownership and positive behavior change.

"Another strength is that we are not coming in as experts, but we are using people within the community, and in health, we are using people within the health system, and we are building their capacity."

KII Implementing Partner, Turkana

Women's empowerment: Women are empowered through nutrition education and gender-focused social behavior change (SBC) in community contact points and MMSGs, and they provide increasing access and control to income. MMSGs are linked to women's success in table banking,[7] village saving loans, poultry farming, and kitchen gardening to economically empower them to improve dietary habits, health care, and overall well-being. In addition, stakeholders have continued to champion for girls' education and reduction of early marriages to provide young girls with an opportunity to grow and achieve their full potential. One key informant interviewee mentioned explained:

"…We are also introducing the VSLs (Village Savings and Loans) to empower the women to get income. We formed table banking to support our members to get advances or loans to buy food for their children and pay for their own medical care."

KII Mother-to Mother Support Group, Turkana

Male and elderly women involvement: Males and elderly women are considered key decision makers and influencers of MIYCN practices such as family planning (FP), maternal health, child health, and WASH. Most of the country's nutrition and SBC programs, including programs supported by partners, target and involve husbands and elderly women, specifically mothers-in-law. Two key informant interviews reported:

"…Another approach that would work best is men's involvement. Men play a key role, but at times, we neglect them. We focus on women so much."

KII Community Health Extension Worker (CHEW)

"…when a young woman has a child, she is told what to do by the mother-in-law, and she will follow."

KII CHEW

Adoption of mobile technologies to contribute to community sensitization strategies: There is some effort to use mobile technology, like text messages, for community mobilization and to promote MIYCN messages to different target groups.

"We are working to pilot a community sensitization approach using an SMS platform where we send targeted messages to different groups, majorly, caregivers on issues around maternal, infant, and young child nutrition to get their views, and we provide feedback..."

KII Implementing Partner

7 Table banking is a group-based funding system where members of a group meet to contribute weekly savings to a "kitty," from which members can borrow.

Improved access to water: The county government, in collaboration with key stakeholders, has improved access to water by drilling new boreholes and upgrading water sources. Improved access to water has reduced the time mothers have to travel to fetch water, and households use the water for communal kitchen gardens to increase productivity.

"I know the pastoralists are not covering long distances like before because some boreholes have been drilled nearer communities making it easier to reach them."

KII Implementing Partner

Strengths and Opportunities

Presence of multisectoral stakeholders to support strategic partnerships in health, agriculture, education, water, and gender and social protection: Several local organizations and INGOs supporting various sectors—such as WASH, livelihoods, health, nutrition, social protection and gender-based violence—are ideally positioned to address underlying determinants of the poor MIYCN and health care and services and the persistently high acute malnutrition in the county.

Use the strong community health structure and capacity: A clear CHS structure with well-defined community health units (CHUs) has made feasible the scale-up of BFCI and health and nutrition interventions and services at community level, and linked community services to health facilities. In addition, the number of health care workers has increased dramatically following the evolution of health care in the counties, but there is still a significant gap in a few CHUs and health facilities. Trained health workers such as nutritionists, nurses, community health assistants, and community health volunteers have facilitated implementation of programs and approaches to improve MIYCN care and services in the county.

"Another thing is the structures that exist…the government structures. If you go to far places like Kibish, you will find health facilities. So, that is a strength according to me because that is a point where you will be able to meet mothers and children."

KII Implementing Partner, Turkana

"We have an elaborate community health strategy service in the county where we have structures up to the community level. We have Community Units. We have CHVs; carrying out these tasks is easier because the strategy is county wide."

KII Turkana, CHS Focal Person

Availability of coordination platforms that bring stakeholders together: The county MoH has continued to engage NGOs, FBOs, CBOs, and UN agencies through county nutrition technical forums and multisectoral platforms to discuss progress toward and barriers to effective implementation of nutrition programs.

Challenges/Barriers

Most projects/programs should be heavily focused on nutrition-specific interventions and strategies: Optimal MIYCN care and practice require both nutrition-specific and

sensitive interventions to address the immediate and underlying determinants of MIYCN and PAM. However, most partners have concentrated their efforts and resources on nutrition-specific interventions such as IMAM, FLM, MIYCN, micronutrient supplementation, nutrition counseling, and education. Few partners support or fund nutrition-sensitive interventions because of their resource-intensive nature. This has created a significant gap in improving MIYCN practices and tackling acute malnutrition.

The Department of Agriculture should provide information to communities and households on the most nutritious crops to grow, which are appropriate for the rainy or dry season, and appropriate food preservation methods for Turkana's semi-arid climate.

"...For example, if you visit an area like Poro, they have a lot of vegetables and even throw away during the rainy season, but during the dry seasons, they have nothing; yet this is a community that you can teach to dry the vegetables and use during the dry season."

KII Implementing Partner

CHVs' incentives and performance: Although the county government has continued providing CHVs with monthly stipends of KES 3,000 (30 USD), it has not been effective at incentivizing CHVs to perform optimally because the amount is small for the workload they are expected to carry. In addition, the payments are not consistent or timely. CHVs have not facilitated community-level sessions or conducted household visits, especially for households living in remote or hard-to-reach areas, because of transport and financial constraints.

"The major problem is facilitation in offering services for people living in remote areas. For example, CHWs do not receive airtime cards to communicate and support women living in remote areas."

KII CHEW

Non participatory program design and weak monitoring and evaluation, including research: Several participants reported poor documentation of strategies or approaches that improved MIYCN outcomes, which are instrumental in guiding and improving current and future MIYCN interventions. In addition, most partners do not involve the county stakeholders and communities when they design monitoring, evaluation, and research plans. For instance, most partners come with preconceived interventions without input from the county and community. These challenges have made it difficult to implement effective interventions that lead to sustainable nutrition outcomes.

"There is no clear documentation of evidence emerging from the different approaches we are using because we need to document the evidence when implementing the strategies to demonstrate that this kind of approach is effective. So, we need to document these strategies that have been lacking."

KII Key County Government Representative

4.1.4 Challenges common to all health and nutrition programs including those to improve MIYCN

Expansive geographic coverage: Turkana County is a vast region of around 7,700 km with a sparsely settled population. It is challenging to reach deserving children and mothers with

nutrition interventions due to constraints in government budget allocation for nutrition and limited ability of CHWs and transport.

"The community is sparsely populated, which makes it very expensive because there is a need for a highly educated workforce over there."

KII Implementing Partner

Limited budget and reliance on partners' resources: Nutrition and health activities are still underfunded because the county has been allocating insufficient funding to the MoH Nutrition Department to support and implement planned nutrition activities at the county, subcounty, and ward levels. Hence, MoH heavily relies on resources from donors and partners to implement activities such as BFCI, IMAM Surge, and ICCM. Sometimes, the government perceives health and nutrition programs as a partner's responsibility. For budget reasons, the county government has no long-term plan to fund evidence-based interventions. These challenges have negatively affected county ownership and sustainability of positive nutritional outcomes from partner-supported nutrition programs/projects. In addition, disbursement of the budget allocated for nutrition is not predictable, which has affected the timely implementation of health and nutrition activities at the community and health facility levels.

"Some of these strategies are heavily dependent on partners and donors. So, sometimes when partners pull out, it is grounded."

KII County Government Representative

Strategies and program adaptation to different contexts (stresses/shocks and livelihood zones)

Adaptation to shocks/stresses: Turkana has been affected by several expected and unexpected shocks, such as floods, drought, COVID-19, and locust infestation. Turkana County and implementing partners usually redirect resources from their existing program activities to respond to the humanitarian situations triggered by these shocks or stresses. The government and partners also worked jointly to mobilize additional resources to respond to drought, floods, and COVID-19. KIs suggested that the county should have a well-resourced contingency plan for health and nutrition to respond to commonly known shocks and unexpected ones like COVID-19 in the future.

"I think there is a need to have a contingency plan for health. I know there are contingency plans in times of drought when there are floods. There is a need for a contingency plan that takes care of health because when COVID-19 came, there was limited access to face masks and sanitizers, so I think there is a need for a contingency plan in place, specifically for health…"

KII Implementing Partner, Turkana

Community health and nutrition activities that attracted big crowds, such as integrated outreach, mass MUAC screening, and surveys, were on hold to reduce COVID-19 community transmission. The health and nutrition programs' specific adaptation to COVID-19 are summarized below:

- The MoH department and implementing partners rolled out FLM at the community unit for mothers, caregivers, and other family members to develop skills and knowledge in screening for acute malnutrition using a special family/mother MUAC tape and self-referral to the nearest health facilities for early treatment if their children have acute malnutrition.
- Health facilities adopted all COVID-19 public health measures such as masking and social distancing, and continued identifying and treating children with acute malnutrition using the COVID-19 adapted procedure for IMAM. This included less frequent visits, for example, monthly rather than the biweekly distribution of RUSF and RUTF for children 6–59 months enrolled in the IMAM program.
- The strengthening of the CHS has enabled the county government to withstand the impact of high GAM prevalence levels despite few resources to support community and health nutrition.

"When COVID-19 came, most implementing partners supported the communities by providing information about COVID-19. Others provided protective gear like masks, hand sanitizer, and provision of cash transfer for livelihood."

KII Implementing Partner

"Another example is that families/caregivers were trained and provided with family MUAC tape to screen their children at home. When there is any case of malnutrition, they're able to refer to the nearest health facilities instead of the busy health workers to come to the village…"

KII CHEW, Turkana

"The IMAM surge is a perfect fit. The IMAM surge helps the facility anticipate and plan to respond when there is a surge number of cases so that beneficiaries get timely and better management of acute malnutrition."

KII Implementing Partner

Adaptation to different livelihood zones: Turkana has different livelihood zones (pastoralists, agro-pastoralists, fisher folk, and urbanites); however, there has been limited attempt to adapt MIYCN and health program strategies and interventions to the specific context of each livelihood zone. Instead, the strategies and interventions are the same across the zones. A few adaptations were made mainly for pastoralist livelihood zones. For example, the county government and partners used a mobile ambulance to provide health and nutrition services for a mobile pastoralist community; however, it is challenging to sustain the mobile approach. It is expensive and requires high-level commitment from sub counties and frontline workers. Partners used Nyumba Kumi for advocacy, social mobilization, and communication.

"If you meet elders in different communities, they can mobilize people together, and it's easier to share your message through this channel."

KII CHEW

Another partner designed a strategy to harness floods for crops and vegetable production in areas commonly affected by floods. The partner developed this strategy, which includes capacity building, based on findings of a study that was conducted in the communities affected by flooding.

> *"We undertook studies to understand how to harness floods for crop productions. We introduced the strategy for budgeting and started harvesting flood water for crop production. For example, if you visit Jukjuk, in Turkana, in the past there was no farming. People used to go for many kilometers looking for food, and livestock was gone. Now, there is farming. They can access vegetables from the cowpeas leaves and grain from sorghum and maize…"*
>
> *KII IP, Turkana*

4.1.5 MIYCN program targeting and geographic coverage

The target group for MIYCN activities varies depending on the approach and the design of the project implemented by MoH or partners. The majority of the population targeted by the MoH, NGOs, UN agencies, and FBOs includes children under 5 years of age, adolescent women and pregnant and lactating mothers, women of reproductive age, and children under 5 with acute malnutrition. In addition, most partners target traditional birth attendants, caregivers, and opinion leaders for SBC activities. The Ministry of Agriculture and Agricultural Cooperative Development/International Volunteers in Overseas Cooperative Assistance (ACDI-VOCA) targeted youth and older men with nutrition-sensitive interventions such as poultry, kitchen gardening and agriculture, and livestock inputs to boost household food security.

It is important to note that the leading institution implementing MIYCN is the Department of Health, which has already integrated MIYCN into health facility and community activities including FBOs such as the Catholic health facilities in the county. ACDI-VOCA, WFP, UNICEF, CHS FP, and the Red Cross have supported the county on policy, strategy, and implementation of MIYCN, IMAM, and infant, young, and child feeding (IYCF) in emergencies and nutrition-sensitive plans, interventions, and activities. The Red Cross is also supporting all three sub-counties targeting areas experiencing emergencies and shocks. The USAID Afya Timiza Project and the NHP Plus Project had supported MIYCN activities before they closed out. Table 1 summarizes the key nutrition program areas where partners support MoH and their geographic coverage.

The mapping exercise found duplication of work by partners. Three different organizations work in the same areas, using the same approach, and targeting the same beneficiaries. For example, Turkana North has five partners doing similar nutrition projects, while in Turkana East, there is only one partner. Moreover, poor coordination among partners in the county has contributed to fragmentation of nutrition, making it difficult to engage MoH staff, because of competing activities and interests.

Table 1. Mapping of Partners by Geography and Key Program Areas of Support		
Partner	**Subcounty/ward**	**Program areas (MIYCN, health, IMAM, adolescent nutrition, nutrition-sensitive agriculture, emergency nutrition)**
UNICEF	Whole county	▪ Supports BFCI approach for the improvement of MIYCN, provides in-kind donations such as Plumpy Nut, F100, and F75, for management of SAM, vitamin A for children 6–59 months and iron–folic acid supplementation for pregnant women. This support ended. ▪ Develops and supplies the MoH with social behavior change communication (SBCC) materials that promote uptake of MIYCN and other health-related interventions such as MIYCN counseling cards, FLM illustration cards, and ICCM. They provide some anthropometric equipment for growth monitoring of under-5 children and PLWs. ▪ Provides capacity building for MoH, county, and partner staff for health and nutrition training like MIYCN, ICCM, FLM, and IMAM surge. ▪ Supports FBOs, CBOs, and INGOs for various nutrition programs and capacity building.
WFP	Whole county	▪ Provides nutrition therapeutic supplements such as CSB++ and RUSF required for management of MAM among children 6–59 months and PLWs. Provided SBCC integrated education curriculum (IEC) materials that promote handwashing during critical times and proper preparation of CSB++. ▪ Funds and supports integrated outreach activities in remote, hard-to-reach areas where MIYCN counseling to PLWs with children 6–23 months is normally conducted.
Concern Worldwide	Loima Subcounty and Kibich Subcounty	▪ Supports implementation at health facilities and MIYCN activities such as health and nutrition education, vitamin A supplementation, and provision and dissemination of key SBC messages to improve uptake of MIYCN services. Supports linkages of community birth referral agents and CHVs to promote complementary feeding practices among PLWs. ▪ Regularly funds and supports MIYCN-E assessments.
Feed the Children	Kalokol, Turkana Central Subcounty	▪ Implements MIYCN through care group model for behavior change where community-based volunteer behavior change agents work closely with CHVs, and mentor mothers. ▪ CHAs promote positive behavior change among women enrolled in community support groups.
AFRICARE International	Turkwel and Loima wards	▪ Provides MMSGs with optimal MIYCN messaging through supply of MIYCN counseling cards/materials. Provides funds and resources such as agri-nutrition training, seeds, and farming equipment for MMSGs that have embraced farming or kitchen gardening.

World Relief International	Kaaleng and Kaikor, Kibich Subcounty	▪ Supports provision of MIYCN services at the health facility level. These include individual and group counseling of PLWs on optimal breastfeeding and complementary feeding practices, proper maternal dietary intake, under-5 growth monitoring, and vitamin A supplementation of children 6–59 months during malezi bora campaigns. ▪ Implements MIYCN through care group model for behavior change where community-based volunteer behavior change agents work closely with CHVs, and mentor mothers.
Diocese of Lodwar	Countywide	▪ Provides MIYCN services at the health facility level. These include individual and group counseling of PLWs on optimal breastfeeding and complementary feeding practices, proper maternal dietary intake, under-5 growth monitoring, and vitamin A supplementation of children 6–59 months; implements the target supplementary feeding program (TSFP) for malnourished PLWs.

4.1.6 Community-level strategies or approaches to engage and support mothers and families

Existing SBC platforms and communication channels

The county Department of Health and its partners have effectively used the following facility and community platforms and communication channels to promote optimal MIYCN key behaviors and change practices at the household and individual levels.

CHVs are key for individual or group counseling and support: MoH and partners use CHVs to promote key MIYCN and health-related behaviors to caregivers, households, and communities through individual counseling during home visits, supporting MMSGs, facilitating community talks, and using outreach sites and church platforms.

"We have community health volunteers who visit those households. Community health volunteers are sensitized on MIYCN practices, and then they visit households to deliver the same messages."

KII County Government Representative

MMSGs and CCGs: These were the most commonly mentioned community platforms used to educate mother/caregivers, promote optimal MIYCN and health behaviors, and increase demand for health and nutrition services.

"MMSGs are helpful as they will help women learn from each other to be self-reliant through various activities, e.g., the kitchen garden."

KII CHEW

"Formation of mother-to-mother support groups is extensively used by most of the partners. It is a strategy that has helped put mothers together to share knowledge on nutrition and advance practices on nutrition care for children and adolescents."

KII Implementing Partner

Integrated outreach: Growth monitoring and promotion (GMP), immunization, and community antenatal care (ANC) have been used by health workers and CHEWs to provide health and nutrition services, including promoting optimal MIYCN and health messages to caregivers.

Radio talk shows and radio spots: Partners, through the county Department of Health and other departments, have supported radio spots and radio expert talk shows to disseminate MIYCN and care messages and other health-related messages to influential community members, households, caregivers, and county government stakeholders. The media use local languages, making it easier for communities to comprehend and support or change MIYCN practices.

> *"We have given messages through the radio and used songs in events like when we are marking events like breastfeeding week. The communities invented songs that encouraged breastfeeding, and they are performed, and become hits."*
>
> *KII Implementing Partner*

Digital platforms: USAID Afya Timiza used Digi-Somo, a digital platform feed with MIYCN messages and music, to cascade MIYCN education and care messages to caregivers. Digi-Somo is no longer used because of the cost of replacing batteries to run the Digi-Somo machines. Other partners are using SMS-based platforms to reach communities and share targeted messages on MIYCN.

Lessons learned and challenges in community SBC

Lack of appropriate skills and adequate materials: The majority of frontline workers, such as CHAs, CHVs, and mentor mothers, have not received training on how to use available SBC materials. Furthermore, the number of copies of these materials provided by MoH and partners is inadequate for the CHV population.

Low attendance of community members: Members of MMSGs and CCGs missed sessions because of competing community and household activities and high maternal workload. This has made it difficult to communicate all health and nutrition messages to all members of the group.

Limited involvement of husbands and community gatekeepers: CHVs and lead mothers should make every effort to involve community supreme members who want to be informed of everything yet to happen in the community. In addition, women are afraid of attending community SBC activities and clinics unless their husbands are informed. Thus, CHVs should try to engage husbands to create awareness about MMSGs and community meetings.

Illiteracy among community members: The majority of mothers and caregivers are illiterate, which makes it difficult to use digital technologies and posters. For illiterate caregivers, it is important to use a combination of platforms and channels, mainly individual counseling by CHVs/CHAs, MMSGs, and radio/TV, to effectively promote health and nutrition messages.

> *"Most people in our community are illiterate. They are not educated. Thus, most of them do not know how to use these devices like mobile phones and radios. It makes it even difficult to pass information to them. So the only way*

you can pass information to them is through these meetings, house-to-house visits, and methods that require your physical presence…"

KII Chair Lady, Adolescent Group, Turkana

Language barrier: Apart from the MIYCN counseling cards, most SBC materials are not translated into the local dialect, Ng'aturkana. This makes it difficult for CHVs to interpret during household visits.

Limited radio network coverage: Radio talk shows do not reach the majority of the population due to limited radio network coverage in the county. For example, in Katilu Ward, Turkana South Subcounty, the radio frequency is very weak, and the CHVs and CHAs have resorted to using community forums to educate the public.

Poor monitoring and reporting system: Despite existing monitoring and evaluation structures to monitor programs, there is no structured way of monitoring and reporting the effectiveness of the available MIYCN SBC strategies.

Lessons Learned: For proper delivery of the key MIYCN messages and information, there is a need to develop context-specific SBC delivery channels for adoption of both permanent and nomadic populations living in different livelihood zones. Furthermore, all SBC materials must be translated into the local Ng'aturkana language for easy dissemination by CHAs, CHVs, mentor mothers, and comprehension by the community. Periodic monitoring and evaluation of SBC strategies is vital to assessing its effectiveness in improving and promoting optimal MIYCN behavior and practices

Migration: Due to the nomadic nature of the Turkana people, it is challenging to target migrating families with important MIYCN and health messages because they are constantly on the move. Furthermore, CHVs tend to remain with permanent populations, as it is easier to deliver services. This means that migrating families are not covered.

Distance to health facilities: Long distances deter people living in the outskirts from accessing health facilities and getting MIYCN and health information during clinic days, as they rarely visit the clinics.

Insecurity: Some parts of Turkana South, East, and North Subcounties are insecure; hence, CHVs or health workers are unable to deliver health and nutrition services, including dissemination of key SBC information/messages.

4.1.7 Frontline health workers' support (lessons learned and remaining challenges)

The majority of frontline health workers have provided good counseling and support for caregivers/mothers during health facility and home visits. They have also provided lifesaving MCHN services at health facilities and outreach sites. The participants reported that the community appreciated the efforts and dedication of health facility workers and CHWs. They even reported that a few go the extra mile to deliver quality service despite existing challenges.

Significant challenges affecting health workers' ability to provide quality MIYCN counseling and support include heavy workloads and insufficient time to counsel mothers/caregivers. Some also lack counseling skills and MIYCN knowledge.

"That one works very well, but again the main challenge is the workload and shortage of health workers. The health worker may not have adequate time to counsel the cases."

KII, Samburu CHC

"Truth be told, the health care workers are usually overwhelmed, and there is not adequate time to be with the mothers and do the counseling the way it was designed. The high workload hinders effectiveness, but otherwise, it is a good approach to use if there is no issue with the workload."

KII, Turkana, Africare

The participants said that CHVs' low morale and poor performance have affected MIYCN and other health counseling and support efforts, mainly because of the mismatch between the incentives they are getting and the high workload they are expected to carry. In addition, the subcounty should work with the community health committee to ensure communities accept and respect CHVs.

"We need to find the means to support the community health volunteers in a way that they will be listened to and respected by the community because they are too casual."

KII Implementing Partner

Last, a shortage of critical frontline health workers such as nurses, nutritionists, and CHVs has compromised the quality of MIYCN service delivery, treatment of acute malnutrition, and nutrition/health education and counseling.

Lessons Learned: Frontline health workers should receive training on how to utilize various SBC materials designed to promote uptake of MIYCN services, as need to be taught the best approaches to use for information dissemination. It is equally important to either manage the caseload of health workers, increase staffing, or shift nutrition counseling support to nutritionists and CHEWs.

4.1.8 Mapping of SBC materials

Over time, the county and development partners have produced some MIYCN SBC materials to facilitate individual counseling and group education by frontline workers and MMSGs. Table 2 summarizes the type of SBC material, its purpose, primary users, and partners/government who produced the material.

The major gap to address is the limited number of copies provided by MoH and partners in the local dialect, Ng'aturkana, for the CHV population.

Table 2 SBC Materials Mapping

Table 2. SBC materials mapping			
SBC Material	**Purpose**	**Users**	**Organization That Produced the SBC Material**
MIYCN counseling cards	Promote uptake of MIYCN and WASH services among PLWs	CHAs, health care workers (HCWs), and CHVs	MOH, UNICEF, and Save the Children
Nutrition job aids: Has pictures on one side and information on the other side	Promote and support uptake of MIYCN services	CHVs, HCWs, community members	MoH and partners
Nutrition and health banners and posters	Create awareness about MIYCN activities at the health facilities and community levels	CHVs, CHAs, HCWs, and all community members	MoH and partners
Speaking cards: Key health and nutrition messages are captured on simple cards used during health education sessions	Counsel caregivers at facility and household levels	HCWs and CHVs	MoH, county Department of Agriculture, and partners
MCH booklets	Educate and counsel mothers about MCH behaviors and services including IYCN, such as complementary feeding, and optimal breastfeeding practices	Mothers and CHV	MoH and UNICEF
Radio shows/talk radio	Create awareness of MIYCN and other health issues	All community members	MoH and partners
Drawings/clip charts/talking walls[1]	Create awareness of MIYCN and other health issues	CHVs, CHAs, HCWs, and all community members	MoH and partners

[1] Talking walls are drawings or pictures on the walls of the health facilities used to share key SBC messages on nutrition, health, WASH, and other topics.

4.1.9 Approaches and platforms for pregnant adolescents and adolescent mothers

There is no clearly defined platform/approach for reaching pregnant adolescents and adolescent mothers to implement MIYCN or other health-related activities. It has been a challenge for both partners and MoH to reach adolescents; they do not attend services or community groups because of associated stigma, especially if they are pregnant. This means they are not getting parental and community support and they have low literacy levels or access to information, which affects their ability to make informed decisions. However, partners have tried to implement approaches that can comfortably bring adolescents together to discuss how they can improve their MIYCN practice and sexual and reproductive health status. These approaches are summarized as follows:

1. **Use of radio platforms to educate on health and nutrition:** Most adolescents can be reached with health education through radio talks shows.
2. **Adolescent support groups**: Create a separate adolescent MMSG group or care model to educate adolescents with different health and nutrition issues.
3. **Church or religious platforms:** Hold youth groups where adolescents can be approached confidentially. "Many churches have youth groups that we can use to reach out to the youths and pass the messages to them" – KII Implementing Partner. "We can find adolescent mothers and other mothers during church days and teach them" – KII Secretary MtMtSG
6. **Health facilities:** Adolescent mothers visit facilities to get preventive or curative services for their children and if they have health issues. Health workers trained on MIYCN can provide special counseling and support adolescent mothers with breastfeeding, for example, when they come to seek services for their children at a clinic.
7. **Use of existing structures:** For example, community units, health facilities, and youth structures.
8. **Individual counseling by CHVs or CHEWs during home visits:** Most adolescent mothers are too shy to voice issues in front of other people, but when visiting them in their houses and speaking to them one-on-one, they are more likely to voice their concerns.

4.1.10 Challenges with current platforms, approaches, and outreach strategies for engaging pregnant adolescents and adolescent mothers

Lack of adolescent-friendly services: Currently, the best approach to target adolescents is through their friends and guardians, who they trust more than others. Community approaches such as Community Dialogue Days are inappropriate because older men and women usually dominate these meetings, and youth and adolescents rarely participate.

Poor network coverage: To some degree, the MoH and partners have tried to engage the adolescent group through social media, but poor network coverage and limited smart phone accessibility create a barrier.

Lack of community support: Community members often mistrust CHVs or health workers, and question CHVs or health workers when they try to link adolescents with key health and

nutrition services. This negative impression stems from the belief that most adolescents are susceptible to sexual abuse, rape, and forced early marriages.

Illiteracy among adolescents: Most pregnant adolescent mothers are illiterate, and it takes time to explain concepts for them to understand and follow. This can be addressed by using simple techniques that convey messages with pictorial or live demonstrations so that participants can grasp the content more easily.

Challenges in accessing pregnant adolescents: It is very difficult to access pregnant adolescents; most of them do not trust people easily because of negative experiences that often contributed to their pregnancies.

4.1.11 Programmatic implications

The assessment team offers the following programmatic implications and additional areas for investigation to improve MIYCN and health practices in USAID Nawiri's geographic areas. This section is organized according to the specific areas analyzed.

Alignment with county and community priorities/involvement of key stakeholders in design and implementation

Existing county platforms at all levels are key to aligning partner work with county nutrition priorities, including MIYCN, and coordinating stakeholders working on nutrition: The county engages partners and coordinates their nutrition work through the CNTF, the Multisectoral Platform (MSP), and the CSG platforms to align with the county nutrition plans and programs, ensure complementarity of projects, and discuss progress and barriers to implementation. CBOs and INGOs find the CHS meetings at the CHUs helpful for monitoring the progress of implementation of MIYCN activities and provide an opportunity to engage CHEWs and CHWs. In addition, joint monitoring, support supervision, and nutrition assessments with MoH are vital to track the performance of nutrition indicators and advocate for change.

1. Stakeholders coverage and targeting

It is encouraging to see the Turkana County's MIYCN programs and partner projects target children under 5 years of age, adolescent women, pregnant and lactating mothers, women of reproductive age, and children under 5 with acute malnutrition. In addition, most partners target traditional birth attendants, opinion leaders, and FBOs for SBC and community mobilization as secondary targets. The Ministry of Agriculture and Livestock Department and ACDI-VOCA targets youth and older men for nutrition-sensitive interventions. There are few programs specifically targeting adolescent pregnant mothers.

Several partners support the county Department of Health at all levels to strengthen policy, strategy, and implementation of MIYCN, IMAM, MIYCN in emergencies, and nutrition-sensitive interventions and activities. The landscape analysis showed there is duplication of work by partners, as described earlier.

2. MIYCN strategy and programs

Modify BCFI's approach to improve MIYCN practices and care: BFCI is the most organized community-based strategy/program adopted by the county that primarily uses health facilities, CHUs, MMSGs, and home visits as delivery platforms, and has a

straightforward training approach, tools, and monitoring system. It has improved MIYCN and care practices, including hygiene and sanitation, early childhood stimulation, and the enrollment of empowered women in CMSGs. However, its coverage is limited because of the cost of training and implementation, limited integration at the community units, and parallel data recording tools and reporting systems not integrated with MOH KHIS. BFCI is a promising community approach, but the county and USAID Nawiri should address these challenges. Specifically, the cost and integration with county CHUs and KHIS system, as well as some of its approaches, should be modified to facilitate a rapid scale-up for improving MIYCN practices and care. USAID Nawiri's MIYCN human-centered design (HCD) process should be used to investigate these challenges further and propose solutions by engaging the county/subcounty MoH, CHUs, CHEWs, and UNICEF. In addition, USAID Nawiri will need to engage with the NICHE program, which will utilize BFCI for counseling on nutrition and health at community levels.

Strengthen IMAM and FLM to promote MIYCN: The county and USAID Nawiri should review IMAM training packages, services, and monitoring tools to systematically and effectively integrate and promote MIYCN practices and care, as IMAM is another existing community program and platform with wide coverage and acceptability by health care providers, CHVs, and households/caregivers. In addition, FLM, through the MMSGs, has empowered mothers to screen their children for acute malnutrition and take control of their children's referral to IMAM services. IMAM is another potential community contact point to promote MIYCN practices and health care for mothers/caregivers. FLM enabled brainstorming sessions where men and women were equally involved in problem solving at the household level. The new approach was more effective in the development of household solutions designed to improve dietary diversity and other health and nutrition-related issues as well as family-driven action plans that CHVs followed up on during subsequent visits. MMSGs provided a proper platform for CHVs to remind mothers about the frequency with which they should take MUAC measurements, because most of them forget to take the measurements often enough due to competing household activities.

Leverage the county's existing community health structures and engage communities: The county nutrition programs, including partner-supported nutrition projects, have been using the community health structures (health facilities, CHUs) with large coverage and trained health workers and CHWs/CHVs for the CCG models to implement and scale MIYCN SBC and interventions at the community level. The county provides 3,000 KES for each CHV to incentivize their health and nutrition work, which is key to improving their performance. However, the compensation is small relative to the high workload they are expected to carry, which negatively affects community and household-level MIYCN and health activities. The county and USAID Nawiri should continue using these community structures and capacities with more training and supportive supervision to scale up MIYCN and health practices and care at community and household levels. Other types of incentives for CHWs, such as IGAs and nonmonetary incentives, should be considered to help streamline workloads. USAID Nawiri's CHS, including incentives for CHV performance, will provide information to address this challenge in collaboration with the county's Department of Health. USAID Nawiri could build on the method taken by partners and the county in which they involve frontline workers and communities to identify community approaches and develop nutrition interventions appropriate for their context.

Build on women's empowerment and household influencers' involvement efforts for improving gender issues of MIYCN: Adopt best practices that have influenced women's adoption of MIYCN and health behaviors. These include increasing their nutrition and gender-related knowledge and skills in MMSGs; increasing access to income, such as table banking and village saving loans; and involving husbands and elderly women, especially mothers-in-law, in community nutrition and SBC programs. Programs have been empowering adolescents using champions for girls' education and termination of early marriages. The county and USAID Nawiri can scale up and streamline these best practices in community SBC programming for optimizing MIYCN and health practices and care.

Increase programming of community nutrition-sensitive interventions: Although most program approaches are focused on nutrition-specific interventions, the county agriculture department and partners have implemented only a few nutrition-sensitive interventions targeting households and communities. These interventions include kitchen gardens, merry-go-round systems, poultry production, and increased presence of markets with nutritious food to increase food security and diet diversity, which are key to improving MIYCN practices. The county agriculture department continues to allocate land for communal vegetable production, and collaborates with partners like USAID Nawiri to invest more in these interventions and promote vegetable preservation techniques during the rainy season. The county has also increased access to water; the county and partners continue investing in boreholes and developing springs that have multiple water point use. Better access to water has helped reduce the workload for women and increased vegetable production. This, in turn, contributed to an uptake in practicing MIYCN and health behaviors.

Program adaptation to shocks and special contexts

Strengthen current adaptations and test innovative ways to mitigate shocks/stresses: The Turkana County population faces common shocks/stresses and has limited MIYCN program adaptation experience. The most common adaptations include shifting resources from their existing program activities and finding new resources to respond to drought, floods, and recently to COVID-19. The county should have a well-resourced contingency plan for health and nutrition to respond to common shocks and unexpected crises like COVID-19. Partners could support the county to study and identify MIYCN program adaptation strategies for commonly occurring system shocks, including those conducted for COVID-19 described below.

Institutionalize MIYCN/nutrition programs' adaptation to COVID-19 for other shocks: The MoH and implementing partners introduced FLM and modified IMAM community management to identify and refer children early, as well as treat children with acute malnutrition by empowering families and CHWs and strengthening referral and linkages to health facilities. These adaptations were also used to promote IYCF. The county could work with partners to document lessons learned and outcomes of these program adaptations, and institutionalize them for MIYCN adaptations to commonly occurring shocks like flood, drought, and similar shocks.

MIYCN programs and approaches need to be contextualized to different livelihood zones: The team observed limited attempts to adapt MIYCN and health program strategies and interventions to different livelihood zones in Turkana. The county and partners are using similar strategies and interventions across the different livelihood zones, with few adaptations

for pastoralist livelihood zones, such as harnessing floodwater for crop and vegetable production and context-specific counseling cards and digital platforms to cascade SBC messages. They found adaptations too expensive to scale and sustain; however, the counties should challenge their departments and partners to avoid a "one size fits all" MIYCN approach, and urge them to contextualize MIYCN strategies, programs, and SBC materials to consider the livelihood needs of each zone.

Adolescent nutrition programming

The landscape analysis identified limited programs and approaches in health facilities and communities that tried to address pregnant adolescent mothers, MIYCN, and adolescent and sexual reproductive health (ASRH) issues. This also includes poor access to adolescent-responsive services during health and community contacts, and low utilization of health and nutrition services due to stigma, trust, and limited access to information. Therefore, a strong need exists for more innovative and scalable approaches to improve nutrition and health services for adolescent and pregnant mothers.

Strengthen capacity of health facilities and CHUs to provide adolescent-responsive support and services: Adolescent pregnant mothers seek preventive and curative services for themselves and their children from health facility visits and during community and home visits; however, these visits do not happen frequently. The county and partners should leverage opportunities to provide MIYCN counseling and services and adolescent-responsive ANC, PNC, and FP services, including gender-related counseling. They should also ensure that such services are delivered in a way that reduces associated stigma and facilitates peer-to-peer dialogue. For instance, the county, with support from partners and adolescent mothers' participation, could build the capacity of health workers, CHEWs and CHWs providing ASRH, ANC, FP, and child health services as integrated counseling and service provision. This would create a conducive environment and community support groups that encourage adolescent dialogue and minimize stigma.

Use community platforms and media to reach and support adolescents: It is equally important to understand the combination of community groups/platforms and media that would be most effective in reaching adolescents, including pregnant mothers, and increasing their trust. Having a separate adolescent MMSG care model and older school adolescent club, collaborating with church or religious youth groups, and radio talk shows are identified as key community approaches and platforms that ensure confidentiality. They can help educate adolescents on health and nutrition issues, empower them to increase demand and utilization of services, and change MIYCN practices.

1. Community SBC strategies, platforms, and materials to improve MIYCN and care practices

Community SBC approaches, platforms, and materials have been implemented by the county and partners to promote MIYCN and care behaviors. This report recommends strengthening the combination of these community SBC strategies to increase demand and utilize health and nutrition services, and improve MIYCN practice and health care in the county.

Strengthen and scale-up existing community MIYCN's SBC approaches: The county and partners applied the following SBC approaches to improve MIYCN and care practice and increase utilization of services: individual or group counseling and support by CHWs and

CHEWs; community dialogue and mobilization through MMSGs and CCGs; and reinforcing MIYCN and health behaviors and services using radio talk shows and radio spots. However, there is a need to address the challenges mentioned in the findings section to fully leverage the potential of these SBC approaches to improve MIYCN and care practices. The county and partners should build skills and increase the knowledge of CHAs, CHVs, and mentor mothers in MIYCN counseling by holding group sessions using SBC materials; plan short and less frequent sessions to address low attendance by community members of MMSGs because of competing household activities and high maternal workload; and engage husbands and community gatekeepers.

The analysis also revealed two major gaps. There is a need to design and implement a simple and sustainable SBC approach that addresses mobile communities of the pastoralists, and an SBC strategy adaption to Turkana South, East, and North Sub-counties, which are commonly affected by conflict. USAID Nawiri's MIYCN and SBC HCD could shed light in these areas. In addition, the county should put in place a monitoring and reporting system to monitor the progress and effectiveness of these SBC strategies.

Individual counseling by frontline health workers: Health facility workers and CHEWs have played key roles providing good counseling and support for caregivers/mothers during health facility and home visits. The community values MIYCN and health care counseling and support provided by frontline health workers. The county and partners continued to use this SBC strategy to address the key challenges affecting quality of counseling by training health workers to better use various SBC materials to support counseling. It is also important to try to manage the caseload of health workers by increasing staffing or shifting nutrition counseling support to nutritionists and CHEWs.

Leverage community SBC platforms to promote MIYCN and care practices and mobilize communities: The MoH and its partners have used multiple community platforms for integration, such as community outreach programs (GMP, ANC, immunization, IMAM), community groups (MMSGs and CCGs), home visits, and digital platforms like Digi-Somo to promote optimal MIYCN behaviors and change practices at the household and individual level. Radio is also commonly used to target whole communities. For most mothers and caregivers who are illiterate, a combination of platforms—mainly individual counseling, community groups, and radio/TV—are appropriate to promote health and nutrition messages.

Customize, translate, and utilize existing SBC materials: The LAS identified several MIYCN SBC materials produced and used by the county and partners to facilitate individual counseling and group education conducted by frontline workers and MMSGs. These include MIYCN counseling cards, nutrition job aids, nutrition and health banners and posters, MCH booklets, health and nutrition speaking cards, and radio spots and talk shows. However, there is a need to develop context-specific SBC materials for both permanent and nomadic populations living in different livelihood zones. In addition, only the MIYCN counseling cards are translated into Ng'aturkana, the local dialect. Thus, existing and new SBC materials must be translated into Ng'aturkana for easy dissemination by CHAs, CHVs, and mentor mothers, and to improve understanding on the part of communities, influencers, and caregivers.

4.2 SAMBURU COUNTY

4.2.1 Key stakeholders and their support to counties

In Samburu County, the county MoH, in collaboration with NGOs (local and international), FBOs, and UN agencies, is currently supporting implementation and monitoring of MIYCN activities in 107 health facilities and 82 CHUs. The county government has continued to fund the majority of the health and nutrition activities at the county, subcounty, and ward level through establishing a functioning community health system, operationalizing health activities at the facility, deploying a health care workforce, and implementing health promotion activities like community dialogues. The county and partners have supported the development of the County Nutrition Action Plans that provide strategic direction for nutrition and health programming in Samburu.

CBOs such as Kisima Bawaa, and NGOs like the African Medical and Research Foundation (AMREF), Feed the Children, World Vision, Palladium, NHS Plus, and others, supported implementation of MIYCN activities to complement the county government efforts. These partners supported implementation of BFCI activities, development and dissemination of MIYCN SBC materials, malezi bora campaigns, and capacity development of health workers on IMAM, MIYCN, BFCI, Baby Friendly Hospital Initiative (BFHI), and FLM. The county governments actively engaged partners at the time that these health and nutrition programs were designed, to align their programs to the county plans and priorities.

UN agencies such as UNICEF and WFP have continued to provide funds and in-kind donations to support the management of both SAM and MAM in the county. UNICEF provides anthropometric equipment (MUAC, weighing scales, height boards), vitamin A supplements, and RUTFs such as Plumpy nuts, F100, and F75, while WFP provides RUSF and CSB++ for children 6–59 months of age and pregnant and lactating women, respectively.

4.2.2 Country/subcounty/community engagement in MIYCN projects/program development, implementation, coordination, and accountability

At the county level, coordination of all nutrition activities are spearheaded by the county MoH through the CNTF platform, which is chaired by the County Nutrition Coordinator. This forum provided an opportunity for local and international partners to collaborate with MoH, discuss challenges that affect implementation of nutrition and health-related programs, and recommend solutions.

The CSG platform is where representatives from various county government departments, including health and nutrition, and NGOs meet to discuss challenges that affect the population. Topics include health and nutrition, WASH, pending emergencies such as floods, droughts, etc., and advice on a path forward to improve or mitigate a worsening situation. In addition, the Community health system has a hierarchical coordination structure that extends from the community level to the CHVs to the CHAs to the county community focal person. The county MoH and partners have used this structure to monitor the implementation of MIYCN and health activities, because they find it crucial to get first-hand information on the delivery of MIYCN and health programs in the community.

CBOs and INGOs have used the existing local administration structure in the coordination and implementation of the health and nutrition interventions at the community and health

facility level by working closely with the ward administrators, community leaders, and MoH officials.

4.2.3 Strategies and program interventions to improve MIYCN

The LASM looked at strategies and interventions of previous and current programs/projects implemented by key stakeholders with the objectives of improving MIYCN outcomes in the counties. The analysis specifically collected information about the strengths and challenges of these programs as well as their adaptations to different contexts.

Strategies and Interventions

Use of BFCI: BFCI is a community-based approach to promote and support breastfeeding and promote optimal complementary feeding and maternal nutrition practices. BFCI accomplishes its goal through training of frontline health workers and CHWs and by forming and training MMSGs. It provides for cooking demonstrations, conducting home visits, and referrals to link mothers with primary health care facilities. BFCI also includes feeding sick children, promoting hygiene and sanitation, early childhood stimulation, and referrals to and from MCH clinics. KIs reported that BFCI has improved MIYCN outcomes in areas where it was implemented per the standard approach. However, the coverage is low—only 22 out of 81 CHUs are currently implementing BFCI. BFCI's reporting tools were not linked to the Kenya Health Information System (KHIS) creating a parallel reporting system.

...if you look at the MIYCN indicators in the facility, you will see that they are improving compared to before BFCI and are better than facilities without BFCI..."

KII IP, Samburu

"We realized that we needed the entire community to support a breastfeeding woman, a woman pregnant and a woman doing complementary feeding. I can say that the baby friendly community initiative, is one of the initiatives that has worked in the social behavior change of women and community."

KII, Key County Government Representative

Health education at the health facilities and communities: Health providers (health workers and CHEWs) provide integrated SBC messages to caregivers at health facilities to positively change MIYCN behaviors and increase uptake of health and nutrition services. Trained CHVs promote MIYCN messages and facilitate discussion at community level through community mobilization, community dialogues, home visits, care groups/MMSGs, and radio talk shows. In addition, CHWs are empowered to conduct nutrition screening, malnutrition case identification, and referrals to health facilities.

Community groups are important platforms to change MIYCN practice and care: In Samburu, care group models and MMSGs are effective community platforms to promote adoption of MIYCN behaviors by caregivers or mothers.

"Use the care group model, a behavior change model, in the community made of 10-15 neighboring mothers, who meet monthly the where the care group promoter led by our staff delivers promotional behaviors on MIYCN. The lead

mothers cascade the information to other neighboring women, focusing mostly on behavior adoption."

KII IP, Samburu

"I think mother-to-mother support groups have been successful because the mothers are part of the community and encourage each other…"

KII IP, Samburu

Leveraging economic empowerment opportunities with health and nutrition: To encourage the participation of mothers to BFCI activities and adoption of MIYCN practices, the county government and partners supported mother groups to engage in economic empowerment programs, such as Village Savings and Loan Associations (VSLAs) and IGAs, for example, to establish bread-making businesses or to raise poultry and sell eggs. This has motivated the mothers to engage in the groups and education sessions alongside the VSLA activities.

"VSLA is very effective. The mothers are now empowered; they have their own money. A mother can borrow and even refund it at her own will. Poultry is also a woman's territory. The men don't venture there. When she sells eggs, the income is only for her..."

KII County Government Representative

Male involvement: Males are considered the custodians of customary practices, and it is critical to involve them in MIYCN and care messaging. The men have been sensitized on FP, maternal health, child health, and WASH.

"…We involved men in five areas family planning, maternal health, child health, nutrition and WASH, but that one was done across the county at least in five parts in every sub-county. So far, we have done some training and some barazas with the men…"

KII County Government Representative, Samburu

Use of contextualized SBC communication channels: KIs reported that a best practice in digital technology was used, the Digi-Somo radio app that has pre-uploaded MIYCN messages in the local language to reach caretakers and families with appropriate MIYCN messages. It is easy to use, but it needs batteries or electric recharging. In addition, programs use radio talk shows, community dialogues, churches, and public address systems to have health care workers and CHVs communicate nutrition messages in local languages to communities and households.

Supporting community nutrition-sensitive approaches and interventions: The county and partners are scaling up kitchen gardens, promoting consumption of indigenous foods and poultry, introducing drought-resistant crops in Samburu Central and some parts of Samburu North, and hardy animal breeds like camels in Samburu North and East to increase production and consumption of nutrient dense locally available foods and improve resilience.

" …We have a program providing camels as they can withstand drought, subsidizing our pastoralists with camels; we also have brought in hardy

breeds like Galla goats that can withstand the drought and provide dairy products milk to the family…"

KII Key County Government Representative

"…We are looking at the orange-fleshed sweet potato which we are collaborating with the International Potato Center. We are also looking at iron-rich beans which we are collaborating with Centre Agro-tropical Agriculture. We are also trying to improve consumption and production of African indigenous vegetables; the 'terere', 'managu' and all that…"

KII Implementing Partner, Samburu

"…When we scale up nutrition-sensitive agriculture, it means that nutrition will be entrenched in production. We are not looking at nutrition at the tail end of consumption only…"

KII Implementing Partner, Samburu

Implementation of Healthy Baby Living Clubs: These clubs are peer support groups that worked with the MoH and Ministry of Agriculture, Livestock and Fisheries, to promote nutrition-sensitive interventions at the community level. Interventions such as consuming and producing orange-fleshed sweet potatoes through vertical-farm-bag kitchen gardens to boost food security and diversify diets, especially foods needed by mothers and small children. Vertical-bag farming is a high-yield food security technology that uses the vertical space to maximize land and increase water efficiency. The vertical-farm bags were mostly used to produce indigenous vegetables such as 'sukuma wiki', 'managu' and 'terere'. The Healthy Baby Living Clubs, together with WFP and the International Potato Center, purchased a baby tool kit for complementary feeding. This intervention involved CHVs who would work with the clubs.

"…The focus is on the production and utilization of orange-fleshed sweet potato at household level but again looking at other foods that can be grown and produced locally at the household level through kitchen gardens…"

KII Implementing Partner, Samburu

Strengths

Synergistic partnership and integration: The multisectoral approach and strategic partnership of the county Department of Health with CBOs, INGOs, and UN agencies (WFP and UNICEF) have ensured that different sectors, such as WASH, Health and Nutrition, and Agriculture and Education, are well integrated for sustainable reduction of PAM. Integrating vitamin A supplementation into the early childhood education program helped to accelerate coverage. However, the scale of coverage was limited to a few sub-counties.

Leveraging the strong community health structure and capacity: A strong CHS structure with well-defined CHUs, and CHWs and CHVs, has made a feasible scale-up of BFCI and health and nutrition interventions and services at the community level and linkage of community services to health facilities. Using CHVs/CHWs from the community has proved to be cost-effective and sustainable because they understand their community and know how to work with diverse population groups.

Innovative behavior change communication strategies: Use of radio talks shows from local radio stations such as Serian, Digi-Somo, and baba shujaa, among others, have provided appropriate health and nutrition messages in the local Samburu dialect. Use of radio has improved health and nutrition practices and literacy and enhanced the community and women's ability to practice MIYCN behaviors.

"I am glad we have health promotion officers at the radio stations. Occasionally they disseminate MIYCN messages through the live sessions of the local radio station Serian in Samburu language which they can understand. They also have a question-and-answer session in which the locals can participate in…"

KII IP, Samburu

Strengthened data collection, monitoring, evaluation, and research: The various MIYCN programs—their conceptualization, design, and implementation strategies—are informed by findings from research and surveys, such as knowledge, attitude, and practice surveys (KAP) and SMART surveys that have been conducted in Samburu County. Nonetheless, there are still information gaps in critical aspects around MIYCN programming.

Continuous capacity development of CHVs and CHAs has enabled them to acquire skills on MIYCN counseling and support and management of acute nutrition, and enabled them to provide quality counseling on nutrition to caregivers during home visits and facilitate community discussions.

Existing nutrition policies and strategies that are cascaded to sub-counties and facilities: Existing strategies and action plans developed by the county include MIYCN policy, County Nutrition Action Plans, and a MIYCN SBCC strategy. Most of these policies and strategies have been cascaded to sub-counties and health facilities to guide implementation of MIYCN and IMAM programs at facility and community levels.

Challenges/Barriers

Health workers' training is limited: There is no system to train newly recruited healthcare workers on nutrition and health. In addition, there is a knowledge gap among mentors of CHVs. Samburu County nutrition department has a small nutrition team to provide the necessary supportive supervision and mentoring to health workers, CHVs, and CHWs on MIYCN activities. Some facilities are operated by only one staff member, which makes it difficult to provide outreach services as well as facility-based services at the same time.

Limited effort to provide monetary incentives for CHWs: There are no county-instituted incentives for CHVs, which adversely affects their performance in providing community-level health and nutrition promotion activities and supporting caretakers/mothers. Some partners have provided different kinds of incentives to motivate CHVs, but they have not been consistent because they depend on project funding. AMREF provided performance-based cash or IGA incentives to CHVs in Samburu Central and East. Feed the Children also supported Waso Ward of Samburu East with cash incentives under its Care Group Model interventions. A few subcounties have these incentive mechanisms. Samburu North has no form of incentives for the CHVs.

"From time to time, we have attrition of volunteers. In the society we live in, everyone wants to have something small to support them. To address that, we motivate them with branded materials, and lessons modules."

KII Implementing Partner, Samburu

Community units' linkage to health facilities: Not all communities are connected to a health facility through a community unit and CHVs. This means communities miss out on key community health services provided by CHVs especially in areas where there are no functional community units or health facilities. This speaks to non-functional community units and health facilities making deliveries at community level for one health services. A solution is to have an integrated mobile outreach for areas that take health and nutrition services to those underserved communities.

Caregivers' low level of knowledge and awareness on MIYCN: Caregivers and community members still lack appropriate information on the importance of consuming nutritious foods, especially by women during pregnancy and lactation, what constitutes a nutritious diet, and challenges of practicing exclusive breastfeeding (EBF) and the timely start of complementary foods.

Sociocultural factors: Some communities still believe or follow the traditional beliefs and cultural practices that negatively affect the uptake of MIYCN care and practices. These practices include early weaning; also, it is believed that pregnant women should avoid certain foods such as eggs to prevent the baby being big at birth, and in most parts of Samburu, some foods like fish, chicken, traditional vegetables, and sorghum are not consumed because of cultural beliefs. However, fish consumption is gradually improving in Samburu Central. Older women are involved in decision making about food consumption; however, there was limited engagement of them on MIYCN community discussion and activities.

Patriarchal nature of the society: Men are key decision makers on key MIYCN aspects, household food distribution, and what needs to be purchased for a household. For instance, women do not have permission to sell animals without their husbands' permission, and certain parts of foods are reserved for the men, while other parts are given to women. Men travel to market to sell animals and thereafter purchase food for the family. Despite the men's dominance, there is still limited engagement of the men in counseling and community activities meant to improve MIYCN care and practice.

"For a woman to do exclusive breastfeeding and complementary feeding, she requires support from her husband; so if the husband decides on everything, it becomes a hindrance even to the women feed the child well and the other children…"

KII Implementing Partner, Samburu

Limited food preservation initiatives: The consumption of fruits and vegetables is generally a challenge in Samburu County. According to the Samburu County KAP Survey 2018, the consumption of fruits and vegetables was reported at 40.4% and 41.6%, respectively. Access and demand for fruits and vegetables are key barriers to the consumption of these foods. These barriers are more conspicuous in Samburu East and North, which are

mainly pastoral livelihood zones. There is lack of adequate information on preserving foods for a longer period to increase shelf life, especially vegetables and fruits.

"…People lack information on how to get enough food for a longer period, at least one year to sustain themselves…"

KII CHA, Samburu

"The skill of drying and keeping it for future is not valued, although it is nutritious and valuable..."

KII Key County Government Representative

Migration/pastoralism: The nomadic nature of the Samburu community has hindered the uptake of MIYCN practices and consumption of a nutritious diet. When they are on the move, they miss MIYCN counseling and support session by CHVs and CHEWs, and rely mostly on the nonperishables like cereals and milk rather than vegetables.

Alcoholism and drug abuse: Alcoholism among women is a growing concern. It was cited as an important barrier to appropriate health care and practicing optimal MIYCN behaviors,[8] especially if the woman is lactating or pregnant.

"…Women alcoholism is rampant. It is an issue to these women if they are breastfeeding. They don't take care of the young children at home so they leave their children under the care of grandmothers"

KII Subcounty Reproductive Health Official

Early and underage marriages: Early marriages and pregnancies affected young people's nutrition. The young are not mature enough to withstand the burden of childbearing, therefore they are at higher risk of malnutrition. Early marriage and adolescent pregnancy are common is Samburu.

"We are seeing many adolescents getting pregnant; some are in early marriages and others are not married."

KII, Samburu Key County Government Representative

Expansive geography and scattered population distribution affected access to health and nutrition services: Remote areas have few health facilities and CHUs, with limited numbers of health care workers and CHVs, and no care group models. These are the main barriers to accessing MIYCN and health services. For example, a mother opted to skip ANC and child welfare if the facility was far, and has limited financial resources. The vastness of the regions occasionally interfered with medicine supplies arriving on time.

Poor and inconsistent coverage of key interventions: Some nutrition and health interventions did not cover the entire county. For instance, the male engagement approach only covered Samburu Central and Samburu East Sub-counties. Integrated mobile outreaches were only occasionally supported and were inconsistent.

[8] Samburu County KAP Survey Report, 2018.

"…Male engagement is not done across the county and it is sporadically done in some areas. So, I think if it is done well, it can improve MIYCN practices…"

KII Implementing Partner, Samburu

Budget constraints for nutrition-specific interventions under the Department of Health. The county budget lacks a specific budget line for nutrition coupled with delayed disbursement of funds. The budget for nutrition comes out of the health budget. However, the highest proportion of the budget is allocated to ambulatory services and procurement of drugs rather than for nutrition interventions.

Sustainability of CCGs: Several partners formed care support groups and MMSGs, which improved MIYCN care and practices; however, these groups failed to continue after the project ended, because their incentives and reasons to meet monthly ended with the projects. USAID Nawiri and the county should have clear and built-in sustainability plans before scaling up the care group model.

"…The aspect of cost and even printing some of those tools have a cost implication on programs. Sometimes, when the program's exit, the same activity does not continue as supposed to because of that issue of cost…"

KII Implementing Partner, Samburu

Strategies and program adaptation to different contexts (stresses/shocks, and livelihood zones)

Adaptation to shocks/stresses

Limited information was elicited from the respondents because the majority of them did not clearly state strategies to adapt MIYCN activities for stresses and shocks such as the COVID-19 pandemic, floods, and drought. The following adaptations were reported to ensure continuity and proper implementation of MIYCN at the community and health facility:

- Dissemination of contextualized (local language-based) SBC messages through radio talk shows, community dialogues, churches, and public address systems by health care workers and CHVs.
- Use of digital platforms like Digi-Somo devices powered by batteries. The devices were fed interactive messages, discussion and music on reproductive, maternal, newborn, child, and adolescent health (RMNCAH), WASH, and nutrition in local languages. CHVs can listen to these messages in their free time to prepare for dissemination to the caregivers.
- Use of care group models: The cascade models were used to raise awareness of pertinent issues contributing to malnutrition, such as poor hygiene and sanitation, poor latrine utilization/open defecation, and MIYCN and care practices, but at a smaller scale/geographic area. These can be further scrutinized and scaled up if viable.

Adaptation to different livelihood zones

This LASM identified some practices already being used to implement MIYCN strategies and interventions in the contexts of major livelihood zones. For instance, BFHI is already contextualized to agro-pastoralist and pastoralist livelihood zones. The county also adapted

the ecological-zone approach to decide which locally produced nutritious foods to promote for which livelihood zones. In addition, partners adapted community sensitization, for example, using chief barazas to pass on nutrition information, which is ideal for people in rural areas.

"…The BFCI is being implemented in the agro-pastoral and purely pastoral livelihood zones and customized to them. You do not tell the pastoralists today you must begin farming but slowly they pick the practice. Some communities are planting vegetables besides their homes. The reception is positive but adoption scale is not large…"

KII Implementing Partner, Samburu

4.2.4 MIYCN and health programs/projects complementarity/overlap (target groups, geography, and projects)

The primary target groups include children under 5 years of age, women of childbearing age (15–49 years), adolescents, CHVs, HCWs and—to some extent—men, through male engagement approaches. Programs for improving MIYCN care practices have been implemented in all 107 health facilities including government, private health facilities, and faith-based facilities across the county.

BFCI activities have been implemented across the county but only 22 of the 81 CHUs use them. The BFCI is implemented in 7 out of 36 CHUs in Samburu Central; Kisima, Maralal Referral, Lolmolog, loosuk, Sirata, Porro, Barsaloi, and Samburu East. Out of 24 CHUs, 4 have implemented BFCI (Wamba HC, Archers Post, Sere Olipi, and Lerrata). In Samburu North, 7 out of 21 CHUs have implemented BFCI (Marti, Nachola, Baragoi, Latakweny, Lesirikan, South Horr and Tuum).

There are several partners supporting projects/programs to improve MIYCN, specifically BFCI, SBC, IMAM, FLM, and capacity building of frontline workers. In addition, UNICEF and WFP supported capacity building, nutrition supplies, and anthropometric equipment for IMAM. The male engagement approach has mainly been implemented in Samburu East and Central Subcounties through the former USAID Afya Timiza and Koota Injena Project, targeting FP/RH MNCAH, WASH and nutrition, and FGM/C, respectively. Additionally, Feed the Children implemented a care group model in Samburu East. The partners' support is complementary rather than duplicative. Table 3 summarizes the key nutrition program areas where partners support MoH, and their geographic coverage.

CBOs also implement community-level MIYCN activities including the care model—e.g., Kisima Baawa CBO in Suguta marmar and Lodekejek; Lderkesi CBO in Archer's post, Laresore, Lorubae and Lderkesi; Mararal Rep in Porro, Lporos, Maralal, and Miliman wards in Samburu Central; and Ngilaa CBO in 10 villages in Ngilai Central.

Table 3 Mapping of partners by geography and key program areas of support

Table 3. Mapping of partners by geography and key program areas of support		
Partner	**County/Subcounty/ ward**	**Program Areas (MIYCN, health, IMAM, adolescent nutrition, nutrition-sensitive agriculture, emergency nutrition)**
MOH	Countywide	▪ Custodian of the health and nutrition activities at the county level. ▪ Supports BFCI, BFHI, target supplementary feeding program (TSFP) for PLWs, development and supply of SBC materials, malezi bora campaigns, GMP, vitamin A supplementation for children 6–59 months, celebration of World Breastfeeding Week community action days.
UNICEF	Countywide	▪ Supports BFCI approach for the improvement of MIYCN. ▪ Provides in kind donation of nutrition supplies (RUTF, F100, & F75, Vitamin A, and IFA) and anthropometric equipment. ▪ Develops and supplies the MOH with MIYCN SBCC materials, such as MIYCN Counseling cards, FLM illustration cards. ▪ Supports capacity building of the county, frontline workers, and partners' staff with relevant health and nutrition trainings such as MIYCN, FLM, IMAM, BFCI, and IMAM Surge.
WFP	Whole county (Baawa, Angata Nanyokie, Lodokejek and Suguta Marmar)	▪ Provides nutrition supplementary foods (CSB++ and RUSF) required for management of MAM. ▪ Provides IEC materials that promote handwashing during critical times and proper preparation of CSB++.
Feed the Children	Samburu East (Waso Ward)	▪ Implements MIYCN through care group model for behavior change and work closely with CHVs, mentor mothers, and CHAs to promote positive behavior changes.
Kisima–Baawa CBO	Samburu Central (Lodokejek, Suguta Ward-Longewan and Baawa Ward)	▪ Targets the orphans and vulnerable children, children, pregnant and lactating mothers, adolescents, and people living with disabilities, but it was not clear in the research what specific activities they conducted.
Amref – Uzazi Salama	Countywide, but in limited pockets	▪ Supported reproductive health, basic emergency obstetric care, emergency medical obstetric care, Safe Care and strengthening CHS referrals systems. The project just ended.
Amref – Afya Timiza	Samburu East and Samburu Central	▪ Supports health system strengthening with a focus on RMNCAH, WASH, and nutrition activities including SBC and demand creation. The project just ended.

4.2.5 Community-level strategies or approaches to engage and support mothers and families

Existing SBC platforms and communication channels

The MoH and its partners have effectively used the following facility and community platforms and communication channels to promote optimal MIYCN key behaviors and change practices at household and individual level.

- Radio talk shows aired in local radio stations such as the Serian FM and radio Mchungaji, which broadcast health and nutrition messages in the local Samburu dialect.
- Community meetings such as local chief's baraza, dialogue meetings, and action days to convey vital MIYCN SBC information and messages.
- Digi-Somo app that has preloaded messages for CHVs to use during household visits.
- Talking walls at the health facilities and youth centers to disseminate key nutrition messages.
- Face-to-face counseling at the household level or facility level.
- Integrated outreach activities to touch remote populations.
- Community support groups to rely MIYCN and health messages.
- Counseling cards, fliers, and IEC SBC materials that contained MIYCN and care practices.
- Community barazas/meetings have also been used to pass MIYCN and care practices information to communities.

Lessons learned and challenges in community SBC

Traditional beliefs and cultural practices negatively affecting MIYCN practice and care*:* Men are the principal decision makers, and influence the food bought, cooked, and consumed. Pregnant women are prohibited from eating certain types of food. Men and women could not sit together with old people for discussion/education session, as this is not allowed by cultural norms. Infant diarrhea is believed to be connected to tooth problems, not sanitation and nutrition.

Limited distribution of CCGs: The care support groups and MMSGs were not formed in some CHUs. Records from the Department of Health showed that only 28 out of 81 CHUs in the county have care groups or MMSGs supported by several partners.

Misconception to health services: KIs reported that mothers do not give birth at health facilities because they fear that they would be subjected to caesarian delivery.

Poor radio network coverage: It has been difficult to reach communities and households with nutrition messages using mobile and local radio stations, such as Serian FM, Radio Mchungaji and Watch Man, because of low coverage, especially in Samburu East and North. The cell phone coverage in Samburu County is 27.2% according to the 2019 Census.

High illiteracy levels among community members: Some community members were not able to understand SBC materials that were presented in Swahili and English. Translation of the SBC materials into selected local dialects spoken by many communities is important to address this challenge, as translating to every local dialect has a huge cost implication.

Nomadic communities and insecurity: CHVs found it difficult to promote MIYCN regularly and conduct follow-up home visits because of mobility of the pastoralist communities and insecurity in some places like Wamba. When some communities moved from one place to another, sometimes the CHVs must move with the community to promote MIYCN behaviors and provide health and nutrition services.

4.2.6 Frontline health worker support (lessons learned and remaining challenges)

The majority of the frontline health workers understand the community dynamics and support the clients. Some of the workers also come from the same community they serve, therefore gaining the communities' trust and respect. Frontline health workers provided a wide range of services such as ANC, child welfare services, MIYCN care and services, IMAM, and other services. The KIs reported frontline works are key to promoting MIYCN behaviors and services at health facilities and community level.

Frontline care workers' challenges

Some frontline health care workers (HCWs) are not trained on MIYCN modules; therefore, they are unable to adequately sensitize mothers and caregivers on MIYCN and care practices. Some frontline HCWs do not take time to sensitize the mothers on MIYCN and care practices due to competing activities at the health facility or community unit. Another challenge is the language barrier. Some frontline HCWs do not understand the local language, therefore they are not able to effectively communicate to mothers and other caregivers. The HCWs' ability to provide better support is bolstered by the high demand and favorable health-care-seeking behavior of the users, but this demand is generally still poor in Samburu County. Limited caregiver support skills is attributed to HCWs' not taking enough time to understand the caregiver and their needs, with only a general predetermined idea of how to support a mother.

4.2.7 Mapping of SBC materials

The county and partners produced several MIYCN SBC materials to facilitate individual counseling and group education by frontline workers and MMSGs. Table 4 summarizes the type of SBC material, its purpose, primary users, and partners or government that produced the material. The major gap is the limited number of copies provided by MoH and partners in the local dialect, Ng'aturkana, for the CHV population.

Table 4 SBC Materials mapping

Table 4. SBC materials mapping			
SBC Material	Purpose	Users	Organization That Produced SBC Material
Audio SBC materials: Digi-Somo, songs, short dramas	Create awareness, SBC and demand creation on health and nutrition services including MIYCN, RMNCAH, WASH and Nutrition.	CHWs, HWs, and CHVs, Caregivers	Afya Timiza- Amref
Visual SBC materials: drawings, charts, talking walls, ABC boards, banners, posters, flyers, lessons given to mothers, calendars	Create awareness, SBC and demand creation on health and nutrition services including MIYCN, RMNCAH, WASH, and nutrition.	CHWs, HCWs, and CHVs, caregivers	MoH and partners (Afya Timiza, UNICEF)
Radios/talk radio	Create awareness, SBC and demand creation on health and nutrition services including MIYCN, RMNCAH, WASH, and nutrition.	CHWs, HCWs, and CHVs, caregivers, wide community coverage, all	MoH and partners (Afya Timiza)
MIYCN counseling cards & job aids	Promote uptake and demand for MIYCN practices	CHWs, HCWs, and CHVs, caregivers	MoH, UNICEF, and Afya Timiza
MCH booklets	To educate and counsel mothers about MCH behaviors and services including IYCF, such as complementary feeding, optimal breastfeeding practices, etc.	CHWs, HCWs, and CHVs, caregivers	MoH and UNICEF
Mhealth: Bulk SMS	Create awareness and demand for health and nutrition services including MIYCN.	Caregivers and CHVs	MoH and partners

4.2.8 Approaches and platforms for adolescent or pregnant mothers

The MoH and other relevant county departments, CBOs, and INGOs have used the following approaches to engage adolescent groups to improve uptake of health and nutrition as well as social services.

Adolescent and youth (A&Y) champions/binti shujaas: USAID Afya Timiza Project used binji shujaas and morans as role models and champions for demand creation on FP/RMNCAH, WASH, and nutrition services in the community. Binti shujaas and morans then can influence other peers to adopt positive practices on MIYCN, WASH, and RMNCAH.

Use of health care facilities to reach A&Y: A growing number of youth and adolescents still go to the hospital for various services. These opportunities can be used to target youth through youth-friendly initiatives.

Care group models and support groups: To some degree, MoH, CBOs, and INGOs have used this group to target caregivers. Some A&Y are reached using these platforms, although some may not be comfortable with this approach because they may be reluctant to freely interact with older adults.

Dialogue days and mini-dialogues at the household: These events are ***c***onducted by CHVs at the community and household levels, which provides a greater opportunity to interact with adolescents because of guaranteed privacy.

Ong'an integrated mobile outreaches: Nighttime Ong'an integrated outreaches were used by the USAID Afya Timiza Project to reach morans, youth, and adolescents at night, a time when they are expected to be less busy and have finished their animal-herding chores of the day. It can be used to educate hard-to-reach adolescents.

Digital messaging apps and bulk SMS: Some projects used bulk digital messaging applications to send messages to targeted youth through CHVs and HCWs.

Utilization of health clubs for adolescents who are still in school: In health clubs, adolescents can discuss topics in health and nutrition. This platform can be used to promote specific behaviors.

Religious institutions such as churches: A&Y attending regular church services can be easily reached with health and nutrition services**.**

Challenges for engaging pregnant adolescents and adolescent mothers

Limited contextualization of interventions: The messages, as currently designed, are mainly for older mothers and caregivers. There is a need to adapt the MIYCN messages for A&Y as well as for other topics such sanitary pads and clothing.

Migration: The nomadic nature of the Samburu makes it difficult to target adolescent groups who are constantly on the move with their families, caregivers, or guardians. Sometimes, CHVs are forced to walk long distances to track adolescents, but it becomes a resource challenge.

Lack of organized groups for A&Y: There are limited county-recognized adolescent groups, which makes it difficult to engage many adolescents. This is specifically relevant for adolescents with early pregnancies; MIYCN is affected, and many of these girls are forced into early marriages. Unlike MMSGs, father-to-father support groups, and care groups, there are limited organized platforms for adolescent mothers.

4.2.9 Programmatic implications

The following programmatic implications and additional areas for investigation are proposed to improve MIYCN and health practices across USAID Nawiri's geographic areas. The programmatic implications are organized according to the specific areas analyzed.

Alignment with county and community priorities/involvement of key stakeholders in design and implementation

Existing county platforms and structures are key to aligning partners' work with country nutrition priorities. The county government coordinates nutrition activities including MIYCN, and aligns partners' projects with government priorities through its existing county platforms (County Nutrition Technical Forum, County Steering Committee, and Community Health System)**.** The County Project Steering Committee Meetings play a key role in aligning NGOs' work plans with the county development plans, including nutrition plans. The County MoH Nutrition Coordinator coordinates all nutrition activities and the County Ministry of Agriculture Economics Advisor coordinates nutrition-sensitive activities. CHAs and CHVs are responsible for coordinating community nutrition activities. Partners find the CHS meetings at the CHU level to be effective platforms to monitor implementation progress of MIYCN activities and provide an opportunity to engage CHEWs and CHWs. The County MoH has put in place a joint work planning process and implementation plan to ensure that partners' nutrition projects are well aligned with the county's priorities and health and nutrition plan.

1. Stakeholders' coverage and targeting

The county's MIYCN programs target children under 5 years of age, pregnant and lactating mothers, women of reproductive age, children under 5 years with acute malnutrition as primary targets, and fathers/men as influencers. Depending on their scope of work and resources, partners' projects target one or all of these target populations (children under 5, pregnant and lactating mothers, women of reproductive age, and children under 5 with acute malnutrition). They also target frontline workers as providers, community groups (care models and MMSGs), morans, and fathers/men as key influencers. Only two programs specifically target adolescents.

There are several partners that support the implementation of MIYCN, specifically BFCI, care model group, and malezi bora campaigns for MIYCN, SBC, IMAM, FLM, for capacity building of frontline workers. In addition, UNICEF and WFP supported capacity building, nutrition supplies, and anthropometric equipment for IMAM. There were no duplication efforts, which shows that the county has a strong system of coordinating partners' plans, activities, and geographic coverage.

2. MIYCN strategy and programs

Increase coverage of BFCI to improve MIYCN practices and care: BFCI is a promising community approach that improves MIYCN and care practices. However, there is a need to address vertical reporting to ensure it is integrated to the KHIS and the District Health Information Systems. It is recommended that USAID Nawiri's MIYCN HCD process further investigate this challenge and propose solutions by engaging the county/subcounty MoH, CHUs and CHEWs, and UNICEF.

Strengthen IMAM and family-led MUAC to promote MIYCN: USAID Nawiri could review IMAM training packages, services, and monitoring tools to formally integrate and promote optimal MIYCN and care practices. This is particularly important as IMAM is an existing community program with wide coverage and acceptance by health providers, CHWs, and households/caregivers. In addition, the family-led MUAC, through MMSGs approach, which was introduced recently, has empowered mothers to screen their children for acute malnutrition and take control of their children's referral to IMAM services. This offers another potential community contact point to promote MIYCN practices and heath care to mothers/caregivers.

Leverage county's existing community health structures and engage communities: The county nutrition programs, including partners' supported nutrition projects, have scaled up MIYCN interventions through the existing three levels of the health system: the facility, community, and household/individual levels. The community health structure (health facilities, CHUs), which has broad coverage, trained workforces, and community groups like care group models (i.e., MMSGs), are reported to be effective strategies to scale up MIYCN and care interventions and SBC and improve nutritional outcomes at community level. The county and USAID Nawiri should continue to use these community structures and capacities with more training and supportive supervision to scale up MIYCN and health practices and care at community and household levels. However, the county and partners should put in place monetary and nonmonetary incentives that are dispensed on a consistent basis to motivate CHWs.

Build on women's empowerment and household influencers' involvement for improving gender factors of MIYCN: A number of best practices have helped improve women's agency to adopt MIYCN and health behaviors. For example, participation in MMSGs has increased women's nutrition and gender-related knowledge and skills, and improved their access to income (e.g., poultry raising and VSLAs); and husbands/fathers, morans, and MCAs have participated in community nutrition and SBC programs. Programs have been empowering adolescents to use youth leaders, health clubs, and mini-dialogues with adolescents supported by CHVs during home visits. The county and USAID Nawiri can scale up and streamline these best practices in community SBC programming for improving MIYCN and health practices and care.

Increase programming of community nutrition-sensitive interventions: The county department of agriculture, fisheries and livestock and partners implemented promising nutrition-sensitive interventions, such as kitchen gardens, poultry raising, and Healthy Baby Living Clubs to increase consumption and production of orange-fleshed sweet potatoes; they have promoted the use of indigenous nutritious foods and introduction of drought-resistant crops and hardy animal breeds to increase consumption of nutrient-dense and diversified locally available foods. The county and partners should continue to allocate resources and build the capacities of extension workers to scale up these promising interventions to more sub-counties and wards to improve complementary feeding and dietary diversity of women and adolescents.

Program adaptation to shocks and special contexts

Strengthen current adaptations and test innovative ways to adapt to shocks/stresses: Some MIYCN program adaptions to shocks were identified that should be considered in

future programming. The county used intercommunity elders meetings to discuss resource sharing during shocks like droughts and floods; engaged morans to address shocks due to insecurity/conflicts; and encouraged community members to engage in diversified livelihood activities, such as farming, livestock keeping, and loans and savings to enhance resilience in times of shocks and stresses. In addition, some programs activated their emergency fund to respond to the shocks and protect gains before shocks happened, and to promote MIYCN and care practices. The county should have a well-resourced contingency plan for health and nutrition, and programs should be allocated flexible funds to respond to both commonly known shocks and unexpected ones. Partners could support the county to study and identify MIYCN program adaptation strategies, including those done for COVID-19 (as mentioned below), to commonly occurring shocks.

MIYCN programs and approaches need to be contextualized to different livelihood zones: The LAS identified some ways that the MIYCN program was adapted to agro-pastoralist and pastoralist livelihood zones, but more innovative ways need to be explored in the future. For instance, the BFHI approach is adapted to pastoral and agro-pastoral livelihoods. Building on these promising contextualizations for different livelihood zones, the county should continue to work with partners to identify new areas of adaptation for its MIYCN strategies, programs, and SBC materials to respond to the specific needs of each livelihood zone.

Adolescent nutrition programming: The Landscape Analysis and Stakeholder Mapping identified limited programs or approaches in health facilities and communities that have tried to address adolescents, specifically pregnant adolescents and those who are already mothers. There is poor access to adolescent-responsive services during health and community contacts, and low utilization of health and nutrition services due to stigma, trust issues, and limited access to information. There is a dire need for more innovative and scalable approaches that will improve nutrition and health services for pregnant adolescents and those who are already mothers.

Strengthen the capacity of health facilities and CHUs to provide adolescent-responsive support and services: There is little demand on the part of pregnant adolescents or mothers for preventive and curative services for their children and themselves from health facility visits and during community and home visits. The county and partners should promote these opportunities to provide MIYCN counseling and services and adolescent-responsive support to ANC, PNC, and FP services, including gender-related counseling and measures to reduce stigma and facilitate peer-to-peer dialogue. A county with support from partners and strong adolescent mothers' participation can build the capacity of health workers, CHEWs, and CHWs who provide ASRH, ANC, FP, and child health services through integrated counseling and service provision. This would create the opportunity to form community support groups that are conducive to adolescent dialogue and would minimize stigma. MIYCN counseling tools and materials appropriate for each facility and community contacts could be improved.

Use community platforms and media to reach and support adolescents: It is equally important to understand the optimal combination of community groups/platforms and media to reach gain the trust of adolescents, including those who are pregnant and already mothers. Existing tested platforms and approaches in the county need to be scaled up to more sub-

counties, for instance, using A&Y champions/binti shujaas and morans as role models; supporting dialogue days and mini-dialogues at the household level; having a separate adolescent MMSG or care group and clubs for older adolescents; collaborating with church or religious youth groups; and using radio talk shows. These key community approaches and platforms would ensure that adolescents can be counseled with confidentiality on different health and nutrition issues, and can empower them to seek and use services and change MIYCN practices. In addition, mobile technologies, such as digital messaging apps, bulk SMS, and Ong'an integrated mobile outreaches could be used to promote health and MIYCN behaviors to pregnant adolescents and those who are already mothers.

Community SBC strategies, platforms, and materials to improve MIYCN and care practices

Strengthen and scale up existing community MIYCN SBC approaches: The county and partners applied the following SBC approaches to improve MIYCN and care practice and increase utilization of services: individual or group counseling and support by CHVs and CHAs; talking walls at the health facilities and youth centers; community dialogue and mobilization through MMSGs and CCGs; community meetings such as local chief's baraza and dialogue meetings; and using radio talk shows, radio spots, and Digi-Somo app to reinforce MIYCN and health behaviors and services. However, there is a need to improve engagement of husbands and community gatekeepers. The analysis also revealed two major gaps: (1) the need to design and implement a simple and sustainable SBC approach that addresses the nomadic pastoralist community and (2) an SBC strategy/materials to address growing alcoholism and drug abuse problems and early and underage marriages affecting MIYCN and care. USAID Nawiri's MIYCN and SBC HCD could shed light in these areas.

Individual counseling by frontline health workers: Health facility workers and CHEWs have played a key role in providing counseling and support for caregivers/mothers during health facility and home visits. There is community value in MIYCN and health care counseling and support provided by frontline health workers. The county and partners should continue to use this SBC strategy and address the key challenges affecting quality of counseling, including: (1) training health workers on better use of various SBC materials to support counseling; and (2) managing the caseloads of health workers or increasing staffing, or shifting the task of nutrition counseling to nutritionists and CHEWs.

Customize, translate, and use existing SBC materials: The LAS identified several MIYCN SBC materials produced and used by the county and partners to facilitate individual counseling and group education by frontline workers and MMSGs. These include MIYCN counseling cards, nutrition job aids, nutrition and health banners and posters, MCH booklets, health and nutrition speaking cards, and radio spots and talk shows. However, these opportunities remain: (1) SBC materials should be developed that address alcoholism and adolescent marriage; and (2) existing and new SBC print materials should be translated into Ng'aturkana for easier dissemination by CHAs, CHVs, and mentor mothers, and for community members to understand more easily.

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