REVIEW REPORT OF KENYA NUTRITION CAPACITY DEVELOPMENT FRAMEWORK- 2014 – 2019

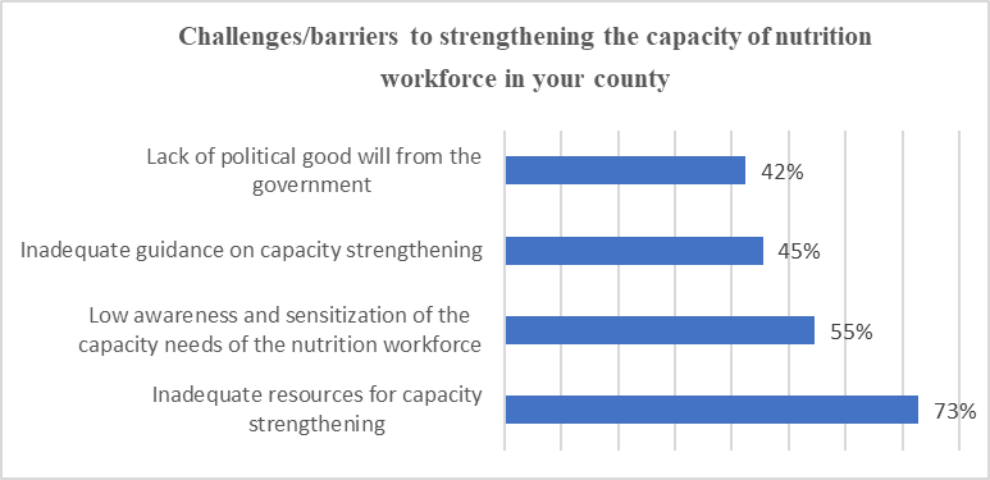
NOVEMBER 2022

ACRONYMS AND ABBREVIATIONS

ANLS	Agri-Nutrition Implementation Strategy
ASAL	Arid and Semi-Arid Lands
AWP	Annual Work Plan
BFCI	Baby Friendly Community Initiative
CDWG	Capacity Development Working Group
CTWG	Capacity Technical Working Group
CHAs	Community Health Assistants
CHMT	Community Health Management Team
CHVs	Community Health Volunteers
CIDP	County Integrated Development Plan
CNAP	County Nutrition Action Plans
CNCs	County Nutrition Coordinators
COVID-19	*Coronavirus* Disease 2019
CSO	Civil Society Organizations
CU	Community Unit
DND	Division of Nutrition and Dietetics
FGDs	Focus Group Discussions
HIS	Health Information System
IMAM	Integrated Management of Acute Malnutrition
IPs	Implementing Partners
JSI	John Snow Research & Training Institute, Inc
KIIs	Key Informant Interviews
KHIS	Kenya Health Information System
KMTC	Kenya Medical Training College
KNAP	Kenya Nutrition Action Plan

KNCDF	Kenya Nutrition Capacity Development Framework
KNDI	Kenya Nutrition and Dietetics Institute
KRA	Key Result Area
MoA	Ministry of Agriculture
MoE	Ministry of Education
MoH	Ministry of Health
MOH-DND	Ministry of Health-Division of Nutrition and Dietetics
MSN	Multi-Sectoral Nutrition
NGO	Non-Governmental Organizations
NICC	Nutrition Inter-Agency Coordinating Committee
NICC	Nutrition Inter-Agency Coordination Committee
NNAP	National Nutrition Action Plans
TOR	Terms of Reference
TWG	Technical Working Group
USAID	United States Agency for International Development

TABLE OF CONTENTS



LIST OF TABLES

LIST OF FIGURES

ACKNOWLEDGEMENTS

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GLOSSARY OF PROFESSIONAL WORDS

Academic Qualification [1] The end product or output of an academic program.

Accreditation [2] The procedure by which KNDI formally recognizes an individual as a member or an institution as a training institution in Nutrition and Dietetics.

Approved [3] Passed as sufficient and adequate by Council or other body legally empowered to declare persons and processes fit and proper.

Certification [4] The process of giving a mark of quality to a product or service by a statutory body.

Continuing Professional Development[1]**:** The concept of progression of professionals to have the needed skills, knowledge, and attitude commensurate with efficiency and effectiveness in performing tasks. This concept has since been institutionalized by the regulatory bodies and operationalized through guidelines known as ‘‘CPD Guidelines’’ that is specific to each professional body.

Curriculum [3]: An organized programme of study for a given certificate, diploma or degree awards incorporating all matters including rationale of the programme, purpose, and expected learning outcome, academic resources for the support of the programme, academic organization of the programme mode of delivery, admission requirements programme content requirements for the award of the certificate, diploma or degree.

Guideline [3]**:** Principles that provide guidance to set standards.

Indexing[7]**:** The process of gathering information on an individual student pursuing a course in Nutrition and Dietetics and/or dietetics for purposes of monitoring and subsequent registration with KNDI upon graduation.

Nutrition workforce: Has been used in this document to depict every cadre of staff involved in the nutrition and dietetics service delivery and not limited to professional nutritionists and dietetics service delivery.

Nutrition and sensitive Interventions[8] Projects/programs/activities that are not necessarily nutrition oriented but have an influence on the nutrition outcomes and indicators

Nutrition Specific Interventions [9] Projects/programs/activities that are targeted to tackle specific nutritional and dietetics problems within a people

Policy environment [10] Regulatory surrounding of an activity to be implemented.

Registration [10] A document issued by the Registration Committee as evidence of registration of a good standing KNDI member section 18 of the Act.

Regulations[13] Any statement of policy or interpretation of general application and future effect that also has institution-wide effect or affects the right or interest of the programme or institution.

Trainer of Trainers A professional with high order of motor and cognitive skills and is proficient to impart on to other professionals who then later train others on basic competencies.

Standards [11, 13] A reference point against which different aspects of the programme are compared or evaluated for quality.

1. CPD, Training Standards, Indexing Internship and CUE guidelines
2 NDA act No. 18 2007 (cap 253 B of the Kenyan Laws)
3 Nutrition and Dietician's regulation and codes of ethics and practice2014
4 Nutrition and Dieticians regulation and codes of ethics and practice2014
5 Nutrition and Dieticians regulation and codes of ethics and practice2014
6 Nutrition and Dieticians regulation and codes of ethics and practice2014
7 CPD, Training Standards, Indexing Internship and CUE guideline
8 Lancet 2013
9 Lancet 2013
10 Nutrition and Dieticians Regulation and Codes of Ethics and Practice 2014

EXECUTIVE SUMMARY

Introduction

One of the challenges faced in scaling-up nutrition interventions in Kenya is the limited capacity of the workforce to effectively deliver services, without which, achieving favorable nutrition and dietetics outcomes will remain a daunting task. The Ministry of Health (MOH), Division of Nutrition and Dietetics (DND), developed the Kenya Nutrition Capacity Development Framework (KNCDF) 2014 - 2019 to guide capacity development in nutrition. The framework is organized around four areas of capacity; systemic, organizational, technical and community.

Aim of the review

The overall aim of the review of KNCDF 2014-2019 is to document emerging issues and recommendations in strengthening nutrition capacity and priorities for the next KNCDF.

Methodology

The review of KNCDF was cross-sectional in design and the data collected was mainly qualitative with an application of relevant quantitative approaches. A total of eight counties were included in the sample for the review; in four of the counties data was collected virtually and the other four physically. The counties were selected based on the following criteria: regional balance; urban and rural representation; representation of counties in which KNCDF 2014-2019 capacity assessment had been conducted; representation of counties in which capacity assessment had not been conducted; and performance in capacity assessment taking into consideration the best performing and worst performing. Qualitative data was collected through Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs). The KIIs were conducted with stakeholders at the national, county, and health facility levels. FGDs were conducted at the community. Primary quantitative data was collected through an *Online Survey* targeting the 47 County Nutrition Coordinators (CNCs) to gather information to triangulate the qualitative data. The *Online Survey* data collection enabled more respondents to be reached than would have been reached through face-to-face interviews. The review was guided by the indicators based on the KNCDF 2014-2019 thematic areas.

Findings

- Awareness of the KNCDF 2014-2019 was low among the stakeholders at both the national and county levels due to inadequate dissemination and sensitization of the framework because of lack of resources.
- The KNCDF 2014- 2019 addressed the capacity needs in a holistic manner based on the four pillars of nutrition capacity strengthening but nutrition sensitive programming and multi-sectoral coordination were not adequately included in the framework.

- **Systemic Pillar:** Capacity Assessments were conducted in 24 out of 47 counties and a second one conducted in only 3 counties. The assessments were partner driven and the findings were used as advocacy tools to lobby for recruitment of more nutritionists and for funding for nutrition programs. The assessments were conducted in 16 ASAL and 8 non-ASAL counties.

- Resource mobilization: Overall, resource availability for nutrition programs is limited, the programs are mainly donor funded and the amount of funding is decreasing over time. There is, however, some improvement in budget allocation for nutrition activities at the counties. Resource availability is similarly limited for nutrition sensitive interventions.

  Leadership and governance: Competency in leadership and governance is a big gap among the nutritionists at both national and county levels.

- **Organizational Capacity**
  The level of planning, coordination and linkage between stakeholders and partnerships is stronger at the national than county level. Currently, there is improvement with the multi-sectoral coordination gaining ground in most of the counties.
  Nutrition information systems strengthening and management: The nutrition data is captured in the Kenya Health Information System (KHIS) although it does not contain all the nutrition indicators. The Kenya Nutrition SCORECARD and the Capacity SCORECARD are additional nutrition databases.
  As a whole, the infrastructure in the nutrition sector at the county level is wanting, especially at the health facility level in terms of office space availability for nutritionists, and anthropometric equipment and storage for nutrition commodities.

- **Technical Capacity**
  - Nutritionists are inadequate in terms of numbers and competence to efficiently implement nutrition programmes despite the increase in numbers over time. They lack competence in: leadership and governance; nutrition sensitive programming; clinical nutrition; data management; capacity in qualitative data management; advocacy and resource mobilization and writing of proposals and research grants.
  - Pre-service training of nutritionists is regulated and harmonized by the regulation body KNDI. The training is adequate in terms of specific nutrition. There are gaps in nutrition sensitive competence.
  - The policy environment is conducive for nutritionists to pursue in-service training and further training as long as the course is in line with one's job.

- **Community-related Capacity**
  There is strong linkage between health facilities and communities through the Community Health Strategy. The level of linkage depends on functional Community Units (CUs), and the availability and motivation of Community Health Volunteers (CHVs). The community is knowledgeable on the health and nutrition services available to them at the health facilities but the utilization is low due to access mainly because of distance.

- **Effectiveness of the KNCDF 2014-2019**

There is improvement of the capacity of the nutrition workforce over time, but to what extent this can be attributed to the KNCDF 2014-2019, is not easy to measure. There was recruitment of nutritionists and budget allocation to nutrition following the dissemination of the capacity assessment findings.

Strengths/successes in the implementation of the KNCDF 2014-2019

- The framework addresses nutrition capacity strengthening in a holistic manner, going beyond knowledge and skills.
- The framework is a critical tool for the identification of nutrition capacity gaps based on the four pillars of the capacity framework.
- The findings of the Capacity Assessments have the potential to be used positively as advocacy and lobbying tools for employment of more nutritionists and for allocation of funds for nutrition activities.
- Varied data collection methods used in Capacity Assessment, quantitative and qualitative data collection and observation. Provides a holistic assessment of the capacity of the nutrition workforce.
- The framework addressed the supply (services provision) and the demand (services utilization) capacity aspects.

Best practices in the implementation of the KNCDF 2014-2019

- The findings of the capacity assessments were used as an advocacy and lobbying tool for recruitment of nutritionists and for a budget for nutrition.
- The use of the SCORECARD was a motivation for the counties to strive and improve their capacity.

Gaps in the implementation of the KNCDF 2014-2019

- Inadequate dissemination of the KNCDF 2014- 2019 at both national and county levels.
- The nutrition sensitive, multi-sectoral coordination and community capacity strengthening are not adequately addressed in the framework. The operational guidelines and tools do not include nutrition sensitive programming. The operational guidelines are focused on how to conduct Capacity Assessments only and do not include other broader issues of nutrition capacity.
- The pre-service training is focused on nutrition specific and limited in nutrition sensitive aspects. The graduates from the academic institutions need induction to orientate them to understand the nexus between nutrition specific and nutrition sensitive programming.
- Not all the data collected from the Capacity Assessments was utilized particularly qualitative data because of the lack of expertise in the analysis of such data.

- The monitoring and evaluation component of the framework is weak. It was designed to assess compliance to the implementation of the framework without indicators for measuring achievement or the performance of the implementation.

Challenges in strengthening nutrition capacity of nutrition workforce

- Limited resources for dissemination and for conducting capacity assessments mentioned by all the respondents for the KIIs.
- Limited expertise in qualitative data management and consequently very little of the qualitative data from the Capacity Assessments has been utilized.
- Inadequate guidance on nutrition capacity mentioned by 45% of the CNC participants of the *Online Survey*.
- The capacity framework was viewed by some as being too complex especially for the lower cadre of health workers to comprehend.

Recommendations

- Dissemination and launch of the nutrition capacity framework and the dissemination should be improved by developing a detailed plan/road map for its launch, sensitization and implementation.
- Dissemination of the findings and recommendations of the Capacity Assessments should also include the Committee of Health at both National and County Assemblies, Committee of Education at both levels, Budget Committees and the Human Resource for Health personnel so as to understand and embrace the nutrition capacity needs, beyond the nutrition sector. These persons are major decision makers, influencing nutrition programming..
- The county government should be sensitized on the need to provide a budget for nutrition activities. This can be done, for example, by using the Capacity Assessment findings as an advocacy and lobbying tool.
- Inclusion/strengthening of the sectors- nutrition sensitive, multi-sectoral coordination, and community capacity strengthening in the framework so as to make the framework holistic in providing information on the capacity needs.
- There should be concerted efforts to conduct Capacity Assessments should be conducted in all counties so as to establish the nutrition workforce capacity status and needs.
- The framework guide and tools should include nutrition sensitive components and other critical sectors. The operation guide should also give guidance on how to engage or work with other sectors, for example, research and academic institutions.
- Development of a monitoring and evaluation framework with indicators to track the implementation of the KNCDF.
- Inclusion or strengthening of nutrition sensitive aspects in the pre-service curriculum from certificate to graduate level.
- The universities in collaboration with the MOH to mount short practical-oriented courses for the graduates to bridge the gap in the skills required at the job place so that employers do not

have to take time inducting and training fresh graduates upon employment. These courses would earn the trainees CPD points.

- Greater efforts should be made on capacity strengthening for leadership and governance, clinical nutrition, data management, qualitative data analysis, advocacy, proposal writing and research grant writing among the nutritionists.

1. Introduction

1.1 Background on the Review of Kenya Nutrition Capacity Development Framework

Improving nutrition and dietetics workforce capacity to deliver services is pertinent in scaling up nutrition agenda. To reverse the unfavorable malnutrition trends in Kenya, the capacity of the nutrition and dietetics workforce should be developed to the required levels. The Ministry of Health (MOH), Division of Nutrition and Dietetics (DND), developed the Kenya Nutrition Capacity Development Framework (KNCDF) 2014 - 2019 to guide capacity development in nutrition. The development of the framework was supported financially and technically by UNICEF. The KNCDF is one of the first documents to provide a comprehensive guide for shaping nutrition capacity development, recognizing the role of policies, funding mechanisms, organizational synergies, as well as coordination, monitoring and evaluation strategies. The framework provides standardized approaches for evidence-based nutrition capacity building notably the key pillars (systemic, organization, technical and community) for enhancing efficiency and effectiveness in nutrition service delivery.

The capacity assessment process was facilitated and led by the Nutrition Capacity Development Group (CDWG) of the MOH-DND. The first process in the development of KNCDF 2014-2019 was desk review and capacity assessment conducted to identify capacity gaps and make recommendations for the development of the framework. The capacity assessment process used a participatory approach and widespread consultations with MOH representatives, Kenya Nutritionists and Dieticians Institute (KNDI), Academia, Development and Implementing Partners. The data collection tools for the Key Informant Interviews (KIIs) were developed and reviewed by the members of CDWG. The selection of the stakeholders to participate in the KIIs was also guided by members of the CDWG. Documents reviewed included a number of Policies, Strategies and Action Plans in Kenya. The draft report was validated in a CDWG meeting and comments and further inputs obtained for incorporation into the assessment. The draft report was presented and validated in a national workshop that consisted of all partners and County Nutrition Coordinators (CNCs) from the 47 counties and their comments incorporated into the final report, which was further validated at the CDWG. The report informed the development of the Framework was well informed by views from wide stakeholder consultations at national and subnational levels.

1.2 Background to Kenya Nutrition Capacity Development Framework 2014-2019

One of the challenges faced in scaling-up nutrition interventions in Kenya is the limited capacity of the workforce to effectively deliver services, without which, achieving favorable nutrition and dietetics outcomes will remain a daunting task. Several nutrition sensitive and specific interventions have been initiated to reverse optimal nutrition trends. However, the capacities of nutrition systems, organizations and workforce have limited the scaling up of nutrition programs

for decades. Due to this, an assessment was conducted with an aim of identifying gaps and recommendations that eventually formed the basis for developing the KNCDF 2014-2019. This is a document that holistically explored the capacity gaps, recommended stakeholders' actions, and provided a monitoring, evaluation, and costing framework for undertaking capacity development initiatives. The process employed a participatory approach and widespread consultations with Capacity Development Steering Committee, MOH representatives, Kenyan Nutrition and Dieticians Institute, Academia, the UN and other key partners.

The assessment established four broad categories of capacity development relevant to the nutrition fraternity in Kenya: The systemic capacity was envisaged to address the capacity of nutrition workforce to create enabling environment to develop, review and implement policies, legal/regulatory, advocacy, lobbying and fundraising for nutrition specific and sensitive interventions at national and county levels. Organizational capacity on the other hand focused on developing the capacities of the nutrition workforce to increase knowledge and skills in planning, coordination of nutrition activities, utilization of information systems, system strengthening and management skills. Technical capacity addressed strategies to increase/enhance proficiencies and competencies of nutrition workforce through pre-service and in-service trainings, continuous medical education (CME), continuous professional development (CPD), on-job trainings (OJTs) as well as employment of skilled nutrition workforce to provide nutrition specific and sensitive interventions/programs. Community capacity focused on enabling a vibrant community linkage to health facilities and visibility of the nutrition sector using champions for increased uptake and utilization of nutrition services by communities.

1.3 Justification for the review of Kenya Nutrition Capacity Development Framework

The implementation period for the KNCDF ended in 2019, and its review is one of the activities spelt out in the Kenya Nutrition Action Plan (2018-2022) to generate evidence to inform the development of the next framework. From December 2021 through January 2022, the MOH/DND with stakeholders developed a detailed KNCDF roadmap that identified the review of KNCDF and operational guide and tools as a precursor step to developing the next generation capacity framework. This would allow sharing of lessons learned and the effective participation and involvement of key stakeholders such as the county governments.

2.0 Goal and objectives of the review of Kenya Nutrition Capacity Development framework

2.1 Goal of the review of Kenya Nutrition Capacity Development Framework

The overall aim of the review of Kenya Nutrition Capacity Development Framework 2014-2019 was to document emerging issues and recommendations in strengthening nutrition capacity and priorities for the next KNCDF.

2.2 Specific objectives of the Review

The specific objectives of the review were to:

- To assess the implementation status of the KNCDF – outcomes, milestones, gaps, resources and best practices.
- To assess the effectiveness of capacity strengthening on implementation structures, approaches, and tools and implementation of improvement-specific action plans.
- To establish the existence and application of capacity strengthening approaches and frameworks in nutrition sensitive sectors.
- To document lessons learned and emerging issues in nutrition capacity strengthening.
- To provide key recommendations in strengthening nutrition capacity and priorities for the next KNCDF.

3.0 Approach and Methodology

3.1 Overall coordination of the assignment

The MOH-DND was in- charge of the coordination of the review of the KNCDF. The consultant worked under overall supervision of the MOH-DND Capacity Program Manager and Save the Children. The consultant worked closely with the Capacity Technical Working Group (CTWG), to ensure the objectives of the assignment were achieved in an appropriate and timely manner. The MOH-DND responsibilities also included introduction of the consultant to the stakeholders at the national and county levels. The sequence and approach used in the implementation of the activities are shown in Figure 1.

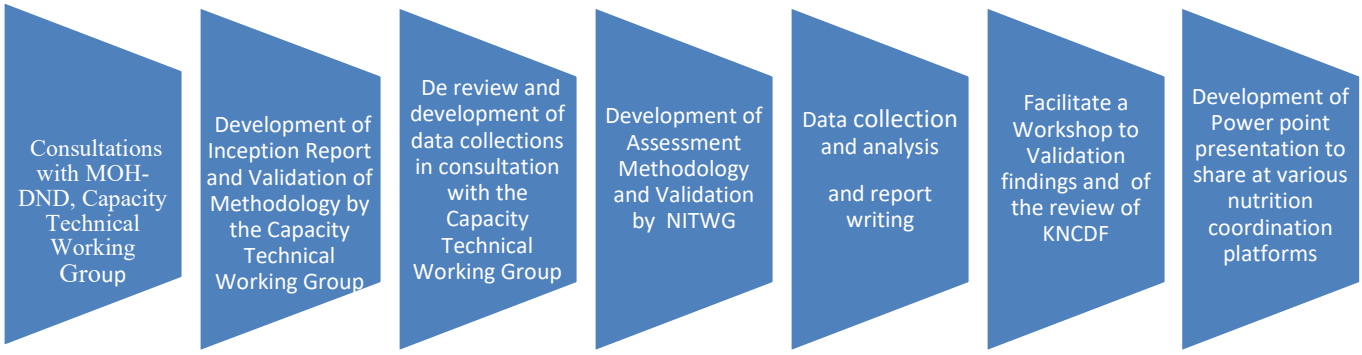


Figure 1: Approach in the implementation of the KNCDF 2014-2019

3.2 Design for the review of Kenya Nutrition Capacity Development Framework 2014-2019

The review of KNCDF was cross-sectional in design and the data collected was mainly qualitative with an application of relevant quantitative approaches.

Qualitative Component

Primary qualitative data was collected through Key Informant Interviews (KIIs); and focus group discussions (FGDs) with various stakeholders. The KIIs were conducted with stakeholders at the national, County, and health facility levels while FGDs were conducted at the community.

Quantitative data

Primary quantitative data was collected through an *Online Survey* to gather information on the implementation of KNDCF at the county level from the County Nutrition Coordinators (CNCs). The *Online Survey* data collection enabled more respondents to be reached than would otherwise be reached through face-to-face interviews.

The assessment was undertaken in **two** phases.

3.2.1 Phase one of the review

Phase one of the review consisted of stakeholder consultations and desk review of relevant documents.

Stakeholder consultations

Stakeholder consultations were conducted between the external consultants Ministry of Health-DND Capacity Manager and focal persons at Save the Children to discuss further the requirement of the assignment and agree on the scope of the work. The consultations also included mapping of eight Counties and stakeholders within the line Ministries of Health, Agriculture and Education as well as Implementing Partners, Development Partners, donors and other relevant government Ministries, departments and sectors. Additionally, through these consultations, the consultant sought guidance on documents to review. Similar consultations were conducted at the Counties that were selected for inclusion in the review.

Desk and literature review

A desk review provided a foundation upon which to build subsequent steps in the review. Desk review activities included scanning the literature, analyzing secondary data, and creating a reference list so that all documents are organized and easily accessible to the team. The findings of the desk review facilitated establishment of implementation status; achievements, gaps, best practices, lessons learnt, strengths, weaknesses and implementation framework for the next

KNCDF. In addition, the desk review facilitated identification of key recommendations for strengthening nutrition capacity and priorities for the next KNCDF.

A desk review framework was developed to guide the analysis of the documents reviewed so that all aspects of the assignments were covered. Desk review of relevant capacity policies, strategies, project documents from MOH-DND and line ministries and sectors were conducted.

3.2.2 Phase two of the review

Phase two of the study involved data collection from stakeholders both at the national and in the selected Counties. Data analysis, synthesis and validation of findings in various forums and report writing.

3.3 Sampling of counties

3.3.1 Sampling of counties for qualitative data collection

According to the TOR, 8 counties were to be included in the assessment. The counties were purposively selected based on the following criteria to meet the objectives of the review:

- Regional balance.
- Urban and Rural representation.
- Representation of counties in which KNDCF capacity assessment had been conducted.
- Representation of counties in which capacity assessment had not been conducted; and
- Performance based on the thematic areas (pillars) – looking at the best performing and worst performing counties. A review of the nutrition Scorecard gave a snapshot of the performance of the counties.

These criteria enabled identification of gaps, strengths, lessons learnt and best practices through comparison of those counties that were well performing and those performing minimally in implementation of KNCDF. Regional representation also facilitated identification of context specific differences in the implementation of KNCDF. The 8 counties selected for the review of KNDCF are shown in Table 1. In 4 out of the 8 counties data was collected physically and in four counties data was collected virtually to minimize field data collection costs. Two counties in which KNDCF has not been assessed (Capacity Assessment) were also included in the sample to establish why the assessment was not conducted.

Table 1: Sampled Counties to be included in the review of KNDCF 2014-2019

S/N	Geographical Region	Counties in the region	Selected County	Rural/Urban	Status of Capacity Assessment	Physical or virtual data collection
1	Nairobi	Nairobi	Nairobi *	Urban	Conducted	Physical
2	Coast	Tana River, Kilifi, Kwale, Lamu, Mombasa, Taita Taveta	Kilifi	Rural	Conducted twice	Virtual
3	Nyanza	Homa-Bay, Kisii, Nyamiria, Kisumu, Migori, Siaya	Kisumu	Rural	Not conducted	Physical
4	North Rift Valley	Baringo, Elgeyo/Marakwet, Laikipia, Nandi, Trans Nzoia, Turkana, Uasin Gishu, West Pokot, Samburu	Samburu	Rural	Conducted	Virtual
6	Central	Kiambu, Kirinyanga, Muranga, Nyandarua, Nyeri	Kiambu	Rural	Not conducted	Virtual
7	Western	Bungoma, Busia, Kakamega, Vihiga	Kakamega	Rural	Not conducted	Physical
8	Upper Eastern	Marsabit, Meru, Tharaka Nithi, Embu, Isiolo	Marsabit	Rural	Conducted	Virtual
9	Lower Eastern	Kitui, Machakos, Makueni	Kitui	Rural	Conducted	Physical

3.3.2 Sampling of health facilities in each of the counties

Selection of health facilities was based on the levels/cadres of the facilities and ownership to include private and/or faith-based facilities. In each County the Referral hospital and one other health facility was included in the sample.

3.3.3 Sampling of participants for qualitative data collection

Mapping of participants at the National and County level was carried out in consultation with the MOH-DND, Save the Children and the relevant IPs.

3.4 Sampling for the *Online Survey* quantitative data collection

An *Online Survey* was conducted for all the 47 CNCs from all the Counties. The online survey targeted those who were not reached through face-to-face, telephone, or virtual interviews. The online survey participants were not intended to be a representative sample but rather to provide information to supplement that collected through KIIs. This widened the scope and covered more stakeholders than would otherwise be reached for KIIs. The targeting of all the 47 CNCs provided an opportunity to reach more CNCs than in the selected Counties. The purpose of the *Online* Survey was therefore to provide information to supplement the findings from the KIIs.

3.5 Indicators for conducting reviewing the KNCDF 2014-2019

The indicators for reviewing the KNCDF 2014-2019 were organized according to the thematic areas in Nutrition Capacity Development Framework and included the following:

1. **Systemic Capacity Development:** Under this key thematic area, the following indicators were considered for the assessment
    - Macro level information available for capacity development on policy review, advocacy and fundraising
    - Policy guides, strategies and plans valid, disseminated and used for training health staff at national and sub-national level, it included nutrition and dietetics action plans, development and implementation of county specific training plans for curricular development and policy review
    - Creation of demand for nutrition and dietetics training through advocacy among health workers for the inclusion of more nutrition indicators in health worker performance indicators.
    - Review of the policies in health, agriculture, education, labor and other relevant sectors to make them nutrition sensitive and capacity development on nutrition sensitive policies and strategies
    - Improved communication and linkages between the factory and standards organizations and the nutrition partners regarding capacity development, strengthening and coordination between regulatory bodies and nutrition practitioners

- Improved standards of practice among the nutrition and dietetics practitioners and front-line service providers through development of in-service training and audit standards, licensing of TOTs in nutrition training
- Improved understanding of the legal and regulatory frameworks for nutrition and dietetics workforce
- Harmonized and integrated approach to nutrition and dietetics training regulations with the existing standards and regulations.

2. **Organizational capacity**: Under this key thematic area, the following indicators were considered for the assessment:
    - Nutrition and Dietetics workforce
    - On Job Training
    - Continuing Professional Development
    - Organizational infrastructure
    - Capacity Coordination
    - Capacity for improved advocacy
    - Capacity to collect and manage data
    - Capacity to mobilize resources

3. **Technical capacity**: Under this key thematic area, the following indicators were considered for the assessment:
    - Pre-service training and professional standards
    - In-service training
    - Workload considerations

4. **Community related capacity**: Under this key thematic area, the following indicators were considered for the assessment:
    - Level of awareness communities possess
    - Ability of communities to access, demand and utilize health services
    - Level of linkages existing between communities and health institutions at different levels
    - Increased nutrition sector visibility through use of champions at various levels

3.6 Data collection tools

Key Informant Interview and Focus Group Guides

The consultant developed KII and FGD guides in consultation with MOH-DND and the Capacity Technical Working Group. Different KII guides were developed the different target groups (MOH,

Line Ministries, Implementing Partners and other stakeholders) to collect relevant and appropriate information at both the national and county levels. The FGD guides were developed to collect information on community related capacities from the CHAs and CHVs. Information was also solicited on community related capacities such as level of awareness on existing nutrition and health services, ability of communities to access and demand nutrition and health services and the level of linkages between communities and health facilities and also linkages with partner organizations. See Annex 1 for the data collection guides.

An online survey questionnaire was used to solicit information for information from the County Nutrition Coordinators (CNCs) on their perceptions on the implementation and of the KNCDF 2104-2019. See Annex 2 for online questionnaire.

3.7 Data collection, target groups and information collected

3.7.1 Qualitative field data collection

Data collection methods were majorly qualitative through the use of KIIs at the national and county levels and Focus Group Discussions (FGDs) at the community level. The data was solicited from various stakeholders to inform capacity-strengthening activities and the information was relevant for making recommendations in strengthening nutrition capacity and priorities for the next KNCDF. *Virtual and mobile phone calls* were used as alternative means of collecting qualitative data from KII participants who were not reached through physical means. The FGDs were conducted with community health workers and members of the community.

At the national level, the participants included members of the capacity Technical Working Group (TWG), MSN Nutrition Inter-Agency Coordinating Committee (NICC), Kenya Nutritionist and Dieticians Institute (KNDI), as well as participants from the line Ministries of Health, Agriculture, Education, Labour and Social Protection, Academia and Implementing Partners. At the County level, participants were drawn from the key government departments of Health, IPs, Planning Department, CSO Networks, CECMs for the various MSN departments, Community Health Assistants (CHAs) and other relevant government sectors. The participants for the KIIs also included health workers from the Referral and other levels of health facilities and private and faith-based hospitals. Focus group discussions (FGDs) were conducted with members of the community. The target groups for data collection through KIIs and FGD participants and those who participated in the KIIs and FGDs are presented in Annex 3.

Quantitative online data collection

Primary quantitative data was collected through an online survey targeting the CNCs from the 47 counties. The CNCs were given one month in which to respond to the survey. The online survey targeted those officers who were not interviewed through face to face. This strategy allowed access to a larger sample than would otherwise be reached through face-to-face, telephone, or virtual

interviews. Information on the implementation status of the KNCDF, the lessons learnt, gaps, successes, best practices, and suggestions for improvement of capacity assessment was solicited.

4.0 Implementation of the KNCDF review

4.1 Review Team

The study team was composed of a Lead Consultant assisted by two technical persons, a nutritionist and a qualitative data management expert. The lead Consultant was the overall in charge of the execution and quality data control of the assessment.

4.2 Recruitment and training of enumerators

The criteria for selection of enumerators were developed and shared with the MOH-DND and Save the Children. Primarily, the survey team members were expected to come from the local communities and be fluent in both English and local dialects, should have at least Bachelor's Degree and have previous experience in data collection. This was important so as to enhance effective communication during data collection and ensure collection of quality data. Previous participation in a qualitative survey was an added advantage. The enumerators were expected to have access to a laptop. The advertisement, shortlisting and recruitment of the enumerators was conducted by Save the Children.

Training was conducted for enumerators from the four counties where the data was to be collected physically. A centralized training was conducted for the enumerators from Kitui, Nairobi and Kisumu. A second training was conducted for the enumerators from Kakamega at a later date. The trainings of the enumerators were conducted by the consultants in collaboration with the MOH-DND and Save the Children to ensure standardized training to assure quality data collection.

Training for data collection was conducted over a four-day period inclusive of one day for pre-testing of data collection tools. The training focused on the objectives of the study, safeguarding and ethical issues in research, interviewing techniques; how to conduct and record interviews for KIIs and FGDs including the use of voice recorders. Pre-testing of data collection tools was conducted on the last day of training. The data collection tools were reviewed based on feedback from the field.

4.3 Data collection procedure and duration

Each of the KIIs took between 45 minutes to one hour. One of the research assistants was facilitating/moderating the discussion and the other one took notes of the deliberations. The interviews were recorded with the participants' permission. Each FGD took between one to one and a half hours. The enumerators collected data only at the health facility and community level. The Interviews at the national and county levels were conducted by the consultants either face to face, virtually or through telephone.

4.4 Data Management and Analysis

The data from interviews and the FGDs were first transcribed and content analysis conducted. Content analysis involved the detailed exploration for common themes and assigning of labels to variable categories. The categories or themes were identified or predetermined in advance. The themes were in line with the objectives and scope of the assessment. The coding consisted of searching for the common themes which could be established as categories into which later information was inserted. The themes were clustered in a patterned order to identify variables that predict general concepts and isolate repetitions. Care was taken to ensure that the result of the categorization agreed with the context it was taken from (re-contextualization). Inferences were made from data under each theme. Conclusions were drawn from the findings and used to triangulate data.

The *online data* were analyzed quantitatively and presented in graphs and tables and were used to complement the qualitative findings from KIIs and FGDs.

4.5 Techniques to verify and interpret the findings

A number of techniques were used to verify and interpret results. Triangulation, in which the findings from KIIs data, FGD data and *Online Survey* data were compared. An agreement between the findings from the sources of data confirmed the validity of the data and any differences were also noted.

4.6 Data quality control

The quality of data was controlled as follows:

- Regular consultations with MOH-DND, Save the Children, IPs, and other stakeholders throughout the assessment process.
- Validation of the proposed methodology by technical forums at national level (e.g. Capacity Technical Working Group (TWG), before proceeding to the field for data collection.
- Validation of findings in a workshop by the Capacity Technical Working Group (CTWG), and other stakeholders.

4.7 Ethical Considerations

Risks & Risk management: The researchers ensured continuous assessment of physical, psychological, invasion of privacy, breach of confidentiality and other community risks associated with the research. The consultant adhered to the guidelines developed by MOH and Save the Children during this assessment, including child and adult safeguarding.

Data confidentiality: No identifying information was collected during the study. Instead, all participants were issued unique identifiers to mask their identity.

Informed Consent issues: Prior to their participation in the study, informed consent in the form of written consent by signature or thumbprint was sought from participants. The participants briefed on the objectives and methods used to collect the data. Every participant was informed of their right to refrain from the assessment and their right to withdraw at any time of the assessment without repercussions. This was communicated clearly and in the language the participant understood. A structured informed consent form was administered to all participants detailing the study title, purpose of the assessment and procedures.

4.8 Safety Precautions and adherence to COVID-19 public health guidelines

The researchers at all times adhered to the Ministry of Health Infection Control and Preventions (IPC) guidance to limit the spread of COVID-19. The following safety precautions will be practiced: social distancing especially when in doors; wearing of masks especially when in doors and frequent sanitization of hands.

5. FINDINGS

The findings are presented for the four pillars of the KNCDF 2014-2019. The findings are mainly qualitative but triangulated or complemented with quantitative findings from the *Online Survey* targeting County Nutrition Officers from all the 47 Counties. In total, 33 participants out of the invited 47 CNCs (70.2%) responded to the questionnaire.

5.1 Dissemination, awareness and sensitization of the KNCDF 2014- 2019.

Awareness of the KNCDF 2014- 2019

Awareness of the framework is low among the stakeholders.

At the national level, all the participants interviewed from the line Ministries; Ministry of Agriculture, Ministry of Labour and Social Protection and Ministry of Education were not aware of the framework. The majority of the programme officers in MOH-DND indicated that they were aware of the existence of the KNCDF 2014- 2019 but had not interacted with it in a detailed manner because of their busy schedules. They were also aware that Capacity Assessments had been conducted in some counties. The following sentiment illustrates this statement; *"I have a general overview of the framework but do not have detailed information about it",* stated one of the MOH-DND officers.

The level of awareness was low at the County level, even among the County Nutrition Coordinators. As a whole, those who were aware of the framework were those who had been: involved in its development; interviewed as a respondent during its development and those in Counties where Capacity Assessment has been conducted. The findings of the Online *Survey* illustrate this view. Of the 26 out of 33 CNCs who participated in this survey 79% were aware of the KNCDF 2014- 2019 and also indicated that they had engaged with the framework in one way or another (Figure 2).

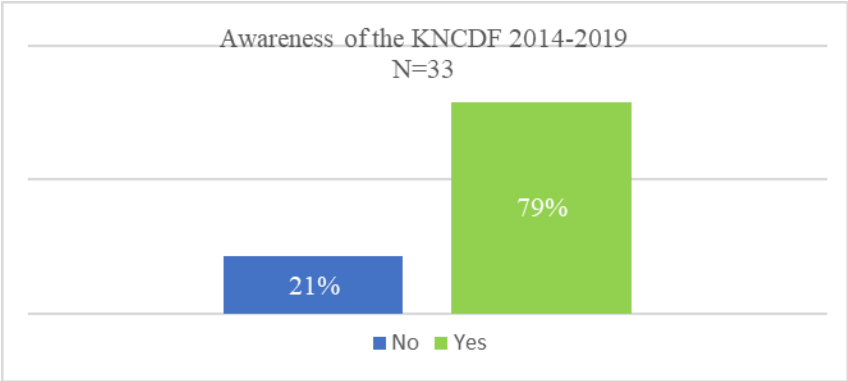


Figure 2: County Nutrition Coordinators' Awareness of the KNCDF 2014-2019

Of those who had engaged with the framework, 39% of them had participated in Capacity Assessment, 21% participated in the forum where it was disseminated at the national level, 18% participated in interviews during its development and 12% were involved in the development of the framework. Other responses included hearing about it during dissemination but not interacted with it to understand what it entails, through participation of the review and heard of it in one of the national meetings but there was no detailed engagement and support on the same (Figure 3).

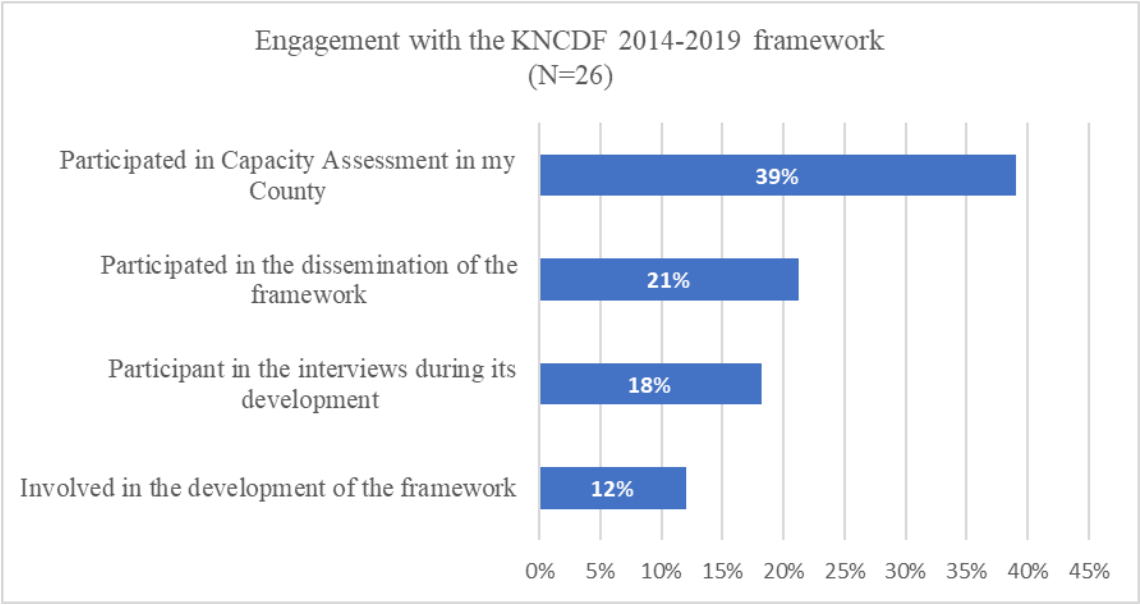


Figure 3: County Nutrition Coordinators' awareness and engagement of the KNCDF 2014- 2019

At the health facility and community levels, the KNCDF 2014- 2019 was not known to almost all the respondents; the health workers, the CHAs and the CHVs. It was reported that there is usually a gap in the dissemination of documents and policies from the Sub-County to the health facilities and not only for the framework. One health facility participant stated that, *"Dissemination of policies and guidelines at County and Sub-County level is usually perfect. We start experiencing gaps in cascading these documents to health facility level".* At the community, it was reported that there is usually no deliberate plans or effort for the dissemination of documents to the community especially for the CHVs.

The low awareness was as a result of inadequate dissemination of the framework from the national level to the Counties. At the national level, the KNCDF framework was not disseminated as a stand-alone document but in a forum amidst other activities. It was also disseminated through the MOH Nutrition Portal. Nonetheless, the nutrition portal is accessed by few people. "*At the time of the launching of this document in 2014, the virtual platform was not being used for dissemination of documents, otherwise if this channel had been used more counties would probably have been reached. We only started using the virtual platform during the Covid-19 pandemic";* reported one

of the MOH-DND officers. A national stakeholder stated that, "*There was no road map developed for the dissemination and implementation of the* KNCDF 2014- 2019*"*.

The major reason for inadequate dissemination of the KNCDF 2014- 2019 was lack of resources. Nonetheless, there was agreement by all the MOH_DND programme officers interviewed and other stakeholders at the national level that the KNCDF 2014- 2019 was important in giving guidance to nutrition capacity strengthening in a holistic manner.

5.2 Appropriateness, relevance and comprehensiveness of the KNCDF 2014- 2019

The KNCDF 2014- 2019 framework is based on UNICEF Global Guidance and is therefore aligned to international guidelines on nutrition Capacity Strengthening. At the time of its development there were hardly any countries in the region with a nutrition capacity framework. Since then Uganda and Somalia have developed Nutrition and Capacity Strengthening Frameworks basing them to a large extent to the Kenya one.

As a whole, it was reported that the KNCDF 2014-2019 addresses capacity strengthening in a holistic manner, based on the four pillars of capacity strengthening (systemic, organizational, technical and community capacities) in addition the cross-cutting issue of monitoring and evaluation (M&E). The framework addressed the nutrition capacity beyond resources, human skills and knowledge. The four pillars were viewed as adequate and relevant in addressing issues of nutrition capacity strengthening. As a whole, the guides and data collection tools were also viewed as being adequate in assessing nutrition capacity.

Nonetheless, it was felt that the framework did not adequately address issues of nutrition sensitive capacity strengthening and that it is addressed in a subtle manner in the entire document. Similarly, multi-sectoral coordination of nutrition capacity strengthening does not feature strongly in the framework and yet nutritionists need to work in collaboration with other relevant sectors in order to achieve sustainable nutrition outcomes. These sentiments were expressed at both the national and sub-national levels. One of the key informants at the county level had this to say about the comprehensiveness of the KNCDF 2014-2019 on the nutrition sensitive work force, '*'I don't think so because it is really structured only to the health systems, it looks at what health delivers and not what other partners and sectors deliver, so it may not be effective, or it may not be implemented in nutrition sensitive sectors. When I have used it, I have focused only on health, so I cannot be able to – it's not clear on how we can establish the capacity of staff establishment for other sectors especially within the ministry, I think I clearly talked about the ministry, but if we could also expand to touch partners so that we can be able to have strong work force which is multi-sectoral''*.

Another aspect that has not been adequately addressed in terms of comprehensiveness, is the capacity strengthening at the community level. The sentiments of CNCs on this aspect is illustrated in the box below.

> *''I think through the four thematic areas, apart from that component you're bringing in about the nutrition sensitive. Basically, it has been able to capture quite a lot but the community aspects need to be... I feel has not really looked at nutrition at community level. Looking through, I think basically it's not bad, in depth and ensure that nothing is left, in terms of what exactly we want to deliver from the capacity assessment''*, reported by a CNC.

On the tools used for data collection, it was the opinion of some of the respondents that the data solicited by these tools was too much and a lot of data was not utilized. Only data that is useful should be collected so that time and money are not wasted. The qualitative data, for example, was not fully analyzed and used, mainly because of inadequate capacity in terms of analysis.

Some of the participants, were of the opinion that operational guidelines for the framework focused too much on how to conduct Capacity Assessment without including the broader areas of capacity strengthening. Another gap mentioned was *how to operationalize the recommendations in the KNCDF framework 2014 -2019.*

The findings of the *Online Survey* on comprehensiveness of the framework, were to a large extent in agreement with the qualitative findings. Only 11% of the participants were of the opinion that the KNCDF 2014-2019 was very comprehensive in terms of content for nutrition capacity strengthening, whereas 54% indicated it was comprehensive and 11% not comprehensive respectively (Figure 4).

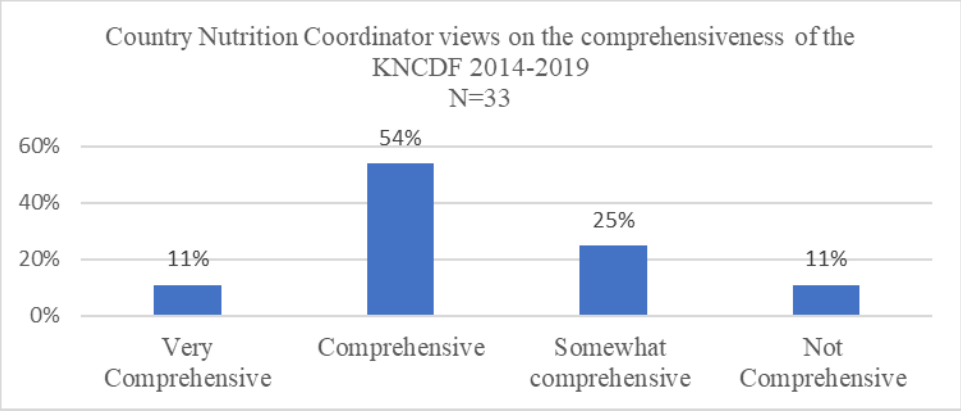


Figure 4: County Nutrition Coordinators views on the comprehensiveness of the framework

At the County level, some of the participants who had engaged with the KNCDF 2014-2019 felt that it was complex and that it should be simplified so that it can be easily understood by the lower cadre officers or that a simplified manual could be developed from it for use by these cadres for easy implementation.

Another gap that was identified was in the Monitoring and Evaluation component. It was felt that the framework should provide a detailed plan for monitoring including how to establish the extent to which the Action Plans developed after Capacity Assessments had been implemented. The plan should include the monitoring and evaluation indicators.

5.3 Implementation Status of the KNCDF 2014-2019

Given the low awareness of the KNCDF 2014-2019 by the majority of the stakeholders, many counties did not specifically implement the framework. Nevertheless, capacity strengthening took place with a number of the strategies and activities aligned to the recommendations in the framework. In this section, therefore, most of the findings presented are on the nutrition workforce strengthening strategies conducted at the county and not necessarily guided by the framework. The findings are presented under the four pillars of the KNCDF 2014-2019. Reference is made to the findings in the few cases where there was deliberate effort to implement the framework, that is Capacity Assessments.

5.3.1 Periodic Capacity Assessments

The implementation of the framework in the counties where this took place was conducted through the Capacity Assessments. Capacity Assessment was as to be conducted periodically to provide evidence-based information on capacity building available for policy review, advocacy and fundraising. The results of the Capacity Assessment was to be used for the development of action points at national, county and sub-county levels for policy review and advocacy. Capacity Assessment was conducted in 24 counties, 16 of them in ASAL and 8 in non-ASAL counties once and twice in 3 Counties. It was reported that the assessments were partner driven and funded. In the counties where Capacity Assessment was conducted, the findings were used to develop Action Plans, which were incorporated into the Annual Work Plans. It was reported that since the county and sub-county CHMT, and top management (executive and Director) attended the dissemination meetings of the findings of the Capacity Assessments, this resulted in appreciation and embracement of the capacity needs of the nutrition workforce. Consequently, the findings resulted in some positive changes. For example, Marsabit County, has been able to implement a number of the recommendations in the first Capacity Assessment Action Plan. There has been an increment, albeit small, of the nutrition budget; nutrition capacity issues are being integrated into the county policy documents; there recruitment of additional nutritionists (though number is still inadequate); and improved multi-sectoral coordination. Review of the policies, (FSNP, Food Systems Strategy, and School ECD Policy, County ECD Meal Strategy etc.) to include nutrition sensitive are

currently ongoing. Radio messages have been developed on Agri-Nutrition and implementation of activities in schools on hygiene and nutrition etc. In Kilifi, there is also goodwill and appreciation of the limited capacity of the nutrition workforce and the County government has responded by employing more nutritionists.

On the whole, those who had interacted with the tools and also participated in the assessments felt that the findings of the Capacity Assessment were underutilized. One of the implementing partners sentiments echo these findings, "*For me, I think it's a good tool that enables us to identify key gaps across all levels. But the problem that I have noticed, like the use of the result from the tool is very minimal. Like for capacity assessment is done, yes and the results released. But from my point of view the tool is supposed to be used to advocate for key issues, based on the gaps that were identified in the tool. The tool is underutilized as the results from the capacity framework assessment is usually underutilized''.*

Secondly, in the Counties where the Capacity Assessment was conducted, the findings have been used for advocacy. The statement below illustrates the sentiments of one of the CNCs where the assessment had been conducted.

'We have tried to strengthen advocacy in terms of sensitizing legislature, the key decision makers like the budget are aware of the gaps, our strengths and everything but we also realized that sometimes the key decision makers, the leadership they are not aware of these things, when we talk about malnutrition and the nutrition situation, how we are doing as a County, the needs of staffing, the financing. Most of the time we assume that they understand but we also realize that we need to do a lot of advocacies in terms of sensitizing them and also making them buy the idea of supporting the nutrition services. So, it has helped us a lot''.

Frequency of assessing the nutrition capacity is not on a need basis but more on resource availability. It is a challenge that there is no financial resource allocated to this activity by the government and therefore resources have to be mobilized from the partners. Out of the CNCs who participated in the *Online Survey,* 30% reported that the governments in their counties gives financial support for nutrition capacity strengthening but the amount is minimal. In terms of frequency, assessments are not conducted in line with the recommendations. Furthermore, the assessment is not based on county need. The national government may have a plan but according to the county it may not be their priority. Another issue for the county is the time factor, the capacity assessment may not be priority, especially if there is another planned activity/activities that takes the priority at the time.

5.3.2 Policy Environment

Nutrition policy formulation is mostly guided by the national government and supported by UNICEF though the provision of funds and technical capacity. Kenya has developed many relevant policies, strategies and guidelines used in the implementation of nutrition activities in the country. The policies include: Food Security and Nutrition Policy (FSNP) 2011; Kenya Nutrition Action Plan (KNAP) 2018-2022; The Multi-Sectoral National Food and Nutrition Security Policy Implementation Framework (2017-2022); Agri-Nutrition Implementation Strategy (ANIS) 2020-2025; Food Fortification Policy, Community Health Strategy, and Nutrition Monitoring and Evaluation Framework. There are also a number of Strategic Guidelines focusing on various nutrition programmes, for example, Maternal and Young Child Nutrition (MIYCN), Integrated Management of Acute Malnutrition (IMAM), Clinical Nutrition; iCCM, BFCI guidelines. As a whole, these documents provide adequately for capacity strengthening for nutrition specific and not for nutrition sensitive programming. However, the KNAP includes detailed description of capacity strengthening to achieve the desired Key Results Areas or outcomes for both the nutrition specific and the nutrition sensitive programming. The policies and guidelines provide information to be used in the development of Annual Work Plans (AWP) focusing on specific activities and time lines. It is the mandate of the MOH at the national level to disseminate the documents to the County level who then should disseminate to the sub-county for onward transmission to the health facilities and the community. But this process does not always take place adequately because of budgetary constraints.

Efforts are in place by the MOH to make the policies, strategies and guidelines appropriate in creating an enabling environment for capacity strengthening by allowing contextualization at the County level. Counties have domesticated the KNAP and developed CNAPs which are supposed to incorporate the nutrition sensitive components.

In terms of nutrition sensitive programming, the Ministry of Agriculture is currently in the process of developing additional policies, strategies and training curriculum to incorporate agriculture nutrition sensitive strategies, such as the National Agriculture Extension Policy, Agri-Nutrition Implementation Strategy (ANIS) and a Curriculum for In-Service for Extension Workers. Counties will then domesticate ANIS while trying to unpack the KRA 10 stipulated in KNAP once it is disseminated to the Counties. The Ministry of Agriculture, as a starting point, is currently in the process of developing a Nutrition Sensitive Training Package. In addition, the Extension Policy is being revived and Agri-Nutrition being strengthened. One big challenge experienced is that indicators for Agri-Nutrition are not clear in addition to the ministry having inadequate capacity to implement Agri-Nutrition at the ground level. The MOA is no longer employing Home Economics Extension workers who used to educate households on agriculture and nutrition related issues. The Agri-Nutrition Unit at the national level does not have a budget to implement activities. There is political good will in the ministry but this has yet to translate into action. An additional

challenge is the lack of interest in Agri-Nutrition at the County level. Nonetheless, there is a positive change as multi-sectoral coordination is improving at the County level. The positive strides made by MoA in promoting Agri-Nutrition is commendable. One of the respondents at the national level indicated that; *"If the Kenya Nutrition Capacity Framework is well designed, that is, clearly including nutrition-sensitive components and well disseminated, it may be used as an advocacy tool for employment of nutritionists and budget allocation in MoA".*

For the Ministry of Labour and Social Protection, their policies have not yet incorporated or been reviewed to make them nutrition-sensitive. However, after sensitization and awareness creation, there have been positive development and capacity strengthening, for example, in the NICHE program which has embraced nutrition sensitive activities. Great strides have been made through this program although it is operational only in a few counties.

The Ministry of Education Policies include the School Meal Policy which has nutrition component but has yet to ne be harmonized with the Home Grown School Feeding program. The MOH nutrition and public health together with the MOE however, work in collaboration to distribute Vitamin A supplements, deworming drugs and WASH activities at the ECDs. WASH activities include water harvesting and storage at the schools as well as messages on hygiene such as hand washing. These activities are implemented on the vitamin A supplementation and deworming guidelines and public health guidelines for WASH. In addition, there are policy guidelines at national level on health and nutrition for ECD but have not been fully domesticated by many of the counties.

5.3.3 Capacity for Standards, Legal and Regulatory Environment

Nutrition and health issues are broader than the services provided at the health facilities and other line ministries and therefore standards, linkages and the regulatory issues are critical to the improvement of nutrition outcomes. On the whole, there is limited linkage between the nutrition sector and industries. A lot of nutrition-related work is conducted in the industries, for example, on food safety. In such cases, the industry links with the specific program in the nutrition sector mainly at the national level. There has been a lot of engagements and collaboration between KEBS and the MOH Food Fortification program at the national level. The linkage with KEBS is not on a regular basis but more on needs basis. It was reported that KEBS hardly attends the national coordination meetings and similarly their presence is not felt at the County level. The KNCDF 2014-2019 has not helped much in linking the private sector working in the nutrition sector with KEBS that would benefit a lot from such engagements. At the county level, the nutrition sector would like to have more linkages with KEBS but this may be limited by the fact that KEBS do not have offices in all the counties.

The Kenya Nutrition Dietetics Institute (KNDI) is the body mandated to regulate the profession in terms of registration and licensing of nutritionists. In terms of the linkage between KNDI and

stakeholders including the nutrition sector, there is good representation of various stakeholders at the KNDI Council at the national level. The nutrition sector, through MoH –DND, Kenya Medical Technical Colleges (KMTC), universities etc. are members of the Council. In this respect, therefore, there is good linkage. Engagement with KNDI was also evident during the development of the KNCDF 2014-2019 framework, in which the institution participated.

At the County level, it was reported that there is limited linkage and engagement with KNDI. KNDI writes to employers reminding them that only registered nutritionists should be employed. In this respect the regulatory body is doing a good job but this seems to be the only activity it engages in. There is therefore, limited visibility of KNDI at the County level. One of the participants stated that, *"The general feeling is that KNDI is just about registering and licensing of nutritionists. Many employers are not aware of KNDI and therefore there is need for mass education to create awareness and sensitization about the regularity body, their roles and responsibilities".*

Engagements between Research Institutes and Academia with the nutrition sector and partners were reported to be much better than with KEBS and KNDI. There have been collaborative researches conducted between the nutrition sector (MoH–DND), with development partners and implementing partners. In addition, engagements also take place in the form of internships for students from academic institutions. The engagement has been mainly with academic institutions in Nairobi and therefore does not have a national representation. There is however, need for improvement, especially in terms of utilization of research findings from academic and research institutions in nutrition programming. There is potential for conducting more research between the nutrition sector and the academic institutions and the research institutions to provide evidence for policy formulation and programming.

5.3.4 Resource Mobilization

Overall, resource availability is limited and funding has been decreasing over time. Nutrition programs are mainly donor funded with limited budget allocation from the government. The donor funding is also on the downward trend with Kenya having transitioned into a Lower Middle Income Country (LMIC). There is, however, some improvement in budget allocation for nutrition at the counties. The nutrition programs are mainly partner supported. At the national level, resource mobilization has been prioritized but there is variation on level of involvement at the County level. The Ministry of Health especially at the County level has not been aggressive in looking for funds, and this, constitutes a large gap for nutrition programming.

As a whole, there is limited capacity among professional nutritionists to mobilize and lobby for funding. It was reported that nutritionists, on the whole, lack the skills to push their case, and lobby for resources. Furthermore, resource mobilization skills are not well captured in the framework. One of the MoH participants at the national level stated that: *"There is limited Capacity for Grant writing. We do not have the capacity to lobby for funds".*

It was reported that the findings of the Capacity Assessments, in the Counties where it was conducted, were used to advocate and lobby for funding and other resources. In Isiolo, Marsabit, and Kilifi, for example, additional nutritionists were employed by the County governments. In addition, the County governments also provided some funding for nutrition, even, if it was much less than the requirement. This was however, a positive move. The additional budget was used to conduct trainings to bridge the capacity needs. In these Counties, the top management (County and Sub-county CHMTs, CeCs etc.), participated in the dissemination of the Capacity Assessment findings and therefore embraced the resource needs for nutrition programmes. The findings of these assessments have contributed, to some extent, political good will for nutrition. The sentiments in Marsabit County, where a second Capacity Assessment had been conducted echo these sentiments, "*There is great improvement as a result of the Capacity Assessment findings. More nutritionists have been employed, trainings conducted and there is a change in the policy landscape. Policies are being reviewed and domesticated to integrate nutrition issues e.g. The Food Systems Strategy, School ECD Policy etc. and are now awaiting ratification".*

It was also observed, that there is limited or lack of resources for nutrition sensitive interventions. This is particularly critical given that this is a relatively new area and needs political goodwill from the line Ministries as well as capacity to make the programs nutrition sensitive. With inadequate capacity, it is challenging to mobilize for resources. The Ministry of Agriculture, has made great strides including having an Agri- Nutrition Unit and one nutritionist employed at the national level, yet there have no budget allocation. Most of the nutrition-sensitive activities are partner supported.

5.3.5 Leadership and governance

Leadership and governance is a very dynamic area. The level of competency in leadership and governance among nutrition professionals is low, starting from the national (MOH – DND) to the County level. This creates a gap, among other issues, on how to plan for and respond to emerging issues such as Covid 19 pandemic and climate change appropriately.

It was reported that the level of competency in leadership and governance depend to a large extent on individual motivation and interest. There has been no particular intention by MOH to train officers in Nutrition Leadership neither is there a locally available course targeting nutrition leadership such as the African Nutrition Leadership Programme (ANLP) offered by the University of Western Cape, South Africa. It was suggested that such a course could be developed and mounted by one of the local universities offering nutrition in collaboration with the MOH. Currently, the nutritionists who have interest in leadership and governance training enroll for the government generic courses on Senior Management and Strategic Leadership. These courses address the general aspects of leadership and governance but not nutrition leadership. These courses are mainly for career progression.

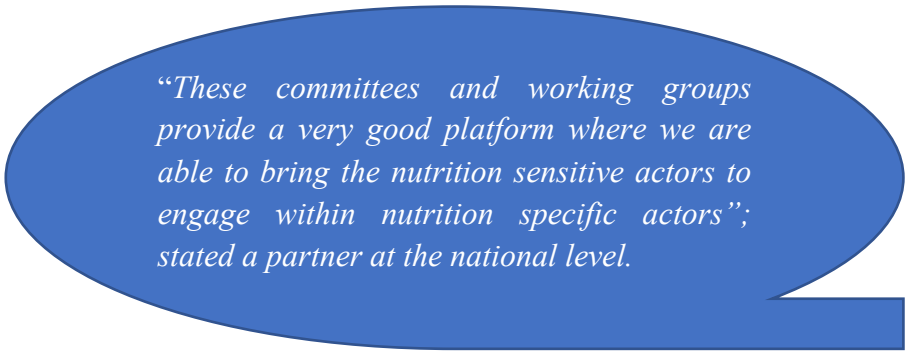
Competency in leadership and governance is a big gap at both national and county levels. MOH – DND is planning to be intentional in training in nutrition leadership especially for the CNCs. This is to ensure that there is adequate capacity for implementation of the of national nutrition agenda across the counties.

5.4 Organizational capacity

According to the KNCDF 2014-2019, the result areas under organizational capacity included establishment and operationalization of nutrition capacity office within MOH-DND, expanding capacity steering committee and capacity working groups, planning, coordination, and multi-sectoral collaboration of nutrition interventions as well as utilization of information systems, system strengthening and management skills by nutrition workforce.

5.4.1 Planning, coordination, linkage, and collaborations

The level of planning, coordination and linkage between stakeholders and partnerships is stronger at the national level than the county level. At the national level there is a well-established coordination system starting from the National Technical Coordination Committee to the various technical working groups targeting different programmes in the MOH- DND e.g. Nutrition Information Technical Working Group (NITWG), Research Technical Working Group and the Capacity Technical Working Group. These groups do not only ensure quality in programming but the Capacity Technical Working Group's mandate is to address issues of capacity strengthening and harmonization of the nutrition workforce. These platforms have enabled the identification of capacity gaps, for example, in nutrition sensitive interventions. This sentiment is illustrated by the following statement expressed by a partner at the national level.



It is the Capacity Technical Working Group that was responsible for the development of the KNCDF 2014-2019 and also took a leading role in the implementation of the Capacity Assessments. The Capacity Technical Working Group, did not, however, actively engage in sensitization of the counties to implement the framework due to limited resources.

In counties where Capacity Assessments was conducted, it was partner driven. Overall, the assessment was guided by MOH-DND Capacity Technical Working Group.

At the county level, coordination of various sectors is not as strong as at the national level. There is improvement, however, in this aspect with the degree and strength of the coordination varying from county to county. In every county there is a level of coordination of the nutrition programs where there are nutrition technical working groups or forums and these technical forums are multi-sectoral in nature. It was reported that multi-sectoral coordination is improving in a majority of the counties. The sectors involved in the coordination are the private sector, academia, research institutions, and line ministries (Labour and Social Services, Education and Agriculture). Multi-sectoral coordination continuously being embraced and appreciated as critical in the achievement of sustainable nutrition outcomes by other sectors. One of the members of the multi-sectoral coordination committee member reported that:

"Before I could not imagine how nutrition can be useful in social protection, but after engagement with other county officers from various departments and especially after we were included in the multi-sectoral meetings, I now understand how I can address nutrition needs and even identify malnutrition in those with physical disability, something that I only see happening in the developed countries like the USA. I'm now able to discern information I read on social media about nutrition and disability".

One of the CNCs described in detail the multi-sectoral coordination within the counties and she had this to say "*Currently we are trying to set up multi- sectoral nutrition working group, where we have the top leadership; we have the first lady as the champion. Then from the first lady we have the CEC heal, we have the CEC education, CEC health, and CEC agriculture. CEC health takes the secretarial role. Then agriculture, the chair role. Then from the CEC, then we come to the various departmental heads where we meet and discuss the technical issues and feed the top leadership. Because they may not have that time to attend meetings. So we update them on what is happening. So we have the various directors, we have somebody from Social Protection. There is Water, we have Trade, and we have Agriculture, the different sectors and the different partners. Then we now come to the various sub counties. At sub county level., they also have their multi-sectoral working groups where now they update the county. At the sub county they meet on monthly basis. At the county, we meet on quarterly basis''.*

The developments in the multi-sectoral coordination are happening even without the implementation or knowledge of the KNCDF 2014-2019 but are need based.

Nonetheless, in the counties where Capacity Assessment was conducted, the findings triggered increased interest and efforts in multi-sectoral coordination. The Key Informant Findings (KIIs) with the stakeholders from; CHMT, Ministries of Agriculture, Education and Labour and Social Protection; and Implementing Partners from Kitui, Marsabit and Kilifi Counties confirm this observation.

In some counties for example, Kitui, Kakamega and Kisumu, multi Multi-Sectoral Nutrition (MSN) coordination is gaining strength. In these Counties MSN coordination platforms have been established and Terms of Reference (TOR) developed to guide the frequency of meetings and responsibilities of each sector/collaborator. Meetings are held regularly and minutes of meetings

taken to guide activities. The major activity undertaken is training of the committees on the coordination. The ToR makes the members accountable to the decisions made by the committee. Consequently, the capacity building provided to the committees is appreciated by the members and has been instrumental in making some sectors implement nutrition sensitive activities.

In the MoA in Kakamega, for example, reported that the leadership is very supportive of the MSN coordination and that the different sectors have agreed to work together. They have had some joint activities, for example, during the MOH Open Days which are supported by the partners. The MoA is conducting activities in collaboration with MOH and Academia (Musinde Muliro University) on kitchen gardening, Child Health and Education in Early Childhood Education (ECD). This activity is partner supported.

In Kisumu County, there has seen a number of inter-sectoral engagements between Agriculture Department, the Department of Health, the Department of Water and also the Department of Education. The following sentiments illustrate the benefits of multispectral coordination as expressed by the participants.

> *"You find that this multi-sectoral approach is very important because you create synergies across departments. You realize that budgetary constraints and other constraints will be minimal. So when they partner together they avoid duplication at County level. So that whatever they do in tandem with each other, in that way they optimize the resources that they have in the process. So that is a big plus",* stated a member of the CHMT in Kisumu County

Findings from the counties where there is strong multi-sectoral nutrition coordination indicated that the coordination is effective in strengthening capacities of workforce in terms of proficiency and knowledge to plan, implement and monitor both nutrition specific and sensitive interventions in the county. This was the opinion of one of the CHMT KII participants illustrated in the in the following statement: "*Due to effective multi-sectoral coordination in various counties we are seeing this issue of kitchen gardens, growth monitoring in schools at the end of the day, like now with growth monitoring in schools, we are even seeing children being referred from the school to the facility because some parents don't know that a child is malnourished. So growth monitoring helps in referral. Then with sensitization, like when they have the ECD teachers come and they're sensitized on issues of nutrition, the same trickle to the parents. And when the parents are empowered, it goes to the community".* This is very encouraging, but the capacity strengthening in multi-sectoral coordination should now translate into increased collaborative implementation of activities.

This needs to be cascaded down to the sub-county and community levels. For instance, the Nutrition Capacity Working Group at the national level has clear terms of reference but not so at the County level. One of the KII participants had this to say about coordination of nutrition interventions:

> *"In every county there is some form of coordination of the nutrition programs where there are nutrition technical working groups or forums, and these technical forums are multi-sectoral in nature".*

5.4.2 Nutrition information systems strengthening and management

The nutrition data is captured in the Kenya Health Information System (KHIS). Data from the community activities is collected by CHVs using prescribed data reporting tools and submitted to the CHAs who compile the data from all the villages for the CU they are in-charge of using prescribed data reporting tools. The CHAs submit the data to the linking health facilities who then compile all the data from the CUs. These data is integrated into the health facility data reporting tools and passed onto the sub-county who then likewise compile and send the data to the County. The Counties pass the data to the national level. (Figure 5). From this database, nutrition data is available for the Sub-County, County and national level. A gap in the KHIS is that it does not include all the nutrition indicators for example, exclusive breastfeeding, MUAC for children underfive years of age.

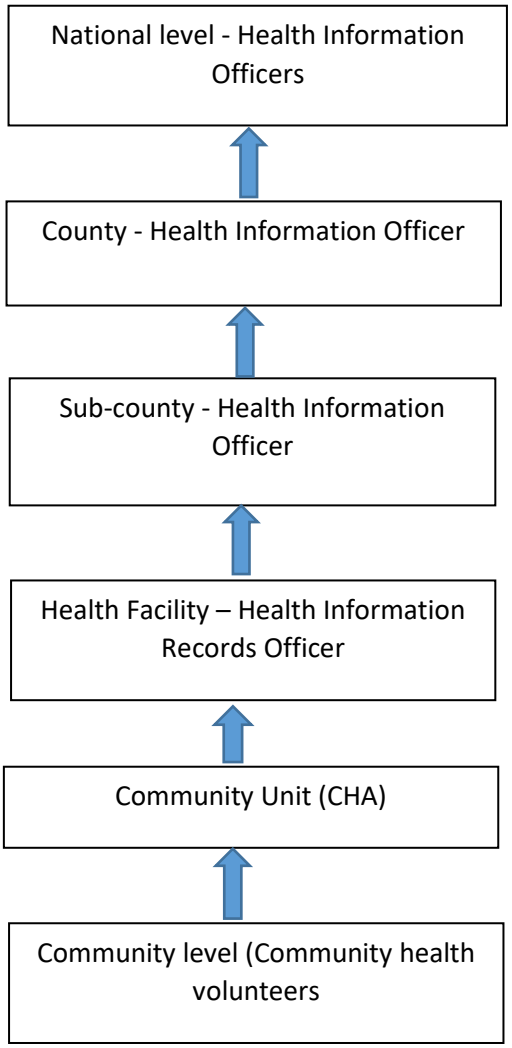


Figure 5: A flow chart of the flow of health and nutrition information from the community to the national level

In addition, the Kenya Nutrition SCORE card is another nutrition sector data base which includes data on 26 indicators. For the nutrition capacity strengthening, the Capacity Technical Working group has also developed a SCORE card in which the scores on the findings of the capacity assessment based on the four pillars of the KNCDF 2014-2019 is presented. The nutrition sector is therefore able to build evidence on the status of capacity strengthening that is County specific, e.g. use the data to advocate for employment of more nutritionists. Subsequent Capacity Assessments finding scores are presented in the same SCORE card and therefore provides a monitoring tool on the performance of the counties.

The nutrition capacity working groups at the national and county levels conduct regular monitoring and evaluation of various programs. At the County level joint supervision is conducted to collect information of the performance of predetermined nutrition indicators of various nutrition programs. Meetings are held regularly to discuss the performance of the indicators. The feedback

is supposed to be cascaded downwards to the sub-county and lower levels, but this does not usually happen adequately especially from the sub-county to the health facilities and consequently to the community.

Information system for the nutrition sensitive programs is not yet well developed. The Ministry of Agriculture, for example, is currently in the process of developing and Monitoring and Evaluation Framework. The Ministries of Education and Labour and Social Protection have not yet started the process of developing and Information Systems for nutrition sensitive programs.

5.4.3 Date management

Appropriate data management is key to the interpretation and utilization of data. There is a big gap in data management capacity in the nutrition sector. The nutrition sector on the whole, does not have the capacity to analyse, interrogate, interpret, present and use data appropriately. The data is mostly used to present status and not to interrogate the *Why*. This creates a gap in that the data is underutilized in terms of appropriately informing programming. The capacity for data management was also reported to be a huge gap even in the ministries implementing nutrition sensitive programs.

5.4.4 Infrastructure

As a whole, the infrastructure in nutrition sector at the county is wanting especially at the health facility level. Many of the nutritionists have no offices and either have or are sharing small offices with other officers.

Availability of adequate functional anthropometric equipment is a challenge in many health facilities. The broken down equipment are hardly replaced, or they are replaced after a long time.

Availability of rooms for the storage of the nutrition commodities is a challenge in many of the health facilities. The nutrition commodities are mostly stored in the nutritionists' offices. Despite this, it was reported that there is improvement in capacity in terms of procurement and forecasting for the quantities of nutrition commodities needed at the county and subsequently at the health facilities.

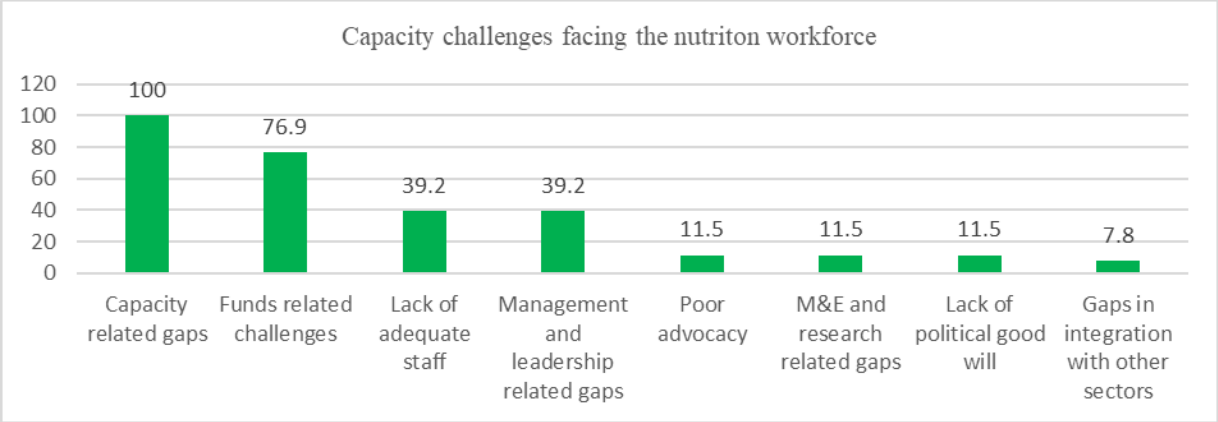
5.5 Technical Capacity

5.5.1 Overall adequacy in number of nutritionists and technical competency

On the whole, the technical capacity for nutritionists is inadequate in terms of numbers and competence to efficiently implement nutrition programmes. Currently due to the challenge of staffing for nutrition workforce, nutritionists are only available mainly in level four to level six hospitals but not at the health centres and dispensaries. Because of the shortage of nutritionists nutrition services are delivered by nurses at the health facilities. The inadequacy also includes

leadership as there is need to have DND at directorate level to engage in high level decision making nutrition agenda including creating an enabling environment for capacity strengthening.

The findings from the *Online Survey* show that all the respondents indicated capacity gaps a major gap mentioned by 100%, funds related challenges mentioned by 76.9%, lack of adequate staff mentioned by 39.2% and management and leadership related gaps by a similar percentage (Figure 5).



**Multiple responses*

Figure 6: Capacity challenges facing the nutrition workforce

It was reported that there has been improvement in the number of the nutritionists. Nonetheless, the number practicing per population is still very low. Table 2 shows the number of nutritionists in the KNDI database by qualification, registration, and licensing and job status.

Table 2: KNDI database of nutritionists

Total registered nutritionists 13, 411	Degree 4,357
	Diploma 6,575
	Certificate 1.062
Active licenses	3,791
Working in government (MOH-both national and county)	Approx. 1,650
Total number of nutritionists employed (public and private sector)	2,500
Nutritionists not formally employed	**Over 6,000**

There has also been improvement in the competency of nutrition workforce particularly at the county level. The *Online Survey* findings in Figure 7 shows the trainings conducted in the last one year in the counties where the respondent CNCs work. The most commonly conducted training in was BFCI in 53%, IMAM in 47% and MIYCN in 40% of the counties.

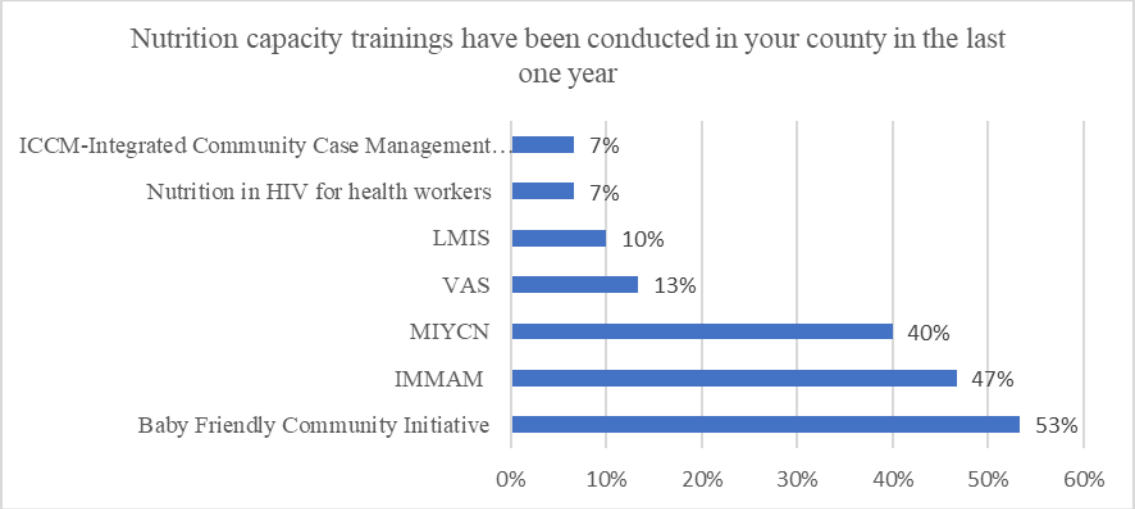


Figure 7: Trainings conducted at the county level in the last one year

KNDCF 2014-2019 contributed, to some extent, in terms of numbers of nutritionists employed and those who received training in the counties where Capacity Assessment was conducted. For instance, in Kitui County a total of 51 nutritionists were employed after Capacity Assessment to reduce the existing gap of nutritionists. The nutritionists were distributed at the county and sub county's health facilities up to level 3 hospitals. A sub-county nutritionist in Kitui stated that; "After *capacity assessment, the recommendations to employ nutritionists were taken seriously by the County Government especially with the high malnutrition rates indicated in the SMART survey, we ended up employing nutritionists in sub-county hospitals and some dispensaries".*

The shortage of the workforce does not only affect nutrition specific workforce but also nutrition sensitive workforce. *"Actually employment of expertise in Home Economics stopped long time ago, we use to have this cadre in the Ministry of Agriculture and I think it was a mistake phasing it out"*, stated a CHMT member Kitui County.

In terms of competence of the nutrition workforce, it was reported that there are gaps in the following areas of capacity:

- Leadership and governance
- Nutrition sensitive programming
- Clinical Nutrition
- Data management including analysis, interpretation and utilization of data. Capacity in qualitative data management was reported to be very low.
- Advocacy and resource mobilization.
- Writing of research grants

5.5.2 Pre-service training

At the national level, it was the views of the majority of the stakeholders that the graduates from universities and mid-level colleges were on the whole well trained but did not have all the necessary practical skills. Consequently, upon employment, they have to undergo thorough induction to enable them perform their roles efficiently. It was felt that this is a waste of time and resources for people who are supposed to have undergone training. On the other hand, it was also acknowledged that it is challenging for the institutions to provide all the practical skills during the pre-service training. It was the feeling of a number of the stakeholders that short courses should be mounted for the graduates. These could be offered by the Universities in collaboration with the MoH and could earn the graduates CPD points.

The following gaps in the curriculum content were identified; clinical nutrition and nutrition sensitive as well as emerging issues such as climate change and its effects on nutrition. There is need therefore, to regularly update the curriculum. Some participants appreciated the efforts by the regulatory and standards bodies in advocating for a harmonized curriculum although some institutions still offer curriculum which is outdated and limited in nutrition sensitive and clinical aspects. "*So there is that missing link between theory and clinical practice as evident in some students we do interact with during attachment".*

KNDI as the regulatory body is charged with the responsibility of harmonization of pre-service training nutrition curriculum. The curricular are developed and reviewed by the institutions offering nutrition programs for Certificates, Diplomas and Degrees. The pre-service training curricular are reviewed in line with KNDI, Commission for University Education (CUE) and Technical and Vocational Education and Training Curriculum Development Competence Assessment and Certification Council (TVET-CDACC).

Findings indicate that academic institutions involve stakeholders from other academic institutions, regulatory bodies, industries, post graduate students and nutritionists from the ministries of health and IPs in the curriculum reviews to make them market driven as expressed in the statement in the box.

"*The implementing partners are playing a very big role in helping with the review of the curriculum and they are working closely with the academic institutions. As part of strengthening that kind of curriculum, I'm glad to say that the MOH, KNDI and other organization provide technical and financial support to curriculum review, and we are benchmarking with the academic institutions/Universities to ensure that curriculum that are being offered in our institutions are right for nutrition students",* reported by a participant from a public university.

There are policies addressing the training needs of nutrition specific and sensitive sectors and there is good will to support professional growth of employees as guided by the policies. One of the CHMT members stated that, "*We have a training policy and we expect every cadre in the county to participate in relevant trainings annually*". There is provision for study leave for the work force to advance their education through full time and partial engagements in local institutions of higher learning.

On the training needs assessment of the workforce, the findings showed a mix of opinion on how it is conducted and the respective training policies are not clear on the training needs assessment. At national level and hospitals, the training needs are identified through proficiency gaps reported by the workforce in the performance contracts and staff appraisal. Once identified, the nominations of relevant workforce for the identified proficiency gap is conducted and are sponsored to participate in short courses for a period of 6-12 months. The trained cadres become TOTs in their respective departments and share the knowledge and experiences through OJTs, CMEs, conferences and workshops and CHMT briefs usually conducted through weekly meetings. The presentations especially on CMEs are useful for considerations for Continuous Professional Development (CPDs)/appraisals especially among clinical or facility workforce. The KNCDF 2014-2019, however, does not address the issue of training needs assessment.

The nutrition workforce were reported to have participated in refresher trainings on newly developed or revised policies and guidelines mainly through virtual platform during Covid-19 and physically before and after covid-19. These views are illustrated by a KII participant; *'So far, I think there is some enabling environment for somebody who wants to go for further studies, like, if you want to go and do some course so long as it's within your line".*

5.5.3 Workload considerations

Nutrition is one of the cadres with minimal workforce in most settings despite having large numbers of unemployed nutrition graduates. Much as the employment of nutrition workforce has been undertaken in some counties, the numbers are still below the recommended rates as expressed by a CNC in one of the counties, "C*urrently the county has a total of 35 nutritionists. That is both on contract and permanent and pensionable. The gap is large because when you look at the HRH norms and standards, we are supposed to have around 90, the gap is large".*

Task transfers of nutrition services to other cadres (nurses and CHVs) at the facilities and community address workload challenges. "*Okay you know initially we had tough time in terms of human resources towards nutrition because you could find aside from nurses doing their normal duties they could chip in on the side of nutrition. They have been trained to undertake nutrition activities but this is over and above their normal duties",* reported a health facility worker. A nutritionist at one of the health facilities also complained about the heavy workload, raising a concern that in as much as she gets help from the other cadres but sometimes there are cases that requires her personal attention and she is forced to attend to such nutrition cases. '*'I can say sometimes I find myself overwhelmed because there is some key information that you can't entrust with a maybe a CHV, so you find I'm needed everywhere. But I'm just doing a lot. It is not easy to manoeuver".*

The CHVs conduct active case findings within the community where they identify the malnourished children. They take MUAC measurements and referral of malnourished cases to the health facilities for management. "*We sensitize mothers on good nutrition and how to prepare healthy meals where we do food preparation demonstrations. We sensitize mothers on the food groups. We also advise mothers on the importance of exclusive breastfeeding for the first six months of the baby's life, we advocate for WASH and kitchen gardening within the community. We also conduct active case findings within the community where we identify the malnourished children",* stated a CHV FGD participant Kisumu County.

There has been improvement in recent times in the number of nutritionists employed. This was necessitated by the onset of the Covid-19 Pandemic and also the stakeholders embracing and appreciating nutrition as a result of the improved multi-sectoral coordination across the counties and also as result of the findings of the Capacity Assessment where they have been conducted. However, the number of nutritionists is still inadequate.

The shortage is not only affecting nutrition specific workforce but also nutrition sensitive workforce. "*Actually employment of expertise in Home Economics stopped long time ago, we use to have this cadre in the Ministry of Agriculture and I think it was a mistake phasing it out",* stated on the CHMT members in Kitui County. "*There is improvement in this area especially with multi-sectoral engagements. We have seen an improvement to the extent that we have a well-established ToR for the Ministry of Agriculture, Ministry of Education and Social protection for the focal persons at the county level, we even have provision to recruit workforce at the sub-counties which I think will take place once we start implementing fully"*, reported a CHMT member in Kitui County.

5.6 Community Capacity

Community capacity focuses on the linkage to health facilities and visibility of nutrition sector using champions for increased uptake and utilization of nutrition services by communities. Additionally, community capacity looks at the ability of a community to access, consume and make demand for nutrition services through increased nutrition service awareness.

As a whole, there is strong linkage between health facilities and communities through Community Health Strategy. Most of the counties have well established structured Community Health Strategy where each Community Unit (CU) is manned by a Community Health Assistant (CHA) and attached to a health facility. The CHAs in most counties are professionals in public health. Each CU has CHVs that are in close contact with the household and therefore provide some health facility-based nutrition related services directly. CHVs are trained and sensitized on the guidelines/manuals for service delivery in communities especially in counties with financial support from partners. "*The CHVs offer a number of health services to the community members for example when one is pregnant, they do visit, and also when you give birth to ensure you go to the clinics and ensure your baby gets all the vaccines'',* stated an FGD participant.

The community members were aware about the various services that are offered at the facilities. They reported that their children are offered various vaccines, such as Vitamin A and deworming

tablets (which is provided both at the facility level and the community level) and for the caregivers they usually receive health talks on how to feed their children this includes information on exclusive breastfeeding for the first six months and complementary feeding and weight monitoring. "*Normally when we come to the clinic, they always take weight and height, so the food that the baby eats determine the weight and the growth of the baby, so there is that food that when the baby eats, the baby becomes overweight and there is that food that when the baby eats the baby will have good weight. At the same the baby grows; the baby increases in height''.*

The findings also indicated that health services are available at the facilities, but the community members are not utilizing them fully due to various cross cutting issues such as poor roads and means of transport to the health facilities especially in the rural areas, few health facilities within the communities, congestion in the public facilities and lack of adequate service delivery at the public health facilities. "*The services are available yes but not everyone is utilizing them. We have insufficient health centers, so you see somebody who is not able to access a private health center, will not be helped because sometimes the public health centers are congested and also, we know that the public health centers are not to the expected standard. The services are there but not everybody is able to access them''* reported a participant in an FGD for young fathers.

There is variability in the functionality of the CHS across the counties. Siaya, Kakemega, Kisumu and Marsabit are among those counties reported to have well functional CHS. In Kisumu, the CHS is digitalized in some sub-counties for example, the health and nutrition database as well as nutrition sensitive databases (Agriculture and Social Protection), reporting tools.

5.7 Monitoring and Evaluation

The objective of Monitoring and Evaluation (M&E) is to inform decision making by ensuring that planned capacity development activities are implemented and expected outcomes achieved by relevant stakeholders. This M&E framework was to consider a consolidated 4 pronged approach based on the themes. The following considerations were to be taken into account: the gaps, strategies implemented and progress made on the 4 thematic areas. Verifiable indicators such as: program documents, working group coordination meeting minutes and other relevant reports showing activities undertaken were to serve as verification. Qualitative and quantitative assessments and evaluations conducted by NGOs or other project-based activities were also to depict capacity development issues and progress made.

The M&E was very limited in terms of tracking of the implementation of the KNCDF 2014-2019. There was no indication of the time frame for activities nor for monitoring and evaluation of the implementation of the framework. The proposed M&E was based mainly on checking compliance of the implementation of the framework. The indicators focused on the status of the activities by using a check list. There was focus on the Capacity Assessments without including the broader aspects of the framework. A participant at the national level stated that, *"The M&E was the weakest component of the KNCDF 2014-2019. In fact it was a major gap".*

For the counties where Capacity Assessment was conducted, the Capacity SCORECARD provided an appropriate tool for monitoring the status and performance of capacity strengthening based on the four pillars of the KNCDF 2014-2019. THE SCORECARD provided a pictorial presentation of the status of capacity in each of the four pillars therefore allowing identification of areas of priority need for capacity strengthening. These findings facilitated engagement with the counties to prioritize the identified areas for capacity strengthening. The findings were used to develop an Action Plan for capacity strengthening, but unfortunately there was no follow-to check if the activities specified in the plans were implemented. The findings of the SCORECARD provided evidence to enable CNCs lobby for funding for nutrition activities, employment of more nutritionists and review of policies to make to include more nutrition-related activities. In the few counties where a second assessment has been conducted (Kilifi), the SCORECARD provided a monitoring tool showing trends in the performance of capacity strengthening by pillar.

Another gap of the M&E was that there were no plans or strategies for assessing training needs of the nutrition workforce.

5.8 Effectiveness of Capacity Strengthening by KNCDF 2014-2019 in achieving its objectives

There has been improvement in the capacity of the nutrition workforce over time, but to what extent this can be attributed to the KNCDF 2014-2019, is not easy to measure. This is because Capacity Assessment was conducted in only 26 out of the 47 Counties, and a second assessment done in only three of these counties. Additionally, there was no follow up from the nutrition sector to establish if the Action Plans developed based on the findings of the Capacity Assessment were implemented as recommended. Nonetheless, the findings of the Capacity Assessments provided information used to identify priority areas for capacity strengthening based on the four pillars of the framework. The findings were an eye opener and created political goodwill among the top County Management who appreciated and embraced the issues of nutrition capacity. The evidence provided from the assessment was used as an advocacy and lobbying tool for recruitment of nutritionists, and for allocation of funds for nutrition programming. In Marsabit, Kilifi and Kitui Counties, sampled for this review and where the assessments had been conducted, it was reported that nutritionists were recruited as a result of the assessment. In Kitui County, 51 nutritionists were recruited and a nutrition budget included the overall budget. Unfortunately, the funds were not availed for nutrition activities. In Kilifi and Marsabit additional nutritionists were recruited. Additional number of nutritionists implies improved service delivery. In Marsabit, the findings resulted into increased engagement with the partner Concern World Wide. The partner increased their support for training of CHAs and CHVs particularly for the IMAM surge model.

In addition, findings of the *Online Survey* from the CNCs who had engaged with the KNCDF 2014 (26 out of a total of 33 CNCs) who participated in the survey reported that the findings of the Capacity Assessments improved knowledge on some aspects of nutrition capacity strengthening. The CNCs had been asked their perceptions on the effect of the framework on various aspects of capacity strengthening of the nutrition workforce and the findings are presented in this section.

5.8.1 Increased knowledge of the nutrition workforce in advocacy and lobbying for funds

The majority of the CNCs (71%) agreed that the framework increased knowledge of the workforce on advocacy and lobbying for funds whereas 18% strongly agreed with 11% disagreeing (Figure 8).

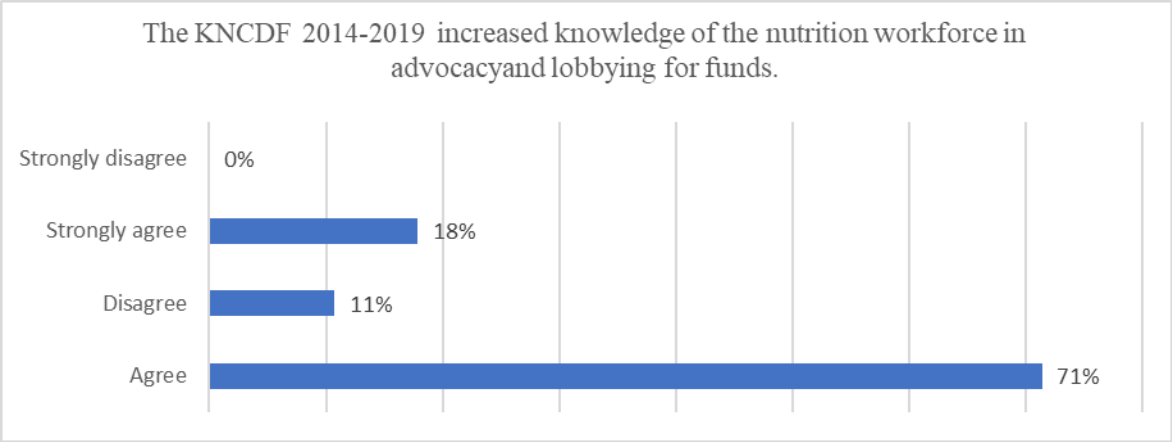


Figure 8: Increase in knowledge of the nutrition workforce in advocacy and lobbying for funds

5.8.2 Increased knowledge of the nutrition workforce in monitoring and evaluation

About two-thirds (64%) of the CNCs agreed 18% strongly agreed and that the framework increased knowledge of nutrition workforce in monitoring and evaluation (Figure 9).

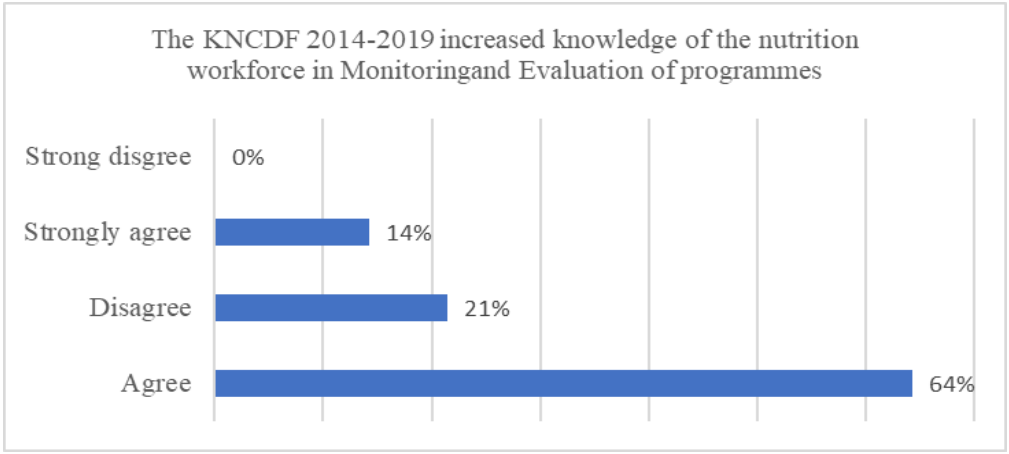


Figure 9: Increase in knowledge of the nutrition workforce in monitoring and evaluation

5.8.3 Knowledge of the nutrition workforce in the implementation of nutrition sensitive interventions

The CNCs reported that the KNCDF 2014-2019 increased knowledge on how to implement nutrition sensitive interventions. The majority (71%) and 14% agreed and strongly agreed respectively that the framework improved knowledge (Figure 10).

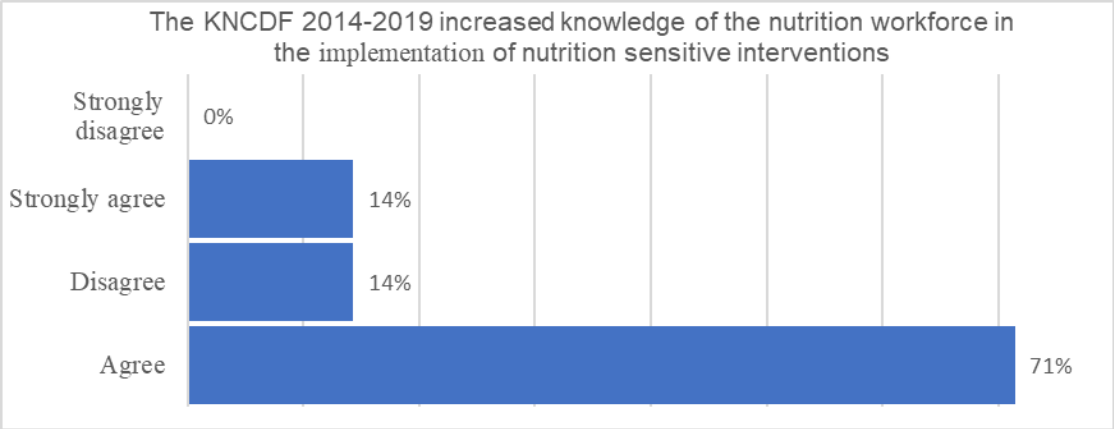


Figure 10: Increase in knowledge of implementation of nutrition sensitive interventions

5.8.4 Creation of an enabling environment for capacity strengthening of the nutrition workforce

The majority of the CNCs (71%) and 25% agreed and strongly agreed respectively that the KNCDF 2014-2019 created an enabling environment for capacity strengthening of the nutrition workforce (Figure 11).

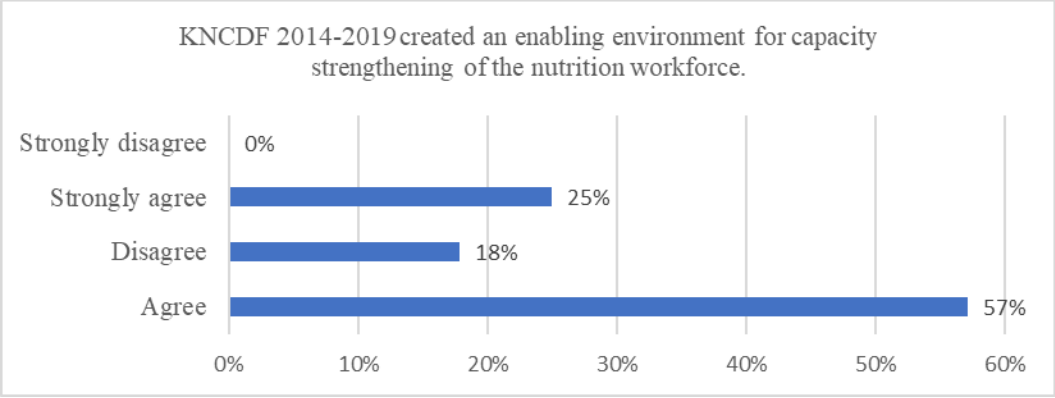


Figure 11: Creation of enabling environment for capacity strengthening of the nutrition workforce

Overall, in the counties where there had been some engagement with the KNCDF 2014-2019, the knowledge of the nutrition workforce on various aspects of nutrition capacity improved. It would seem that the knowledge has yet to translate into action to demonstrate visible outcomes for most

of the aspects of the capacity of the nutrition workforce e.g. resource mobilization since funding is still major issue.

5.9 Strengths/successes of the KNCDF 2014-2019

- On the whole, the framework addresses nutrition capacity strengthening in a holistic manner, going beyond knowledge and skills.
- The framework is a critical tool for the identification of nutrition capacity gaps based on the four pillars of the capacity framework. It is also a useful tool for monitoring the status of nutrition capacity over time. It has guidelines and tools for implementation of Capacity Assessments.
- The findings of the Capacity Assessments have the potential to be used positively as advocacy and lobbying tools for employment of more nutritionists and for allocation of funds for nutrition activities including the training of nutritionists. Engagement with the KNCDF 2014-2019 increased knowledge of various aspects of nutrition capacity strengthening with the multi-sectorial approach in conducting nutrition business reported have increased knowledge by 55% of the CNCs and increased employment of nutritionists by 45% (Figure 12).
- Varied data collection methods used in Capacity Assessment, quantitative and qualitative data collection and observation. Provides a holistic assessment of the capacity of the nutrition workforce.
- The framework addressed the supply (services provision) and the demand (services utilization) capacity.

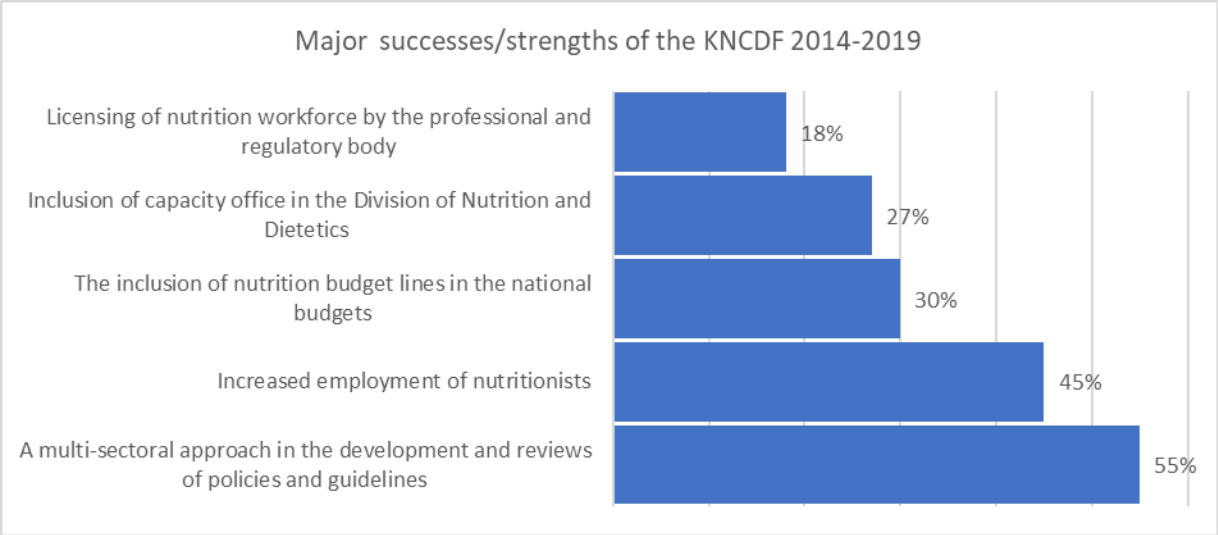


Figure 12: Successes and strengths of the KNCDF 2014-2019

5.10 Best Practices in the implementation of the KNCDF 2014-2019

- Capacity assessments identified the priority capacity needs of the nutrition workforce in the counties where the assessment was conducted. The findings of the capacity assessments were used as an advocacy and lobbying tool for recruitment of nutritionists and for a budget for nutrition.
- The use of the Capacity SCORECARD showing the performance of a county in nutrition capacity from of the thematic areas at a glance was a motivation for the counties to strive and improve their capacity. The SCORECARD also provided a database useful as a monitoring tool for nutrition capacity strengthening.

5.11 Gaps in the implementation of KNCDF 2014-2019

- Inadequate dissemination of the KNCDF 2014- 2019 at both national and county levels. There was no clear road map for dissemination and implementation of the framework.
- The limited knowledge and awareness of the KNCDF 2014- 2019 by the majority of the stakeholders including the CNCs who are supposed to be in the driving seat to move the nutrition agenda at the County level. The majority of the CNCs who were aware of the framework are those in the counties Capacity Assessments had been conducted. Even at the MoH- DND, the majority of the officers were aware of the existence of the framework but had not interacted with it.
- Capacity assessments were conducted in only about half of the counties; 16 in the ASAL and 8 non-ASAL counties only and yet the assessment is necessary for all counties. MOH-DND was not involved in sensitizing the counties about the KNCDF 2014-2019 because of lack of resources. The assessments were partner driven.
- The nutrition sensitive, multi-sectoral coordination and community capacity strengthening not adequately addressed in the framework. The operational guidelines and tools do not include nutrition sensitive programming and thus no information on these aspects is included in the Capacity Assessment. The operational guidelines were focused only on how to conduct Capacity Assessments without consideration to wider issues of capacity.
- The guidelines and the tools do not include other critical sectors, as it is, the capacity assessments do not provide the information of the capacity needs and gaps for these sectors and yet they are critical in the achievement of improved nutrition outcomes.
- The aspect of multi sectoral coordination which is critical in the achievement of nutrition outcomes is not well stipulated in the framework. The framework does not give guidance on how to engage or work with other sectors, for example, research and academic institutions.
- The pre-service training is heavy on nutrition specific and limited in nutrition sensitive aspects. The graduates from the academic institutions need induction to orientate them to understand the nexus between nutrition specific and nutrition sensitive programming.

- Not all the data collected from the capacity assessments was utilized particularly qualitative data because of the lack of expertise in the analysis of such data.
- Monitoring and evaluation component of the framework is weak. It was designed to assess compliance to the implementation and did not include indicators for measuring achievement. The framework did not include capacity needs assessment and the times for assessment.

5.12 Lessons Learnt in the implementation of KNCDF 2014-2019

- Appropriate launch and wide dissemination of a document is critical in sensitization and awareness creation and therefore its implementation and uptake. Without a dissemination road map developed to go hand in hand with the framework, then its objectives cannot be achieved.
- Continuous follow-up by MOH-DND and CHMT of the Action Plans developed after Capacity Assessment is critical for the uptake and implementation of the recommended activities.
- The findings of the Capacity Assessments are instrumental as advocacy and lobbying tools for the recruitment of nutritionists, budget allocation for nutrition and increased multi-sectoral coordination at county level.
- Engagement with the KNCDF 2014-2019 increased the knowledge of the participating stakeholders on various aspects of nutrition capacity.

5.13 Challenges in strengthening nutrition capacity of nutrition workforce

- Limited resources for dissemination and for conducting capacity assessments mentioned by all the respondents for the KIIs. The findings of the online survey concurred with these sentiments with 73% of the CNC participants of the *Online Survey* reported that resources was a major challenge strengthening nutrition capacity (Figure13).
- Limited expertise in qualitative data management and consequently very little of the qualitative data has been utilized.
- Low awareness and sensitization of the capacity needs of the nutrition workforce mentioned by 55% of the CNC participants of the *Online Survey* (Figure13).
- Inadequate guidance on nutrition capacity was mentioned by 45% of the CNC participants of the *Online Survey* (Figure13).
- Lack of political good will reported by 44% of the CNC participants of the *Online Survey* (Figure13).
- The framework was viewed by some as being too complex especially for the lower cadre of health workers to comprehend.

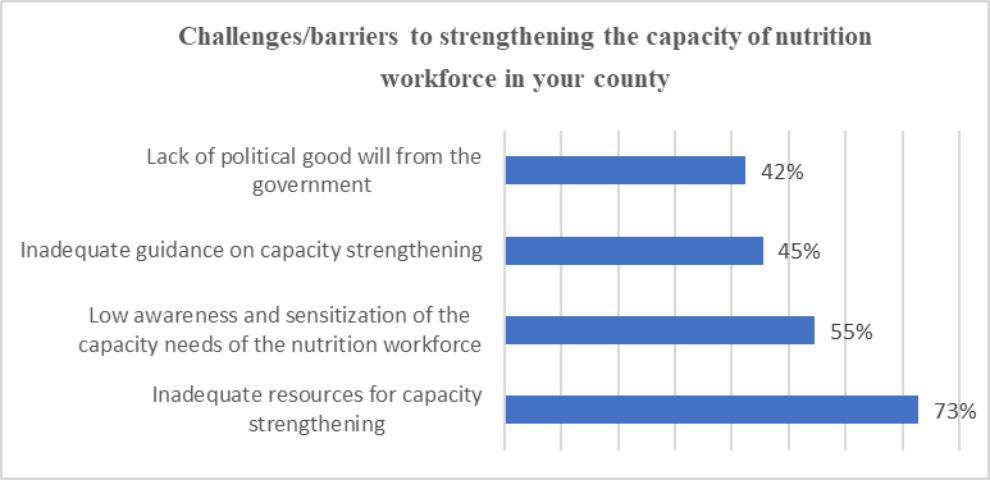


Figure 13: Challenges to strengthening the capacity of nutrition workforce

6. Summary of findings and conclusions

- **Awareness of the KNCDF 2014-2019** was low among the stakeholders at both the national and county levels – the MOH, line ministries and partners. It was only in the counties where Capacity Assessments had been conducted where stakeholders were aware of the framework. The low awareness was because of inadequate dissemination and sensitization of the framework due to lack of resources.
- **Appropriateness, relevance and comprehensiveness of the KNCDF 2014- 2019.** As a whole the framework addressed the capacity needs in a holistic manner based on the four pillars of nutrition capacity strengthening but a few gaps were observed. Nutrition sensitive programming and multi-sectoral coordination were not clearly included in the framework. The focus of the tools and guidelines was on nutrition specific programming and emphasized only Capacity Assessment without taking into consideration broader issues of capacity strengthening. Some of the stakeholders at the county level were of the opinion that the framework was too complex especially for the lower cadres of health workers.

- **Systemic Pillar**

  Periodic Capacity Assessment: The assessments were conducted in a few counties, 26 out of 47 and a second one conducted only in 3 counties. The assessments were partner driven and the findings were used as advocacy tools to lobby for recruitment of more nutritionists and for funding for nutrition programs. The assessments were successful in these respects although the number of the nutritionists and funding for nutrition is still inadequate. The findings also provided and enabling environment for multi-sector engagement conducive for the implementation of nutritive sensitive programs. Implementation of Capacity Assessments were challenged by resource availability and were conducted only in ASAL counties.

  The nutrition policy environment is quiet vibrant with many policies, strategies and guides targeting the various nutrition programs. These documents are adequate in guiding nutrition

programming at the county, sub-county, health facility and county levels. The major challenge is cascading of the dissemination of these documents from the county to the health facility and community level. The policy environment has not been influenced by the KNCDF 2014-2019.

Ministry of Agriculture is making good progress in the Agro-Nutrition policies and strategies as well as training curriculum. The other line ministries, Labour and Social Protection and Education have yet to make progress in this aspect.

Implementation of the KNCDF 2014-2019: The framework has not implemented widely- it has been implemented in only 26 ASAL counties. The implementation has been partner driven. Frequency of assessing the nutrition capacity is not on a need basis but more on resource availability. The MOH did not provide leadership or follow up in the implementation of the capacity assessments.

Capacity for Standards, Legal and Regulatory Environment: On the whole, there is limited linkage between the nutrition sector and industries and is based on a need basis, for example, there has been engagements and collaboration between KEBS and the MOH Food Fortification program at the national level. There is good linkage between the KNDI, the nutrition sector and other stakeholders at the national level. At the county level, KNDI is known as a body registering and licensing nutritionists and nothing else beyond this. There is stronger engagement between Research Institutes and Academia with the nutrition sector and partners through collaborative researches and internships for students from academic institutions. The collaboration is mainly in Nairobi therefore does not have a national representation. KNCDF 2014-2019 has not influenced the regulatory environment.

Resource mobilization: Overall, resource availability for nutrition programs is limited and programs are mainly donor funded and is decreasing over time. There is, however, some improvement in budget allocation for nutrition at the counties especially following the dissemination of the findings of the Capacity Assessments. There is limited capacity for resource mobilization among the nutritionists and for those in nutritive sensitive sectors where resource availability is as also a challenge.

- Leadership and governance: Competency in leadership and governance is a big gap at both national and county levels. MoH – DND is planning to be intentional in training in nutrition leadership especially for the CNCs. This is to ensure that there is adequate capacity for implementation of the of national nutrition agenda across the counties.

- **Organizational Capacity**

The level of planning, coordination and linkage between stakeholders and partnerships is stronger at the national level than county level. However, there is improvement currently with the multi-sectoral coordination gaining ground in most of the counties. This is happening even in the absence of the KNDCF 2014-2019. Improvement in this aspect was observed in the counties where capacity assessments findings took place. There were significant strides made in multi-sector nutrition (MSN) coordination in the counties in which Save the Children

supported the coordination of MSN. In some counties the strengthened MSN coordination committees resulted in the implementation nutrition sensitive programs with support from partners.

- Nutrition information systems strengthening and management: The nutrition data is captured in the Kenya Health Information System (KHIS) although it does not contain all the nutrition indicators. The Kenya Nutrition SCORE card is another nutrition sector database which includes data on 26 indicators. The capacity strengthening SCORE card in which the scores of the findings of the capacity assessment is presented. The development of the capacity assessment SCORE card, was informed by the KNCDF 2014-2019.

- Data management: There is a big gap in data management capacity in the nutrition sector and in the nutrition sensitive programs. The nutrition sector on the whole, does not have the capacity to analyse, interrogate, interpret, present and use data. There is limited capacity for qualitative data management.

- As a whole, the infrastructure in nutrition sector at the county level is wanting especially at the health facility level. This is in terms of offices, anthropometric equipment and storage for nutrition commodities.

- **Technical Capacity**
  - Adequacy and competence of nutritionists: Nutritionists are inadequate in terms of numbers and competence to efficiently implement nutrition programmes despite the increase over time. They lack competence in: leadership and governance; nutrition sensitive programming; clinical nutrition; data management including analysis, interpretation and utilization of data; capacity in qualitative data management; advocacy and resource mobilization and writing of proposals and research grants.

  - Pre service training of nutritionists is regulated and harmonized by the regularly body KNDI. There gaps in terms of nutrition sensitive competence.

  - The policy environment is conducive for nutritionist to pursue in-service training and further training as long as the course is line with one's job. OJTs, CMEs and short courses are continuously conducted by the CHMT. Mentorship is however not commonly conducted because of heavy workload for nutritionists.

- **Community-related Capacity**

  There is strong linkage between health facilities and communities through Community Health Strategy. The level of linkage depends on functional CUs, and the availability and motivation of CHVs and Community Health Committees. Some of the communities also have champions and these groups of people provide capacity strengthening in terms of knowledge and skills on nutrition to the community. The community is knowledgeable on the health and nutrition services available to them at the health facilities but the utilization is low due to access.

- **Monitoring and Evaluation**
  The M&E was very limited in terms of tracking of the implementation of the KNCDF 2014-2019. There was no indication of the time frame for activities nor for monitoring and evaluation of the implementation of the framework but was mainly on checking compliance of the implementation of the framework. For the counties where Capacity Assessment was conducted, the SCORE card provided an appropriate tool for monitoring the status and performance of capacity strengthening based on the four pillars of the KNCDF 2014-2019.

- **Effectiveness of the KNCDF 2014-2019**

  There is improvement of the capacity of the nutrition workforce over time, but to what extent this can be attributed to the KNCDF 2014-2019, is not easy to measure. Nonetheless, the findings of the Capacity Assessments provided information used to identify priority areas for capacity strengthening based on the four pillars of the framework. In those counties where Capacity Assessments were conducted, there was recruitment of nutritionists, allocation of funding for nutrition activities and strengthening of multi-sectoral coordination. The CNCs through the *Online Survey* reported that there was increased knowledge for: advocacy and lobbying for funding; implementation of nutrition sensitive interventions, and creation of an environment for capacity strengthening of the nutrition workshop. It would seem that the knowledge has yet to translate into action to demonstrate visible outcomes for most of the aspects of the capacity of the nutrition workforce e.g. resource mobilization since funding is still major issue.

7. Recommendations

- Dissemination and launch of the nutrition capacity framework should be improved by developing a detailed plan/road map for its launch, sensitization and implementation. The dissemination should be made beyond of the nutrition sector by including the nutrition sensitive sectors and county government management team members for buy in.

- Dissemination of the findings and recommendations of the Capacity Assessments should also be done beyond the nutrition sector to include nutrition sensitive sectors, the Committee of Health at both National and County Assemblies, Committee of Education at both levels, Budget Committees and the Human Resource for Health personnel so that they can be aware of the framework and to also understand and embrace the nutrition capacity needs.

- Resource mobilization is critical for the implementation of the KNCDF framework. The county government should be sensitized on the need to provide a budget for nutrition programme. This can be done, among other strategies, by using the Capacity Assessment findings as an advocacy and lobbying tool.

- The framework should be simplified to make it easy to understand by all cadres of health workers framework. It was suggested that a simplified manual be developed probably with the information presented in bullet points in addition to the framework.

- Inclusion/strengthening of the sectors- nutrition sensitive, multi-sectoral coordination, and community capacity strengthening in the framework so as to make the framework holistic in providing information on the capacity needs. This would allow the other sectors to also provide information on their capacity needs to enable them implement nutrition sensitive interventions. As it is, the framework is limited to nutrition specific programming.

- The Capacity Assessments should be conducted in all counties and not only the ASAL counties but in all counties so as to establish the nutrition workforce capacity status and needs. The county governments should budget for the implementation of the KNCDF 2014-2019 and not rely on donor funding.

- The KNCDF 2014-2019 guide and tools should include nutrition sensitive components and other critical sectors. The guide should also give guidance on how to engage or work with other sectors, for example, research and academic institutions.

- Regulation, standards and linkages especially between the nutrition sector and the industries (KEBS) and KNDI at the county level should be strengthened. KNDI should conduct mass education to educate the masses about their roles beyond licensing and registration of nutritionists. There should be more researches conducted nutrition sectors in collaboration with the academic and research institutions.

- Development of a robust M&E framework with clear indicators to be tracked on the implementation of KNCDF.

- Introduction of nutrition sensitive aspects in the pre-service curriculum showing the nexus between this and nutrition specific, from certificate to graduate level. It was reported that nutrition sensitive issues e.g. *From Field to Fork* presented are presented in the Standard Guidance Checklist together with recommended course content. The courses in the Standard Guidance Checklist are optional. It was also recommended that the universities could work with the other faculties e.g. Agriculture, Public Health etc. to develop nutrition sensitive courses.

- The universities in collaboration with the MOH to mount short practical oriented courses for the graduates to bridge the gap in the skills required at the job place so that employers do not have to take time inducting and training fresh graduates upon employment. These courses would earn the trainees CPD points.

ANNEXES

Annex 1: Qualitative data collection guides

KII-KNCDF.zip

FGD GUIDE_KNCDF.zip

Annex 2: Online Survey Questionnaire

ONLINE QUESTIONNIARE

Annex 3: Target groups for qualitative data collection

KNCDF PARTICIPANTS FOR KIIs AND FGDs

REVIEW OF THE KENYA NUTRITION DEVELOPMENT CAPACITY FRAMEWORK (KNCDF) 2014-2019

		Mode of data collection
National Level	• MOH-DND Director • Nutrition program managers-DND • Focal Person Ministry of Labour and Social Protection • UNICEF • Academia (Private and Public) • KNDI • Partners	Virtual
Nairobi County	• County Nutrition Coordinator • County Community health focal person • County information systems officer • County focal person-Agriculture • County Education focal person • Sub-County Nutrition coordinator • Implementing partner • Health facility in charge • Health facility PHO • Health facility Nursing Officer • Health facility Nutrition Officer • Health facility CHA	Physical
Community level	• Young mothers • Fathers of young children • Older women • CHVs • Youths	FGDs Physical
Kisumu county	County Director of health	KIIs Physical
	• Director of Medical Services • County Nutrition Coordinator • Director Nursing • County Health Information Officer • Officer in charge of procurement • Civil Society Organization • Public Health Officer • County community focal person • Kenya Red Cross Society • Advancing Nutrition/Save the children • Focal Person-Agri nutrition • Focal Person MOL/social protection • CEC MOA Agriculture • Sub-County Nutrition Coordinator • Community based organization • Health facility in charges • Health facility PHO • Health facility Nursing Officer	

	• Health facility Nutrition Officer • Health Facility CHA	
Community level	• Young mothers • Fathers of young children • Older women • CHVs • Youths	FGDs Physical
Kitui County		KII Physical
	• Director of Medical Services • County Nutrition Coordinator • Director Nursing • County Health Information Officer • Officer in charge of procurement • Public Health Officer • County community focal person • World vision • Focal Person-Agri nutrition • Focal Person MOL/Social protection • CEC MOA Agriculture • Sub-County Nutrition Coordinator • Health facility in charges • Health facility PHO • Health facility Nursing Officer • Health facility Nutrition Officer • Health Facility CHA	
Community level	• Young mothers • Fathers of young children • Older women • CHVs • Youths	
Kakamega County	CHMT: • County Nutrition Coordinator • Acting Director of Health- Clinical Pharmacist • Director Public Health • Agri-Nutrition Coordinator • Director ECD • Sub-county Children Officer • Head of Health Information System	Physical
Community level	• Young mothers • Fathers of young children • Older women • CHVs	
Kiambu County	• County Nutrition Coordinator • Sub-County Nutrition Coordinator • County Nursing Officer • County foal person MOE • County focal person MOA • County Publica Health Officer • County focal person MOL/Social protection	Virtual
Samburu County	• County Nutrition Coordinator • County Nursing Officer	Virtual

	• Public Health Officer • County community focal person • Implementing Partner • Focal Person-Agri nutrition • Focal Person MOL/Social protection • Sub-County Nutrition Coordinator • Health facility in charges • Health facility Nutrition Officer • Focal Person MOE	
Marsabit County	• County Nutrition Coordinator • Sub-County Nutrition Coordinator • County Nursing Officer • County foal person MOE • County focal person MOA • County Publica Health Officer • County focal person MOL/Social protection	Virtual
Kilifi County	• County Nutrition Coordinator • County Nursing Officer • County focal person MOA	Virtual