MINISTRY OF HEALTH
GARISSA COUNTY

Nutrition Capacity Assessment

JANUARY 2018

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ACRONYMS

AWP - Annual Work Plan

BMS - Breast Milk Substitute

CMAM - Community Management of Acute malnutrition

CHW- Community Health Workers

CHV - Community Health Volunteer

CHEW - Community Health Extension Worker

CEC – County Executive Committee of Health

COH - Chief Officer of Health

CDH - County Department of Health

CSBCC - County Social Behavior Change Communication

CNC - County Nutrition Coordinator

CNTF - County Nutrition Technical Forum

CIDP - County Integrated development plan

CHSSP - County Health Sector Strategic Plan

CHRIO - County Health Records and Information Officer

CU- Community Unit

CHMT- County Health Management Team

DHIS - District Health information System

ENT - Ear Nose Throat

FBO - Faith Based Organization

FGD - Focus Group Discussion

GAM - Global Acute Malnutrition

HC - Health Centers

HF - Health Facility

HRH - Human resource for Health

ICT - Information Communication technology

IRC – International Rescue Committee

IEC- Information Education and Communication

IFAS - Iron Folic Acid Supplementation

KEMSA - Kenya Medical Supplies Agency

KII - Key Informant Interview

KNCDF - Kenya Nutrition Capacity Development Framework

KMTC - Kenya Medical Training College

LMIS - Logistic Management Information system

IMAM- Integrated Management of Acute Malnutrition

MAM- Moderate Acute Malnutrition

M&E - Monitoring and Evaluation

MOH- Ministry of Health

NCD - Non Communicable Diseases

NITWG - Nutrition Technical Working Group

NGO - Non-Governmental Organization

NDMA- National Drought Management Authority

OS - Outreach Site

OJT- On Job Training

OTP - Outpatient therapeutic programme

PPS - Probability Proportion To size

PHO - Public Health Officers

RUTF- Ready to Use Therapeutic Food

SAM- Severe Acute Malnutrition

SCHMT – Sub County Health Management Team

SCNOS - Sub County Nutrition Officers

SFP- Supplementary Feeding Program

TB - Tuberculosis

TDH - Terre's De homes

UNICEF- United Nations Children's Fund

WHO - World Health Organization

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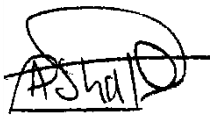


Shale Abdi
Head: Policy, Planning, Monitoring and Evaluation

Executive summary

The Ministry of health and Nutrition department in conjunction with partners conducted the first capacity assessment for Nutrition program in Garissa County. The main objectives of the assessment was to determine nutrition capacity status for Garissa County, to sensitize county health management on Kenya Nutrition Capacity Development Framework (KNCDF), KNCDF operational and nutrition capacity assessment tools,To determine nutrition capacity status for Garissa County ,Document best practices and recommend interventions based on identified gaps .

This assessment was carried out in the entire Garissa County between 30th January to 15th February 2018, 4 hospitals were sampled, 3 owned by GOK in form of a Census and 1 private owned hospitals. 25% of the health centers (21) were sampled hence 6 health Centers taking into account administrative boundaries hence PPS applied across the 7 Sub Counties and 3 health Centers randomly selected.

The assessment applied use of already developed tools by National Capacity Working group (CWG), which has quantitative and qualitative components and targeted different respondents, as shown in the table below which included Key informant interview (KIIs), Focus group discussions (FGDs) and Desk Review.

Most of the CHMT member (CNC) had been sensitized on the various policies and guidelines and dissemination to the operational level staff, although dissemination of the same to the frontline health workers has not yet been done. Only four Technical Guidelines and policies were available at county level.

The most available documents within the 23 facilities were the MIYCN policy statement (21facilities) followed by MAM guidelines (14 facilities). However, only a few facilities had vitamin A schedules, MIYCN operational guideline (4 facilities) deworming schedule (2 facilities) and HIV tool kit (1 facility).

Implementation of health activities is based on the priorities as outlined in the county strategic plans and documents. The assessment revealed that in the last 5 years of devolution, the county had adequate number of staff who has capacity to formulate and implement fiscal laws. The staffs are knowledgeable, competent and experienced in aspect of fiscal processes.

The assessment revealed that all medical commodities are forecasted, and ordered through the pharmacists. Consumption method is used for forecasting and quantification of needs. Health Facilities forecasts are guided by the previous consumptions record.

Twenty five percent (25%) of the health facilities have rain water harvesting while nearly half (46%) of facilities have piped water. The distribution of sanitation facilities is as follows; container with soap was in 5/12 dispensaries while 1/7 health centers.

Per the Garissa Human Resources for health management and development plan, the county requires a total of 707 Nutrition staff (136 officers, 353 technologists and 218 technicians) but only 33 are available leaving a gap of 674 nutritionists. Only 4.7% of the nutrition staff requirements have been met.

Garissa County has invested in community health strategy as a way of improving the health status of its people. The assessment revealed that as a result, there has been a little improvement in the overall health indicators and also the health seeking behaviors of the community. Similarly, the defaulter rates for the different services have decreased although this still remains a challenge.

FGD discussions revealed that a referral system was in existence. Referral of cases was done by the CHV's from community unit to the link facilities using referral forms.

Chapter One

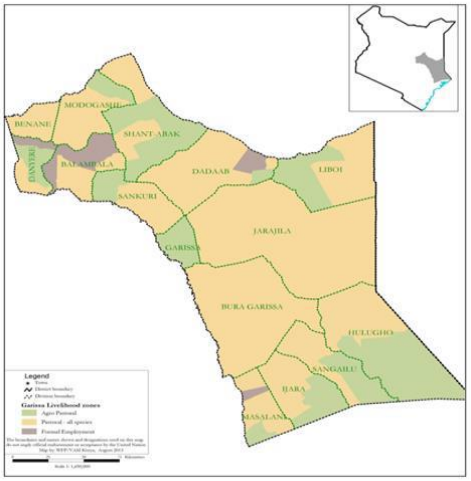
Introduction

Garissa County is located in the former North Eastern province of Kenya and covers an area of 44,175.5 Kms. It borders Wajir County to the North, Tana River County to the West, Isiolo County to the North West, Lamu County to the South and federal republic of Somalia to the East.

Garissa county has 7 Sub Counties namely; Garissa, Fafi, Lagdera, Ijara, Balambala, Hulugho and Dadaab with an estimated projected population of 850 077 persons (KNBS 2009), 4 livelihood zones namely: pastoral (camels, goat, sheep and cattle), agro-pastoral, casual/ waged labour and formal employment.

County Department of Health (CDH), National Government, UNICEF and Terre des Hommes (TDH) and other partners conducted a nutrition capacity assessment which incorporated both training and data collection to generate data for evidence-based programming in January 15th – February 15th, 2018.

The overall objective of the capacity assessment is to determine nutrition capacity status for Garissa County through ssensitizing county health management on Kenya Nutrition Capacity Development Framework (KNCDF), determining nutrition capacity status for Garissa County, documenting best practices and recommend interventions based on identified gaps.



Map1. Showing Garissa County

Chapter 2

Methodology

Nutrition capacity assessment applied use of already developed tools by National Capacity Working group (CWG), which has quantitative and qualitative components and targeted different respondents, as shown in the table below which included Key informant interview (KIIs), Focus group discussions (FGDs) and Desk Review.

Table 1 Key informant interviews

Target	Number of Tools
County Nutrition Coordinator (CNC) and Director for Health	1
County Pharmacist	1
County Health Records and Information officer (CHRIO)	1
Human resource Department (HRD)	1
County Head of planning/ Treasury	1
County Executive Committee (CEC)/ Chief officer for Health	1
County Public Health Officer (CPHO)	1
Community Focal Person	1
Health facility In charges	23

Table 2 Focus Group Discussions

Target	Number of FGDs
County Health Management Team (CHMT)	1
Nutrition workforce	1
Nutritionists	1
Community Health Volunteers (CHVs)	2

Sampling procedure

A criterion to ensure representation of stratum was applied. The criteria included:

- Representation by the **level** of the health facility
- Representation by **administrative boundaries** - sub-counties (4)
- Representation by **ownership- GOK, FBO, NGO & PRIVATE**

FACILITY KII & OBSERVATION CHECKLIST; Hospitals and Health Centers

4 hospitals were sampled, 3 owned by GOK in form of a Census and 1 private owned hospitals.

25% of the health centers (21) were sampled hence 6 health Centers taking into account administrative boundaries hence PPS applied across the 7 Sub Counties and 3 health Centers randomly selected.

FACILITY KII & OBSERVATION CHECKLIST; Dispensaries

Dispensaries were put in cohorts of ownership; GOK, NGO and private. Each cohort sampled differently.

The Private dispensaries, 1 Facility was sampled purposively. 20% of the dispensaries were sampled randomly considering administrative boundaries hence PPS applied across the 7 Sub Counties. 13 dispensaries were sampled, hence 12 GOK and 1 NGO

FOR KII AND FGDs

Most of the KII targeted one specific person per facility as it was not possible to carry out the capacity assessment in all facilities. The facilities were sampled using the following criteria

SAMPLING; Facility KII & Observation checklist

A master facility list provided by the county was used as the sampling frame. A combination of sampling procedures was applied; Stratification, Purposive and random sampling applied

Table 3 CAPACITY ASSESSMENT TIMELINE

Activity	Date
Planning	15th November 2017
Inception	29th January 2018
Training	30th Jan – 2nd Feb 2018
Data Collection	3rd – 7th February 2018
Data Analysis & Draft report writing	8th- 12th February 2018
County Dissemination	14th February 2018
Dissemination at NITWG	22nd February 2018
Finalization of Report	28th – 29th February 2018

CHAPTER 3

FINDINGS

The findings are organized according to the four pillars; systemic, organization, technical and community pillars.

SYSTEMIC PILLAR

System pillar looks at the key policy and governance issues that create the overall environment for *leadership and governance, service delivery, legal and regulatory mechanisms*. The following areas were reviewed under system wide capacity assessment;

Leadership and Governance

This encompasses strategic direction, plans and policies, effective oversight, regulation, motivation, and partnerships that integrate all health systems building blocks to achieve results.

Teamwork and cohesiveness was observed among the members and engaged on matters on relatively on the same level in cadre (free to articulate issues).

The county has an organogram in place that shows levels of management and coordination (see figure 1 below).

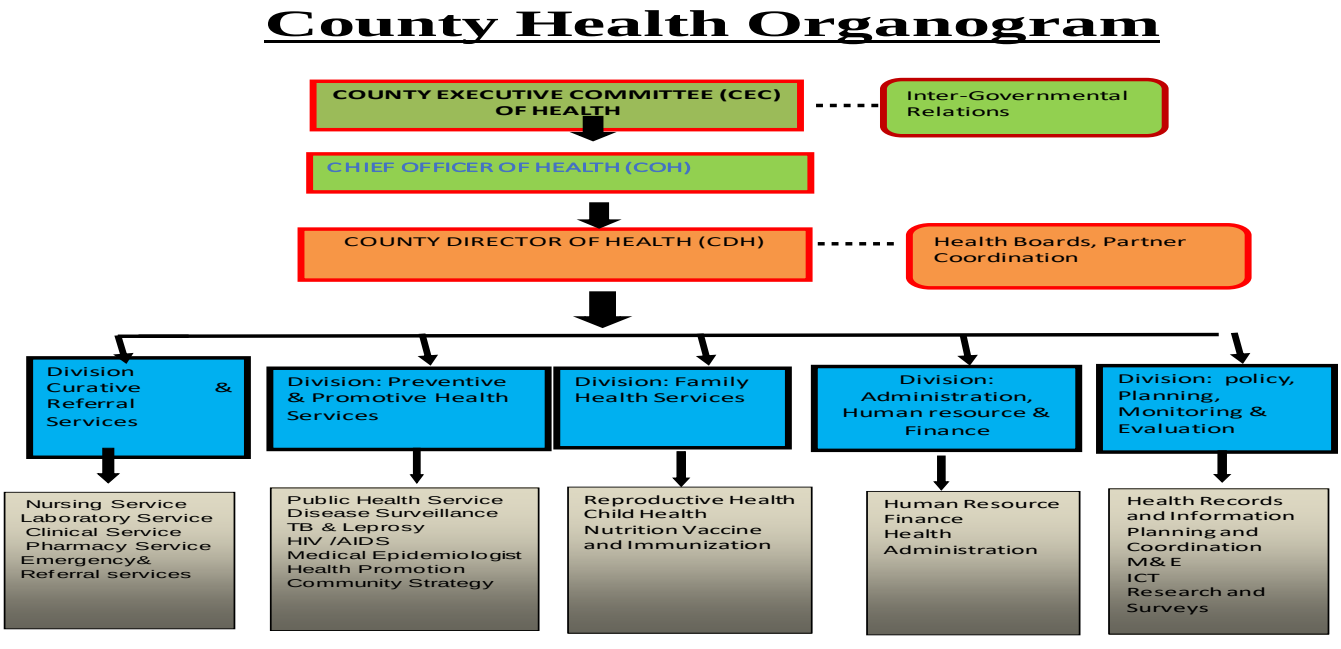


Figure 1 County Health Organogram

National Laws, Regulations and County bills

The constitution of Kenya (2010) gives legislative authority to county assemblies as outlined in the devolved system of governance. The county assembly may make any laws that are necessary for or incidental to, the effective performance of the functions and exercise of the powers of the county government under the Fourth Schedule.

Garissa County so far has not yet approved any county health specific bills. However, the county has a draft bill on health facility improvement fund which is not finalized for submission to the county assembly. Additionally, the County is considering development of service delivery related bills.

The county reinforces implementation of national bills.

BMS act of 2012

For instance, the MOH national level has sensitized some key officers at the county level on the BMS act of 2012, and action plans developed, however sensitization of the lower levels on the same has not yet been done. This act was enacted to support, promote and protect exclusive breastfeeding by regulating the manufacture and sale of breast milk substitutes. There are challenges of enforcing this act at County level because the county structures are not yet in place.

Mandatory law on food fortification

Mandatory law on food fortification requires that manufacturers of pre-packaged food products of maize meal flour, wheat flour and vegetable oil fortify the products with some key micronutrients, vitamins and minerals. The county has enforced this act by conducting frequent iodine fortification market surveillance but not on the other foodstuffs. Fortification logo is shown in Figure 2.

Figure 2 Fortification Logo

Availability of planning documents

Availability of Reference National policy and strategic documents at the county level

The constitution of Kenya 2010 established the national and county governments, which are distinct and interdependent and are to conduct their mutual relationships on the basis of consultation and cooperation.

The fourth schedule, mainly assigns health policy and service delivery to the national and county levels respectively.

Planning and strategic documents provide a roadmap and strategic direction on key priorities in the Health Sector and articulates the ministry's vision, mission, and core values, both at the national and county levels these documents provide strategic objectives, strategies, activities, time frame, resource requirements and assign responsibilities for achieving expected outputs in health Sector.

Table 4 Availability of reference national policy and strategic documents at the county level.

S/NO	POLICY/STRATEGIC DOCUMENTS	AVAILABILITY	HARD COPY	SOFT COPY
1.	National Food and Nutrition Security Policy (2012)	No	No	No
2.	Kenya Nutrition Advocacy communication and social mobilization strategy 2016-2030	No	No	No
3.	Scheme of service for Nutritionist and dietician (March 2014)	Yes	No	Yes
4.	Human resource for health Norms and standards guidelines for the health sector (2014-2018)	Yes	Yes	Yes

5.	KHSSP Kenya health sector strategic and investment plan 2013-2017	Yes	No	Yes
6.	Kenya Health Policy 2012-2030	Yes	No	Yes

Availability of specific key Ministry of Health documents at County level

The county specific documents are shown in Table 2. These documents are used at the county level for planning, implementation, monitoring & evaluation of health services. The county has also developed a HRH plan outlining HRH needs and the staffing norms and standards that have been customized to county needs.

Table 5 Availability of County specific key ministry of Health documents at the County level

S/No	Policy/Strategic Documents	Availability	Hard copy	Soft Copy
1.	County integrated development and investment plan (CIDIP) 2013 - 2018	Yes	No	Yes
2.	County fiscal strategy paper 2015/2016, 2016/2017	Yes	No	Yes
3.	County Health sector strategic Plan (CHSSP) 2013-2018	Yes	Yes	Yes
4.	County Nutrition Action Plan (CNAP)	Yes	Yes	Yes
5.	County SBCC	Yes	Yes	Yes
6.	Annual Performance and Review Plans for the last financial year (2016/2017) (APRP/CIHAWP)	Yes	No	Yes
7	County Human Resource for Health Plan	Yes	No	Yes

Prioritization & inclusion of nutrition activities in key documents

The assessment sought to review key documents existing at the county level to check the level of prioritization and inclusion of nutrition into the county plans. The table below gives more details on this.

Table 6 Prioritization & inclusion of nutrition activities in key documents

Documents	Are Nutrition Activities prioritized in the document
County Integrated development and Investment Plan (CIDIP) 2018 - 2022	The development prioritizes nutrition sensitive intervention e.g.: • School feeding for ECDE • Promotion of food production, livestock farming and fish farming • Education campaign on eat more fish
County Health Sector Strategic Plan (CHSSP) *2018 – 2022*	Nutrition is captured under broad investment areas e.g. community Health services, supportive supervision. Malnutrition has been identified as key in reversing the trend of communicable and non-communicable diseases.
County fiscal strategy paper 2015/2016, 2016/2017	Paper prepared by the treasury team and outlines the targets for every sector. Key areas prioritized in 2016/2017 include: Provision of accessible and quality health services (continued investment in recruitment of health professionals, medical services, health infrastructure and improvement in the working conditions of medical practitioners) and investing in agricultural transformation and food security (to reduce food dependency and increase food security through increased agricultural output and food supply) - aligned to the budget Policy Statement. Prioritized activities: • Construction of irrigation schemes • Provision of agricultural inputs to farmers (seeds, tractors, water pumps etc) • Setting up camel milk value addition, milk processing and packaging plant • Construction of Livestock market in Modogashe and

	completion and equipping of Garissa export slaughter house Other highlights include reduction of re-current expenditure to 60% and ultimately to 50% in the medium term and increase development expenditures
County Nutrition Action Plan (CNAP)	Development informed by National Nutrition Action plan priorities
County SBCC Strategy 20yes7 - 2022	Captures priority key MIYCN behaviors in the context of Garissa County
Annual Performance and Review Plans for the last financial year (2016/2017) (APRP/CIHAWP)	Operationalizes the nutrition activities as outlined in the County Health Sector Strategic plan. Malnutrition has been identified as key in reversing the trend of communicable and non-communicable diseases.
County Human Resource for Health Plan	Garissa county has a Human resource for health management and development plan. Wasting, underweight and stunting outlined as one of the priority areas in health service provision Nutrition cadre included in the analysis of county staffing situation (available staff/HRH stock, requirement/projections, and gaps) Trainings undertaken from 2012 – 2015 including for nutrition programme highlighted in the document (IMAM, MIYCN, SMART surveys) Health department organogram include Nutrition under the division of family health services.

Availability, dissemination and sensitization Status of key Nutrition Guidelines at the County

The assessment looked at whether key CHMT member (CNC) had been sensitized on the various policies and guidelines and dissemination to the operational level staff. The table below shows

that, even though the CNC has been sensitized on the various guidelines, dissemination of the same to the frontline health workers has not yet been done. Only four Technical Guidelines and policies were available at county level.

Table 7 Availability, dissemination and sensitization Status of key Nutrition Guidelines at the County

Guidelines	Available	Sensitized	Disseminated
Diabetes Register	No	yes	No
Deworming Schedule	yes	yes	yes
MIYCN Policy Statement	yes	yes	No
IMAM Guidelines	No	yes	No
MNPs Operational Guide	No	yes	yes
MIYCN Guideline	yes	yes	No
VIT A Schedules	yes	yes	yes
IFAS Policy Schedule	No	yes	No
Cancer Guideline	No	No	No
Clinical and Dietetics Manual	No	No	No

Availability of policies and guidelines at health facilities

Observations done at the sampled facilities showed the availability of policies and guidelines in Figure 3 below. The most available documents within the 23 facilities were the MIYCN policy statement (21facilities) followed by MAM guidelines (14 facilities). However, only a few facilities had vitamin A schedules, MIYCN operational guideline (4 facilities) deworming schedule (2 facilities) and HIV tool kit (1 facility).

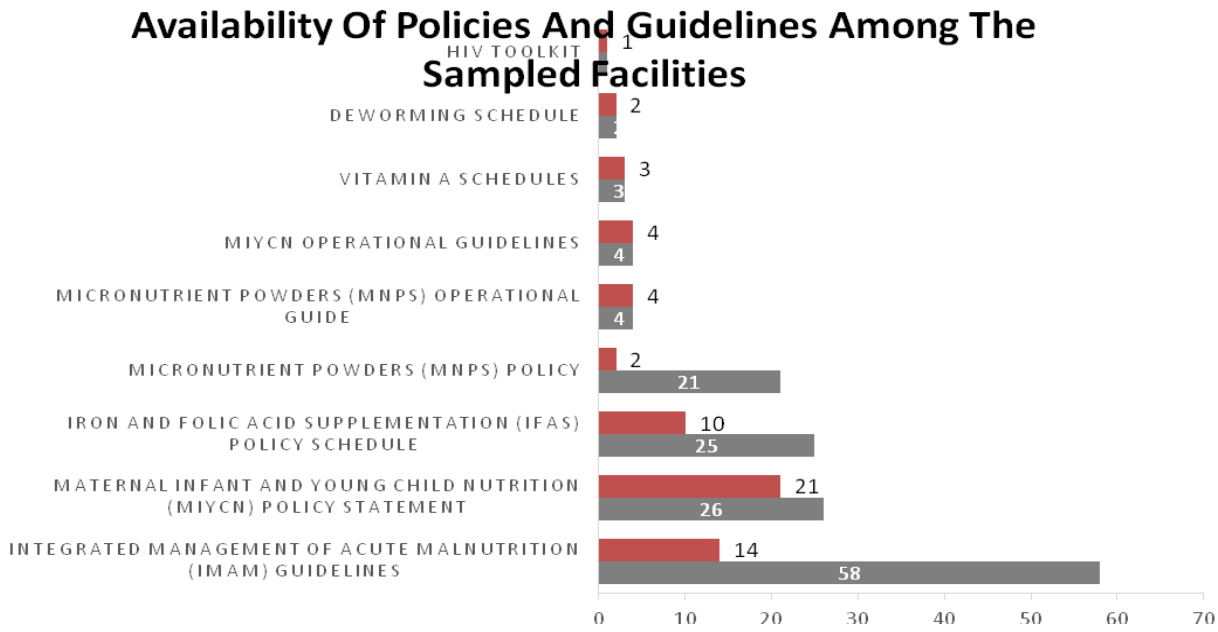


Figure 3 Availability of policies and guidelines among sampled facilities

Development process of available documents and their implementation

Development process

Implementation of health activities is based on the priorities as outlined in the county strategic plans and documents. The FGD conducted for CHMTs indicated that development process of CIDP, CHSSP and AWP employ public participatory approach to identify and prioritize key needs for inclusion in the documents. The CIDP is overly run by the county planning and treasury team who provide a template to each county department and conduct one day sensitization for the county teams on use of template and the overall process. Each department is given a chance to present key priorities and a consolidated list is compiled and sent to the county assembly for review input and validation. The reviewed document is then sent to county executive who makes necessary corrections based on feedback provided and submits final documents to the county treasury. Community representation is ensured at all levels that is, from the community units, sub-county and county level.

The CHSSP and AWP development process was reported to be led by head of policy planning and M&E. Priority needs are identified through a participatory process from community units, to link facilities to sub county and county level for discussions. Bottom up approach is used to ensure all key stakeholders participate at all levels. Implementation of activities is based on CIDP, CHSSP and AWP with no funding provided by the county outside this framework.

Resource planning, allocation and utilization

Interviews with the key informants from the County treasury indicated how resources are planned allocated and utilized within the county. The process is consultative and involves key stakeholders at different levels (County assembly, National and county government and the community). Accounting officers are the ones who prepare budget proposals and present to core team. The county treasury prepares consolidated county budget estimates and submits for ratification by the County Executive Committee before submission to the county assembly. In case of major changes in budgets, review of CIDP is allowed (every 2 years) so that the CIDP is in tandem with the budget/plan. Guidance is available to County through circular from CEC to all accounting officer (Departmental heads).

Public participation is ensured through County Budget & economic forum committee (CBEF). For effective public participation advertisement of the sessions are put in the papers. The county is considering introducing participatory budgeting whereby the public can be engaged in budget decisions through Voting and Monitoring of implementation by a project management committee. The figure below shows the annual planning and budgeting cycle.

County's annual planning and budgeting cycle

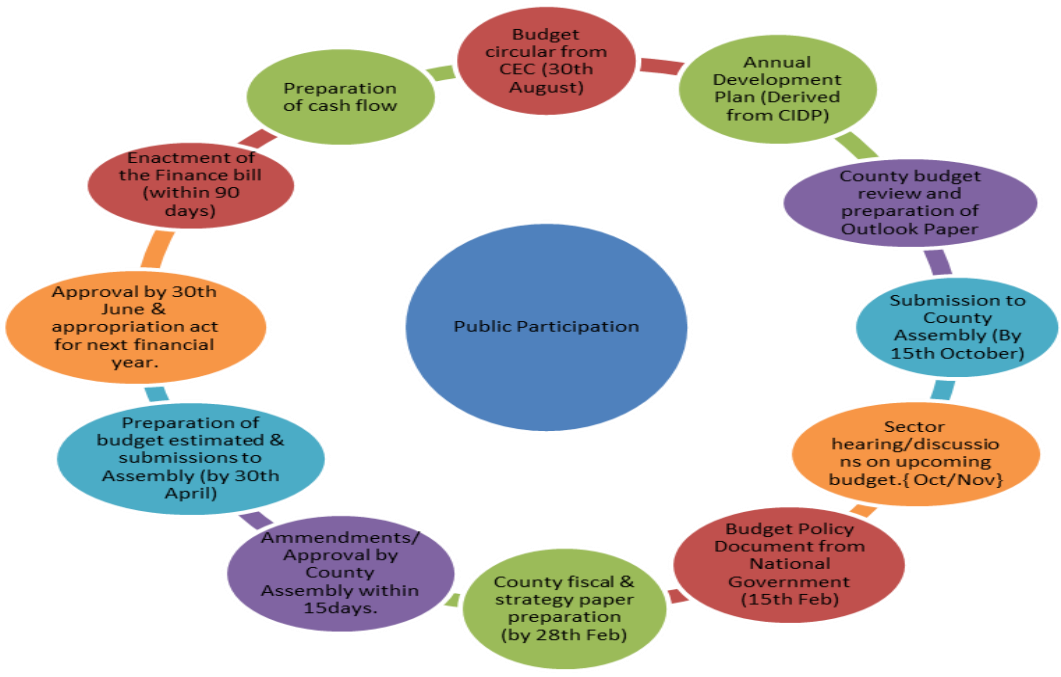


Figure 4 County's annual planning and budgeting cycle

County's ability to implement and formulate fiscal laws

The assessment revealed that in the last 5 years of devolution, the county had adequate number of staff who has capacity to formulate and implement fiscal laws. The staffs are knowledgeable, competent and experienced in aspect of fiscal processes. Among the challenges encountered were in adequate capacity to ensure community/public participation as there are no clear frameworks or structures for satisfactory public engagement. However, guidelines are under development. There was also political interference and Inadequate resources sighted by the respondent.

What are the Priorities for Budget Allocation in Garissa County?

1. Core departments (Health, Water, Agriculture & Livestock) are given high priority for funding.
2. Payroll (Which should not be more than 35% of budget).
3. Operations/Operational costs
4. Development projects (This should be greater than 30% of the budget).
5. Needs/Gaps raised by the public.
6. On-going projects that must be completed before starting new projects.

What strategies has the county put in place to ensure effective fiscal planning?

1. Ensuring balanced budget/avoiding budget deficits (Revenue & Expenditure Balance).
2. Ensuring fiscal discipline/meeting of fiscal responsibilities.
3. Enhancing Ownership: Project management committee, vibrant M&E, internal audit systems in place.
4. Planning within the budgets.

How is county income prioritized?

1. All revenue goes to consolidated account.
2. County Revenue allocated together with funds from the National Government.
3. Highest revenue collections come from the health sector (29M) mainly from the Cost Sharing Funds.
4. Revenue from Land rents (8m) & Business permits (12m)

What are the priorities for Next CIDP

1. Irrigation to enhance food security (28B to go to water and irrigation) flagships projects.
2. Livestock markets (Abattoirs) for export of meat.
3. Construction of Dam (Hulugho)
4. Upgrading of hospitals to Level four.

Figure 5 county's ability to implement and formulate fiscal laws

Budget Allocation to Health sector

Health allocation is 29% of the County Budget which is 2.2 billion. Around 18% of the budget is spent on all staff including for health).

Recurrent and health budget Ratios

1. The Recurrent budget should be less than 70% of total budget; development budget should be above 30% of the total budget as per the guidance/law.
2. The county has managed to maintain these standards (about 70% goes to recurrent and 30% to development)
3. The Health Sector has the highest recurrent expenditure (1.9B).

The county budget has codes provided from treasury and no specific code for Nutrition. However, the county has tried to include/ capture some specific activities related to nutrition (commodities, travel, and trainings)

The budget allocation for the county health sector activities is informed by the departmental priorities as outlined in the AWP/CHSSP/CNAP and other MOH planning and strategic documents in County and further prioritization depending on availability of funding.

The last 3 financial years as shown in the graph below indicate an incremental trend in county health budget allocation and this is attributed to factors including increase in commodity prices and 5-10 percent annual increment in budget allocation from treasury.

Within Health sector, the following were reported to be priorities for resource allocation;

- Staff remuneration (HRH)
- Priorities outlined in the AWP/CHSSP /CNAP
- community demand creation for services utilization
- emergency response
- Health system strengthening
- Health infrastructure development
- Prioritization of low performing indicator

Graph show the trends in allocation and utilization of nutrition in the county. Although the figures for both amounts are high. This was noted to be mainly for food and rations for patients in hospitals.

However, the county as supported nutrition activities like nutrition surveys and Quarterly review meetings/RMNCAH review meetings. The increase in nutrition budget over the years can be

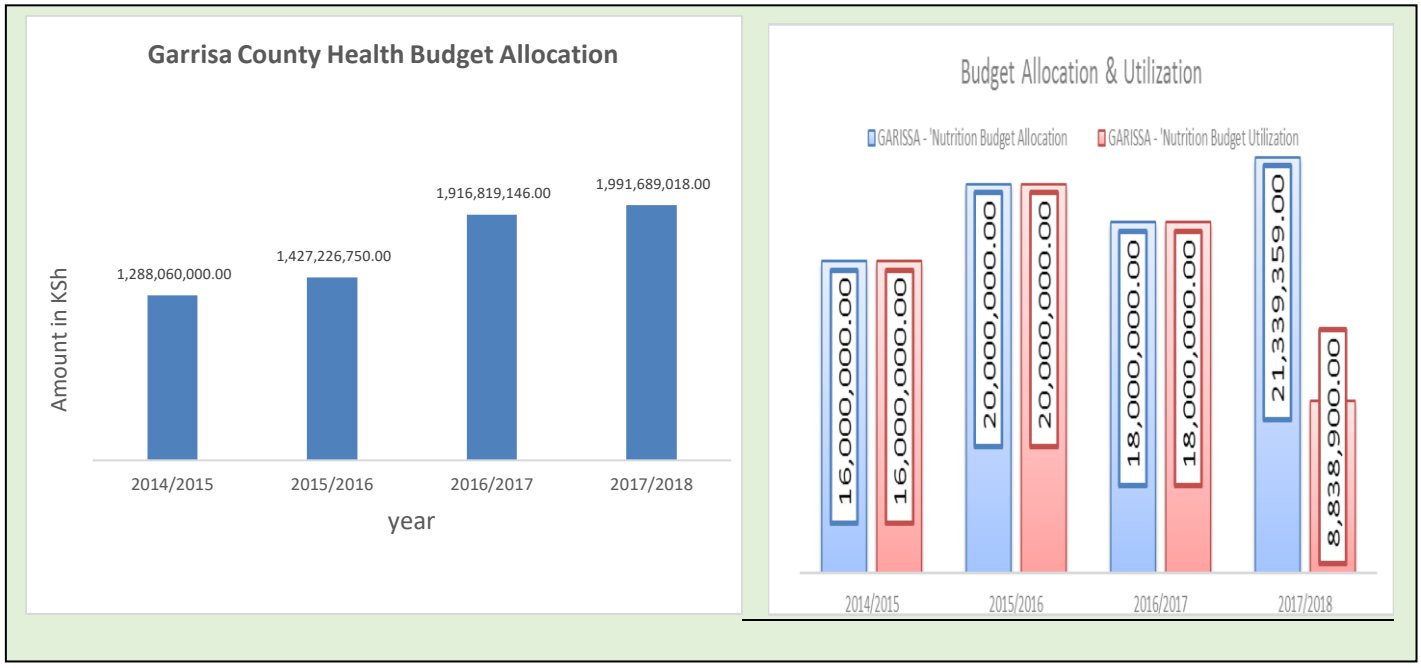


Figure 6 Garissa County Health Budget Allocation

attributed to high level advocacy done at the county level with support from partners.

The main nutrition expenditure from the county budget in the previous financial year 2016/2017 were reported to be; salaries for Nutrition staff, support for SMART Nutrition survey, food for patients in Hospitals and quarterly review meetings/RMNCAH review meetings.

Challenges encountered in health and nutrition management:

- Low utilization of health services
- Poor health infrastructure at country and sub county level
- Inadequate staffing (numbers due to high staff turnover & low recruitment and skills gap)
- Occasional commodities/supplies stock out
- Insecurity (several facilities closed along the border)
- Presence of many refugees in Dadaab camp coupled with a long porous border resulting to disease importation & outbreaks- cholera/measles/polio/rift valley fever
- Weak multi sectoral linkage (WASH/Health/ line ministries –agriculture, education)
- Limited / poor infrastructure (commodity storage capacity)
- Limited resource for M & E Dadaab Camps (porous border points) frequent disease outbreaks
- Political interference in recruitment of health staff
- Inadequate staffing (number/high staff turnover
- Occasional commodities/supplies stock out
- Insecurity several facilities closed along the Border
- Political interference in recruitment of health staff

Recommendations to address the challenges:

- Implement staff retention propose package to retain staff
- Review and increase hardship allowance
- Support housing package for staff and scholarship
- Conduct advocacy on routine service and county and sub county level to increase service demand and utilization
- Operational research (client satisfaction) survey, exit interview/for alternative service delivery)
- Sensitize and train staffs on LMIS to address stock out issues
- Infrastructural development (staff housing/stores)
- Initiate inter-sector co-ordination meeting (health/wash/agriculture and livestock
- Integration with civil registration into MCH
- Promote exchange and inter-county learning

Key Points

- Teamwork and cohesiveness was observed among the members and engaged on matters on relatively on the same level in cadre (free to articulate issues).

-The county has an organogram in place that shows levels of management and coordination.

- The county had adequate number of staff who has capacity to formulate and implement fiscal laws. The staffs are knowledgeable, competent and experienced in aspect of fiscal processes.

- Public participation is ensured through County Budget & economic forum committee (CBEF). For effective public participation advertisement of the sessions are put in the papers.

Organizational Capacity Pillar:

This section looked at the working arrangements, coordination framework and structures of key institutions and organizations (including the Ministry of health, learning and research institutions, regulatory bodies, nutrition sensitive and nutrition specific sector) in Garissa county. The areas assessed included:

- Coordination structures (nutrition sector and multi-sectoral coordination mechanism) in place
- Human resource management (staffing levels, staff establishment, performance appraisal mechanisms, tracking of trainings, feedback platforms)
- Information systems (planning, monitoring and evaluation, reporting and data quality, operational research)
- Supply chain management systems (procurement plan, funding mechanisms for nutrition commodities, supplies availability and reporting).
- Infrastructure (nutritionist's room, storage space for nutrition commodities, ICT and anthropometric equipment hand washing facilities, latrines availability)
- Service delivery (Services offered and status, target setting, support supervision mechanisms)

Coordination mechanisms/structures:

Garissa County has a mechanism for coordination. The forums for coordination as indicated in figure 7 (CNTF/SCNTF) for county and sub county level coordination. CNTF is held on biannual basis, while the SCNTF is held monthly under the leadership of MoH and participation of NGO partners. The sub-county customizes its coordination TOR based on the county level

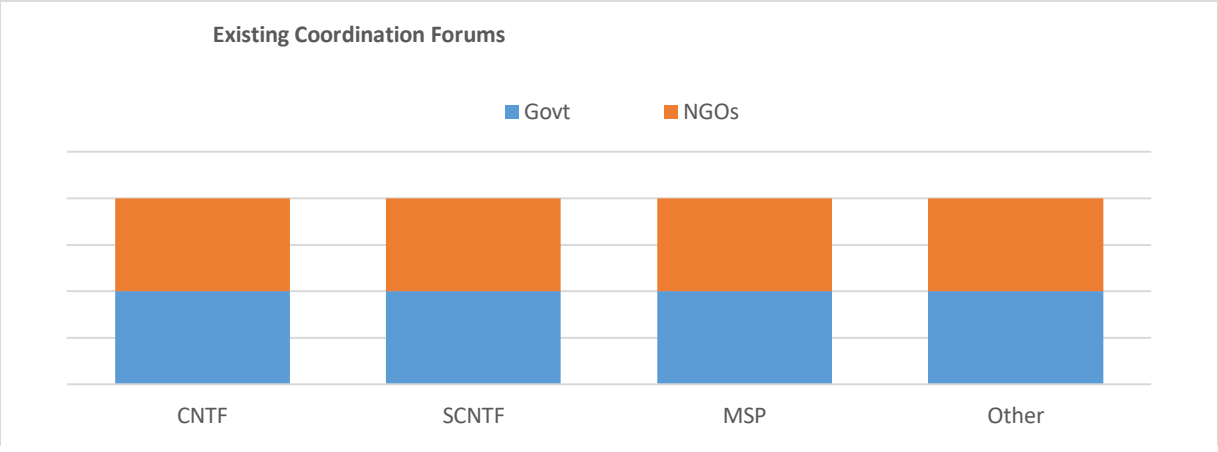


Figure 7 Existing Coordination Forums

TOR.

To advance the nutrition sensitive agenda, the county through support of an NGO partner; International medical corps (IMC) did set up a multisectoral platform (MSP) in place. The MSP forum meets on a quarterly basis with participation of all line ministries and NGO partners. The county expressed the need for continued support for this platform to ensure nutrition is prioritized within other sectors like agriculture, water hygiene and sanitation (WASH), livestock etc. for improved health and nutrition outcomes. This MSP is not strong at the moment.

Other forums that include nutrition are; County health stakeholder forums, County Steering group forums and Reproductive, maternal Neonatal Child and adolescent Health (RMNCAH) review meetings that occur on a quarterly basis with TORs in place. However, "the county steering Group needs improvement since it is the weakest area".

At health facility level, nutrition and health issues are discussed through community health committee meetings, facility committee meetings, in-charges meeting and staff meetings (fig 8).

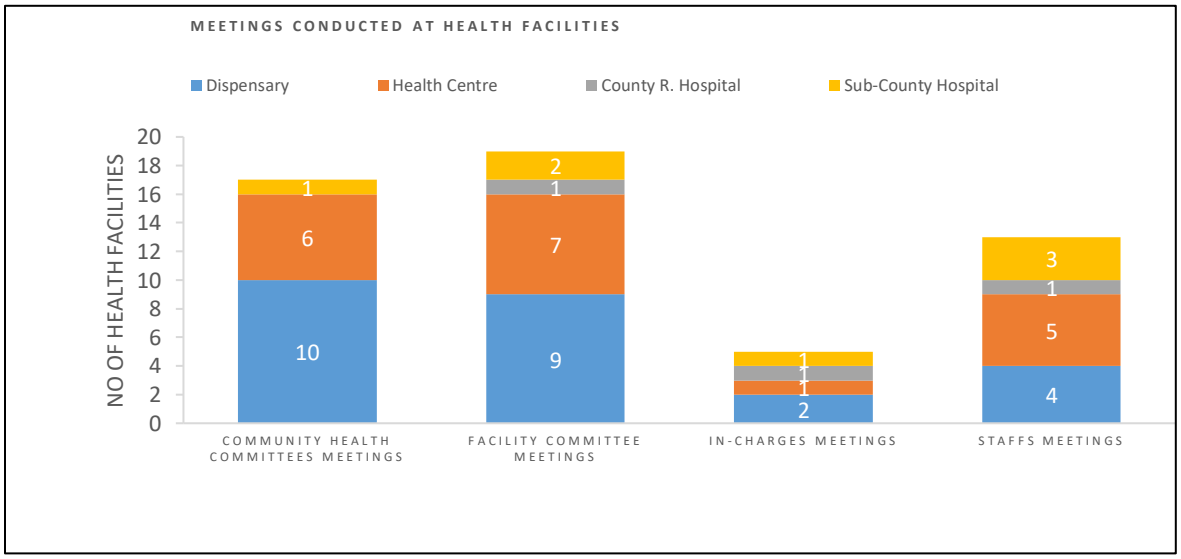


Figure 8 MEETINGS CONDUCTED At health Facilities

A key challenge highlighted is the lack of adequate resources to ensure the forums are held on regular basis as per schedule. For example, the CNTF which is scheduled to happen on a quarterly basis is undertaken on a biannual basis.

Support Supervision:

County support supervision is undertaken using a tool that has been customized to the county context. Prioritization of issues for support supervision is based mainly on data review and audit, emerging issues, disease out-breaks and need for action from other review meetings and as part of routine service support. However, "support supervision is erratic and mainly funded by partners", also "in many occasions the recommendations of support supervisions are not implemented" (CHMT/Nutritionists FGDs). The composition of team is repeated mostly without injecting new team members.

Human resource Management

The Kenya health policy 2012-2030 demonstrates the health sector's commitment, under government stewardship, to ensuring that the country attains the highest possible standards of health, in a manner responsive to the needs of the population. Following devolution the County has made several strides towards achievement of the health policy. As part of strategic response the county has tried to address equitable distribution of health workers in post, improve attraction

and retention of health care workers, improve institutional and health workers performance, strengthen human resource development systems and practice, and strengthening human resource planning and management. However, timely staff promotion, regular staff appraisal, staff job description, regular and proper staff supervision and work climate improvement remain a challenge to the County.

Staff Recruitment: County recruitments are undertaken by the public service board. The human resource for Health (HRH) management and development plan is used as a key policy document by the county and defines strategies to attract, motivate and retain health workers in the county. The document highlights the HR situation and identified gaps. Additionally, gaps are continuously identified and communicated to the HR officer which are captured in the annual work plans and budgetary allocation where feasible.

The current staffing situation in the facilities is not enough, rather it is understaffed. Most of the facilities MCH daily workload is too much with only 1 nutrition staff covering daily.

Sometimes there is political interference in recruitments.

Staff Establishment: The HR department has a staff establishment and all health workers have job descriptions and are expected to be certified by a professional regulatory body before recruitment. All the 34 nutritionists have valid Kenya Nutritionist and Dietetics Institute (KNDI) certificate. The department has a scheme of service which acts as reference for all cadres, and is used for training, promotion, succession and remuneration. Plans are also underway to undertake a HR audit to inform further recruitments.

Staff Professional Development: Various mechanisms exists for continuous professional development which include training programs, exchange forums, study leave. The county pays for some upcoming trainings to equip staff with the relevant skills while some are supported by partners. Scholarships are available based on service needs and are awarded to individuals based on review and approval by the training committee. The health department also has short and long terms training programs in place that are supported by NGO partners including UNICEF, TDH and NASCOP. These monthly training programs are usually shared by heads of department prior to the training dates, where staff are expected to identify their training needs.

Integrated Human resources for Health (IHRIS) database:

A training database exists with all staff cadres included however, the department does not have annual training projections with nutrition incorporated. Though the database includes nutrition trainings, it has not been updated since 2017 due to competing priorities. The database tracks trainings that have been conducted as well as those upcoming trainings. However, the database is not in use as the two officers who had been trained on IHRIS left the county, without training others. The county has developed a county-specific database to track these.

Staff Retention: The County faces challenges with staff retention due to high staff turnover caused by insecurity. To counter this, the department has put in place retention mechanisms, which include; allowances, recognition awards, capacity development, study leave, scholarships and induction programs. For example; housing is provided for officers working in rural areas. Plans are underway to have higher allowances for staff working in rural areas and water provision in the houses. The induction programs has ensured continuous learning and update on new developments in the medical field. In addition, staff who have received training are placed on a higher job group and salaries are also paid in good time.

Succession management Policy: The HR department does not have a succession management policy; however, there is lateral movement within the department to fill in vacancies. Staff also act on positions as a way of preparing them to take over vacant posts.

Platforms for Human Resource for Health (HRH) feedback: The department has a mechanism for feedback which include: emails through hierarchical mechanisms, memos, circulars, meetings for HRH supervisors who provide feedback to staff. The HR also hold meetings with technical staff. Letters serve to communicate to staff on promotion or dismissal. From the mentioned mechanisms, two-way feedback mechanisms exist through correspondences to staff and meetings where staff participate.

Performance appraisal sensitization/conducted in the Health facilities

The latest PA was undertaken in 2015. Five out of 12 dispensaries were not sensitized and never conducted Performance Appraisals (PA). Only 1/7 dispensaries sensitized never conducted the PA.

In 4/7 HC sensitization on PA was done and 2/4 conducted their PAs. Staff in 5/7 never conducted the PA.

Only the private owned tier 3 HF was not sensitized on PA and therefore its staff never conducted the PA.

Sensitization as well as conduction of PA was done at the referral HF and the two GOK Tier 3 HFs.

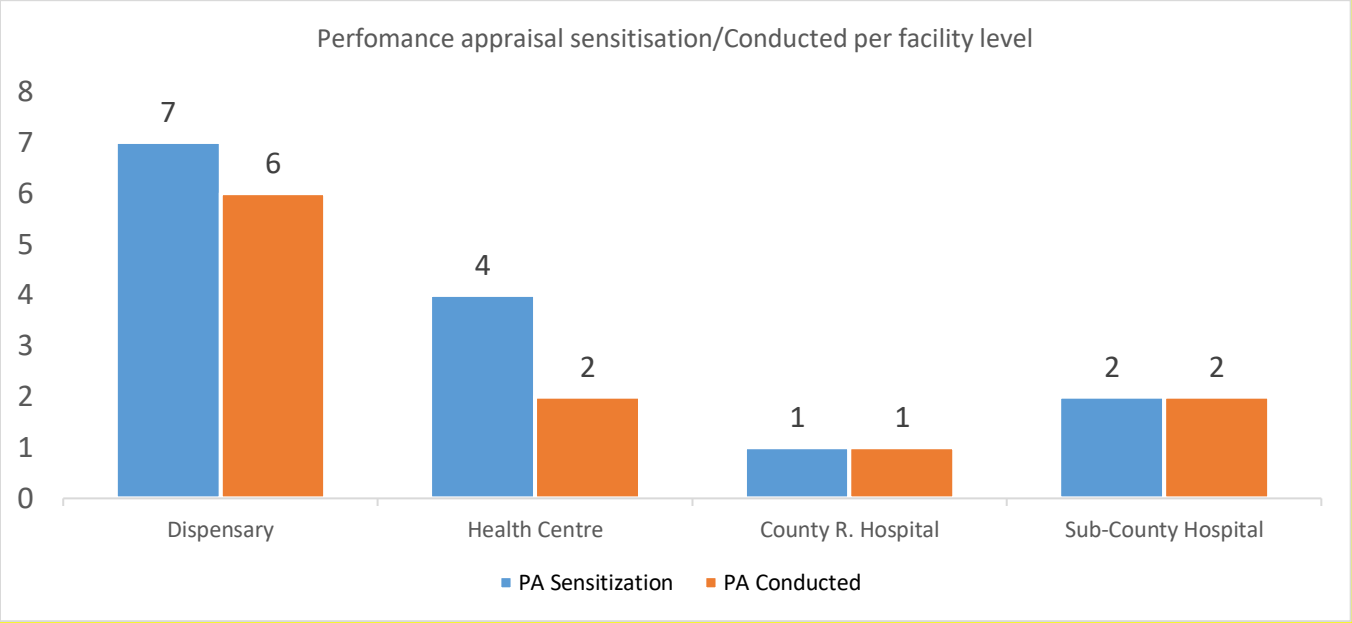


Figure 9 Performance appraisal sensitization/Conducted per facility level

Table below summarizes the key challenges the county is facing under the organizational pillar and measures it has taken to address some of the challenges.

Table 8 the key challenges the county is facing under the organizational pillar

Challenges	Measures county has taken to address the challenges
Resource constraints limiting coordination forums Inadequate qualified nutrition workforce Inadequate partnerships with academic institution to support lower level training of nutritionists. Data quality and use for decision making	Advocacy forums with key departments (county assembly, county treasury, planning etc) Engaging partners in resource mobilization Enhance engagement with academia eg KMTC and Garissa University Undertake periodic checks to ensure data is of good quality Strengthen Further the existing coordination mechanism adhering to schedules including MSP, Data Quality Audits/self-assessment, create data demand and use

Supply chain management

Commodity Security Committee tasked to oversee the supply chain management issues exists but it is not active.

Forecasting and Quantification and ordering and distribution Process: All medical commodities are forecasted, and ordered through the pharmacists. Consumption method is used for forecasting and quantification of needs. Health Facilities forecasts are guided by the previous consumptions record. The stages undertaken in forecasting and quantification of commodities is indicated in figure 10 below

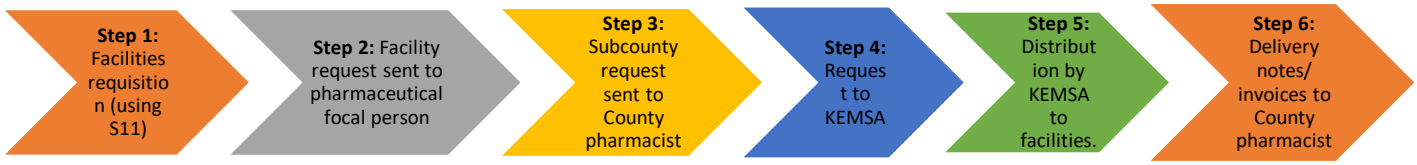


Figure 10 Forecasting and Quantification

Until October 2017, the ordering process for nutrition commodities was through the County Nutrition Coordinator (CNC) directly to the supporting partners, while some nutrition commodities like IFAS, Vitamin A supplements through the County Pharmacists. In December 2017, the county was sensitized on the Logistics Management information system (LMIS) and facility ordering is now done through the LMIS system.

Distribution of nutrition commodities is mainly through KEMSA and Kenya Red cross society (supplies for management of moderate acute malnutrition)

Procurement Process: County procurement plan is available and it consolidates the procurement needs based on the Annual Working Plans (AWPs) from the various departments. The procurement process begins once a requisition is made by a department.

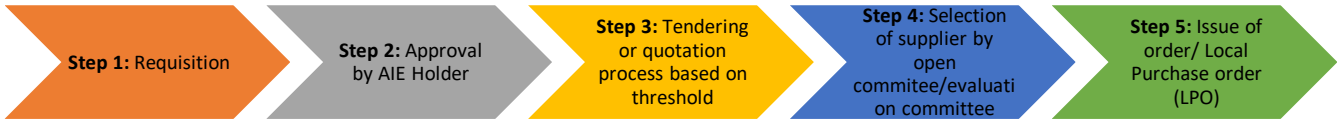


Figure 11 Procurement Process

Majority of the nutrition commodities are procured by partners (UNICEF, WFP) as indicated in the figure 12 below, with a few commodities (mainly Iron and Folic Acid, and Vitamin A supplements) being procured by the national and county government. County nutrition commodity procurement is done directly through the county pharmacist and not through county procurement office.

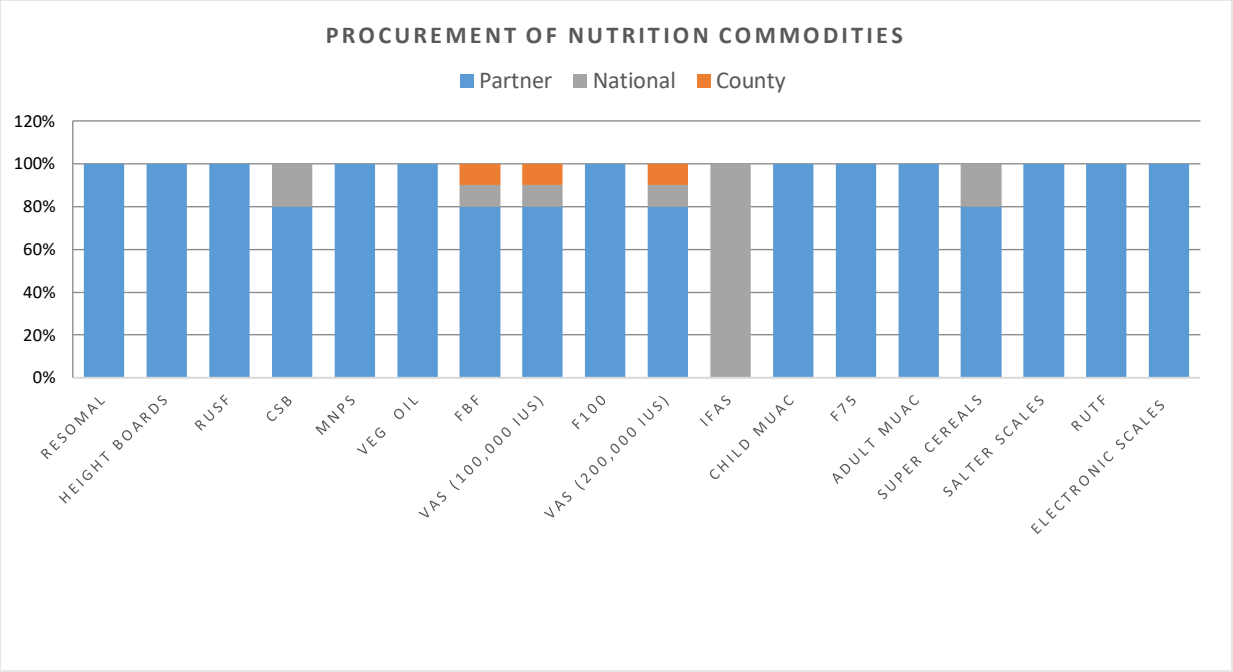


Figure 12 Procurement of NUTRITION COMMODITIES

Availability of commodities:

At county level, nutrition commodities have been largely available. In the last one year, stock out of some commodities (Micronutrient powders, Ready to use therapeutic foods, super cereals and Fortified blended foods, adult MUAC tapes) were experienced. The period of stock outs was less that than 3 months. Adult MUAC tapes were not available.

The health facilities also reported stock outs for commodities for management of acute malnutrition, micronutrients and fortified blended foods as shown in figure 13 below. The highest stock outs were reported for SFP commodities followed by Vitamin A supplements. No stock outs were reported for deworming commodities.

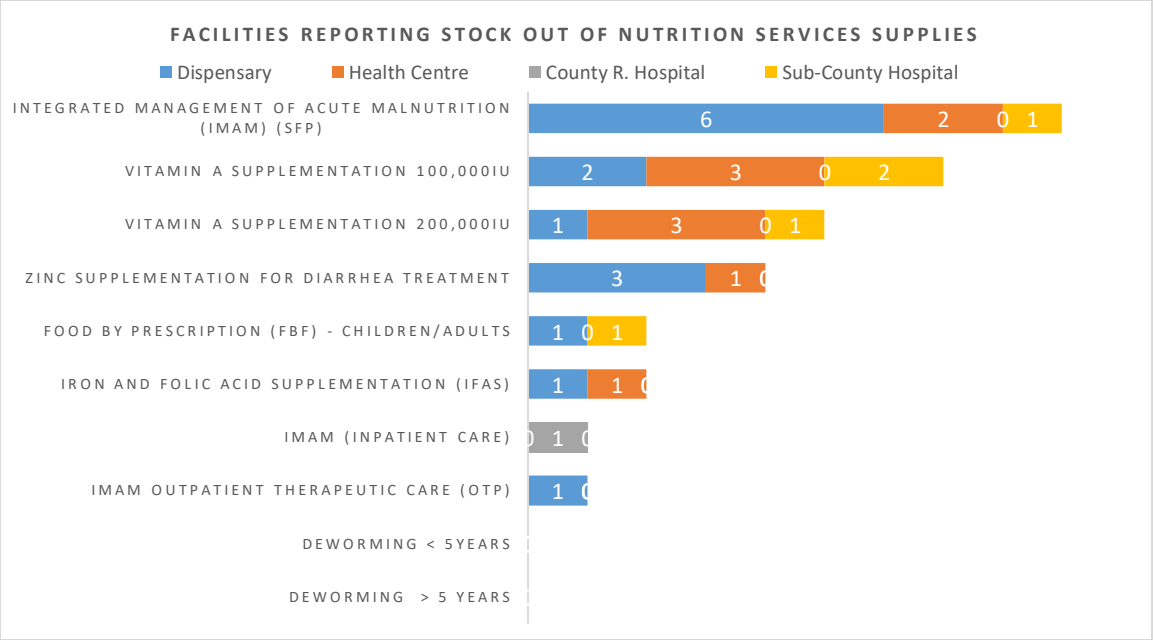


Figure 13 Facilities reporting stock out of nutrition services supplies

The reported period of commodity stock outs for most sampled health facilities was less than one month as indicated in figure 14 below. 1 -2 months' stock outs of SFP supplies, VAS, zinc and FBF. Over 3 months' stock outs were also reported for SFP supplies and VAS (200,000IUs) in some facilities.

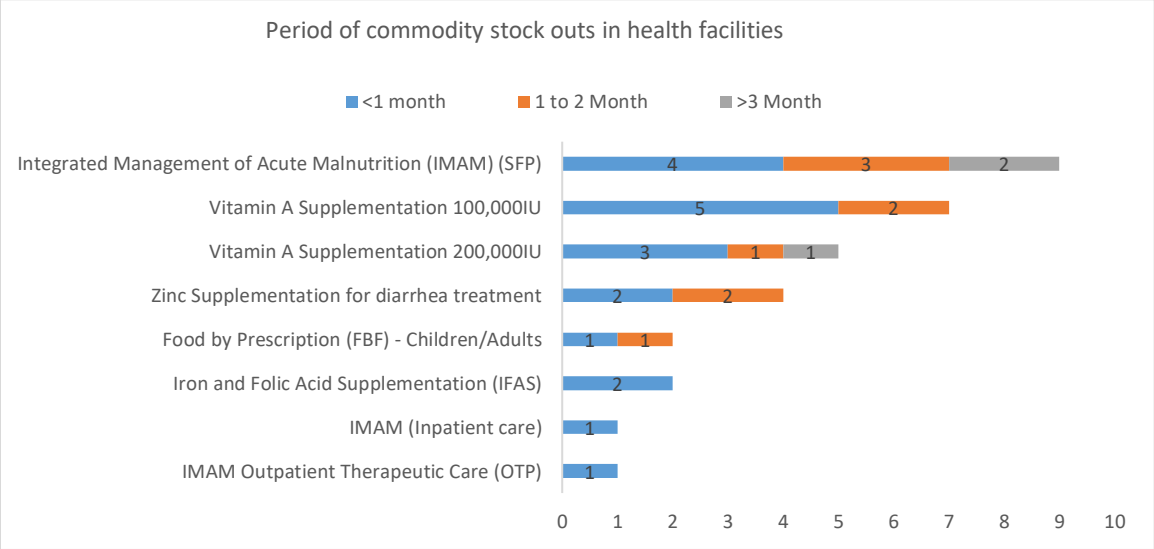


Figure 14 Period of commodity stock outs in health facilities

Reporting:

Reporting of Nutrition supplies is being done through the LMIS platform, and so far, the county has maintained good reporting rates of above 80 percent as indicated in figure 16 below. However, there is need to ensure 100 percent reporting rate so that facilities do not miss out on

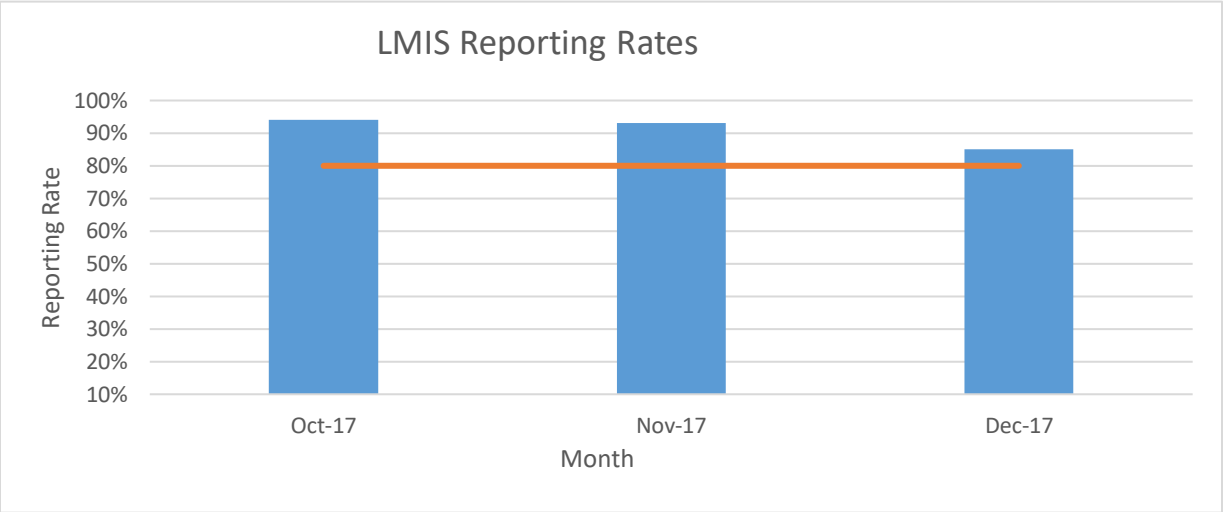


Figure 16 LMIS Reporting Rates

commodity resupply which is based on LMIS reporting.

The challenges experienced by procurement department include; inadequate capacity in supply chain management (Forecasting and quantification, ordering, reporting and good storage practices) and inadequate storage capacity especially for nutrition commodities.

Nutrition Service Delivery

Nutrition services including vitamin A supplementation, Zinc supplementation for management of diarrhea, deworming and iron folate supplementation for pregnant women, integrated management of acute malnutrition, nutrition counselling and maternal infant and young child nutrition services were available in over 90 percent of the sampled health facilities. Nutrition in diabetes management, cancer, parenteral and enteral nutrition were mainly offered in the sub county and county hospitals.

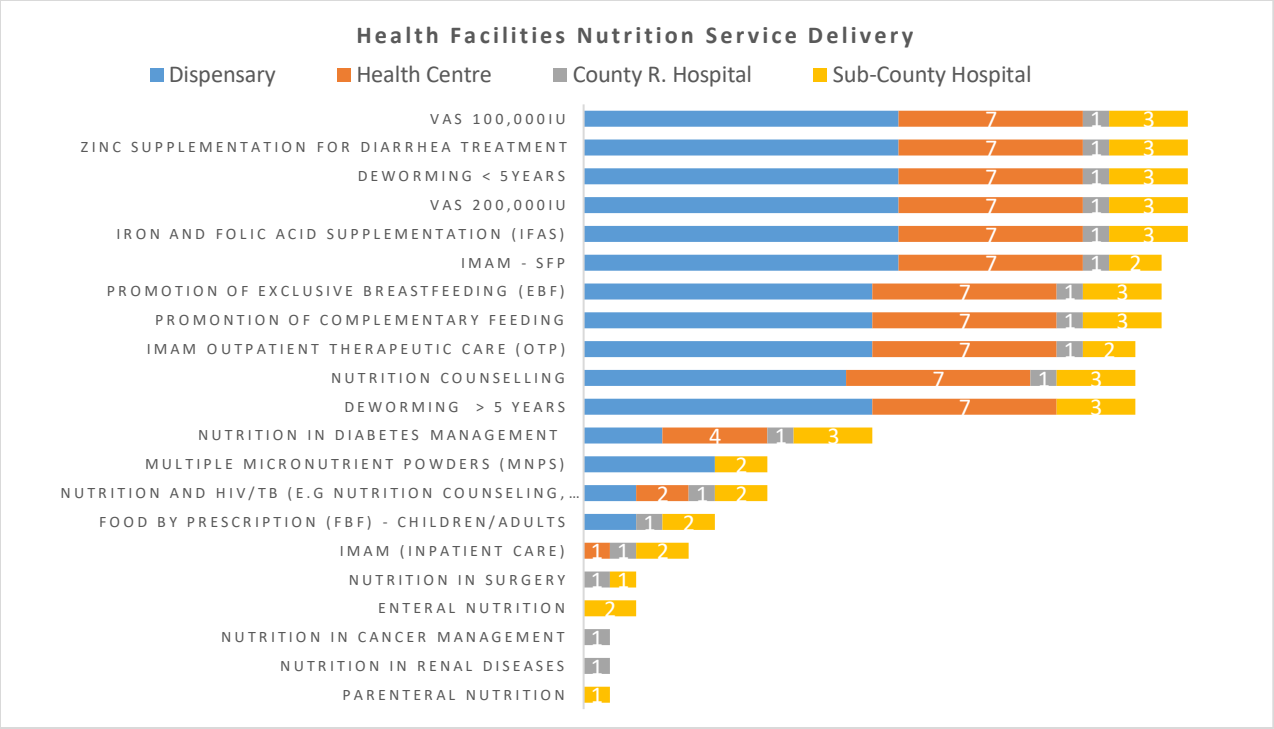


Figure 17 Health Facilities Nutrition Service Delivery

Who offers Nutrition services: Nutrition services are offered by various cadres of nutrition workface. The bulk of the services are offered by Nurses followed by CHVs as indicated in figure 18 below,3 support staff were also reported to be involved in nutrition service delivery.

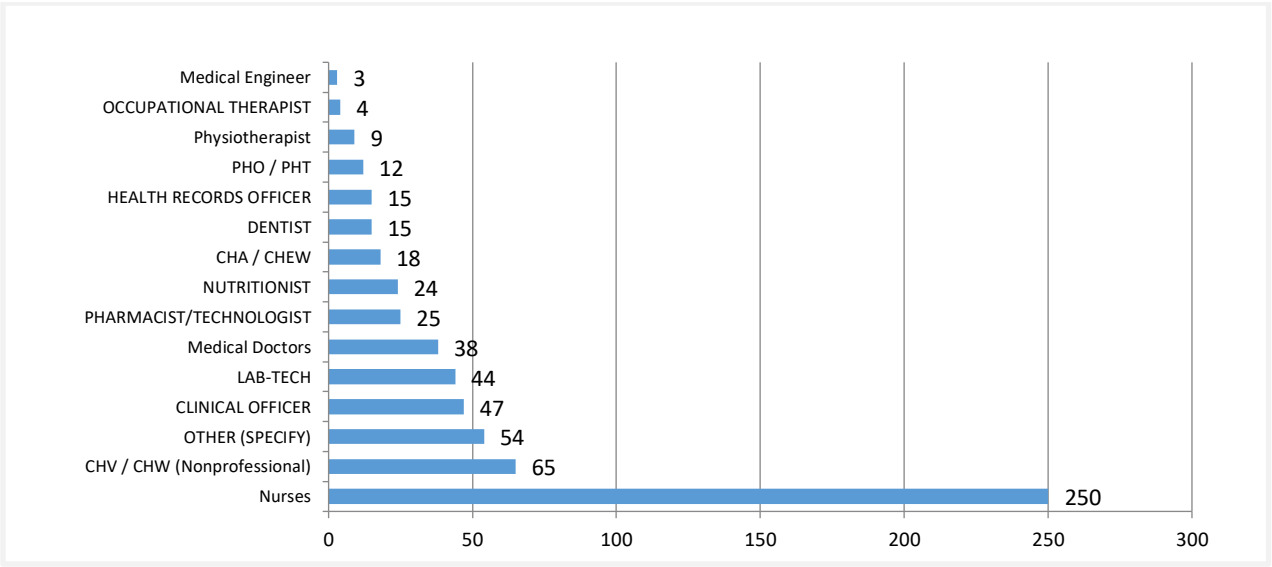


Figure 18 who offers Nutrition services

Figure 19 below also gives an illustration of service delivery by cadre with the nursing cadre providing most of the nutrition services.

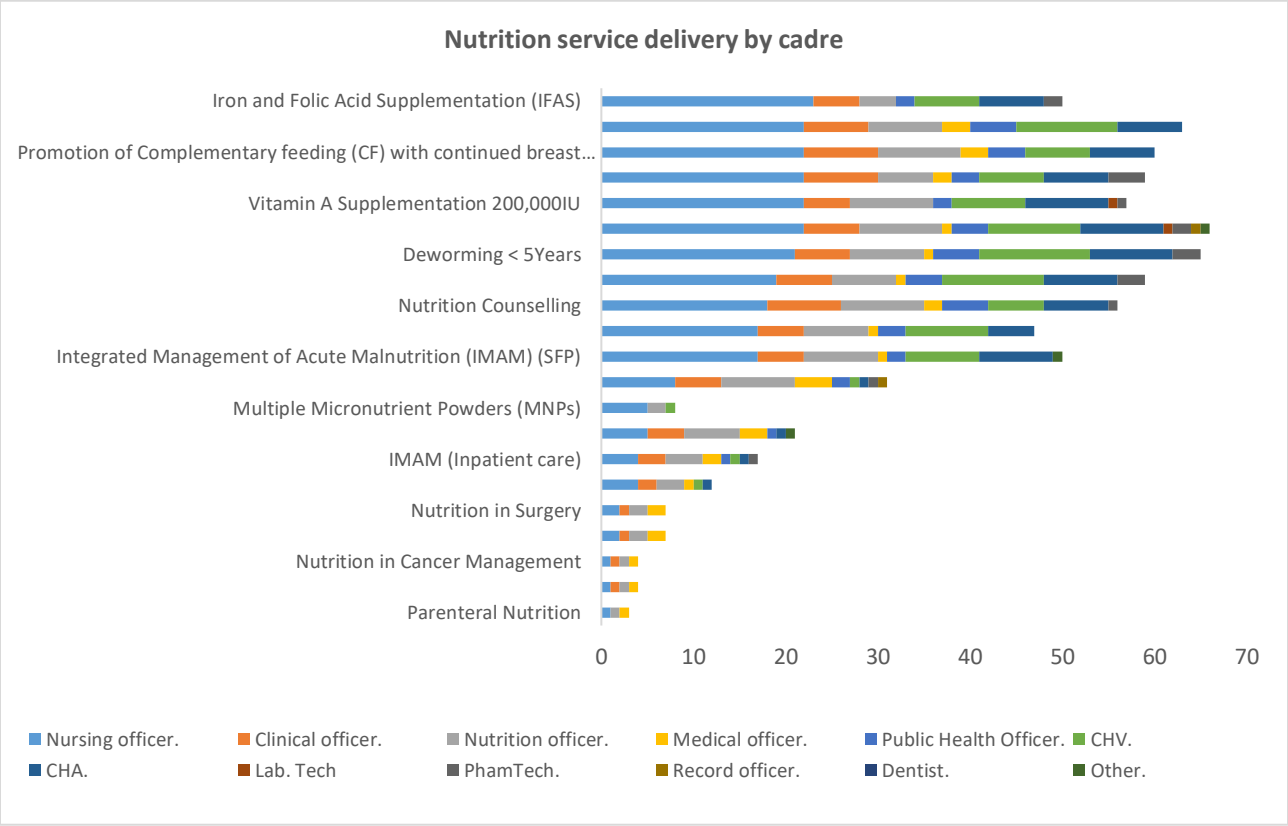


Figure 19 Nutrition service delivery by cadre

Nutritionists offer all the assayed services at the referral, sub county and few health centers At the Sub-County HFs the nurses offer most of the nutrition services except MNPs, HIV/TB, SFP, OTP, and FBF. But at the Referral HF nurses offer the later services. Quite interesting, 17 nutrition services at the referral HF were offered equally by nutritionists and nurses. After nurses, the MOs and Lab-technicians offer most nutrition services 8/19 while Cos offered only 3 out of 19.

At the dispensaries, nutrition services were mainly offered by nurses, but at the HCs other different cadres were involved. For instance IMAM was offered by six different cadres including nurses, Cos, NO, PHO, CHV, CHAs.

Health workers offering nutrition services at the Tier three and four Health facilities

Figure 20 Health workers offering Nutrition services at tier 3 & 4 health facilities

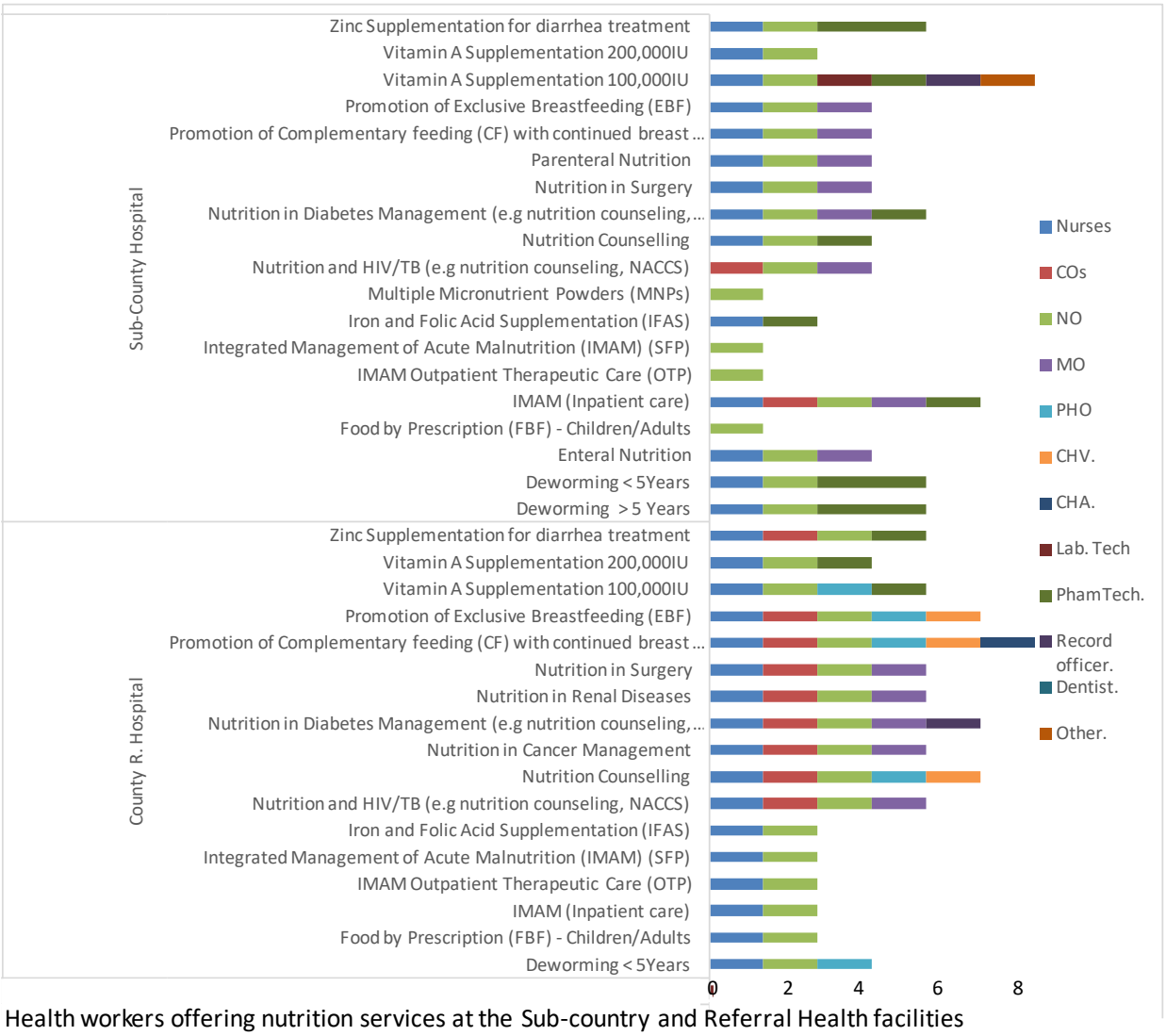


Figure 21 Health workers offering nutrition Services at the Sub county and referral health facilities

Target Setting: Target setting for VAS, IFAS, deworming and management of acute malnutrition programs had targets set but in less than 50 percent of the sampled facilities. The main reasons highlighted for not setting targets include lack of knowledge on how to calculate for the various targets (based on the population estimated from CHRIO and SCHRIOs), lack of awareness that targets need to be set, facilities not given targets for the year by the county/sub county and lack of monitoring charts (for vitamin A). The CHRIO and SCHRIOs are responsible for annual target setting for all facilities except for community units. They first compute each HF annual targets based on the population estimates and projections of the catchment population as

per the growth rate (3.9% for Garissa). After this the HFHWs should populate for the specific targets for the various nutrition services (this is where the gap is).

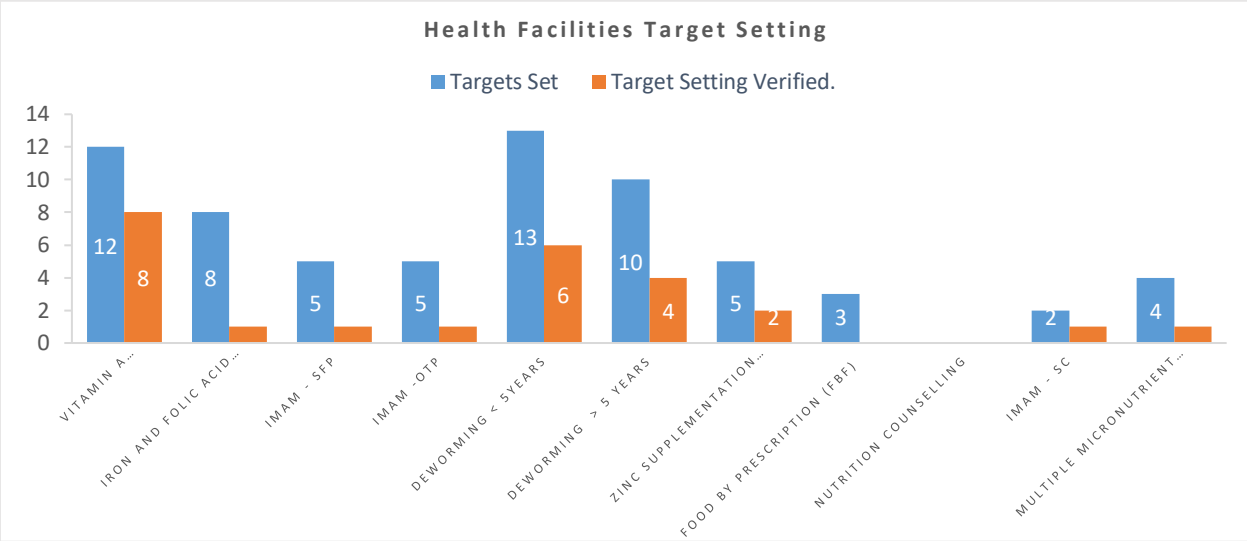


Figure 22 Health Facilities Target Setting

Specialized clinic services:

Majority of the specialized clinics are available at the sub-county hospital and the county referral hospital and they include tuberculosis/leprosy clinic, medical outpatient clinics, HIV, pediatric outpatient clinic, surgical, ear nose and throat (ENT) clinics, diabetes, hypertension, palliative and cancer care clinic.

Most of the specialized services are integrated with nutrition except for cancer, palliative, diabetic, hypertension and ENT clinics. This may require further strengthening considering the growing burden of non-communicable diseases (NCDs)

M&E and operational Research

M&E Systems

Sound and reliable information is the foundation of decision-making across all health system building blocks, and is essential for health system development and implementation, health research and service delivery.

The County has functional system in all areas under review. However, gaps exist in data quality but currently the county is beginning to support the quality processes through MNH review

meetings at County and Sub County level. The MNH has scorecards which have integrated nutrition and this provides a snapshot of the performance indicators.

The Ministry of Health recommends quarterly review of performance and quality to ensure information is available for evidence based decision. Annual performance review meeting is held at the end of the year to consolidate the yearly performance and gauge quality of the system**.** The end product of the yearly meeting is annual performance report that is disseminated to all stakeholders including National Ministry of Health.

The county has not conducted operational research in the last two years due to weak partnership with the academic and research institutions, lack of capacity and technical expertise to write proposals and undertake researches and resource constraints due to low mobilization of funds. "KEMRI once asked for a list of key research areas but there is no feedback yet" (Quotation from CNC)

Data Collection and Reporting:

Data collection entails the use of standard tools in collection of relevant data. These tools are registers used on a daily basis and monthly reporting summaries. The registers are the primary source of data collection. The availability, use and adequacy of these tools are paramount to ensure consistency of data collection.

Tools for NCDs, parenteral and enteral nutrition are lacking. Some facilities lack adequate reporting tools especially the MoH 734, MoH 733, MOH 410A/B, MoH 409, MOH 368 and Vitamin A monitoring charts.

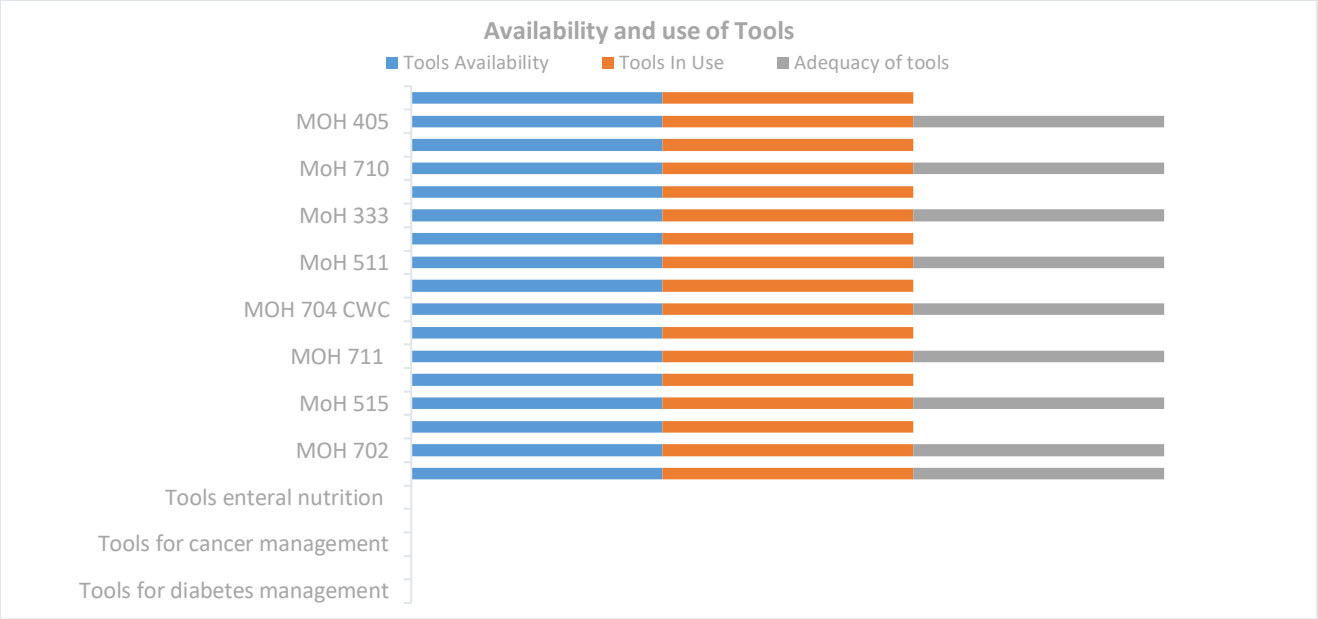


Figure 23 availability and use of tools

At health facility level, tools were available but this was not consistent for all the tools for example, CHANIS tally sheets - MOH 704, MOH 516, MOH 711, and MOH 733B 2016 revised/MOH 516 were lacking at the referral hospitals.

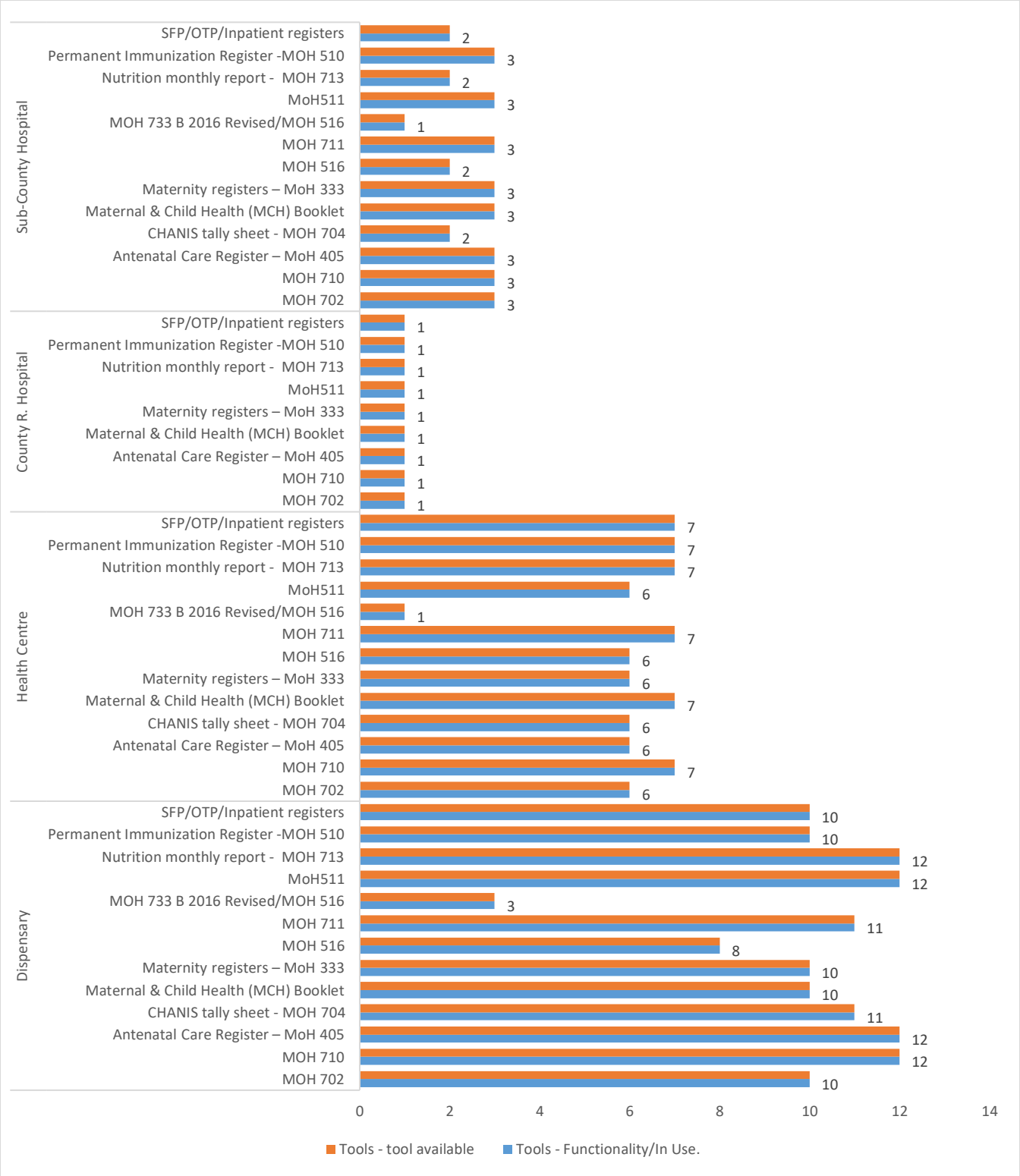


Figure 24 Tools Availability and functionality

Reporting rates for nutrition indicators by tools

Figure 25 below shows the integrated management of acute malnutrition (MoH 713) reporting rates by sub-county for the last 3 years. Overall, the County has maintained reporting rates of above 80%. In 2017 reporting rates were affected by the nurses' strike. Reporting in Dadaab and Hulugho sub counties were also affected by insecurity.

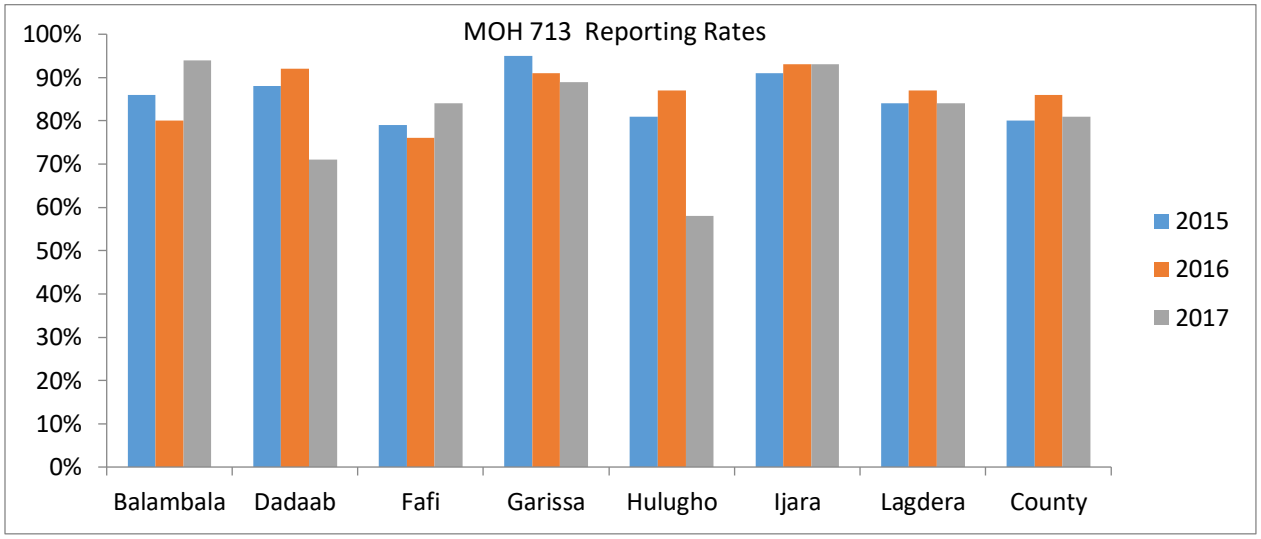


Figure 25 Reporting rates for nutrition indicators by tools

Operational costs for Reporting

The County level budget for operational cost such as internet, printing and airtime in relation to nutrition data collection and transmission is not available regularly. This are supported by the County government, TDH and IRC. Printing costs are not available in the budget.

Nutrition infrastructure

Availability of room for Nutritionists

Sixty one percent (61%) of health facilities did not have a room that nutritionists can use to offer services e.g. counselling etc.

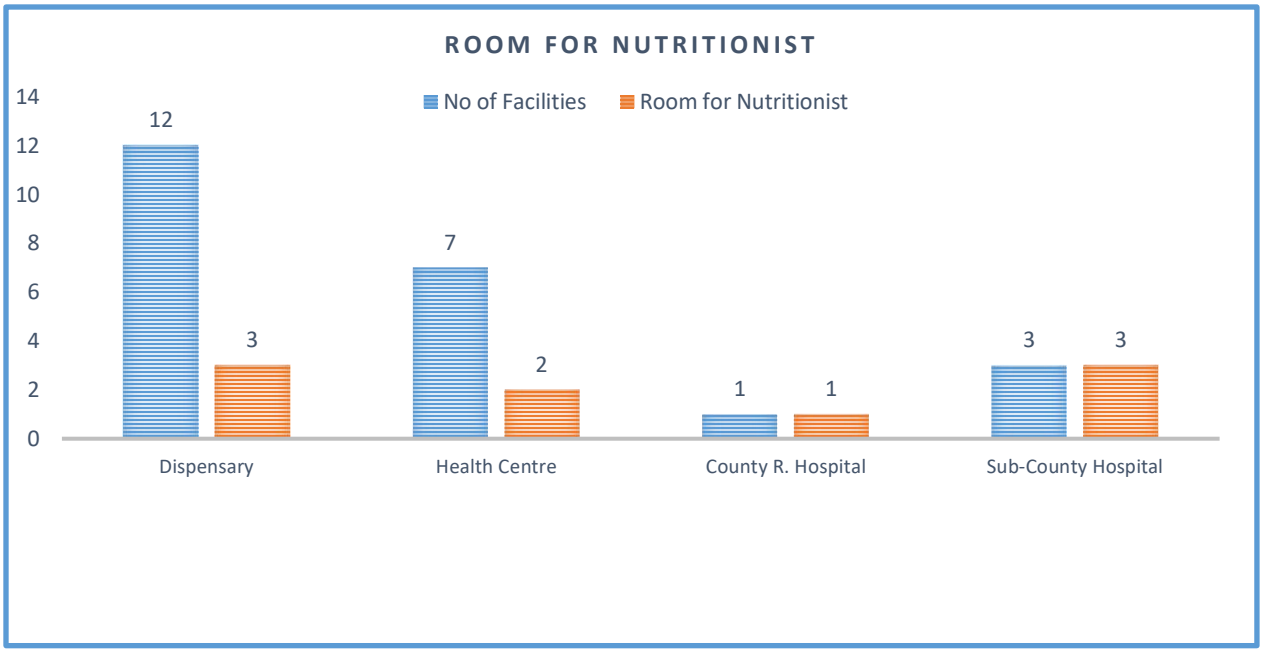


Figure 26 Room for nutritionist

The nutritionists at county referral and sub county hospitals have rooms while dispensary and health center level had no rooms for nutritionists (Only 3/12 of the dispensaries and 2/7 of the HC had a room for the nutritionists).

Storage of commodities

The key parameters assessed for storage of commodities included availability of well-ventilated stores and pallets/shelves, availability of recording tools including bin cards/ stock control cards and S11. The private owned lacked reporting tools (S11, delivery notes, and Bin /Stock Control cards) as well as pallets for therapeutic and supplementary food supplies and a well-ventilated room.

S11 was lacking also lacking at the health centers (6/7 selected HCs). Delivery notes missed in 2/7 HC. Stock control cards for VAS/IFAs/MNPs lacked in 3/7 HCs.

Ventilation and shelving for commodities was present in 4/7 HCs. S11 was lacking in 9-10/12 dispensaries. Bin cards/Stock control cards, delivery notes were available for RUTF/RUSF/FBP but lacking mostly for IFAS.

Shelving and ventilation can be improved since in only 3-5/12 dispensaries had them.

The county referral Hospital lacked a well-ventilated room but all the other parameters were satisfactory.

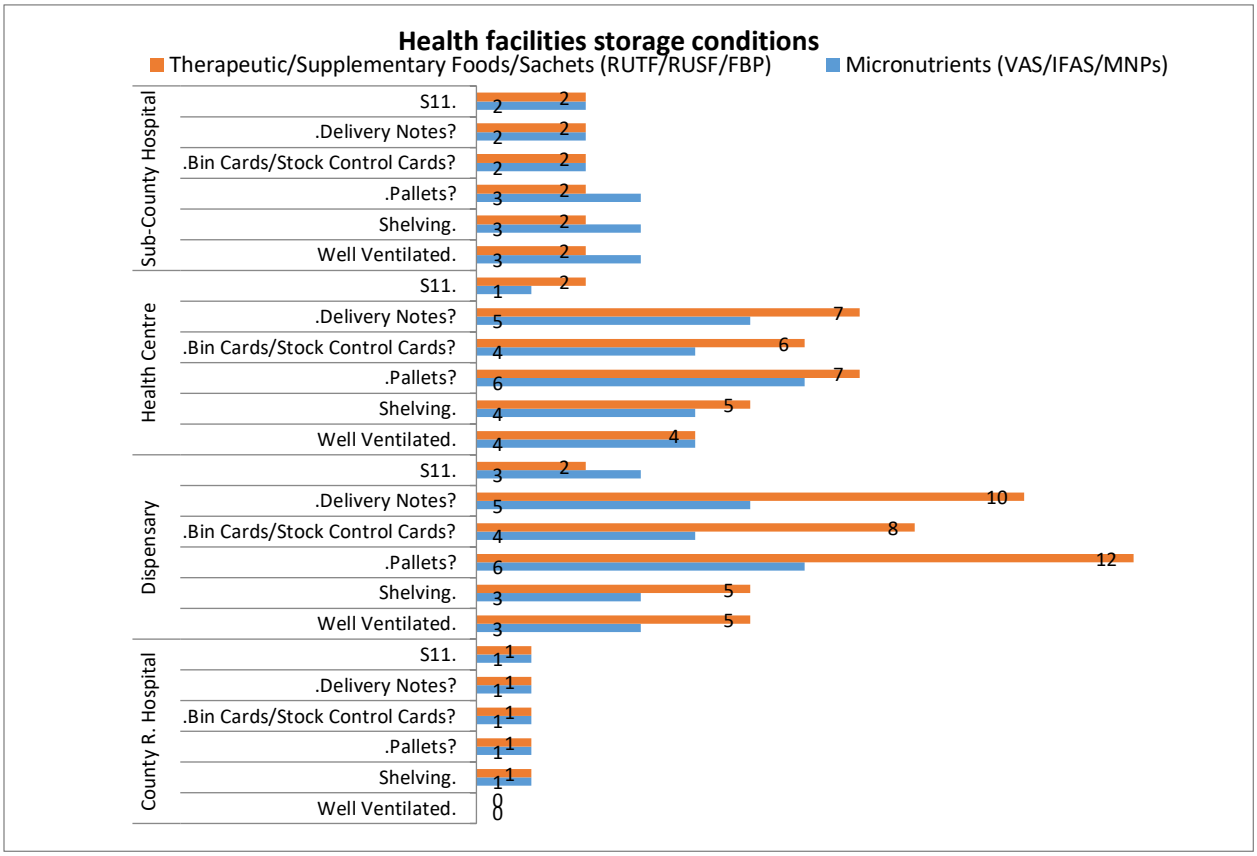


Figure 27 Health facilities storage conditions

Counseling cards

The Sub-County HFs and dispensaries had all 5 counseling cards Unexpectedly, HC lacked HIV/TB Nutrition counseling card, Vitamin A monitoring charts which were highly available at the dispensaries.

The County referral hospital lacked HIV/TB Nutrition counseling card, Vitamin A monitoring charts, and WHO growth chart.

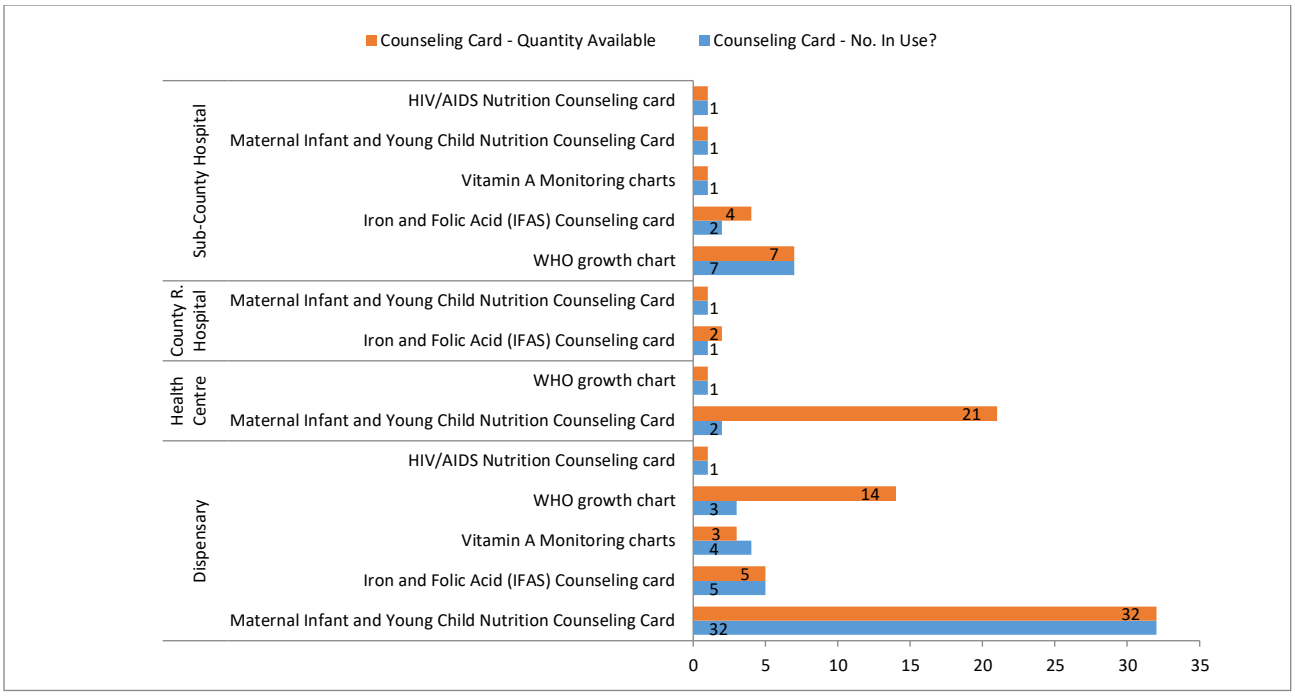


Figure 28 Counselling Cards Availability

ICT and related equipment

The Referral and Sub-County HFs had all ICT and related gadgets (Figure). The dispensaries did not have any ICT equipment. At health center level internet gadgets, mobile phones and photocopiers were lacking (6/7 HCs). It was reported that electronic registers are in use for collection and storage of data at the health center level (AFYA eHMS). The computes are interconnected through local area network (LAN). Printers were lacking in 5/7 HCs while 3/7 lacked a scanner. All sampled HC (7/7) had a computer which was being utilized.

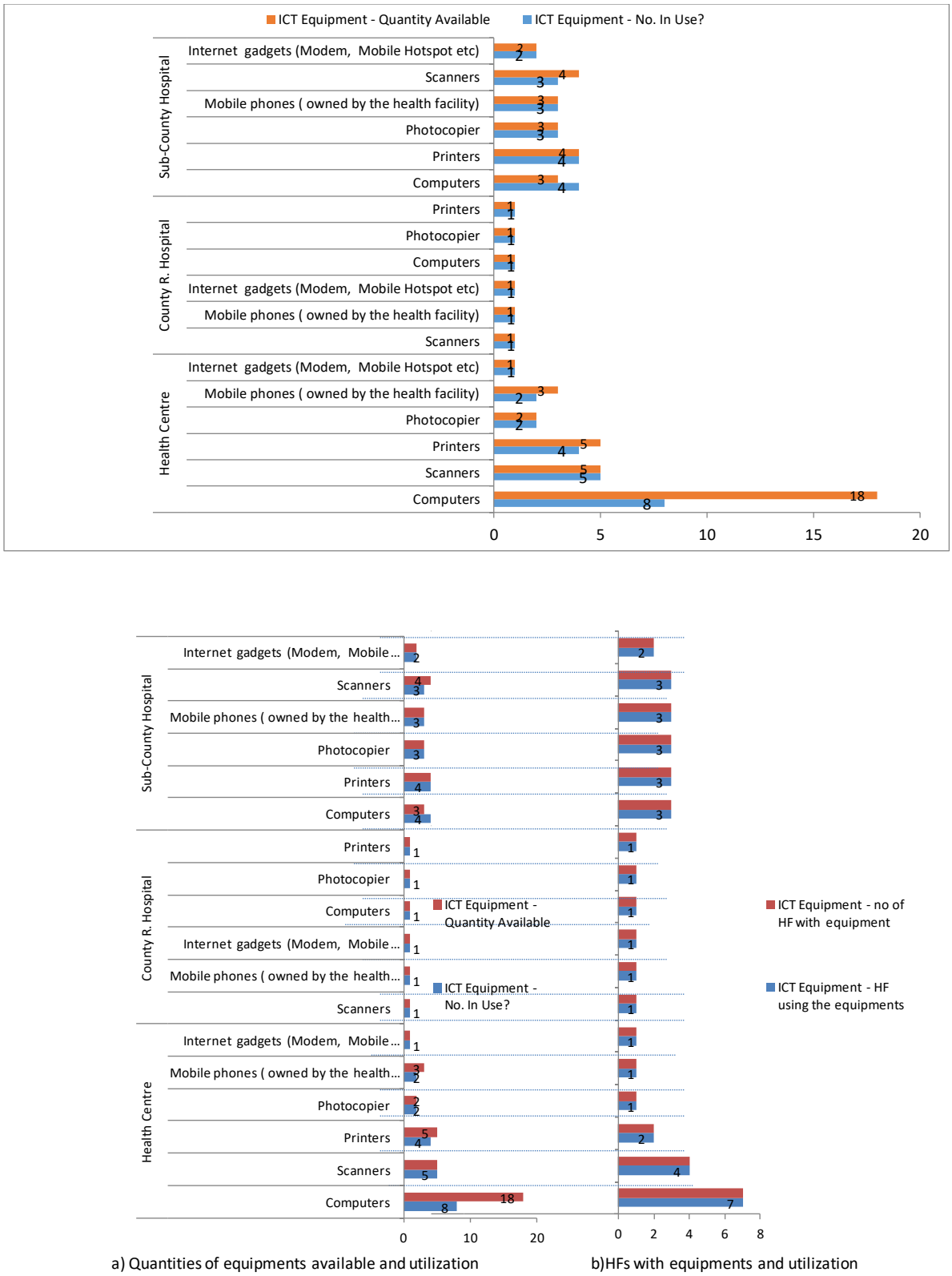


Figure 29 ICT and related equipment

Anthropometric equipment

County Referral and Sub-County Hospitals were well equipped with all assayed anthropometric equipment, however, adult height measuring equipment were only available in one (out of three the Sub-County hospital) or out of all 23 selected HFs.

Only 2/7 HC had an improvised adult height measuring equipment which was also available at the tier 4 and 3 HFs and was lacking completely in dispensaries.

BMI wheels were only missing at the dispensaries while length mats were only available at the referral hospital and in 1/3Sub-County HFs.

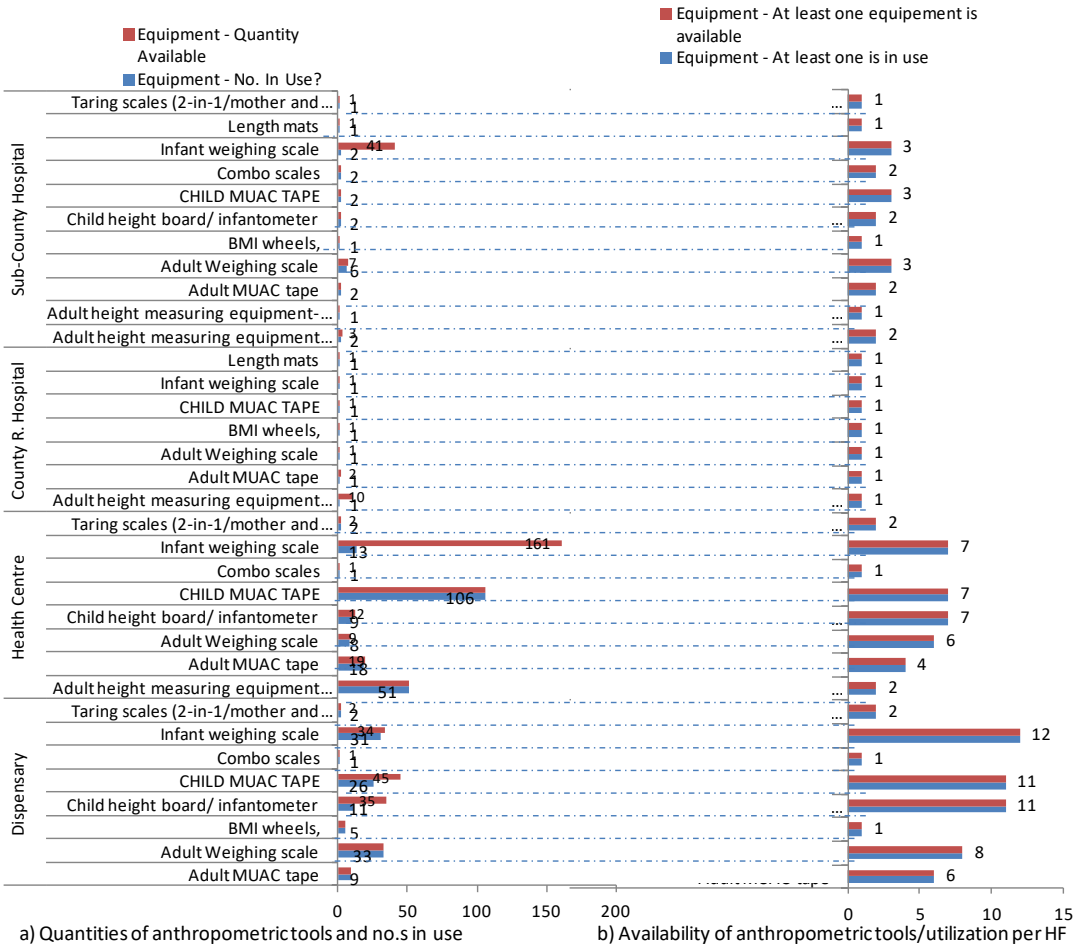


Figure 30 Anthropometric equipment

Health Facilities Water sources, Availability of hand washing facilities and latrines.

Twenty five percent (25%) of the health facilities have rain water harvesting while nearly half (46%) of facilities have piped water. The distribution of sanitation facilities is as follows; container with soap was in 5/12 dispensaries while 1/7 health centers. In case of availability of running water 4/12 of dispensaries have, 2/7 HC have running water. The availability of soap or detergent was low in tier two facilities with only 2/12 and 2/7, dispensaries and HC, respectively having them Latrine/toilet facilities were available in 91% of the health facilities.

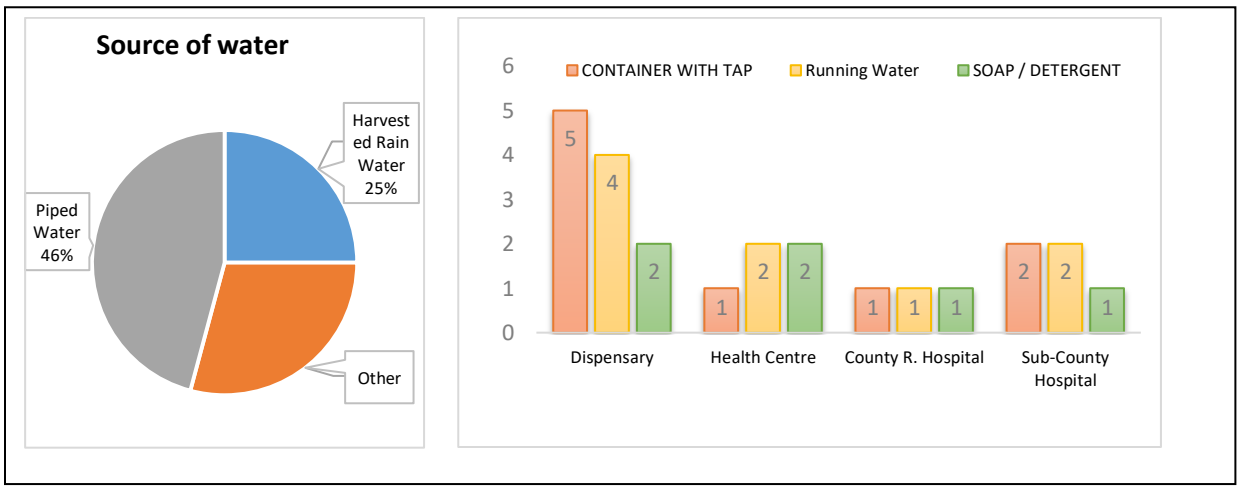


Figure 31 Water sources, Availability of hand washing facilities and latrines

Key Points:

- Good staff attraction and retention mechanisms is in place through timely salaries payment, housing for staff in rural health facilities.
- Insecurity is contribution to high Staff turnover especially in other cadres except for nutrition
- Coordination forums in place with TORs, however regular schedule of meetings is not observed due to inadequate resources. The multisectoral platform which has been crucial in advancing the nutrition sensitive agenda needs continued support.
- Engagement with academia for pre-service trainings and continuous professional development is a key gap in ensuring adequate qualified workforce in the county

Technical capacity Pillar

This section looked at the technical and human resource capacity of nutrition workforce to support and improve nutrition service delivery. The key areas assessed for Garissa county included:

- Nutrition workforce numbers and distribution
- Training undertaken for the nutrition workforce and proficiency

Nutrition workforce numbers:

Per the Garissa Human Resources for health management and development plan, the county requires a total of 707 Nutrition staff (136 officers, 353 technologists and 218 technicians).

But only 33 are available leaving a gap of 674 nutritionists. However, as per Garissa Human Resources for health management and Development plan 17% of the HRH norms envisions 120. Source Human Resources for health management and Development plan.

Table 9 Nutrition Workforce Numbers

Sub Category	Total HRH Required (Norms)	Total Staff Available	Total HRH Gap	Desired Change 17% of HRH Norms
Nutrition & Dietetic Officer	**136**	**10**	**-126**	**23**
Nutrition & Dietetic Technologist	**353**	**11**	**-342**	**60**
Nutrition & Dietetic Technician	**218**	**10**	**-208**	**37**
Total	**707**	**33**	**674**	**120**

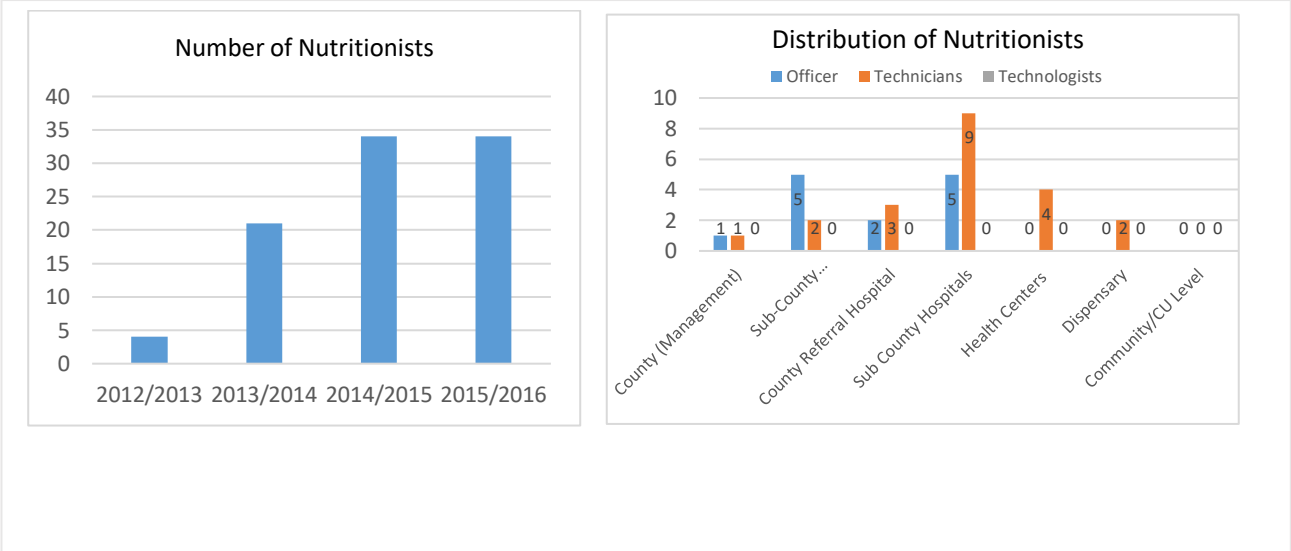


Figure 32 Number of Nutritionist vs Distribution of Nutritionist

The number of nutritionists increased progressively from 4 already employed in 2012/2013 financial year to 34 in 2015/2016 financial year. Though no new staff were recruited in 2012/2013 financial year, 17 staff were recruited in 2013/2014 financial year and 14 in 2014/2015 financial year. Thereafter, there has not been new recruitment. The nutritionists are well distributed across the various level. According to the CNC, the distribution has been based on the workload at this various levels.

Trainings:

Trainings are done based on service need plus on job training and mentorship, The County has a total workforce of 3,479 inclusive of CHVs and support staff. There were a total of 31 MoH approved courses. Out of the 31 approved courses, training had been conducted in 14 courses in 17 training sessions conducted in the last 2.5 years. The most popular trainings were nutrition assessments and IMAM with 4 and 3 trainings, respectively, conducted during that period. Out of the 300 requiring IMAM training, 75 were trained. In addition, 80 staff were trained in Nutrition Assessment (e.g. biochemical, anthropometric, clinical), Counseling and Support,

compared to 3,416 that required this training. In addition, no training was conducted on Nutrition in HIV (specific to nutrition cadre) even though a total of 3,416 requiring this training.

Source: Garissa HRH Staff Database- July 2016.

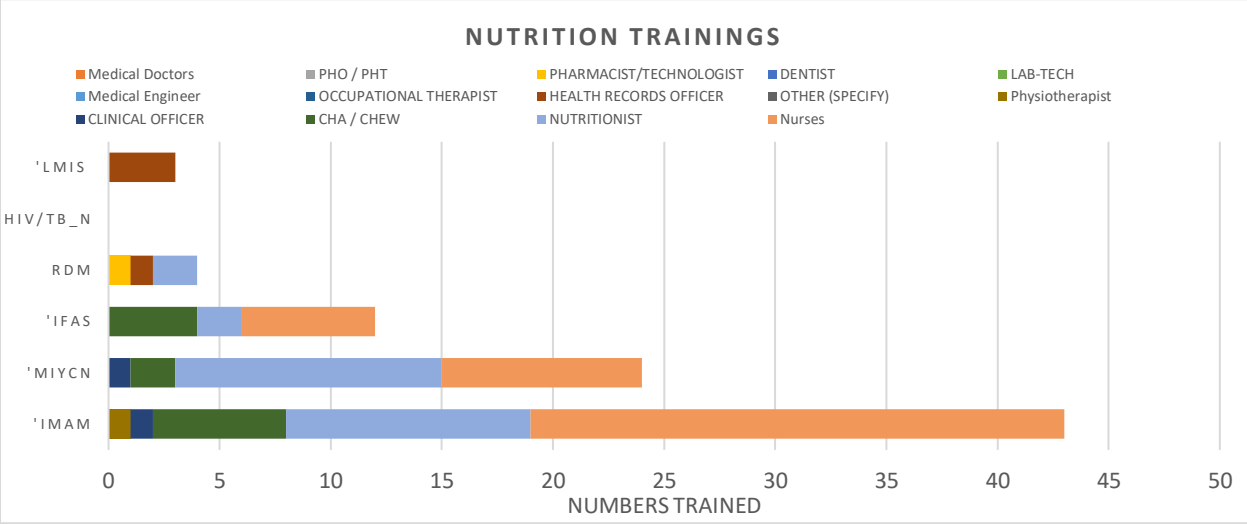


Figure 33 Nutrition Trainings

Key Points:

- Only 4.6% of the nutrition staffing needs have been met based on the County Human resource management and development plan.
- Distribution of staff based on workload at the various levels.
- Trainings have been undertaken…however there is still a huge gap for trainings across the various cadres who are carrying out nutrition services. Nurses, NO, and CHAs were well trained on IMAM, MIYCN, IFAs and were mostly delivering the services at the dispensaries and health centres. However, COs and PHOs were offering this services but had not been trained on the same. Recommendation- recruit more NOs, and also intensify trainings for the different cadres including COs and PHOs in future trainings

COMMUNITY CAPACITY PILLAR

Introduction

Community capacity is the ability of the community to access, consume and make demand for nutrition services through increased nutrition service awareness.

It emanates from interaction with the three thematic areas and effectively leveraging existing resources and capacities within the community to solve collective problems (malnutrition) and improve or maintain wellbeing.

Garissa County has invested in community health strategy as a way of improving the health status of its people. The assessment revealed that as a result, there has been a little improvement in the overall health indicators and also the health seeking behaviors of the community. Similarly, the defaulter rates for the different services have decreased although this still remains a challenge.

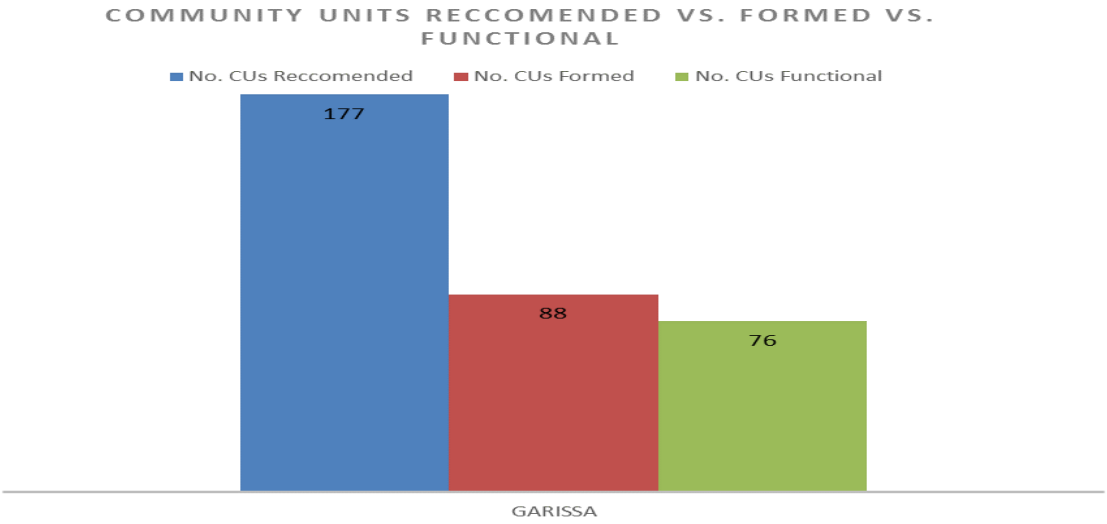


Figure below shows the number of the required CUs based on the population, the formed and the functional community units. The community units that are formed and functional are much far below the recommended figure of 177 CUs.

Description of the Community Health Structure in the county

Garissa County has a total population of 850,630 people. The total number of wards in this county is 30. The number of community units recommended based on the population is one community unit for every 3000 households although this has currently been revised to 5000 households (Source; Health Act 2017, 4th schedule). Out of the 88 formed community Units, only 76 are functional. Functionality of the CU was defined based on the following characteristics; monthly reporting, holding meetings as scheduled, have dialogue days, right

Figure 34 Community unit recommended vs formed and functional

number of CHVs, has a committee supplies and tools available. All the wards in the county are covered by at least one functional CU. The current number of CHEWS is 56 while the CHVs is 1740 in number.

The table shows that Lagdera and Dadaab have the largest formed community units while Garissa and Hulugho have the least.

Distribution of Community units across the different sub counties

Table 10 Distribution of Community units across the different sub counties

Sub-County	Number of CUs
Garissa	18
Ijara	11
Lagdera	15
Dadaab	14
Fafi	13
Balambala	9
Hulugho	8
Total Garissa county	**88**

Community Health Linkage to the sampled Facilities and their functionality

The assessment revealed that 91% of the sampled facilities were linked to community units. However not all were fully functional. The graph below shows the number of functional CUs attached to the different level of sampled facilities.

Most of the sampled facilities had at least one functional CU. One sub county district hospital

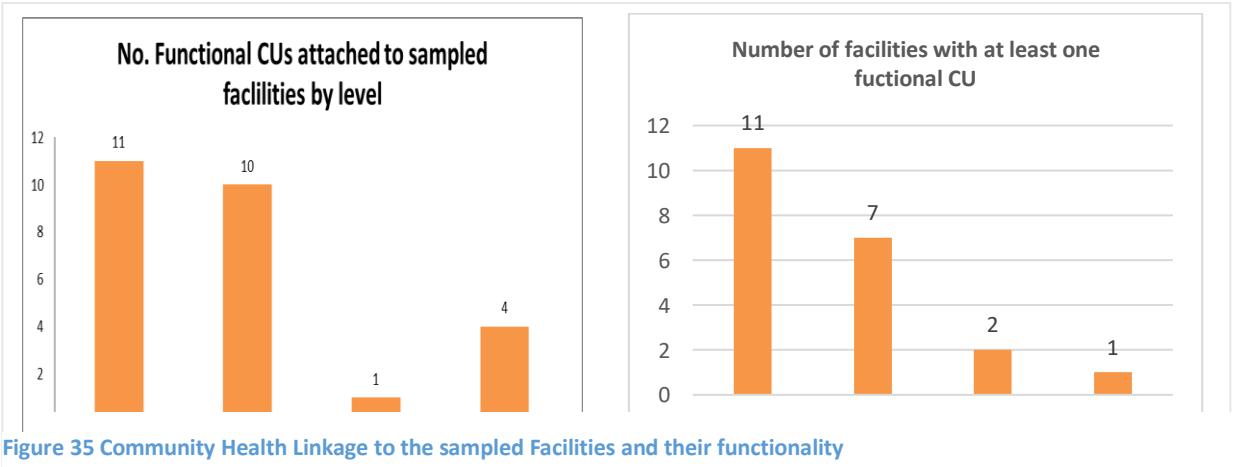


Figure 35 Community Health Linkage to the sampled Facilities and their functionality

lacked at least a functional CU as shown in the graph below.

Community Health Extension Workers and Community Health Workers Trainings on Nutrition

The CHEWS and CHVS reported having been trained on the basic induction module but no trainings have been done on community nutrition module as shown in the table below. Other training s offered to the CHEWs includes IMAM, MIYCN, and IFAS sensitizations. However, the CHEWs highlighted their need for refresher trainings.

Table 11 Chews & CHVS Trainings on Nutrition

S/NO	**Training**	**No of CHEWS Trained**	**No of CHVS Trained**
2.	Basic Modules	56	1740
3.	Nutrition Module	0	0

The CHVs reported involvement in the following activities;

1. Defaulter tracing
2. Offering of nutrition services to the community
3. Screening and referral of children under 5 years of age, pregnant and lactating women.
4. Linkage and referral of patients/ Follow up with community members on health access
5. Health education, hygiene promotion and educating mothers on excusive breastfeeding
6. Nutrition counselling, PMTCT counselling
7. Immunization and community linkage
8. Advice mothers to seek for medical help
9. Supplementation of IFAS
10. Give patients food as per the prescription
11. Deworming
12. TB and HIV program
13. SFP

During induction, the CHVs were given these trainings; Nutrition, Hygiene, Defaulter tracing, importance of hospital delivery, MNCH fistula training. After induction, the CHVs have been sensitized on various topics including TB, Health Promotion and Hygiene.

The level of County government investment in the community Health Strategy in the last financial year.

For any project to be sustainable there is need for the county government has supported the CHEWs monthly salaries

Essentially all the CUs in the county are established through partner support and 75 of these CUs (86%) through UNICEF funding

Number of community groups and forums Groups

- CBO- SIMAHO Health center – offers comprehensive nutrition services
- Mother to mother to mother support groups exists in some facilities but not currently active. Largely supported by partners.
- Activities – Health education, cooking demonstrations & kitchen gardening
- MOH supported CHVs – Engage in IGAs
- KRCS CHVs – share experiences on breastfeeding
- Women Group – Abshir /Bismillahi women Group – offers health education and Nutrition.
- TBAs – Bring women together, CHVs participate in the meetings

CHVs Engagement with Groups

- CHVs are engaged with the TBAs where they bring women together
- Community dialogue
- Planting of trees
- Kitchen gardening
- Latrine Cleaning
- Attend public Barazas and provide health education to the community
- create awareness to the public on the available health services
- Health and nutrition education
- Cleaning, collecting and burning garbage

Community feedback mechanisms/ channels and Public participation

Interviews from key informant showed that community feedback mechanisms were present, this included community dialogue and action days, CHV review meetings, community health committee meetings and Chalkboard. However, public participation was noted only in community dialogue and action days though chalkboards existed in every community unit they were not updated and lacked some indicators. There was also minimal engagement with the community health committee, as most did not meet as expected and a few meet between the facility in charge & chairperson. This is illustrated in the graph below:

Human resource documents such as standards and norms, schemes of service and are in existence and are used in HR management especially on recruitments, trainings, promotion and remuneration however the staff ratios were noted to be far below the recommended standards.

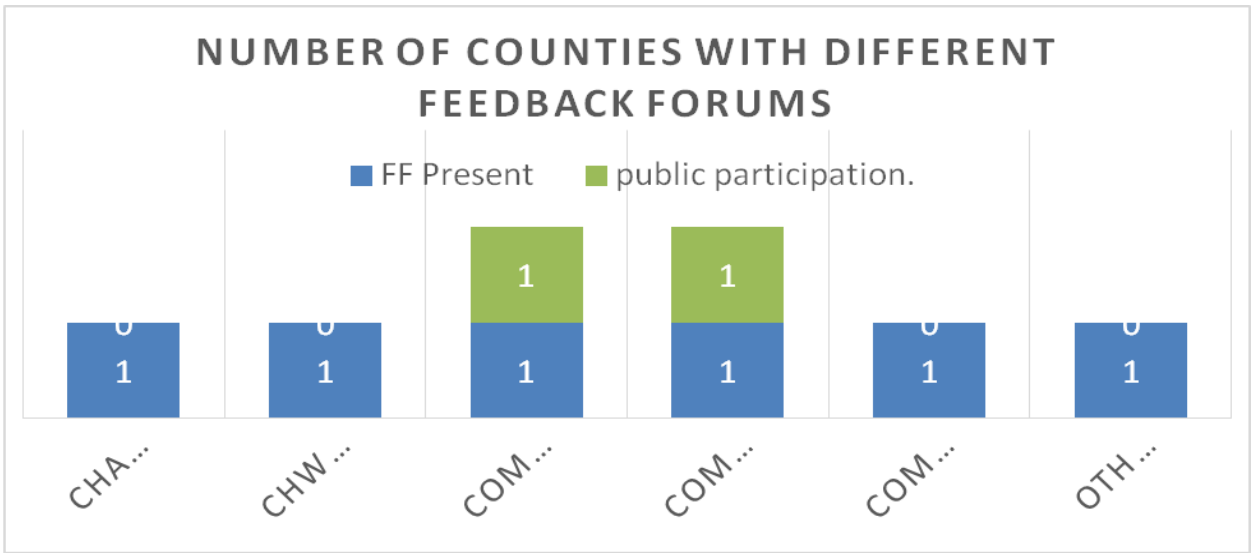


Figure 36 Community feedback mechanisms/ channels and Public participation

Community health information reporting rates (CHS)

Information generated from DHIS showed over 70% CHS reporting rates in the last six months, this fell short of the recommended 80% reporting rate as shown in the graph xx below.

The reporting tools were in existence however, the referral forms were reported to be inadequate.

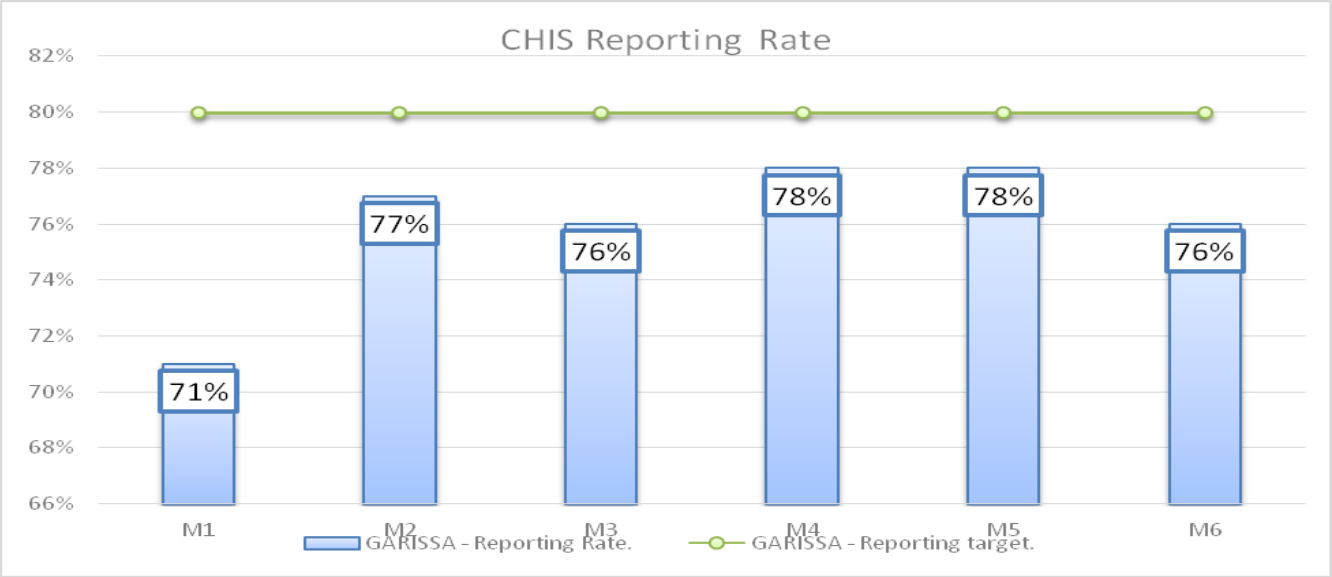


Figure 37 Community health information reporting rates (CHS)

Support given to community strategy

The CHV FGD conducted indicated that the county supported with training for CHS focal person on community health strategy and CHVs on maternal and newborn health, moreover the teams were also provided with CHS reporting tools (Registers).

The county support was only limited to salaries for CHEWS and CHS reporting tools; however, a gap on CHS support was noted on; CHV allowance, CHS training, CHV kit, IGA seed capital and means of transport.

Community empowerment by CHVs

The FGDS conducted among the CHVs showed that best practices were used to empower communities to demand for health services. Strategies employed included: informing mothers and communities on importance of skilled deliveries , availability of incentives for mothers delivering in hospitals (Mama kits provision), availability of free services – for all services at all health centers and dispensaries, for pregnant mothers and under five children and Health education sessions

Referral system

FGD discussions revealed that a referral system was in existence. Referral of cases was done by the CHV's from community unit to the link facilities using referral forms. It was also noted that the system was not effective as no feedback was provided back to the CHV's by the link facilities after referral and services and also some referrals made were rejected at facility and hospital level.

Challenges

- Inadequate IEC materials Job Aids and staff identification tags
- Lack of means of transport (Bicycles and motorbikes)
- Inadequate knowledge on MOH reporting tools
- Lack of incentives (CHV allowance and CHV kit)
- Lack of water – sometimes at the facility
- Poor health seeking behavior among the community members

Recommendations to improve community demand and use of health services.

- Provision of adequate IEC materials, job aids and staff identification tags
- Provide means of transport to overcome long distances by the CHVs
- Provide trainings, refresher trainings and Certification for CHVs
- Provide incentives to motivate CHVs (CHV kit and allowance)
- Provide water in health facilities to ease referral work for CHVs
- Provide public Address system for community Mobilization and support forums for CHVs to create awareness among the communities.

Key Points:

- The County has invested in community health strategy as a way of improving the health status of its people

- The assessment revealed that 91% of the sampled facilities were linked to community units. However not all were fully functional.

- Community feedback mechanisms were present, this included community dialogue and action days, CHV review meetings, community health committee meetings and Chalkboard.

- Human resource documents such as standards and norms, schemes of service and are in existence and are used in HR management especially on recruitments, trainings, promotion and remuneration however the staff ratios were noted to be far below the recommended standards.

- FGD discussions revealed that a referral system was in existence. Referral of cases was done by the CHV's from community unit to the link facilities using referral forms.

ACTION PLAN

Thematic Area	Actions	Responsible	Timeline
Community Pillar	Procure and supply 513, 514 MOH reporting tools and Chalk board for health facilities	HOD PP M&E	Jun-18
	Procure and distribute service delivery Log books to health facilities	HOD PP M&E	Jun-18
	Printing and supplies of CHS tools and CHV identification badges	HOD PP M&E	Jun-18
	Roll out BFCI in the 10 Functional CU's (with current funding from UNICEF)	HOD FHS/ Partners	Mar-18
	Mobilize resources and scale up of BFCI in the Functional CU's	HOD FHS/ Partners	2018-2019
	Launch SBCC strategy	HOD FHS	Jul-18
	Disseminate SBCC strategy	HOD FHS	Mar-18
	Sensitize the CHEWs on Defaulter tracing mechanism	CFP/ Partners	2018-2023
	Use innovative ways including tickler box for tracing and follow up of defaulters in linking with facilities and ensure Chews give feedback	CFP	2018-2023
	Recruitment of CHEWs 2 at least per unit	CFP/ COH	2018-2023
	Recruit more CHVs to meet the recommended number for the functional CUs	CFP	2018-2023
	County Ex-change programs to learn on innovative CHS modalities from other counties and implement what is feasible for Garissa county	CFP/ Partners	2018-2023
	Develop the County specific Bills	CFP/CEC,COH	2018-2023

Technical Pillar			
	Recruiting more Nutrition workforce (24 per year)	HRH/ HOD FHS	2018-2023
	Nutrition staff Training needs assessment (TNA) to develop a training plan	HRH/ HOD FHS/ CNC	2018-2023
Organizational Pillar	**Actions**	**Responsible**	**Timeline**
	Strengthen multisectoral Platforms(MSP) meetings	CEC/ COH	2018-2019
	Implement the work plans for the MSP (TOR and Action Plan already developed with IMC)	CEC/ COH	2018-2019
	Strengthen the facility in charges and staff meetings at facility level	HOD FHS/ Partners	2018-2019
	Reactivate staff Performance Appraisal and feedback	HRH	Annually
	Strengthen Nutrition coordination and supply of nutrition commodities	CNC	Continuously
	Sensitize facility staff on LMIS to operational level i.e HF	MOH/ Partners	Jul-18
	Establish and share nutrition specific indicators at Facility and Community Unit level	M&E	Mar-18
	Strengthen the Facility in charges on Nutrition specific targets at facility and Community Unit level	M&E	Mar-18
	Strengthen integration of Nutrition services in the specialized clinics (Diabetes Clinic).	M&E	Feb-19