KILIFI COUNTY

NUTRITION CAPACITY ASSESSMENT PILOT REPORT

JULY 2017

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- International Medical Corps for technical, administrative and logistical support
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We are very grateful to all others who may not be specifically mentioned here but contributed to this process.

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LIST OF ABBREVIATION

CHMT	County Health Management Team
KNCDF	Kenya Nutrition Capacity Development Framework
UNICEF	United Nations Children's Fund

EXECUTIVE SUMMARY

This document is a report of the National Nutrition Capacity Assessment Pilot conducted in Kilifi County under the overall guidance of the National Capacity Development Working Group and the National Nutrition Information Technical Working Group. The pilot was conducted to inform finalization of the KCNDF operational guideline and tools before scale up of the capacity assessment across all counties. The assessment took place in July 2016.

CHAPTER 1
INTRODUCTION TO THE KENYA NUTRITION CAPACITY DEVELOPMENT FRAMEWORK

BACKGROUND

Good nutrition is a prerequisite for National development and well-being of individuals. While Kenya has made progress towards reduction of malnutrition, about one-quarter (26 percent) of Kenyan children are stunted (too short for their age) with 8 percent being severely stunted; 4 percent are wasted and; 11 percent are underweight. Kenya achieved the Millennium Development Goal (MDG) target in underweight reduction (11 percent underweight), however, the MDG targets for stunting (16.26 percent) and wasting (3.05 percent) are were not achieved. See Figure 1, 2 and 3 below. Non-communicable diet-related disorders, such as overweight, obesity, hypertension and diabetes are becoming increasingly common. With these challenges, scaling up of nutrition services cannot be achieved if the capacity of nutrition workforce which is a key catalyst to delivery of quality nutrition programmes is not developed to required levels. A capacity development framework for Kenya has therefore been developed. However, baseline information on the level of capacities of the nutrition systems, organizations and workforce has been limited. Capacity assessment operational guideline and tools have therefore been developed for use at national and county level. This will allow for holistic assessment of capacity gaps, recommendation of key actions and follow up.

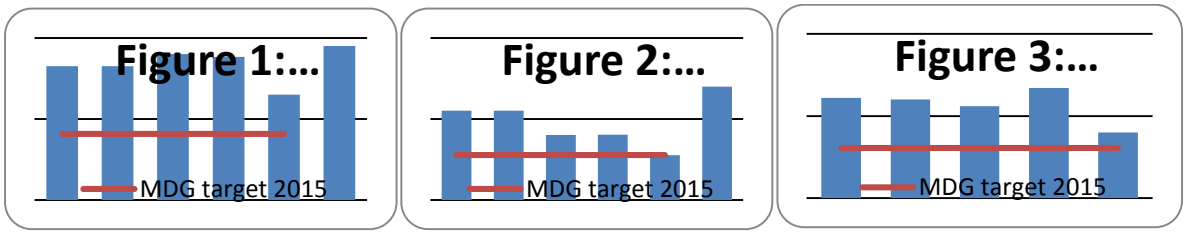


Figure 1: Trends of nutrition status in Kenya

The country is coordinating actions stipulated in the National Nutrition Action Plan 2012 to 2017. Kenya made a commitment to accelerate reduction of malnutrition by signing into the SUN movement in November 2012 as the 30th country member, after concluding efforts to establish the necessary structures for its implementation. The Government has provided leadership by creating an enabling environment to involve all stakeholders in the nutrition field.

THE KENYA NUTRITION CAPACITY DEVELOPMENT FRAMEWORK

The KNCDF was developed to help the nutrition community in the country address capacity development for its workforce. The overriding goal of the framework is to contribute to the improvement of nutrition and health outcomes through enhanced service provision. Specifically, the CDF aims at:

- Determining how existing policy frameworks provide an enabling environment for nutrition capacity development
- Establishing existing systemic, organizational, technical and community capacity for supporting nutrition programs and service delivery
- Identifying technical capacity gaps and needs
- Developing of monitoring and evaluation indicators/framework to monitor progress in the implementation of the KNCDF.
- Developing and costing of a framework for nutrition capacity development for Kenya

The Kenya Nutrition Capacity Development Framework (KNCDF) was developed to provide a comprehensive guide for shaping nutrition capacity development in Kenya. The KNCDF identifies four broad categories of capacity development. These include: system-wide capacity, organizational capacity, technical capacity and community capacity.

Systemic capacity

Systematic capacity focuses on the broad understanding of the macro environment. This includes policy environment, legal and regulatory capacity as well as social economic and cultural dynamics that influence nutrition outcomes.

Organizational capacity

Organizational capacity considers the competencies required by nutrition professionals at organizational level and the areas of focus required for improved organizational capacity. There is focus on coordination and other structures in place, which provide the environment for smooth delivery of services. Organizational capacity development recognizes the need for well-established infrastructure, tools and equipment in addition to skills enhancement.

Technical Capacity

Technical capacity considers the level of proficiency and competency attained by professionals through training. Technical capacity focuses on pre and in-service trainings and professional standards. Specifically, it focuses on:

- Presence of legislations and standards that are in place for each level of cadre for pre-service and in-service training
- Policies governing continuous professional development and adherence to laid down standards for continuous professional development
- Presence of qualified nutrition workforce and their ability to generate, interpret and utilize data for evidence based decision making.
- Ability of individuals to negotiate, network and advocate in a multi-sectoral environment

- Application of appropriate technical knowledge and skills

Community Capacity

Community related capacity considers the level of awareness communities possess; their ability to access, demand and utilize health services and the levels of linkage existing between communities and health institutions at different levels.
Table below shows a simplified nutrition capacity development matrix

Justification of the capacity assessment

Although nutrition in Kenya has evolved greatly, gaps in determining existence of adequate capacity to offer nutrition services. Nutrition just like health is now devolved in Kenya and it is therefore important not only to assess the Country's ability to offer nutrition services, but the Counties as well, since that's the level at which, much implementation takes place. Nutrition capacity assessment is therefore aligned to the Counties, and the assessment is holistic looking at the system, structures, technical and community capacity

Purpose of the capacity assessment

The capacity assessment was conducted to:

- Provide key lessons and inputs for improving the capacity assessment tools and KNCDF operational guide through pre test
- Provide baseline information on county nutrition capacity

Main objective

The main objective of the assessment was to conduct a capacity assessment pilot for the KNDF assessment and determine the nutrition capacity status for Kilifi County

Specific objectives

Specific objectives of the nutrition capacity assessment were;

- To pilot the KNDF assessment tools and methodology
- To determine the nutrition capacity status for Kilifi County
- Document best practices and recommend interventions based on identified gaps
- To provide baseline information on nutrition capacity

CHAPTER 2

METHODOLOGY

Step 1: Drafting of the survey purpose

The purpose of nutrition Capacity assessment was drafted at the National level. The main purpose was to pre-test the assessment tools for learning, basis for scale up to other counties, as well as determine nutrition capacity of Kilifi County

Step 2: Identification of the core team to undertake the assessment

A multi-agency core team led by the Ministry of Health from the national and county level provided oversight throughout the whole process. Enumerators were identified by the county team. Each of the participating entity/agency was allocated roles and responsibilities (Table 3.1)

Table 1: Role and Responsibilities

Agency	Roles and responsibilities	Representation
Ministry of Health – National	• Overall coordination of the assessment • Seeking permission to conduct the activity from Principal Secretary and the County government • Participation in questionnaire design and development of the assessment protocol in the capacity development working group • Planning, budgeting and mobilization of resources to carry out the assessment • Conducting key informant interviews and FGDs • Organization of debrief meeting – invitations • Report writing • Ensure dissemination of results/feedback • Support to counties in action planning to address gaps identified/recommendations	• Two officers from the nutrition unit • One officer Human resource Division Afya house

Department of Health – County level	• Mobilization of relevant authorities/ heads of units and key informants • Follow up approval/validation at county level/ Seeking permission to conduct the activity • Report writing • Attend dissemination of results • Action planning to address gaps identified/recommendations	• County Nutrition Coordinator • Appointed CHMT member – County Medical Laboratory Technologist (CMLT)
UNICEF	• Technical support and provision of funds for capacity assessment • Participation in questionnaire design and development of the assessment protocol in the capacity development working group • Develop capacity development assessment database • Conducting key informant interviews and FGDs • Report writing • Participate in the dissemination of results/ feedback • Support County to develop action plans and recommendations to address gaps identified.	One officer supporting capacity development Two officers - Monitoring and Evaluation One nutrition support officer – Coast

International medical corps	• Logistical support to the whole process; funding, convening meetings, car hire, enumerator's allowances and data clerks- CSO implementing on behalf of UNICEF • Leading in planning for the assessment • Technical support to the whole capacity assessment process through leading/participating in questionnaire design and development of the assessment protocol in the capacity development working group • Conducting key informant interviews and FGDs • Support in the development of the capacity development assessment database • Report writing • Participate in the dissemination of results/ feedback • Support to counties in action planning to address gaps identified/recommendations	• National Capacity Development Officer • Nutrition Project Manager-Kilifi
Nutrition sector coordinator	• Technical support to the whole capacity assessment process ○ Participation in questionnaire design and development of the assessment protocol in the capacity development working group • Report writing	• Two day support at field level by the nutrition sector coordinator

Egerton university	• Train the team on qualitative data collection • Lead focus group discussions • Lead in the analysis of the qualitative data • Support questionnaire review and development of the assessment protocol • Support in the development of the capacity development assessment database • Report writing • Participate in the dissemination of results/ feedback • Support to counties in action planning to address gaps identified/recommendations	One lecturer

Step 3: Orientation of the core team on the framework and the assessment tools and enumerator training

A one-day sensitization workshop of the health management team and partners working in the county prior to conducting the assessment was conducted to promote the overall understanding of KNCDF and the capacity assessment tools. A three-day training of the enumerators was then conducted with the presence of some of 5 CHMT members. The 5 CHMT members were treated as part of a core team and they were in the whole assessment process. The training included a pre-test and a feedback meeting on the third day to ensure the training was well understood before actual data collection. The pre-test also informed on which questions/guidance required to be improved.

Step 4: Desk review of key documents

Several documents were reviewed prior to the actual data collection. These informed on the changes that were made on the capacity assessment tools as well as target for the questions

Step 5: Thematic areas assessed

This being the first and a pilot of the KNCDF assessment tools before national scale up, a comprehensive assessment on all the 4 thematic (systemic, organizational, technical and community) areas using the standard tool was conducted.

Step 6: Review of the assessment tools and determination of the data source

The assessment tools were comprehensively discussed with the county representatives and the tools revised accordingly. The team determined the data sources and the appropriate tools to include specific questions.

Step 7: Sample size and sampling procedure

A master facility list provided by the county was used as the sampling frame. Purposive sampling was applied and forty health facilities were selected. A criterion was set to ensure representation of stratum. The criteria included:

- Representation by the level of the health facility
- Representation by administrative boundaries - sub-counties
- Representation by ownership

After stratification of the facilities all the five county and sub-county were included in the sample. Seven GOK owned health centers were randomly selected – one in each sub-county. Sixteen GOK owned dispensaries were randomly selected across the sub-counties with consideration of proportionate representation. Two faith based hospitals, 2 faith based health centers and 8 faith based and NGO owned dispensaries were also randomly selected.

Table 2: Sampled facilities

NUMBER OF SAMPLED HEALTH FACILITIES					
Ownership	**County Hosp**	**Sub-county and other hospitals**	**Health Centre**	**Dispensary**	**Grand total**
GOK	3	2	7	16	
Other ownership	2		2	8	
Total	3	4	9	24	38

Table 3: List of Sampled Facilities

Facility Code	Health Facility Name	Sub-county	Type	Ownership
11237	Bamba Sub-District Hospital	Ganze	Sub-County Hospital	Ministry of Health
11383	Ganze Health Centre	Ganze	Health Centre	Ministry of Health
11618	Mirihini Dispensary	Ganze	Dispensary	Ministry of Health
11730	Palakumi Dispensary	Ganze	Dispensary	Ministry of Health
11432	Jibana Sub District Hospital	Kaloleni	Sub-District Hospital	Ministry of Health
19189	Kamkomani Dispensary	Kaloleni	Dispensary	Ministry of Health
11566	Mariakani District Hospital	Kaloleni	District Hospital	Ministry of Health
17689	Viragoni Dispensary	Kaloleni	Dispensary	Ministry of Health
18267	Bomu Medical Centre (Mariakani)	Kaloleni	Health Centre	Non-Governmental Organizations
11818	St Luke's (ACK) Hospital Kaloleni	Kaloleni	Other Hospital	Other Faith Based
11474	Kilifi District Hospital	Kilifi North	District Hospital	Ministry of Health

11493	Kiwandani Dispensary	Kilifi North	Dispensary	Ministry of Health
11580	Matsangoni Model Health Centre	Kilifi North	Health Centre	Ministry of Health
11667	Mtondia Dispensary	Kilifi North	Dispensary	Ministry of Health
11826	St Theresa Dispensary	Kilifi South	Dispensary	Christian Health Association of Kenya
11255	Bomani Dispensary	Kilifi South	Dispensary	Ministry of Health
11672	Mtwapa Health Centre	Kilifi South	Health Centre	Ministry of Health
11738	Pingilikani Dispensary	Kilifi South	Dispensary	Ministry of Health
11912	Oasis Community Clinic	Kilifi South	Dispensary	Other Faith Based
11198	Adu Dispensary	Magarini	Dispensary	Ministry of Health
11379	Fundi Issa Dispensary	Magarini	Dispensary	Ministry of Health
11384	Garashi Dispensary	Magarini	Dispensary	Ministry of Health
11401	Gongoni Health Centre	Magarini	Health Centre	Ministry of Health
11562	Marafa Health Centre	Magarini	Health Centre	Ministry of Health
11753	Ramada Dispensary	Magarini	Dispensary	Non-Governmental Organizations
11893	Watamu (SDA) Dispensary	Malindi	Dispensary	Christian Health Association of Kenya
11654	St Marys Msabaha Catholic Dispensary	Malindi	Dispensary	Kenya Episcopal Conference-Catholic Secretariat
11244	Baolala Dispensary	Malindi	Dispensary	Ministry of Health
11453	Kakuyuni Dispensary (Malindi)	Malindi	Dispensary	Ministry of Health
11555	Malindi District Hospital	Malindi	District Hospital	Ministry of Health
11677	Municipal Health Centre	Malindi	Health Centre	Ministry of Health
11196	ADC Danisa Dispensary	Malindi	Dispensary	Non-Governmental Organizations
20116	Amurt Health care Centre (Malindi)	Malindi	Health Centre	Non-Governmental Organizations
18012	Watanu SDA Dispensary	Malindi	Dispensary	Other Faith Based
11843	Tawfiq Muslim Hospital	Malindi	Other Hospital	Supreme Council for Kenya Muslims
11547	Makanzani Dispensary	Rabai	Dispensary	Ministry of Health
11748	Rabai Rural Health Demonstration Centre	Rabai	Health Centre	Ministry of Health
11756	Ribe Dispensary	Rabai	Dispensary	Ministry of Health

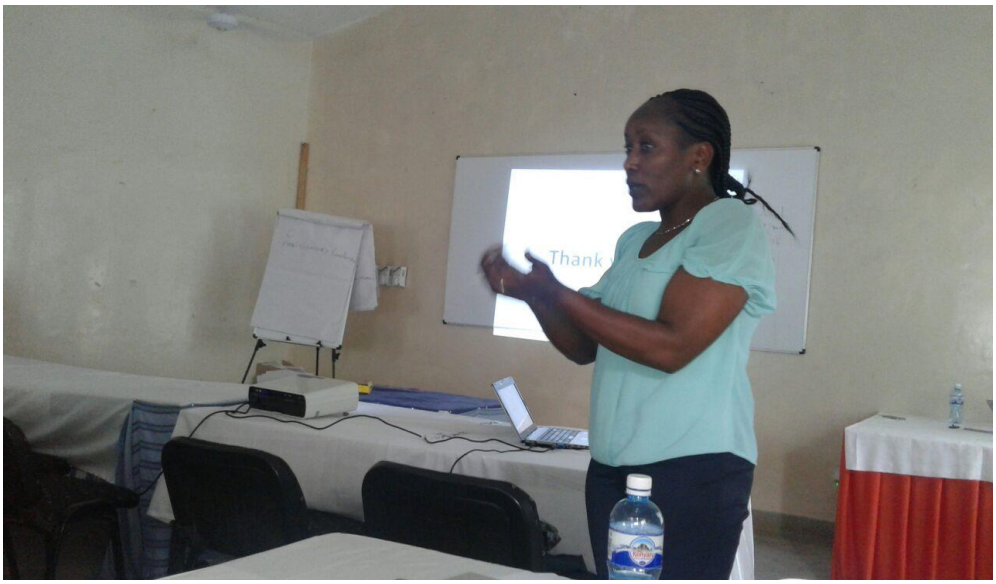
Step 8: Develop/ Review the Data Management system for the assessment

A centralised capacity database (MS Excel) was developed. A score card was developed too.

Step 9. Planning for the enumerators and trainings

Core team selected enumerators and data clerks. Enumerators selected were well versed with the health care system and at least basic understanding on nutrition. Data clerks selected were well versant with the health care system and data entry using computer packages. 6 enumerators and 3 enumerators were selected. The core team formed part of the enumerators especially to interview the high level managers and conduct FGDs. The core team also accompanied the enumerators during the initial days of data collection in order to check on quality of data at the collection stage

- Enumerators were trained for three days by the core team. The training included a one-day pre-test where facilities that were not included in the sample were used in pre testing. The pre-test enhanced understanding of the assessment.
- Data clerks were taken through half a day's training on the nutrition capacity data base



Lucy, Information Officer (NDU) takes participants through a session

Step 10: Develop an assessment plan for phase 3 and 4

A work plan for the assessment was developed by the core team. The workplan included all the activities for phase 3 and 4, and people responsible. Budget and logistical plans were well defined at this stage.

Step 11. Validation of assessment methodology

Methodology of assessment (MS word and Point) was discussed with members of National Information Technical Working Group (NITWG) before actual data collection. NIWG secretariat was involved participated in the whole process of capacity assessment

Step 12: Data collection

The assessment applied mixed methods of data collection. Both quantitative and qualitative data were collected.

Key informant interviews

The interview consisted of asking an individual question using a specific key informant guide, listening attentively to their responses and exploring their views and experiences to provide deep understanding. Each survey team explained the purpose of the survey and issues of confidentiality and obtained verbal consent before proceeding with the KII. The data was submitted to the supervisor at the end of each day for data entryThe national level team conducted all the CHMT key informant interviews. Due to competing priorities among CHMT members, interviews were conducted at their convenient time. The following CHMT members were interviewed:

County Health Administrative Officer
Human Resource focal person
County Officer of Health/CEC
County Director of Health/County Nutrition Coordinator
Community Health Services focal point
County Health Records and Information Officer
County pharmacist
Health Facility In charges (sampled facilities)

Trained enumerators conducted health facility in charge interviews using the standardized KIIs (annex 4)

Facilitators guide for the key informant interviews

Plan for the KII

- ✓ Use the key informant guide
- ✓ Invite respondents individually to participate in an interview.
- ✓ Determine and schedule a meeting time and place convenient for the respondent.
- ✓ Reconfirm before the interview

Key instructions for interviewers

1. Obtain the respondent's informed consent; continue only if the respondent agrees to participate
2. Ask interview questions in a friendly manner to build trust between you and the respondent; this will encourage the respondent to give useful and truthful answers
3. Allow the respondent to express him- or herself. Wait a moment after having asked a question to give him/her time to respond to the question

4. Record all information obtained by taking detailed notes
5. Make notes about relevant issues that are raised during the interview, such as non-verbal or emotional reactions of the respondent or the environment in which the interview is taking place. Note any influence you may have had on the interview
6. Thank the participant at the end of the interview.
7. Review all your notes at the end of the interview while the information is fresh in your mind. Fill in any gaps in the information recorded.

Focus group discussion

Six focus group discussions were conducted using specific FGD guides. Notes were taken following notes guidelines. Hand held recorders (devices) were used to record the discussions. The recording was then uploaded on to a computer on the same day. However, the primary source of information was the notes taken during the interview. A one page summary was written for each of the FGDs. The focus group discussions included:

- One County Health Management Team (CHMT) FGD
- Two nutrition workforce FGDs – Kilifi County Hospital and Matsangoni Model Health Centre
- Two community health volunteers FGDs
- One nutritionists Officer FGD

Focus group discussion facilitator's guide:

1. Inform the health facility in charge of the FGD and the expected participants.
2. Invite respondents to participate in a focus-group discussion. Do not force people to join the group. Try to generate interest and willingness.
3. Find a quiet area suitable for a group of 6 - 8 people to sit. Determine and schedule a meeting time convenient for all participants.
4. Reconfirm attendance of participants before the sessions.
5. Greet the respondents and thank them for attending the meeting. It is important to greet and welcome the participants to make them feel comfortable; this will encourage them to participate with enthusiasm and trust.
6. As an ice-breaking activity, encourage participants to introduce themselves one at a time.
7. Encourage respondents to share their views and experiences and to comment on each other's responses.
8. Explain the objectives of the FGD. We are trying to get their experience to learn more how to improve programming specifically nutrition capacity development and as a result, improve the health and nutrition services and in turn improve the health and nutrition status of the community.
9. Explain that the information is confidential and no names are taken so they can openly explain their real experience/opinions on the topics discussed. However, the discussions will be recorded using a recorder. Explain that they will be referred to using participants number not names in order to assure confidentiality.

10. Assign participant's numbers and make sure you mention a participant's number during introduction and discussion. For example, "Interviewer number 3, in your view, what factors attract health workers to take up posts in this county"
11. The FGD will last 45 minutes - 1 hour. Explain this at the start.
12. Facilitator leads the groups through the discussion, prompting responses and making sure that the main topics are covered. Keep an idea of time spent and keep the discussion on the theme.
13. At the end of each point, the facilitator summarizes what the group has agreed as a response.
14. The note taker writes the summary information for every issue discussed. When possible, use numbers to show how many people in the group agreed on the issue. For example, 5 out of 7 group members believed that 'provision of housing attracts health workers to take up postings in the county'. The other 2 did not comment. Even though the discussion will be taped, the notes remain the primary source of information. It is therefore important to make sure that they are clear, detailed and well organized. The note taker should not write every work but should focus on recording key words and phrases. The note taker can use symbols and abbreviations to save time.
15. Note verbatim quotes word for word
16. Get the group to give concluding remarks on capacity for nutrition.
17. Thank the group.

FGD DEBRIEF

- Listen to the tape to make sure it is recorded properly. If it is not recorded properly, immediately help the note taker to complete the notes with important information
- Expand the notes and add information about group dynamics or any unexpected events
- Give feedback to the moderator on his or her performance and suggest areas of improvement
- Upload the recording onto a computer on the same day and rename each file appropriately
- Write a one-page summary of the FGD based on the debrief final notes guidelines provided at the end of the note takers sheet

Picture of a role play on the facility Key informant interview

Step 13: Data entry, management and analysis

Analysis of quantitative data

Given that most questions in the assessment tools were quantified, databases were developed to analyze key indicators across assessment tools at the county level and, where possible, at sub county and facility levels. A database was developed for each assessment tool, in line with existing information databases at national level, in order to maintain consistency in information management tools at national and county levels. The databases were designed in Microsoft Excel for ease of data entry and analysis. Pivot tables have been generated for key indicators in order to ensure automatic analysis, once data has been entered for each county. Blank databases are attached in Annex xx.

Data entry will require resources in term of time and people in each county. At a minimum, it is recommended that three data entry clerks are recruited for a period of three days, depending on the volume of data collection for each county. Data entry clerks will need to be trained on how to enter data into the databases, in order to generate the analysis as required.

Analysis of qualitative data

Summarize responses by question

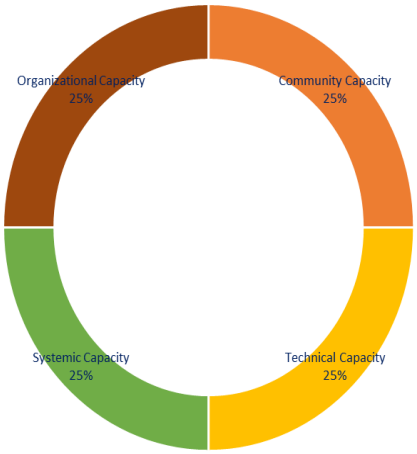
Each question assessed a specific aspect of the respondents of views on factors affecting capacity for nutrition. The first step of analysis consists of summarizing the responses of all participants for each question.

Count the frequency of the same types of responses

Responses were classified/ categorized and then how many respondents gave each type of response was counted. This gave some perspective on how common particular kinds of views. Quotes of respondents' narratives have been included to illustrate the findings.

Step 14: Summarize findings into the score card

Results obtained from the assessment were summarizing in a score card (Annex 4). This helped to easily communicate findings in a snapshot. An index consisting of six indicators was developed for each thematic area, drawing from key representative indicators across the various assessment tools (see Figures 3).



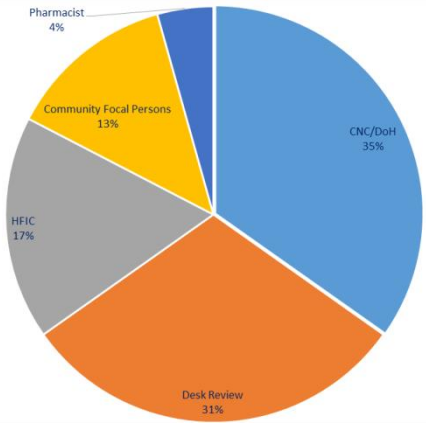


Figure 2: Source of data for score card

Thresholds have been developed for each index, in order to determine whether a particular indicator or the thematic area as a whole is progressing in a satisfactory or non-satisfactory manner. It is anticipated that the weaker indicators on the scorecard (highlighted in red) will be prioritized for action, thereby informing an action plan for the county. Additionally, the scorecard will also enable each county to gauge its progress and performance against other counties in the country, as well as the national average. For example, the scorecard for Kilifi County appears as follows:

			SYSTEMIC CAPACITY						ORGANIZATIONAL CAPACITY										COMMUNITY CAPACITY						
YEAR	COUNTY	KI	CNAP Existence/Endorsement	Nut Activities in AWP	FF Surveillance Frequency	BMS Act Enforced	Nut Allocation in Health Budget	SC Index Score	RMNCH Scorecard Used	Trainings Informed by Needs	Nut in Procurement Plan	Duration IFAS Stock Out	Multisectoral Coord Forum	OC Index Score	MOH 713 RR	Scheme of Service Used	% Nut Trained in MIYCN	Freq Subcounty to HF SS	TC Index Score	CUs formed vs. recommended	Comm Feedback Mechanisms	Comm to HF Referral System	County Investment in CNS	Proportion HFs linked to CU	CC Index Score	Overall Score
2016	KILIFI		100%	0%	0%	100%	0%	40%	0%	100%	0%	100%	0%	40%	23%	100%		100%	74%	30%	100%	100%	50%	0%	56%	53%

Figure 3: summary of results in a score card

As can be seen from Figure 4 above, an index score will be presented for each thematic area, with an overall score for each county. This will enable users at national and county levels to rank performance based on a specific indicator, index score, or overall score.

Step 15: Validate findings and identify the priority areas

Validation of capacity assessment findings was conducted at the County. Disseminations a forum organised solely as capacity assessment affair. The dissemination involved a broad range of stakeholders including CEC for Health, County Director of Health CHMT and implementing partners, a few representation of the Sub County Health Managers and the National team. The stakeholders appreciated the findings and agreed that that was a true reflection of Kilifi County Nutrition capacity. Stakeholders in a participatory way developed recommendations and action points. The findings were further presented in National Nutrition Technical Forum (NTF).

CHAPTER 3:

RESULTS

3.1 DEMOGRAPHICS

Kilifi County covers a total area of 12,609.7km^2 with an estimated population of 1,246,296 in 2014/15 according to KNBS projections 2009. A significant proportion of the population is composed of <15 years (47.5%) with the youth making up 19.4%, the age group 25-59 years making up 28% and the elderly comprise 5% of the population. Children under one year make up 3.6% and those less than 5 years 17.3% of the population. The life expectancy of the county is 56 years, (KDSP 2005/10). 36% of the population in Kilifi has no formal education, with disparities noted across the sub counties. This has implications especially on community capacity and ability to adopt optimal practices including demand for the same.

The County has a total of 95 public health facilities categorized as follows; 5 sub county hospitals, 12 health centres and 77 dispensaries distributed in various sub counties.
Of the sub County Hospitals, Kilifi, Mariakani and Malindi Hospitals are the main referral facilities in the County. The other hospitals are Bamba and Jibana which were upgraded from Health centre status in the recent years but are yet to function as full hospitals. The public health facilities are complimented by 2 Faith Based hospitals, 2 private hospitals, 1 armed forces hospital, 5 private nursing homes and 107 private clinics. The public health facilities have an inpatient bed capacity of 854.

The capacity assessment pilot was carried out in the County Refferal Hospital, 7 sub county hospitals, 9 health facilities and 16 dispensaries. Of these, only 2 sub county hospitals, 2 health centers and 8 dispensaries were owned privately, by NGOs of faith based organization. All the rest were owned by the government as shown in the table below:

Table 4: Sampled facilities

Ownership	County Hospital	Subcounty Hospitals	Health Centres	Dispensaries
GOK	3	2	7	16
OTHER		2	2	8
TOTAL	3	4	9	24

Pie-Charts showing distribution of selected facilities by: (Chart1) Level of facility.

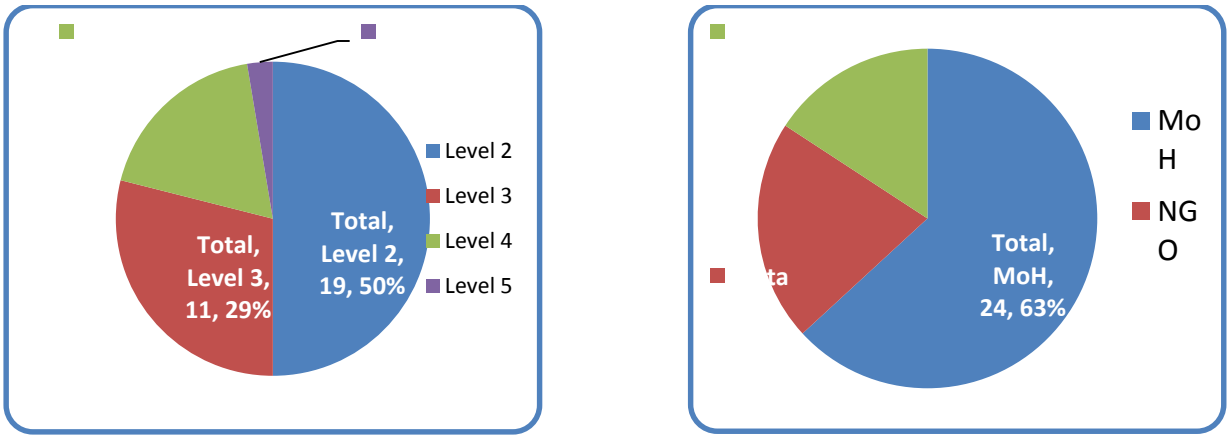


Figure 4: Levels and ownership of facilities

SYSTEMIC

The pilot sought to assess and understand the broader political context as reflected by commitments translated in policies, strategies and other key investment priorities for the county. Understanding the broader macro environment is important in determining the level of prioritization nutrition as a sector has received as well as informing any advocacy and lobbying efforts that will increase commitment both structurally and financially for nutrition.

The following parameters were assessed under the systemic capacity:

Policy environment:

Following devolution, counties were required to spell out their development agenda through the county integrated development plans that are a mirror to the National Vision 2030 which is the blue print for Kenya's socio economic transformation over the next decade or so. CIDPs are investment documents that articulate the vision of the leadership for the citizens of the county and are required to indicate the various strategies and interventions that will yield transformative results across sectors to realize development in totality. Nutrition and indeed health are often covered under social sectors as they are primarily centered around people and are key enablers for economic and social development. Kilifi county CIDP (2013-2018) section highlights nutrition and related indicators. Key areas of focus for nutrition are also included in relation to improving the indicators. However, the link and relationship between good nutrition and overall health and its translation to development is not immediately clear. That said, the county has several other key strategic documents including the County health sector strategic plan, County nutrition action plan, and an annual work plan that spell out the various nutrition programs and indicators that the county intends to address. The linkages between nutrition and other sectors is however not well articulated and far from

ideal. Suffice to note is that counties are implementing National policies and redefining strategies to develop their county specific plans. As a recommendation moving forward, there will be need to clearly undertake a policy coherence and strategy review for the county, as well hold a policy dialogue around the social sectors to further define the various elements that

As regards legislation, the county has developed several bills such as the Health bill, maternal healthcare bill and financial bill which are expected to have a direct or indirect implication on the quality of nutrition services offered to the clients. These are expected to be in place very soon as reported by the CEC, the health bill is expected to be in place by September. Financial bill among other things, allows the major 5 facilities to spend the money they collect. Maternal child was meant to go for a second hearing. And it might come to place by September the engagement of the Nutrition sector is not as optimal and it requires that the county nutrition teams are supported to understand the various Acts that directly impact on their work to stand a better chance of leveraging the discussions.

Resource mobilization as key element for programming is key. All county plans and strategies are costed and therefore, its fairly easy to lobby for interventions. However, much more can be done to enable the team fully undertake resource mobilization through additional skills like coordination and networking that are vital in the county where there are limited resources a myriad of priorities that require attention vis a vis political interests that often dictate the direction of funding.

Bills developed by the county;
The county has developed several bills; Health bill, Maternal healthcare bill and financial bill which are expected to have a direct or indirect implication on the quality of nutrition services offered to the clients. These bills are expected to be in place very soon as reported by the CEC, “The health bill is expected to be in place by September. Financial bill among other things, allows the major 5 facilities to spend the money they collect. Maternal and child care bill was meant to go for a second hearing. And it might come in place by September”

County Planning documents.
There are several health planning documents in Kilifi County. The County integrated development plan (CIDP) recognizes that there is high burden of stunting and wasting in the County, linked to poor infant and young child nutrition practices. Similarly, Kilifi County Health Strategic investment plan (CHSIP) has several nutrition activities embedded in it. However, the county does not always implement the nutrition activities as stipulated in these documents due to a lean budget.
The assessment revealed that the county did not have an annual work plan for 2015/2016. Since this is an important document, the health managers, confessed facing challenges in planning and monitoring of various activities carried out within the year. However, the annual work plan for 2016/2017 is in the process of development.

Upon development and launch of the National Nutrition Action Plan (NNAP), County nutrition stakeholders are meant to develop their own action plan for resource mobilization and planning purposes. Kilifi County has finalized County Nutrition Action Plan (CNAP) and the document is waiting to be launched soon.

Health budget and Nutrition Resource allocation

Kilifi County Health Ministry was allocated 28% of the total County budget in the last financial year (2015 /2016). However most of this money was spent on salaries. Nutrition department was allocated few resources since they are known to have several stakeholders (partners) supporting their programs.

County implementation of the Acts and regulations in Nutrition

Following the enactment of the mandatory law on food fortification, that requires all big millers dealing with prepackaged wheat, Oil and maize flour, to fortify their products with some selected nutrients, counties through the public health department are required to routinely monitor these products both at the industry and the market level. Although the public health department has identified a focal person to oversee these activities on food fortification, they lack the guidance and support from the National level to effectively implement this function.

The Breast Milk Substitute act (BMS) was enacted in the year 2012 to preserve, promote, and protect, breastfeeding of infants. The assessment tried to establish whether there were Structures in place to monitor any BMS act violations and implement the emerging actions. The structures were lacking and any violations of the BMS Act that happen in the county are directly channeled to the national government. However, the county lacks an implementation framework on the same.

Availability of nutrition guidelines and protocols in the selected facilities

The function of the county government is to implement policies and guidelines developed by the national government. It is expected that such policies are disseminated to the county health workers for use and they should be available for reference purposes within the facilities. Maternal infant and young child nutrition policy should be displayed at various points. Vitamin A schedules should be displayed at the point of issues for easy reference. The graph below shows the number of facilities with some selected nutrition guidelines.

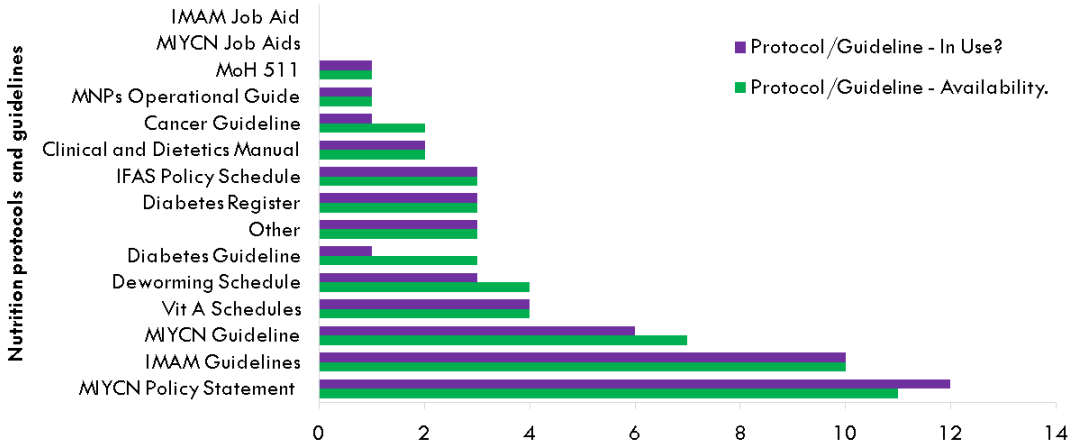


Figure 5: Facilities with nutrition protocols and guidelines

ORGANIZATION CAPACITY

Organizational Capacity involves the working arrangements and coordination framework and structures of key institutions and organizations

Nutrition services

A wide range of nutrition services including micronutrient supplementation, deworming, Integrated management of acute malnutrition (IMAM), MIYCN, diabetes and cancer management, parenteral and enteral nutrition, Nutrition in HIV/TB are provided in level 2, 3 and 4 health facilities. Enteral and parenteral Nutrition, Cancer management are mainly offered in the level 3 and 4 health facilities.

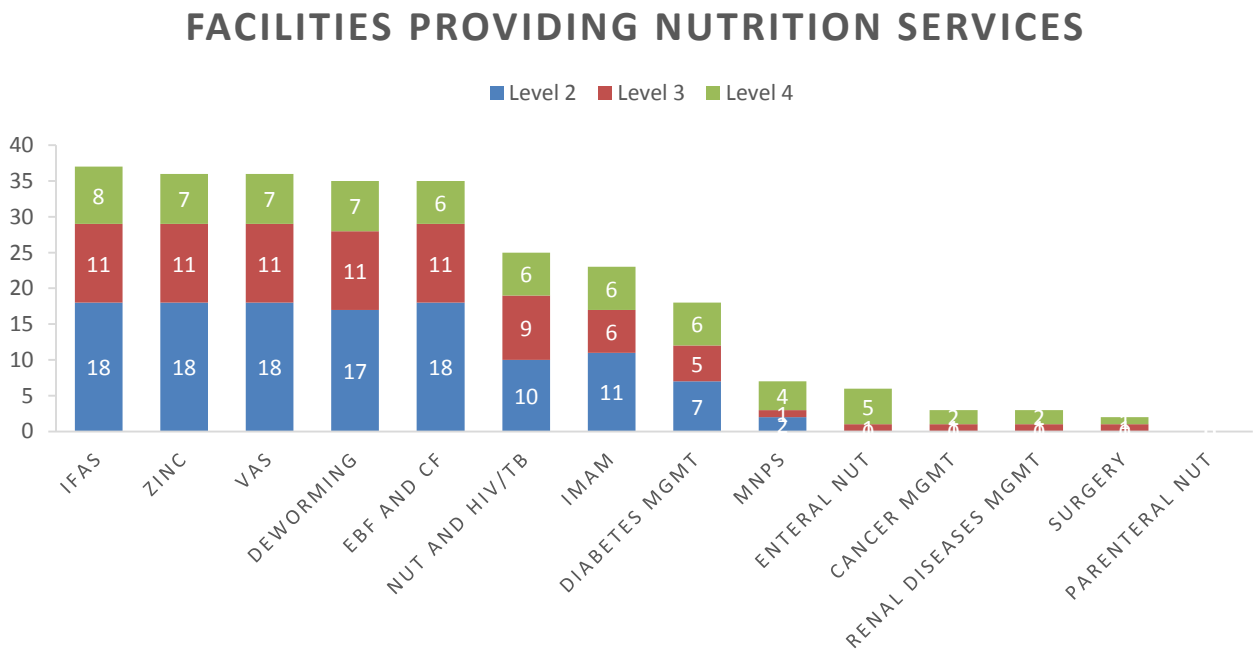


Figure 6: Facilities providing nutrition services

Only a few health facilities are setting targets for the nutrition services they are providing. The targets set are mainly for Vitamin A supplementation, Iron folate supplementation, zinc and deworming. The health workers reported that they do not have the skills to set targets while others reported they are not aware targets for services like IMAM, Zinc supplementation ought to be set.

Infrastructure Supplies, Guidelines, Tools and Equipment

A conducive environment in which nutrition services are offered is critical for efficient and effective service delivery. Kilifi County faces the challenge of availability of a room in which a nutritionist can provide key services to clients eg nutrition counselling. During the FGDs with Nutritionists, it was reported that some were working in tents, and others along the corridors of health centres.

During the visit to the 38 health facilities, availability of commodities, storage conditions and commodity management and reporting tools were checked. The results are summarized in table 6 below. It was reported that nutrition commodities are mostly supported by partners. RUSF, CSB/OIL, FBF, VAS, F75, F100, Resomal and parenteral foods were reported to be supported mainly by partners. The county is however supporting partial procurement of IFAS.

	Commodities present	Storage Space Available	Well ventilated	Shelves	Pallets	Stock Control cards	S11
RUTF	12	9	15	14	14	11	12
RUSF	8	7	14	12	14	10	11
Vitamin A	18	14	20	18	10	17	15
IFAS	17	16	21	20	10	17	16
MNPs	6	3	12	11	10	9	8

Table 5: Storage space

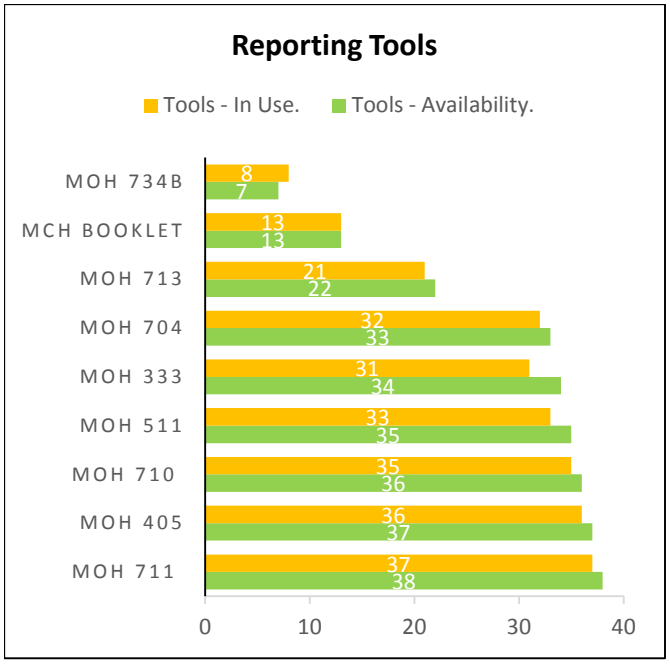
Nutrition reporting tools are available and in use in over 80% of health facilities as indicated in figure 8 below. However, there are gaps for some reporting tools including the MoH 734B (only 7 out of 38 health facilities), MCH booklet (13 out of 38 health facilities) and MoH 713 (22 out of 38 health facilities).

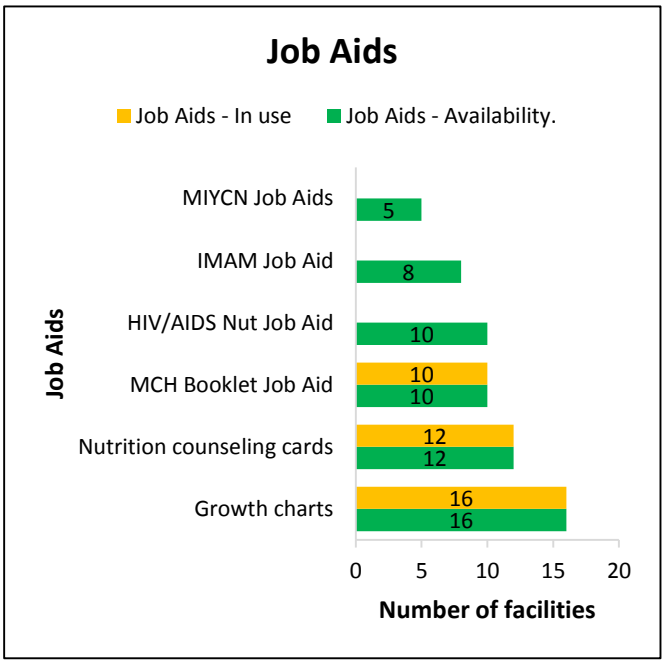
Majority of the health facilities were lacking critical job aids as indicated in figure 8 below. Anthropometric equipment were available in the health facilities.

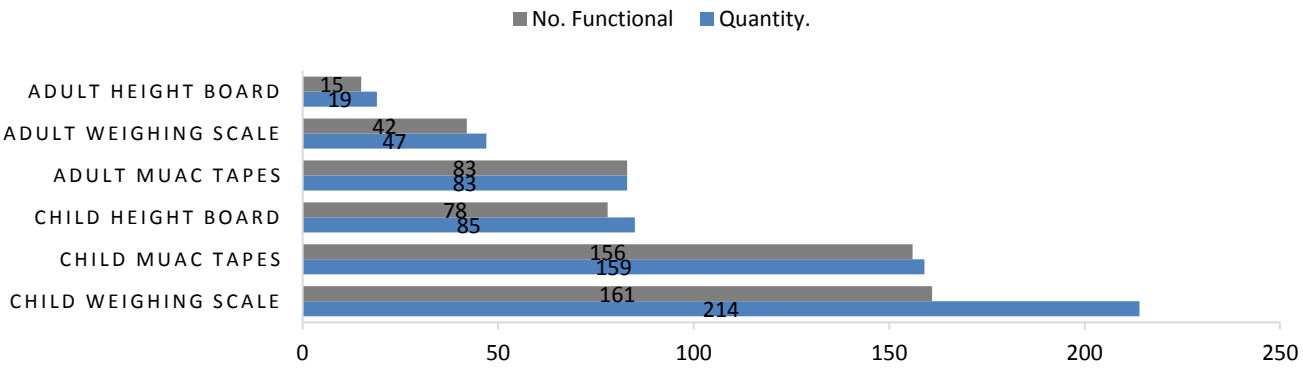
During The FGD with Nutritionists, key gaps on guidelines highlighted include:

- Access: Some guidelines are not available (especially IMAM, VAS).
- There is need for copies of all guidelines on ground.
- Need for SOPs especially with new staff on board.
- Need for guidelines for NCDs: Hepatic disease, cancer, nephrotic disease to be provided, Also on management of conditions eg cerebral palsy (occupational therapy)
- Ensure timeliness in dissemination of guidelines (updated/ revised)
- Need for update/ guide on biochemical analysis/ how to interpreted lab results. Currently only

Figure 7: Availability of reporting tools, job aids and equipment.







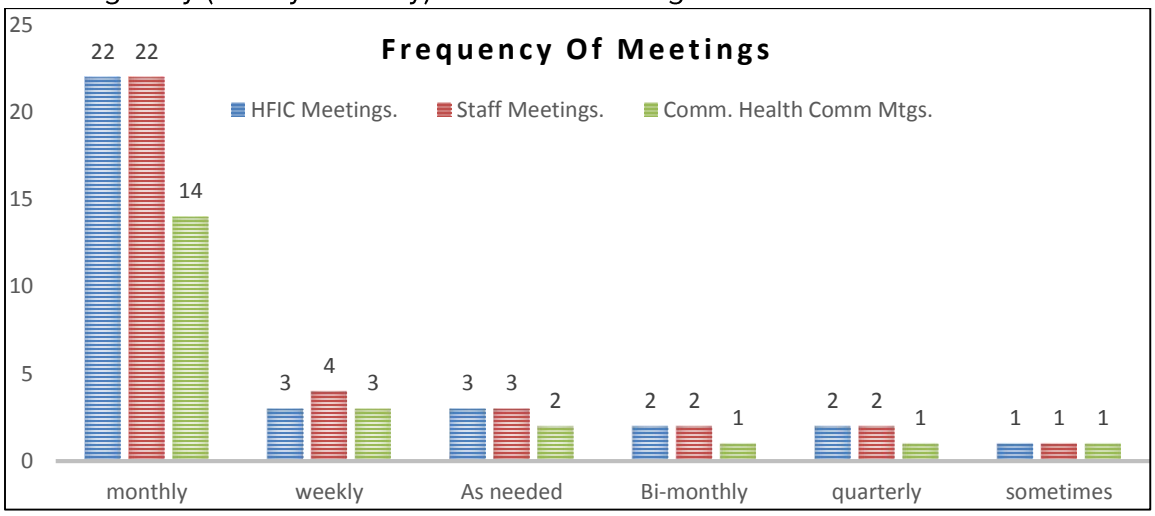
Of the total 38 facilities interviewed, 25 (66%) had computers, 19 (50%) had photocopiers while 18 (47%) had photocopiers and internet.

ICT Equipment	No of Health Facilities
Computers	25
Printer	19
Photocopier	18
Interner	18
Scanner	16

Coordination

At County level, there exists the County Nutrition Coordination forum (CNTF) which is held on a monthly basis with a TOR. The county is in the process of establishing sub county Nutrition coordination forums (SCNTF).

At health facility level, several forums that address data quality and performance are in place. These include; Management data review meeting, The County Nutrition Coordination Forum (CNTF) and Facility in charges meeting, DQA and other technical working groups. Nutrition is often integrated in most of these forums The forums are also held regularly (Mainly Monthly) as indicated in figure 9 below



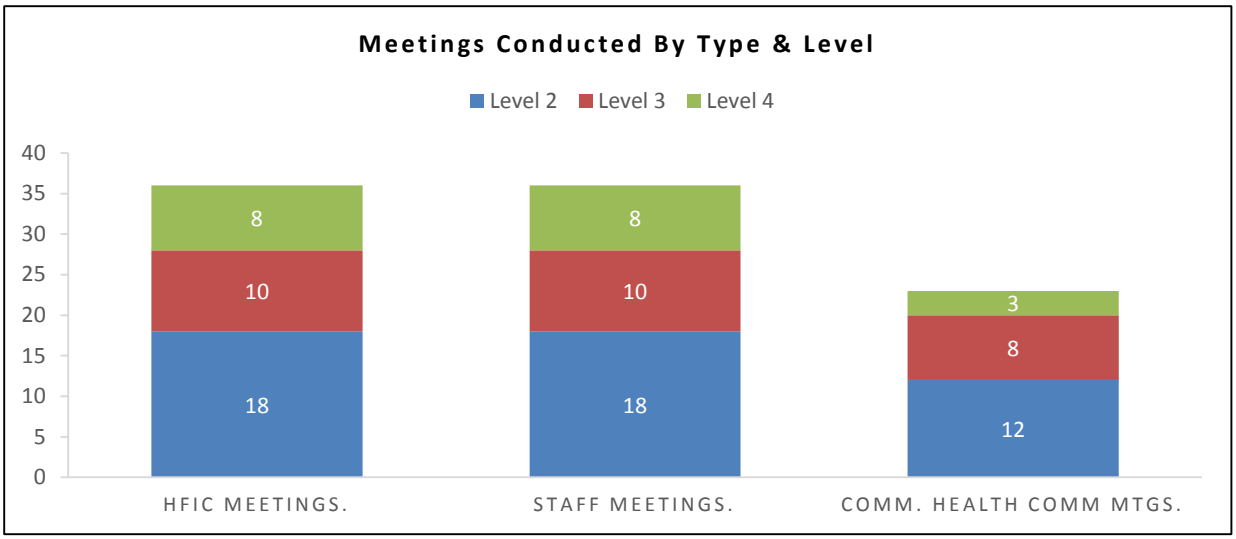


Figure 8: Meeting and forums

Supportive supervision

Supportive supervision is carried out mainly to the health facilities by the county and the sub county health management teams. The county – health facilities supportive supervision is undertaken on a quarterly basis while Sub County – health facilities is undertaken on a monthly basis. There was lack of supportive supervision to the subcounties by the county, a key gap that was also highlighted during the FGDs in which staff requested to be supported.

Human resource Management

Kilifi County is the lead in uptake and utilization of Integrated Human Resource Information Systems (iHRIs)-Both manage and train. The County is also in the process of rolling out EMR which will promote efficiency (saves time and paper) and effectiveness.

During the FGD with Nutritionist, it was highlighted that annual performance appraisal is not conducted but the county is in the process of reviving the performance appraisal process. The nutritionists highlighted the need for an inclusive process for performance appraisal ought to be inclusive and need for sensitization on the process as it was still not clear and very confusing. The need for supervisors to guide team in filling performance appraisal was also highlighted.

TECHNICAL CAPACITY

Role of KNDI in staff recruitment and professional services provided

The Kenya Nutritionists and Dietitians Institute (KNDI) is the professional body responsible for regulation of nutrition training and practice in Kenya. As part of the KNCDF assessment we sought to find out if Kilifi County government reviews KNDI

certification before employing nutritionists. We found that before any nutritionists are employed KNDI certification is a requirement. This is a positive observation as it indicates that professional accreditation which is responsible in maintaining standards is a requirement.

An FGD comprising 6 nutritionists drawn from different sub-counties was conducted. The respondents felt that having a professional accreditation body is a good idea. They also reported that expectations are very high KNDI to provide professional support to its members. They reported a lack of CPD booklets; this was seen as an area that needs to be looked into so that just like their peers in medicine and nursing they can feel professional. They faulted the strong approach used in ensuring subscription fees are paid, yet very minimal returns from KNDI, as one respondent reported "*... KNDI should be a strong body to fight for rights of nutritionists and not just receiving fees from members*".

Staff establishment and In-service training

Before formation of County governments, there were only 3 nutritionists employed in Kilifi County. Currently there are 28 Nutrition staff employed in Kilifi County to serve 108 health facilities.

Table 6: Health facility establishments in Kilifi County

Sub-County	Dispensaries	District Hospital	Health Centre	Sub District Hospital	Grand Total
Ganze	19		1	1	21
Kaloleni	12	1		1	14
Kilifi North	7	1	2		10
Kilifi South	12		4		16
Magarini	18		2		20
Malindi	15	1	1		17
Rabai	8		2		10
Grand Total	91	3	12	2	108

This is minimal given the workload from the many health facilities that require nutrition services. This has led to non-nutrition cadre having to perform nutrition services in situations where a facility does not have a nutritionist. As shown below different cadres constitute the 'nutrition workforce'.

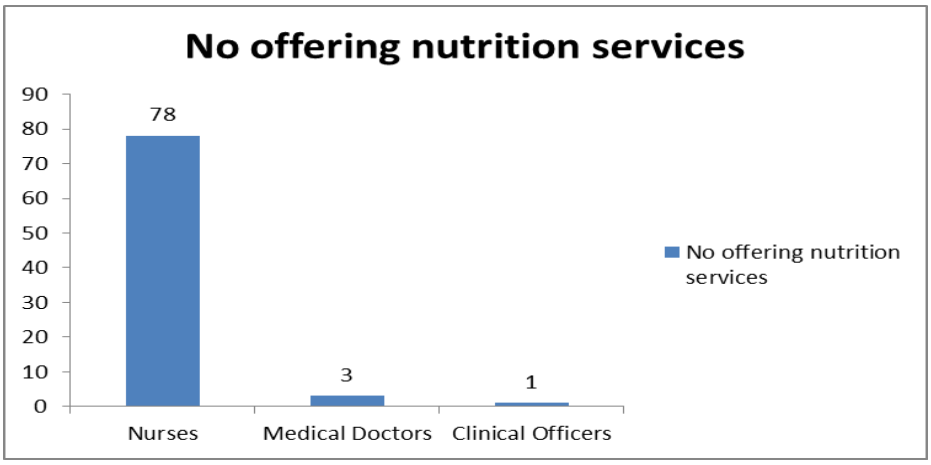


Figure 9: Number of health workers-by cadre-offering nutrition services

With such a high number of non-nutritionists providing nutrition services, the need for urgent recruitment of more nutrition staff is evident. In the short term however, there is need to capacity build the nutrition workforce with up to date information and knowledge so as to enable them effectively deliver. In a nutrition workforce FGD the respondents expressed desire for OJT trainings on nutrition, "Yes I would need support to build up nutrition knowledge as I don't have knowledge to make decision- I just report 1 or so points- I often see IMAM patients' Nutrition workforce FGD respondent.

From the responses from nutritionist FDG there was a feeling that the health workforce only goes for training because of incentives but not for knowledge acquisition. This was further complicated by the fact that those who were selected to attend trainings rarely gave feedback on the trainings thus a need for proper reporting system that allows for dissemination of acquired information. They further commented that others feel that knowledge on nutrition can be attained through the internet/google search hence end up misinforming patients.

Some officers reported that they have the technical capacity but mainly from their college studies, as one FGD participant reported, "we have capacity since we got some training (undergraduate) on nutrition, clinical diagnosis etc. yet in some areas, we are blank- e.g recording and reporting and M&E some areas are very hard even after OJT".

Trained nutritionists also require continuous short courses so as to get up dates on new information, policy guidelines and practice. "Trainings are mainly on IMAM yet there are some emerging conditions e.g. cellulitis, cancer, nephrotic diseases that need training – there is need to look at emerging areas" Nutrition FGD respondent.

Since nutrition is a wide service there is need to capacity build the health workers in order that they are all round in service delivery. This will bring about recognition of

nutrition as not just food and diet but a discipline that addresses emerging lifestyle issues affecting the modern population as explained by Kilifi nutritionists "Nutrition is not recognized as other cadres (Nurses, medical officers etc). There is feeling that one can do without nutritionists"

Training needs to be coordinated by a training committee that will be responsible for selection of candidates on need basis. However, this seems not to be the practice in Kilifi as one respondent lamented "Career progression? if you attend any training and it is not approved by Afya House it's not recognized. However, it's not clear who should communicate to Afya House". This shows a disconnect and lack of guidance on how to approach the issues of training.

It was clear also that the there is no staff training projection as this practice will help identify trainees based on the needs of the county and thus be able to plan as one Nutritionist reported "Trainings –when triggered by office- it's very easy. If personal initiative- it's very hard, and in most cases you end up not going". The officers also reported that they don't do performance appraisal since devolution started which could have been a good source of identifying training needs therefore efforts should be put to re-introduce performance appraisal system

The County reported that trainings were conducted last year, and as shown below we could not establish the specific trainings that the different staff cadres attended. Hence the need for a better information management system to show the specific short courses attended and by which individual staff members within a year. This will clearly indicate if there are specific gap areas based on documented evidence.

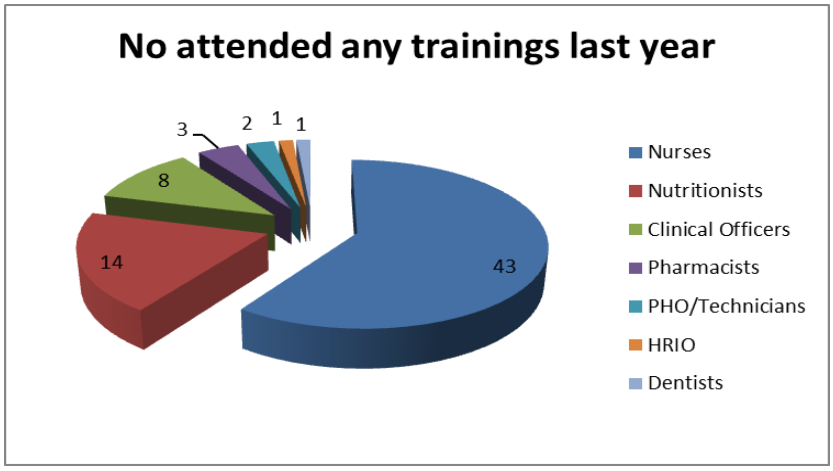


Figure 10: Number of nutrition workforce trained in a nutrition course in the previous year

The following technical challenges were reported at the Nutrition staff FGD;

- Stock outs of food supplements. With great expectations from clients, if no supplies, the counselling provided gets watered down.
- Lack of harmony/ motivation especially amongst the old staff
- Inadequate materials such as policy guidelines and nutrition education resources
- Inadequate equipment (especially weighing scales, height boards, plates for diabetics, scales for measuring food quantities)/outdated equipment (eg weighing scales)
- Inadequate trainings: Nutritionists envy nurses who get updates daily. Some updates eg HIV& food drug interaction not provided to nutritionists.
- Inadequate computers yet a lot of reporting is required – Nutrition reports end up getting lost/ HRIOs prioritize other reports other than nutrition reports nutritionists have to use own computers.
- All other cadres are getting risk allowance except nutritionists yet nutritionists also go to the wards to see TB patients – Nutritionist equally exposed to infections.
- Teaching models not adequate/ not in good condition (have not been replaced/ some lost)
- No nutrition department – patients are directed to the kitchen, or bedside areas where nutritionists might be found etc
- No feedback from trainings from people who have attended trainings. Staff at times face challenge of patients being more informed and up to date than them which is quite embarrassing.
- Trainings on emerging diseases (NCDs): Nurses, doctors, clinical officers are prioritized and not nutritionists, yet nutrition care is needed.

COMMUNITY CAPACITY

The linkage between health facilities and the community is through the Community Units (CUs) as established through the Community Strategy. In Kilifi County there are 74 functional CUs against a recommended establishment of 256 CUs. The roll out plan is still ongoing as only half the health facilities in the County are currently linked to CUs. It is expected as more functional CUs are established the community capacity will be strengthened through linkages with health facilities.

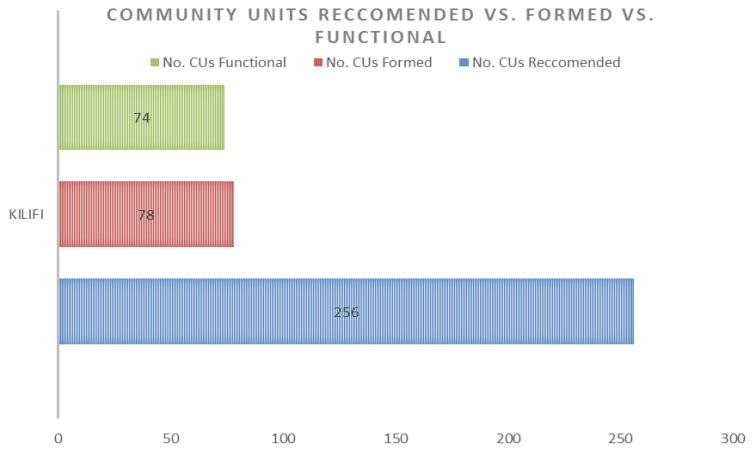


Figure 11: Number of CUs formed, functional and total recommended

The CUs are managed through the Community Health Extension Worker (CHEW), who provides technical support and supervision of Community Health Volunteers (CHVs) who are the frontline link to the community. Nutrition capacity therefore needs to cascade from the nutritionists to the CHEW and CHV levels. That way effective and accurate communication to the community is able to take place.

According to the County records, there was no training conducted last year for CHEWs. This ends up having an impact on the CHVs quality of service delivery and demand creation at the community level. At an FGD for CHVs one participant said “We need refresher training since the knowledge we have is not adequate. Initially when this CU was started, we got several trainings on breastfeeding, TB and farming. Since then we have not had any other”.

Community capacity further requires existence of forums for community feedback. In Kilifi County, several feedback forums exist, and they include; chalkboards, CHV review meetings, community action days, community dialogue, community health committees, and suggestion boxes. It was indicated that last year several advocacy forums were used, mainly; Community dialogue, stakeholder forums, local radio/media, public forums/baraza, suggestion box.

This indicates existence of a wide variety of feedback forums hence an active community capacity existence, as one CHV reported in an FGD 'We see community improvement whereby we see community implement like 70% of what we educate them'.
According to the CHV's several challenges on community empowerment exist in this County. They include;

- At times community is not always ready to sit and listen for free. They want some payment and hence gathering them is a challenge.
- CHVs require pamphlets which they can distribute to the communities. These would aid in increased knowledge
- Involvement of leaders such as chiefs and political class can enhance community demand. They can emphasize the messages for uptake
- The challenge of lack of CHVs recognition by chiefs and other leaders. 'If they recognized us, we would engage the communities better – CHV FGD'.
- Working relations between CHVs and CHCs are challenging at times; when it comes to convening meetings, and general working relations

CHAPTER 4

RECOMMENDATIONS AND ACTION PLAN

The following recommendations were made by the County

Table 7: Recommendations and action plan

Thematic Area	Actions	Responsible	Timeline
Systemic Capacity	1). Customize and adopt key policies and guidelines for use in the county	County Director of Health	
	2). Disseminate (orient) health workers on the existing policies and guidelines	County Nutrition Coordinator	
	3). Institute an M&E system for implementation of the mandatory food fortification policy	County Public Health Officer	
Organizational Capacity	4). Designate a working areas/ offices for nutritionists	County Director of Health	
	5). Enhance support supervision and feedback mechanism (CHMT to sub counties)	County Director of Health	Oct, 2016
	6). Set targets for nutrition indicators/ service areas	County Nutrition Coordinator	
	7). Operationalize nonfunctional health facilities	CEC	End of 2016/17
	8). Upload training information for health department into the iHRIS (program heads to share information with HR & Records office)	CHRIO	
Technical Capacity	9). Develop and implement technical staff motivation/ retention scheme	CEC	End of 2016/17
	10). Explore and conduct capacity building training for frontline health workers	CHMT	
	11). Recruitment of additional health workers to bridge the deficit	CEC	End of 2016/17

Community Capacity	12). Develop and implement technical staff motivation/ retention scheme	CEC	End of 2016/17
	13). Conduct a refresher trainings for CHVs in the existing CUs	Community Strategy focal officer	
	14). Lobby for increased number of CUs	Community Strategy focal officer	End of 2016/17

REFERENCES

1. Service Availability and Readiness Assessment (SARA), an Annual Monitoring System for Service Delivery: Implementation Guide. World Health Organization 2015
2. Report for the Nutrition Capacity Assessment in Malawi Government of the Republic of Malawi and FAO 2009

ANNEXES

Annex 1: KII CEC Health /Chief Officer for Health

KEY INFORMANT INTERVIEW (KII) GUIDE: COUNTY CEC FOR HEALTH/CHIEF OFFICER FOR HEALTH

County: .....

Date of interview: .....

Enumerator Name: .....

Enumerator Number: .....

Assessment results (*tick one*): 1. Completed

2. a) Incomplete,

2. b) State reason and action e.g date and time of revisit: .....

.....

Instructions

Good morning/ afternoon..... The ministry of health both National and County, with support from partners is conducting a nutrition capacity assessment. You have been selected to participate in this assessment. The interview will take about 1 hour. The objective of this assessment is to determine capacity of this County, to deliver nutrition services. This is not intended to victimize you, but your answers will be useful in documenting the best practices and identifying the areas that require improvement.

I am going to ask you some questions about nutrition capacity, please let me know if you need me to clarify any of my questions. Feel free to ask any questions you may have. Can I start now?

Time started: .....

1. How would you describe the current status of the health system in this County? (Refer to the table below)

Health system's Pillar	Current status	Challenges	Measures county has taken to address the challenges
Service delivery Probe for ratio of health facility to population, ambulance and outreach services, emergency response, support supervision, nutrition service integration into health services, coverage of nutrition services, adoption and implementation of nutrition services			
Health / Nutrition workforce Probe for HW numbers, cadres, gaps/ shortages, distribution, skill mix, working conditions/tools, HRH policy, employee's relations/Unions relationships, system, budget allocation, staff attraction and retention. induction, (promotions (No), mentorships, CPD, Training (NO), Re-deployment e.t.c Also check for current staff establishment (iHRIS data base and any challenges/ success in its use).			
Information (probe for IT systems, data tools, evidence based planning and programming, performance monitoring)			
Supplies (Probe for budgetary allocation, adequacy of supplies, storage, distribution)			
Financing (Probe for financial tracking, accounting, transparency, is Nutrition part of health budget discussions, Probe for official allocations, CDF and other funds, NGO funding, Public Private Partnership (PPP), community, insurances etc.)?			
Leadership and governance (Probe for existence of policies, support for implementation of policies, organogram, hierarchy, coordination, evidence based decision making, issues on succession management, existence of feedback mechanisms)			

2. What measures can be taken/ recommendations to improve the health system in this county? (probe for recommendation for each of the health systems pillar – service delivery, nutrition workforce, supplies, information, financing, leadership and governance) _____ _____

3. Who are the partners you are currently collaborating with on health systems? (List partners and their mandate) _____
4. Are the county health sector plans submitted before the county health Budget allocation process to inform decision making? Yes-1 No-0_____
5. a) Are there any bills related to nutrition that have been developed/ being developed in your county within this electoral period? Yes-1 No-0_____

	Bills Developed	Bills being developed
1		
2		

5. b) For the bills that have been passed, how are they being implemented? _____

Time Stopped: .....

Annex 2: KII Director of Health/ County Nutrition Coordinator (CNC)

KII: DIRECTOR OF HEALTH/ COUNTY NUTRITION COORDINATOR (CNC)

County: .....

Date of interview: .....

Enumerator Name: .....

Enumerator Number: .....

Assessment results (*tick one*): 1. Completed

2. a) Incomplete,

b) State reason and action e.g date and time of revisit: ...

.....

.....

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Time started: .....

1.a) What are the top performance indicators for health in this County?

_____

b) Are these performance indicators reflected in the performance appraisal for the health workers in your County?

_____

2. Does this County hold any health and nutrition sector coordination forum? *(Fill out the table below)*

Forum	**Yes – 1, No – 0**	**Frequency of meetings Never - 0, Annually - 1, Bi-Annually - 2, Quarterly - 3, Monthly – 4**	**Who were involved in this forum? *(Multiple responses possible)* Government – 1 Non-Governmental Organizations (NGOs) – 2 Academia - 3 Others, (specify) - 4.**	**Does a finalized and endorsed TOR exist for each of the below: Yes-1 No-0**
County Nutrition technical Forums (CNTF)				
Sub County Nutrition technical forums (SCNTF)				
Multisectoral Platforms (MSP)				
Others (Specify.....				

3.In the last 6 months, has the county enforced BMS Act? Yes-1 No-0 _____

4.a) Are the following policies being implemented? Yes – 1 No – 0 _____

4. b) If Yes How? *(Probe for how they are used for decision making, evidence either qualitative or documentation e.g. staff establishment*

I. Human resource for health Norms and standards guidelines for the health sector

II. Scheme of service for Nutritionist and dietician

5.In the last financial year, have County Assembly health committee members attended any advocacy/ sensitization session/ forums on nutrition? Yes-1 or No 0_____

If yes specify the type of sessions attended_____

_____

_____

6.a) Has the county conducted an operational research (Health and Nutrition eg Vitamin A supplementation in Integrated Community Case Management – ICCM, effectiveness of use of Community health volunteers in Nutrition service delivery etc) in the last 2 years?

Yes-1 No-0 _____

b) If No Why? *(Tick all that apply)*

i. Lack of technical expertise.....
ii. Lack of finances.....
iii. Others, Specify.....

c) If yes, how was the operational research used in decision making? *(Probe)*

_____

_

7.What informs budget allocation for the health sector activities?

_____

_____

8.Does the county have a budget line for nutrition activities? Yes-1 No-0_____

9.a) In the previous financial year, what was the total budget for health (In Kenya shillings)? _____

b) What was the nutrition budget allocation? _____

c) What was the total nutrition budget Utilization?_____

10. What was the **MAIN** nutrition expenditure in the last financial year (2015/2016)? _____

11. In the past three financial years how was the trend in budget allocation for nutrition as a % of the total budget for health? (Increasing-2, remains the same-1, decreasing-0)

12. How many health facilities are currently offering the following nutrition services and report on the same? *(Fill the table below)*

Service	**Number of facilities offering the following nutrition services?** *(Give the total number by type of facility)*			**Number of facilities that consistently reported on nutrition services in the last 3 months? (out of those offering)**	**Means of Verification** *(Desk review)*
	Public	Private	Mission/NGO		
Outpatient Therapeutic Program (OTP)					
Inpatient Therapeutic Program (IP)					
Supplementary Feeding Program (SFP)					
Iron Folic Acid Supplementation (IFAS)					
Micronutrients Powders (MNPs)					
Vitamin A Supplementation					
Deworming					
Growth Monitoring					
Infant and Young Child Nutrition (IYCN) counselling (ANC)					
Breastfeeding counselling and support (CWC)					
Nutrition and HIV/TB					
Nutrition in Renal Diseases					
Nutrition in Diabetes Management					
Nutrition in Cancer Management					
Nutrition in HIV					
Enteral Nutrition					
Parenteral Nutrition					
Nutrition in Surgery					

13. a) Is there an annual procurement plan that includes nutrition commodities Yes- 1 No -0_____

b) Do you assess stock outs? Yes-1 No-0_____

c) If yes, which tool do you use to assess stock outs?

i. Logistics Management Information System (LMIS)
ii. Others, specify: _____

14. What is the frequency of stock outs of Ready to Use Therapeutic Food (RUTF), Iron Folic Acid Supplementation (IFAS) and Vitamin A in your County? (Reference is last financial year)

RUTF: _____

IFAS_____

Vitamin A: _____

15. Is there a steady supply chain for essential commodities? Yes-1 No-0 _____

15 b) If no, what are the main challenges?_____

16 a) How often do you do supportive supervision for each health facility?

	Frequency *(Circle one response)*	**Does the support supervision include nutrition issues?** Yes-1 No-0	**Comments**
County Support Supervision	Monthly – 4 Quarterly – 3 Bi annually – 2 Annually – 1 Others, specify;		
County to Subcounty Support Supervision	Monthly – 4 Quarterly – 3 Bi annually – 2 Annually – 1 Others, specify; ...		
County to Health facilities Support	Monthly – 4 Quarterly – 3 Bi annually – 2		

Supervision	Annually – 1 Others, specify;		
Subcounty to Health facilities Support Supervision	Monthly – 4 Quarterly – 3 Bi annually – 2 Annually – 1 Others, specify;		

16 b) Which tool is used for support supervision? *(Tick one that applies)*

i. MOH integrated support supervision....
ii. Others, specify .....

16 c) What informs prioritization of issues to focus on during support supervision?

_____

_____

17. a) How many nutritionist are there in this county? _____

17. b) How have the nutritionists been distributed in the county?

Level	Numbers
County	
Subcounty	
Hospital	
Health centers	
Dispensaries	
Other (Specify)	

18. What proportion of nutrition staff has renewed their KNDI license?

_____

_____

19. a) Is nutrition integrated into community groups (eg CBOs, FBOs, Support groups)
Yes – 1 No – 0. _____

19. b) If yes, Fill out the table below:

Groups	List the groups *(Names)*	Activities conducted
CBOs		
FBOs		
Support Groups		
Others (Specify)		

16. What is the number of nutrition work force trained in the following MoH approved courses (*compute proportions*)

Training in MoH approved courses	A. Number that Require Training	B. Number trained in the last two and a half years (verify-with standards)	C. Number claiming KNDI credits	D. Number of trainings conducted in the last 2.5 years	E: Was there participation of pre service lecturers/ tutors in this training? Yes = 1, No - 0
Nutrition assessments e.g. biochemical, anthropometric, clinical					
Integrated Management of Acute Malnutrition (IMAM)					
Maternal Infant and Young Child Nutrition (MIYCN)					
Micronutrient (Vitamin A Supplementation/Iron and Folic Acid Supplementation training)					
Preterm and low birth nutrition					
Nutrition in Tuberculosis (TB)					
Nutrition in Renal (specific to nutrition cadre)					
Nutrition in Cancer (specific to nutrition cadre)					
Nutrition in Diabetes (specific nutrition cadre)					
Logistic Management Information System (LMIS)					
Health financing					
District Health information Software (HIS)					
Nutrition in HIV					

(specific to nutrition cadre)					
Parenteral Nutrition					
Enteral Nutrition					
Data management					
Nutrition in critical care(specific to nutrition cadre)					
Nutrition in surgical care					
Senior Management Course					
Supervisory skills					
Strategic leadership and development program					
Coordination, linkages and networking					
Advocacy and communication					
Commodity management training					
Others, Specify					

17. Does the county have resource allocated to continuous professional development?

Yes-1 No-0

18. What strategies are in use for continuous professional development? (Fill the table below)

Strategy	Frequency Monthly - 1 Quarterly - 2 Bi annually - 3 Yearly - 4 Others – 5 Specify...	Remarks
Continuous Medical Education (CMEs)		
On the Job Training		
Others (specify)		

19.a) Does your County have a training committee? Yes-1 No-0 _____

21. b) If Yes who are the members of committee, _____

21. c) How often are the meetings held? _____ _____

21. d) How are the training needs identified and prioritized? _____

21 e) What trainings were prioritized in the last financial year?_____

20.a) Do nutritionists have job descriptions? Yes-1 No-0 _____

b) If No why? _____

21.Are there feedback mechanisms that address service delivery concerns between the following levels?

Level	**Tick all that apply**
County executive/County assembly and CHMT	1. Cabinet meetings 2. County Health committee meetings 3. County Assembly departmental briefs 4. Others (specify)
County Health Management Team (CHMT) and Sub-County Health Management Team (SCHMT)	1. Health Stakeholders forums 2. CNTFs 3. CHMT meetings 4. Suggestion box 5. Others (specify)
SCHMT and facility/health workers	1. SCNTFs 2. In-charges meetings 3. Others (specify)
S/CHMT, Health Facility and Community	1. Health Facility Committee meetings 2. Community health workers review meeting 3. Community Health committees 4. Community dialogue meetings 5. Suggestion box 6. Others (specify)
Members of County Assembly and	1. Community Participation Forums

community	2. Social Accountability reporting 3. Others (specify)
CHMT and Partners(Regulatory Bodies, Research Institutions, Non state actors and private entities	1. County Stake holders forum 2. County Steering Group (CSG) 3. CNTF 4. Others (specify)

Time stopped: .....

ANNEX 3: KII COUNTY PHARMACIST/ COUNTY NUTRITION OFFICER

KII: COUNTY PHARMACIST/ COUNTY NUTRITION OFFICER

County: .....
Date of interview: .....
Enumerator Name: .....
Enumerator Number: .....
Assessment results (*tick one*): 1. Completed
2. a) Incomplete,
2. b) State reason and action e.g date and time of revisit: **...**
.....
.....

INSTRUCTIONS

Good morning/ afternoon…. The ministry of health both National and County, with support from partners is conducting a nutrition capacity assessment. You have been selected to participate in this assessment. The interview will take about 1 hour. The objective of this assessment is to determine capacity of this County, to deliver nutrition services. This is not intended to victimize you, but your answers will be useful in documenting the best practices and identifying the areas that require improvement.
I am going to ask you some questions about nutrition capacity, please let me know if you need me to clarify any of my questions. Feel free to ask any questions you may have. Can I start now?

Time started: ……

1. Fill the table below for the following listed nutrition commodities for the last financial year (2015/2016)?

Commodity	**Were the following commodities procured in your county in the last financial year? Yes – 1 No - 0**	**What proportion supported by National government**	**What proportion supported by County government**	**What proportion supported by Partner** *(List the partners)*	**Has there been stock outs in the last financial year Yes-1 No-0**	**If Yes, what was the duration of stock out? <1 month – 1 1-3 months – 2 >3 months - 3**	**Where are the supplies stored?**
Ready to use therapeutic Food (RUTF)							
Ready to use supplementary Food (RUSF)							
Iron & Folic acid Supplements (IFAS)							
Micronutrients Powder (MNPs)							
Corn Soy Blend (CSB/Oil)							
Super Cereals							
Fortified Blended Foods flour (FBF)							
Vitamin A Supplements							
Therapeutic milk (F75)							
Therapeutic milk (F100)							
Resomal							
Height boards							
MUAC tapes							
Weighing scales							
Parenteral feeds							
Enteral Feeds							
Others (Specify).....							

2. What is the criteria for identifying and prioritizing commodity needs for the different programmes (including Nutrition programme)?

_____

_____

3. a) Describe how the forecasting and quantification process is undertaken in this county.

_____

_____

3. b) Describe the ordering and procurement process.

_____

_____

3. c) Who are the main suppliers of Nutrition commodities (eg Iron folate supplements, Micronutrient powders etc)?

_____

_____

Time Stopped: .....

ANNEX 4 KEY INFORMANT INTERVIEW; HEALTH FACILITY IN-CHARGE

KEY INFORMANT INTERVIEW; HEALTH FACILITY IN-CHARGE

County: ..... Sub county: .....
Health Facility Name: .....
Health Facility code: ..... Date of interview: .....
Enumerator Name: .....
Enumerator Number: .....
Assessment results (*tick one*): 1. Completed
2. a) Incomplete
b) State reason and action e.g date and time of revisit:
.....
.....

INSTRUCTIONS

Good morning/ afternoon..... The ministry of health both National and County, with support from partners is conducting a nutrition capacity assessment. Your facility has been selected to participate in this assessment. The interview will take about 30 minutes. The objective of this assessment is to determine capacity of this health facility, to deliver nutrition services. This is not intended to victimize you, but your answers will be useful in documenting the best practices and identifying the areas that require improvement.

I am going to ask you some questions about nutrition capacity, please let me know if you need me to clarify any of my questions. Feel free to ask any questions you may have. Can I start now?
We will need to review several documents……., kindly ask someone to avail the documents as we proceed with the interview.

Time started: ……

1. What is your responsibility in this facility? (*tick one*):

   a) Facility in charge …. b) Others, Specify……

2. What is your cadre? _____

3. Level of facility (*Tick the one that applies*):
   a) County Referral Hospital (level 5)……. Sub County Hospital (level 4)……

   c) Health Centre (level 3)…… d) Dispensary (level 2)…….

4. Facility Ownership (*tick one that apply*) a. Ministry of Health ……. b. NGO…….

   c. Faith based……..

5. Does the facility provide inpatient services? Yes-1 No-0 _____

6. What is the **CURRENT** catchment population served by the facility? _____

7. What was the total number of clients seen in the last financial year (2015/ 2016)? (Check MoH 717. If data is missing in MoH 717, check from all other sources eg MoH 705A, 705B..)

	Over 5 Male	**Over 5 female**	**Under 5 male**	**Under 5 Female**

July 2015				
Aug 2015				
Sep 2015				
Oct 2015				
Nov 2015				
Dec 2015				
Jan 2016				
Feb 2016				
March 2016				
April 2016				
May 2016				
June 2016				

8. Complete the table below:

	A	**B**	**C**	***D***	**E**	**F**
Nutrition Services	Does the facility offer the following services? *(Check for service even if there are currently no stocks)* Yes-1 No-0 *(If yes proceed to next questions) If no go to the next nutrition service)*	If yes to A, which cadre of staff provides the service *(multiple response possible)*	If yes to A, Do you do target setting? Yes-1 No-0 (*If No skip to F)*	*If yes to C, Verify Yes-1 No-0*	If Yes to C, What was your last year's targets?	If No to C, why?
Vitamin A Supplementation						
Iron and Folic Acid Supplementation (IFAS)						
Multiple Micronutrient Powders (MNPs)						
Integrated Management of Acute Malnutrition (IMAM)						
Deworming						
Zinc Supplementation for diarhoea treatment						
Exclusive Breastfeeding (EBF) and Complementary feeding (CF) promotion						
Nutrition in Diabetes Management						
Nutrition in Surgery						
Nutrition in Cancer Management						
Parenteral Nutrition						

Enteral Nutrition						
Nutrition in Renal Diseases						
Nutrition and HIV/TB						

9. Does the facility have the following tools and anthropometric equipment;

Nurses	**Availability Yes-1 No-0** (*Verify through*	How many? (numbers)	Status (Functional/ In Use)
Equipment			**Functional** *(Numbers)*
Adult Weighing scale			
Child Weighing scales			
Adult Height			
Child height board/ infantometer			
Adult MUAC Tapes			
Child MUAC tapes			
Job Aids			**In Use (Yes – 1, No – 0) Probe**
Maternal & Child Health (MCH) Booklet Job			
Nutrition counselling cards			
Growth charts			
Tools			**In Use (Yes – 1, No – 0)** *Probe*
Child Welfare Clinic (CWC) Registers – MoH			
Maternity registers – MoH 333			
Antenatal Care Register – MoH 405			
Nutrition monthly report - MOH 713			
CHANIS tally sheet - MOH 704			
Integrated programme summary report form: Reproductive & Child health, Medical & Rehabilitative Services.- MOH 711			
Immunization and Vitamin A - MOH 710			
Consumption Data Report and Request (CDRR) for nutrition commodities – MoH			
Maternal & Child Health (MCH) Booklet			

10. Is this facility linked to any Community Units (both functional or non-functional)
    Yes-1 No-0 _____
    If no, Why?
    _____
    _____

11. How many Functional Community Units (CUs) are attached to these facilities? _____

12. a) How many Health professional staff does the facility have? *(Fill the table below)*

	Cadre	**Permanent**	**Temporary**	**Casual**	**How many offering nutrition services**	**How many have undergone a nutrition training (Note in- service) in the last financial year 2015/2016** *(example of trainings include IMAM, MIYCN, Nutrition data management, SMART, IFAS, Vitamin A*

1.	Medical Doctors					
2.	Nurses					
3.	Clinical officers					
4	Dentists					
5.	Lab Technologists/ technicians					
6	Nutritionists					
7.	Public Health officers/					
8.	Pharmacists					
9.	Physiotherapist					
10.	Occupational Therapists					
11	Health records					
12	Medical Engineer					
13	Nurse Aids					
14	Others: Specify.....					

12. b) How many Non Health staff does the facility have?

	Cadres	**Number**	**How many offering nutrition services**	**How many have undergone a nutrition training (Note in- service) in the last financial year 2015/2016** *(example of trainings include IMAM, MIYCN, Nutrition data management, SMART, IFAS,*
1.	Accountant			
2.	Economists/statisticians			
3.	Human resource			
4.	Clerical officers			
5.	Internal auditors			
6.	Finance officers			
7.	Secretaries			
8.	Drivers			
9	Support staff			

13. a) Do you attend in charges meeting? Yes-1 No-0 _____
    b) How often do you attend the in-charges meeting? _____

14. a) Do you hold staff meetings? Yes-1 No-0_____
    b) If yes, how often? *(Probe for agenda, issues of discussion)* _____
    c) If No why? _____

15. a) Do you hold community Health committee meetings? Yes-1 No-0 _____

    c) If no, Why? _____

16. a) Do you have any specialized clinics in this facility? Yes-1 No-0 _____

    b) If yes, which ones? _____

Observe the Following:

Variable	Check for:			Remarks
Service charter	Present Yes =1 No = 0	Strategically located (*located in a position visible as one accesses the facility?)* Yes =1 No =0		
Check for the following on Storage space for nutrition commodities;				
Micronutrient Supplements	Present: Yes– 1 No - 0	Well Ventilated	Yes =1 No =0	
		Secure	Yes =1 No =0	
		Has shelves, racks, cup boards	Yes =1 No =0	
		Pallets	Yes =1 No =0	
		Bin Cards	Yes =1 No =0	
		Stock control cards	Yes =1 No =0	
		Delivery Notes	Yes =1 No =0	
		S11	Yes =1 No =0	
Vitamin A supplements	Present: Yes– 1 No - 0	Well Ventilated	Yes =1 No =0	
		Secure	Yes =1 No =0	
		Has shelves, racks, cup boards	Yes =1 No =0	
		Pallets	Yes =1 No =0	
		Bin Cards	Yes =1 No =0	
		Stock control cards	Yes =1 No =0	
		Delivery Notes	Yes =1 No =0	
		S11	Yes =1 No =0	
Iron Folic Acid supplements	Present: Yes– 1 No - 0	Well Ventilated	Yes =1 No =0	
		Secure	Yes =1 No =0	
		Has shelves, racks, cup boards	Yes =1 No =0	
		Pallets	Yes =1 No =0	
		Bin Cards	Yes =1 No =0	
		Stock control cards	Yes =1 No =0	
		Delivery Notes	Yes =1 No =0	
		S11	Yes =1 No =0	
Ready to use therapeutic foods	Present: Yes– 1 No - 0	Well Ventilated	Yes =1 No =0	
		Secure	Yes =1 No =0	
		Has shelves, racks, cup boards	Yes =1 No =0	
		Pallets	Yes =1 No =0	
		Bin Cards	Yes =1 No =0	
		Stock control cards	Yes =1 No =0	
		Delivery Notes	Yes =1 No =0	
		S11	Yes =1 No =0	

<table>
<tr><th>Variable</th><th>Check for:</th><th>Remarks</th></tr>
<tr><td>Ready to use supplementary foods</td><td>Present:
Yes– 1 No - 0</td><td>
<table>
<tr><td>Well Ventilated</td><td>Yes =1 No =0 .....</td></tr>
<tr><td>Secure</td><td>Yes =1 No =0 .....</td></tr>
<tr><td>Has shelves, racks, cup boards</td><td>Yes =1 No =0 .....</td></tr>
<tr><td>Pallets</td><td>Yes =1 No =0 .....</td></tr>
<tr><td>Bin Cards</td><td>Yes =1 No =0 .....</td></tr>
<tr><td>Stock control cards</td><td>Yes =1 No =0 .....</td></tr>
<tr><td>Delivery Notes</td><td>Yes =1 No =0 .....</td></tr>
<tr><td>S11</td><td>Yes =1 No =0 .....</td></tr>
</table>
</td><td></td></tr>
<tr><td>Standard Treatment Protocols and Policy Guidelines</td><td>Present
Yes = 1
No = 0</td><td>Observe if the following are available and in use:
<table>
<tr><th>Protocols/guidelines</th><th>Available
Yes =1
No =0</th><th>In Use
Yes=1
No =0 (Probe)</th><th></th></tr>
<tr><td>Maternal Infant and Young Child Nutrition (MIYCN) policy statement</td><td></td><td></td><td></td></tr>
<tr><td>Integrated Management of Acute Malnutrition (IMAM) guidelines</td><td></td><td></td><td></td></tr>
<tr><td>MIYCN Guideline</td><td></td><td></td><td></td></tr>
<tr><td>Vitamin A Schedules</td><td></td><td></td><td></td></tr>
<tr><td>Iron and Folic Acid supplementation (IFAS) policy schedule</td><td></td><td></td><td></td></tr>
<tr><td>Deworming Schedule</td><td></td><td></td><td></td></tr>
<tr><td>Micronutrient Powders (MNPs) operational guide</td><td></td><td></td><td></td></tr>
<tr><td>Clinical and dietetics guidelines/Manual</td><td></td><td></td><td></td></tr>
<tr><td>Diabetes Guideline</td><td></td><td></td><td></td></tr>
<tr><td>Cancer guideline</td><td></td><td></td><td></td></tr>
<tr><td>Diabetes register</td><td></td><td></td><td></td></tr>
<tr><td>Others, Specify.....</td><td></td><td></td><td></td></tr>
</table>
</td><td></td></tr>
<tr><td>ICT Equipment</td><td>Present
Yes =1 No =0</td><td>Computers Yes-1 No-0
Printers Yes-1 No-0
Scanners Yes-1 No-0
Photocopier Yes=1 No-0
Internet Yes =1 No-0</td><td></td></tr>
<tr><td>Anthropometry equipment</td><td>Present
Yes = 1 No =0</td><td>Weighing scale (Beam scales) Yes =1 No =0
Weighing scale (Electronic mother and child scale) Yes =1 No =0
Height / Length board Yes =1 No =0
Studiometers (Adult Height board) Yes =1 No =0
MUAC tapes Yes=1 No =0</td><td></td></tr>
</table>

Variable	Check for:		Remarks
Job Aids	Present Yes= 1 No =0	IMAM Job Aids Yes =1 No =0 MIYCN Job Aids Yes =1 No =0 HIV/AIDS Nutrition Job Aids Yes =1 No =0	
Availability of a room that is designated for a nutritionist *(only answer this in facilities that have a nutritionist)*	Present Yes-1 No-0		

Time stopped: .....

Supported By: