

ASSESSMENT OF THE NUTRITION SECTOR

KWALE COUNTY



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ACRONYMS

ADP	Annual Development Plan
CHW/V	Community Health Worker/Volunteer
CBO	Community-based Organization
CHMT	County Health Management Team
CNTF	County Nutrition Technical Forum
CIDP	County Integrated Development Plan
CSO	Civil Society Organization
CNAP	County Nutrition Action Plan
CFSP	County Fiscal Strategy Paper
DHIS	District Health Information System
ECD	Early Childhood Development
FBOs	Faith Based Organizations
FGD	Focus Group Discussion
GDP	Gross Domestic Product
IEA	Institute of Economic Affairs
IMR	Infant Mortality Rate
KDHS	Kenya Demographic and Health Survey
KII	Key Informant Interviews
KEMSA	Kenya Medical Supplies Authority
KIRA	Kenya Inter – Agency Rapid Assessment
KNBS	Kenya National Bureau of Statistics
KNFSP	KNFSP Kenya Nutrition and Food Security Policy
KNAC	Kenya Nutrition Action Plan
MTEF	Medium Term Expenditure Framework
MDG	Millennium Development Goals
MCNP	Maternal and Child Nutrition program
MIYCN	Maternal, Infant and Young Child Nutrition
MCH	Maternal and Child Health
MNCH	Maternal Newborn and Child Health
MOH	Ministry of Health
NCPD	National Council for Population and Development
NNAP	National Nutritional Action Plan
NGO	Non-Governmental Organization
PMTCT	Prevention of Mother-to-Child Transmission
THE	Total Health Expenditure
U5MR	Under-Five Mortality Rate
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

Map of Kenya Showing the Location of Kwale County



FOREWORD

According to the KDHS survey 2014, 29.7% of children in Kwale County are stunted. This is high compared to the national stunting rate of 26% of the same survey. Stunting is a chronic form of malnutrition. This coupled with other acute forms of malnutrition like wasting and underweight, usually leads to adverse effects on the economic development of the county. Malnutrition impairs educational performance of children hence the need to ensure all deficiencies are corrected before the age of two. Maternal nutrition is equally essential in enhancing delivery outcomes and promotion of adequate nutrition during the first 1,000 days of life.

The county government has continued to support the implementation of nutrition activities both at the community level and at the health facility level. Whilst the level of stunting has reduced from 35% to 30% in the most recent (2014) Kenya Demographic Health Survey (KDHS), the rate of reduction is still low, and continues to challenge the achievement of sustainable development goals (SDGs).

The assessment provides highlights on key areas to be addressed on improving nutrition service delivery in the county. It also highlights on some of the challenges that need to be addressed including staffing, visibility, and funding of nutrition activities. Additionally, the assessment identified opportunities that can be used to enhance integration of nutrition services including; devolution and community health strategy among others.

This assessment was done on three pillars namely; governance, capacity to deliver, and awareness and demand for nutrition services. Using the three pillars, the assessment looked at the policy environment supporting nutrition service delivery, availability of guiding policies, and funding of nutrition activities in the county. This will complement the other key nutrition documents, including the National Advocacy, Communication and Social Mobilization (ACSM) Strategy, and Kwale County's own nutrition plans.

The county government of Kwale is committed to implementing the recommendations from the assessment results, and engaging a wide range of stakeholders to continuously improve nutrition in the county. The findings will be used to guide the improvement of policy environment, funding, recruitment and visibility for nutrition services. The Department of Health will use the findings to advocate for nutrition and nutrition services at all levels to create demand for services and nutrition visibility. BNA results will also help the Department of Health in prioritization and funding of nutrition activities.

Dr. Athuman Chiguzo,

County Executive Committee (CEC) Member

Department of Medical Services and Public Health - Kwale County

APPRECIATION AND ACKNOWLEDGMENT

The successful completion of this study would not have been possible without the collaboration and support of key actors in nutrition and health, community representatives and county officials.

The Department of Health, through the able leadership of the County Executive Committee Member for Health Services, Dr. Athman Chiguzo, merits distinct mention for adopting an evidence-based approach to planning and implementing county actions to improve the nutrition of the children of Kwale County, and the overall health of its population.

CISP wishes to thank the Kwale County Health Management Team (CHMT) and the County Nutrition Technical Forum (CNTF) for their direction and commitment towards guiding the study and reviewing the findings, and for useful suggestions that further strengthened the content for the County.

We acknowledge the communities in all sub-counties of Kwale for generously giving information on their experiences in support of a brighter future for nutrition.

The exercise would also not have been possible without the collaboration of Pwani University, through its Department of Foods, Nutrition and Dietetics, specifically Ms. Patricia Mbogoh, and the research assistants involved.

We sincerely appreciate the technical and financial support of UNICEF through the Kenya Nutrition Section who facilitated the implementation of the study.

Valeria Costa

Kenya Program Coordinator.

International Committee for the Development of Peoples - CISP

EXECUTIVE SUMMARY

The improved use of evidence base and knowledge management has been cited as vital in informing policy and strategies in health improvement. Leadership and advocacy for nutrition must be guided by context specific evidence and knowledge to guide interventions and strategies for nutrition. This report highlights the best practices and limitations in the delivery of nutrition services in Kwale County as part of the advocacy programme, the goal of which is to strengthen the enabling environment for evidence based planning and action towards improved nutrition in Kwale County.

This study applied a qualitative approach to explore underlying motivations behind certain positions and practices that may contribute to the existence of bottlenecks to nutrition. This process employed a review of relevant literature, Key Informant Interviews (KIIs) applying semi-structured interview questionnaires, and focus group discussions (FGDs) with open ended question guides targeting officials from the county, sub-county, and health facilities, as well as community members.

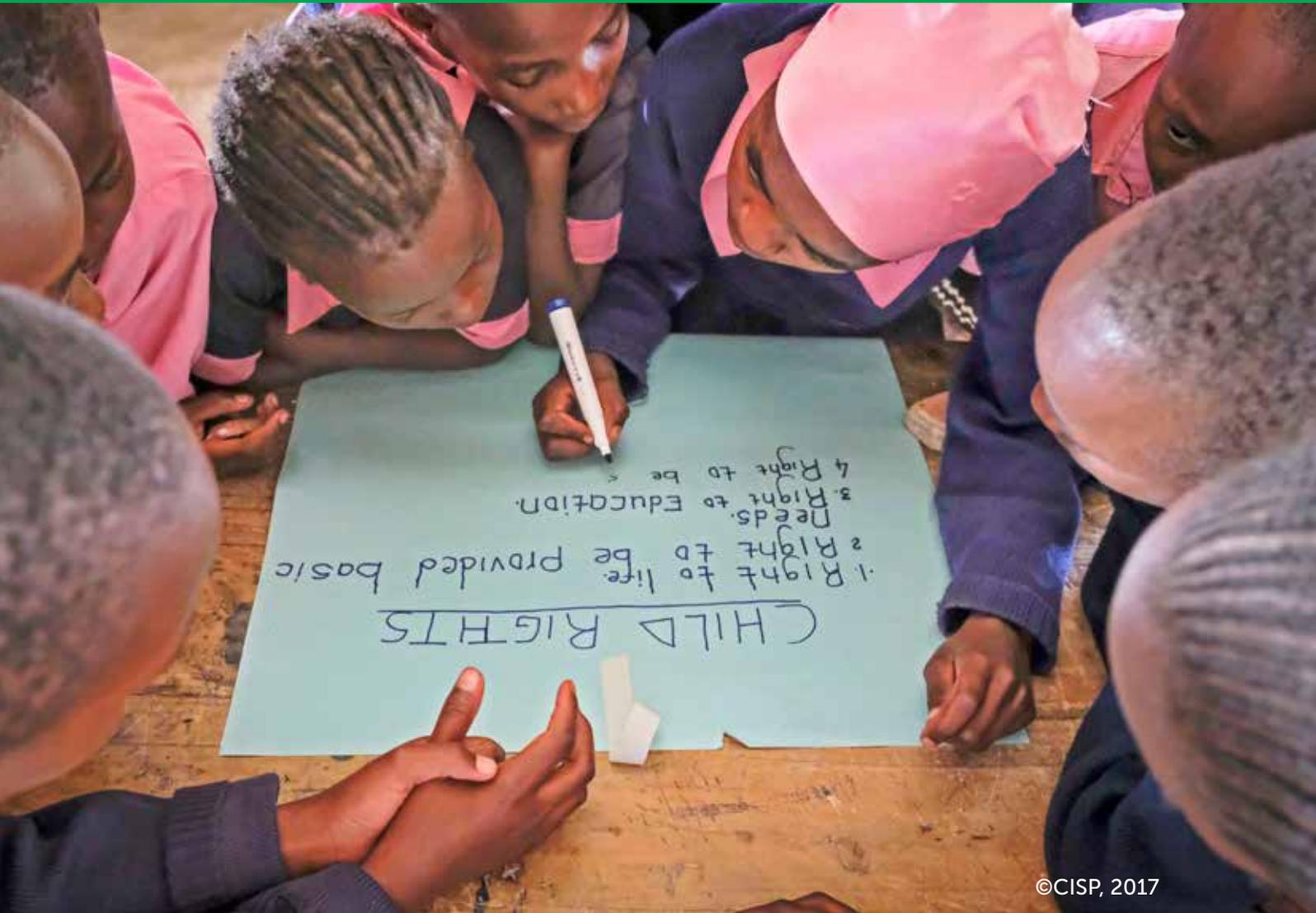
In the study, the governance around nutrition was analyzed, including the decision-making processes, information flow and funding. Under a review of the enabling environment, the existing guidelines and legislation were reviewed, as was the monitoring and evaluation framework, and the coordination and collaboration structures. The capacity to deliver was also examined, under which the staffing levels and their capacity building were points of focus. Finally, the study analyzed the awareness and demand environment, where information access and its dissemination by service providers to service users was reviewed. The visibility of Nutrition actors was similarly examined as a pivotal condition supporting service-seeking behavior.

The findings from the study indicate that the County Government of Kwale has provided leadership and support towards improving overall health through a steady increase in health funding, among other actions supporting nutrition improvement. However, the lack of a specific budget line for nutrition hinders proactive planning for, and timely response to existing and emerging nutrition challenges. Nutrition data and information storage and retrieval framework across the county's health facilities is also not clear enough to support timely monitoring, evaluation and learning.

The county is yet to contextualize existing national policies to fit Kwale needs though it identifies poor policies being a feature of the transition from centralized to devolved government systems. The number of nutritionists employed has increased but will need more opportunities for capacity building to improve their quality and ability to strengthen nutrition actions in the county. Whereas the population still shares nutrition information accessed through field outreach from the county, increased community outreach has potential to snuff out misconceptions existing due to misinformation in some areas.

With the increased attention to nutrition and the effects of drought in the county, a need for enhancing coordination of nutrition actions has become even more important in order to achieve intended results in drought response. A streamlining of actions will support consolidated gains for better nutrition. The ongoing process of developing a County Nutrition Action Plan as a decisive strategy is a welcome step in this regard, providing a shared framework and a common goal of promoting appropriate nutrition and alleviating the ravages of malnutrition.

Recommendations suggested from this analysis include: a line item for nutrition in the county budget, improved information flow among nutrition actors and decision makers, contextualizing of regulatory frameworks and policies, enhancing community participation for sustainability, improving the monitoring and evaluation framework, investing more in nutrition staff quantity and their continued capacity building, support coordination and collaboration around nutrition, improving staff numbers and capacity, and enhance their visibility. If effected, the recommendations should go a long way in supporting county efforts to unlock existing bottlenecks to nutrition actions currently underway, as well as improve actions in the future.



1.1 Background

This report has been produced to highlight the bottlenecks in the demand and delivery of nutrition services in Kwale County to inform county nutrition policies and strategic planning. This assessment report is part of CISP advocacy programme titled “Promoting participation in advocacy for appropriate nutrition in Kwale, Kilifi and Kitui Counties of Kenya”. Through the UNICEF-Supported Maternal and Child Nutrition Programme (MCNP), the International Committee for the Development of Peoples (CISP) is working with the Kwale County Government through its Department of Health Services to: i) Increase knowledge on current nutrition strategies, needs and best practices at county level; ii) Enhance community feedback to increase demand for quality nutrition services; iii) Empower duty bearers to better coordinate stakeholders working in nutrition and cross cutting sectors at county level; and iv) Advocate for realistic resource allocation and accountability in the nutrition sector.

This is in line with the Sustainable Development Goals, (SDGs), most specifically goal 2, which aims to “end hunger, achieve food security and improve nutrition, and promote sustainable agriculture.” A target under this goal that “by 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutrition needs of adolescent girls, pregnant and lactating women and older persons (target 2.2). The Constitution of Kenya (2010) recognizes the right of every person to be free from hunger (article 43), and the right of every child to basic nutrition (article 53). Similarly, Kenya’s long-term development blueprint, Vision 2030, also envisions a globally competitive and prosperous nation with a high quality of life by 2030.

The Government of Kenya has made several efforts support to support nutrition, including allocating additional resources to High Impact Nutrition Interventions (HINI) in 2010, and joining Kenya joined the Scaling Up Nutrition (SUN) Movement in 2011, steps that have contributed to enhancing nutrition outcomes. However, there is a strong need for advocacy and lobbying for increased public funding for nutritional programmes and for increased nutrition budget allocation as a long-term prevention strategy that intends to reduce overall health expenses. However, financial investment in health and nutrition in counties still requires attention. The general themes being explored are around legal frameworks, policy environment and the county nutrition service delivery to populations in the county. These are critical priority issues on which any positive strides and activities in nutrition at the county level will be hinged upon.

There are many anticipated barriers to the establishment of a strong nutrition sector at national and county levels, including: the absence of fully functional citizen participation systems; uncoordinated intra-sectoral and inter-sectoral activities, and where there is coordination it is not fully harnessed for maximum benefits; low awareness and demand for health and nutrition services from communities; lack of appropriate tools for data collection; and evidence-based researches to inform policy and practice (Mburu,2017).

1. Sustainable Development Knowledge Platform; at <https://sustainabledevelopment.un.org/?page=view&nr=164&type=230>

At county level, the Kenya Health Policy 2012-2030 envisions that the County Health Management Team (CHMT) is tasked with planning, coordinating, monitoring and reviewing health service provision and mobilizing resources for county health services. This being a new function requires that support is provided to these teams and other stakeholders for successful implementation of their functions. Without a review and analysis of the bottlenecks affecting nutrition programming at county level, any interventions by state and non-state actors will be devoid of current evidence as a foundation for engagement. This research is meant to provide context specific evidence and knowledge to guide interventions and strategies in nutrition advocacy specific to Kwale County and to provide learning and inform programme direction for the county government and other stakeholders as needed.

Evidence-based planning and interventions is expected to yield better results in nutrition-related activities at county level, while at the nucleus that is the family, individuals will build their understanding of nutrition and its benefits, as well as ways to enhance nutrition within the family system. The appreciation for evidence-based decision-making on nutrition is found in the Nutrition Action Plan that identifies as a strategic objective the enhancement of evidence-based decision-making through research. The plan advocates for best practices being the basis for solving nutrition problems, and specifically asks for county level research to guide intervention (KNAP 2012 -2017). Research findings should inform nutrition program design, budgeting and implementation.

This report draws on a literature review and primary field assessment conducted by Pwani University in collaboration with CISP in the first quarter of 2016. The aim of the report is to support and complement the efforts in place by the County Government of Kwale, through its Health Department by informing practitioners, policy makers and researchers about key governance issues and the capacity to deliver nutrition services towards strengthening of the nutrition sector in Kwale County.

1.2 Literature Review

Malnutrition is a serious medical condition marked by a deficiency of energy, essential proteins, fats, vitamins, and minerals in a diet (Black et al, 2003). In Kenya, the indicators of nutrition status paint a grim picture for children under five years of age. The Kenya Demographic Health Survey (KDHS) 2014 reported that 26% were stunted, 11% were underweight and 4% were wasted nationally. These rates were an improvement on the 2009 figures (35% stunted, 16% underweight and 7% wasted) and require sustained efforts to secure the little progress made.

Overall, the health status of the national population is poor, with an infant mortality rate of 52 deaths per 1,000 live births, an under five mortality rate of 74 deaths per 1,000 live births, and a maternal mortality rate of 441 deaths per 100,000 live births. Stunting is the predominant nutritional problem, especially in rural areas, and the elevated prevalence in older children (between 18-36 months) indicates failure in growth and development during the first year of life. The evidence contributes to the growing scientific consensus that tackling childhood stunting is a high priority for governments (Olack et al, 2011), a consensus backed by increasing global attention to nutrition.

The devastating effects of micronutrient deficiencies in pregnant women and young children are very well known and deficiency rates remain high in Kenya. Children are particularly affected by deficiencies of vitamin A (84%), iron (73.4%) and zinc (51%) (Mwaniki et al, 2002). The highest prevalence of moderate to severe Anaemia has been found in the coastal and semi-arid lowlands, the lake basin and western highlands sub regions. Among women, prevalence of severe to marginal s-retinol deficiency has been found to be 51%, while severe s-retinol deficiency is 10.3%, with a prevalence of 55.1% among pregnant women. The prevalence of iodine deficiency in Kenya is 36.8%, with goiter prevalence of 6%. These statistics indicate that most women get into pregnancy whilst already nutritionally compromised. Concerning infant and young child feeding practices, indicators are also poor with only 61% of infants under six months of age being exclusively breastfed (KDHS 2014).

Kwale County has identified malnutrition as a serious public health problem, and county documents have been consistent in highlighting the need for attention to nutrition. The CIDP notes that the county's nutrition status is very low, with the predominant of manifestation being stunting, underweight and acute malnutrition. The same document proposes that malnutrition has remained high in some areas, especially in rural areas, due to historically lopsided development that has neglected some areas in service provision.

The 2014 KDHS presents data for malnutrition in children less than 5 years in Kwale county as 30% for stunting, wasting at 4% and underweight at 12%. A comparison of the national and the county data therefore reveals that the county's rates for stunting and underweight are both higher than the national averages.

The strides made so far can only be consolidated through enhanced efforts to sustain the nutrition rewards for the county. Otherwise current rates mean a third of children born in the county will still constitute an adult population unable to participate in economic and developmental activities within the county or elsewhere due to malnutrition. While malnutrition can also be fatal, those who survive will be at high risk for impaired growth and learning ability (Devlin, 2012), reduced school achievement and lifetime earnings, limited economic productivity in adulthood and poor maternal reproductive outcomes (Dewey & Begum, 2011). This real risk is supported by the Kenya Inter-Agency Rapid assessment (KIRA) which approximates between 6.2 – 9.1% of children remain at risk for malnutrition (2014) in the county. The Kenya Demographic and Health Survey (2014) also notes that children reported to be "smaller than average" at birth or children whose birth weight was less than 2.5 kilograms are considered to have a higher than average risk of early childhood death (pg.140).

Information about nutrition-specific budgeting at the county levels is scarce, reflecting an assumption that a budget for health by default includes nutrition. This lack of disaggregation is noted elsewhere (IEA 2015) surmising that disaggregation of budget information at the county level has not been fully effected. It is difficult to isolate programmes or projects that are children-specific, and makes cross-county comparisons of budgetary allocations difficult. It is important for counties to consider further disaggregation under health to specify what is for nutrition, and the development expenditure anticipated specifically under nutrition.



Picture 2: Community members discussing nutrition challenges in Mutini, Kauwi Ward in Kitui West. CISP 2016

Key Objective

The main objective of the assessment is to establish what limitations of the legal frameworks, policies and practices at the county level may be hindering the formulation of more effective strategies towards improved nutrition. The results will contribute to improved evidence based and knowledge management in informing programme policies and strategies in Kwale County. The findings will assist in the development of interventions for promotion of participation in advocacy for appropriate nutrition, and in line with the national Advocacy, Communication and Social Mobilization (ACSM) strategy and the National Nutrition Action Plan.

1.3 Methodology

The analysis was qualitative rather than quantitative, which was considered most appropriate given the open-ended and exploratory nature of the research questions and the need to probe for underlying motivations behind certain positions and practices that may contribute to the existence of bottlenecks to nutrition. It will help understand how the nutrition sector functions in the county and to establish any impediments to better outcomes. The acknowledgement that key decision makers, service providers and service users have different perspectives, yet all form a crucial part of the nutrition sector in the county, informed the choice of the qualitative approach.

The initial analysis employed a rolling literature review process, informed by the Food Security and Nutrition Policy, Food Security and Nutrition Strategy, National Nutrition Action Plan, and the National Health Policy. The review then narrowed down from the national context to the county, covering the County Integrated Development Plan, (CIDP), annual Budget Implementation Reports, draft County Nutrition Action Plan (CNAP), Budget Estimates,

Annual Development Plans (ADPs), County Fiscal Strategy Papers, (CFSPs) Medium Term Expenditure Frameworks (MTEF), Budget Review and Outlook Papers (CBROP), and other similarly county-specific documents, policies and strategies. This literature review formed the backdrop to the research.

Research Methods: The specific research methods used were Key Informant Interviews (KIIs) applying semi-structured interview questionnaires, and focus group discussions (FGDs) with open ended question guides.

Interviews: Interviews were semi-structured in nature, and each interview was between 1 and 1.5 hours in duration. The interviews were conducted with the following key respondents: The County Executive Committee Member (CEC), and County Assembly Clerk, County Director Health, County Nutrition Coordinator (CNC), and members of the County Health Management Team (CHMT). The identification of the KIIs is meant to enhance the reproducibility and credibility of the information collected as well as support future implementation of the emerging recommendations by engaging key decision makers in nutrition in the county.

Focus Group Discussions (FGDs): The field research included the community in an effort to establish the awareness and demand for nutrition services in Kwale County. Seven FGDs were conducted in various Kwale county health facilities including Kinango Kwale and Lunga Lunga Sub-County Hospitals, Diani, Tiwi and Samburu Health Centres, and Msambweni Referral. The seven health facilities were purposely selected with the assistance of the County Nutrition Coordinator. They targeted mothers and care givers who are directly involved in child care or use nutrition services. Each FGD was approximately 1 hour in duration and its composition were 10 caregivers of both genders but not necessarily in equal proportions. Since issues of satisfaction or dissatisfaction with any service delivery process are more easily shared in a group settings, and noting the nature of group discussions to sometimes reveal hidden power relations, the role of FGDs in this process was deemed vital.

In total, 19 KIIs and 7 FGDs were conducted with 10 people in each, a total of 89 respondents. Respondents were purposively sampled with assistance from the Health Department, especially the Nutrition staff in Kwale; respondents were selected based on their ability to address the key research issues from a varied range of perspectives to help triangulate the content received for enhanced quality of data. The research, which focused on selected policy makers and implementers of the nutrition services sector in Kwale County was designed to complement the literature review by providing an in-depth study of the bottlenecks affecting the delivery of nutrition services. The field research also focused on the community to establish the awareness and demand for nutrition services in Kwale County.



The assessment explored the following specific issues:

- a) Governance: funding levels for nutrition, the legal frameworks around nutrition
- b) Enabling Environment: sector coordination and collaboration, information-sharing and decision making processes, monitoring and evaluation.
- c) Capacity to deliver: Roles of the nutritionists, skills and qualifications, assessment tools, capacity levels, records and data collection, awareness and demand and resilient approaches of the community.
- d) Awareness and demand for services.

Information from these areas will be useful to: inform county and nutrition stakeholders towards enhancing current nutrition knowledge, strategies, needs and best practices at county level; support the defining of community feedback mechanisms to increase demand for quality nutrition services; and to provide duty bearers with evidence to support realistic resource allocation and strengthen coordination in nutrition and cross cutting sectors at county level.

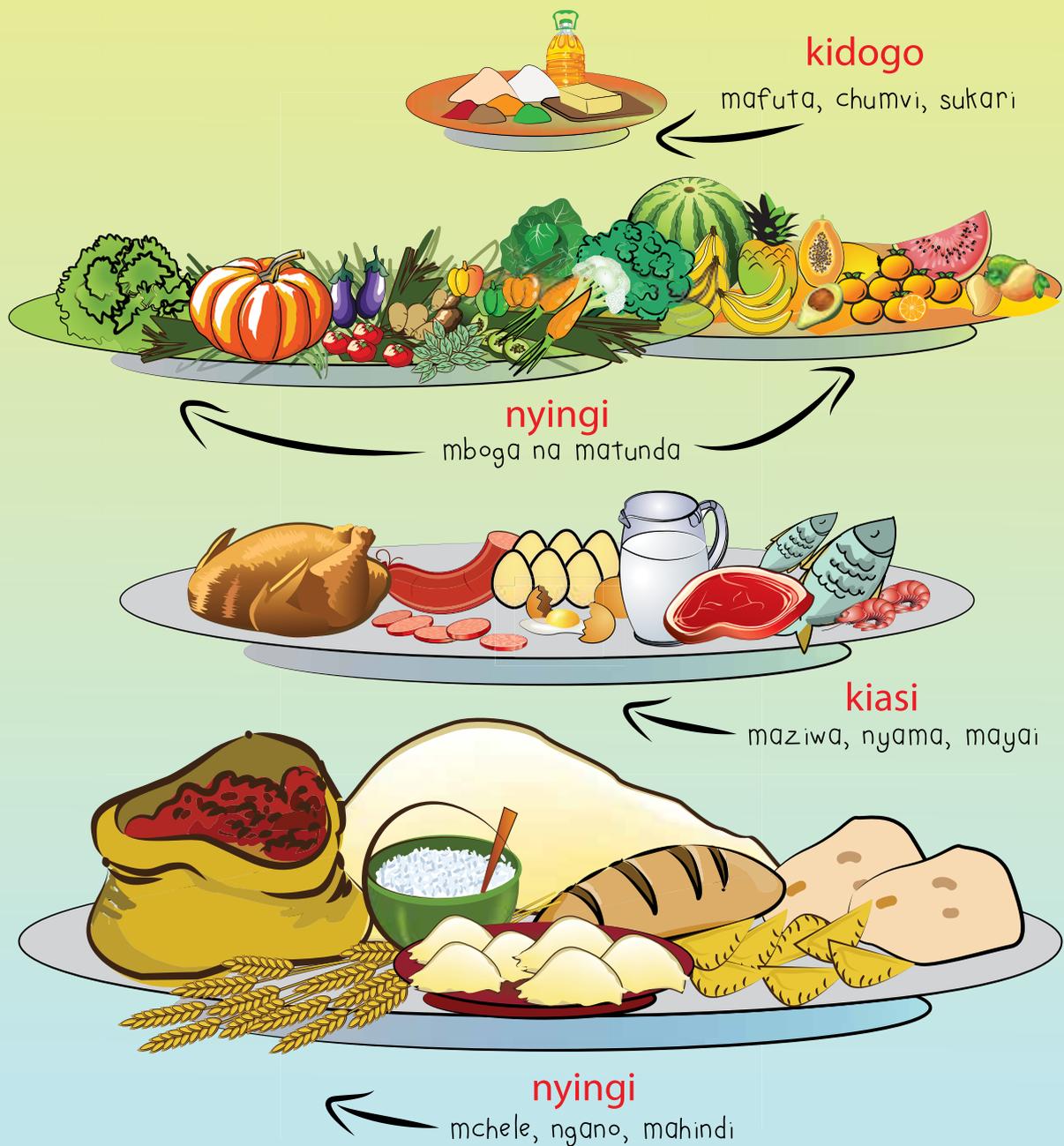
1.4 Limitations

Scope: The assessment was intended to inform advocacy actions at county level and therefore heavily confined itself in scope to the parameters established in the National Advocacy Communication and Social Mobilization (ACSM) Strategy. This means that information on nutrition that falls outside of the ACSM parameters may not be adequately explored within this study. However, the focus on the ACSM is deemed appropriate to inform immediate planning and action by counties as a sub-set of the national efforts.

Future research may consider a wider scope outside of the advocacy strategy, to paint a more elaborate nutrition picture for the county. A focus on community knowledge, attitudes and practices around nutrition will also be a useful update to the information held by the county and will help guide planning and action around community resilience enhancement.

Despite this however, the authors believe that the field research findings provide a reliable snapshot of the situation in Kwale County about the key research questions. The data collected, and the level of participation of key decision makers in the field of nutrition and health in Kwale provides critical information that supports the validity of the findings.

Kula aina tofauti ya chakula kilicho na lishe bora mara tatu kwa siku.



CHAPTER 2: COUNTY NUTRITION SECTOR

This chapter briefly reviews the nutrition situation in Kwale, presenting the status, and exploring in detail the current county efforts and policy trends. It also presents the emerging implications for the nutrition in the county.

2.1 Situational Analysis of the Nutrition Sector in Kwale County

Kwale County is one of the six counties in the coastal region, and is located in the south-eastern corner of Kenya, lying between Latitudes 30 3'and 40 45'south and Longitudes 380 31'and 390 31'east. It borders Taita Taveta County to the North West, Kilifi County to the North East, Taita Taveta and Kilifi to the North, Mombasa County and Indian Ocean to the East and United Republic of Tanzania to the South. The total population of Kwale County during the last (2009) census was 315,997 males, and 333,934 females for a total of 649,931 people. The County Integrated Development Plan (CIDP 2013) projects the total population to rise to 833,527 by 2017. The population of children under 5 in the same projection is estimated to reach 149,479 by the same year.

Table 1: Population Projection by Age Cohort for Kwale County

Age Cohort	2009 (Census)			2012 (Projection)			2015 (Projection)			2017 (Projection)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	58,558	57,996	116,554	64,284	63,667	127,952	70,571	69,894	140,465	75,100	74,379	149,479
5-9	51,722	51,303	103,025	56,780	56,320	113,100	62,333	61,828	124,161	66,333	65,795	132,128
10-14	44,109	43,265	87,374	48,422	47,496	95,918	53,158	52,141	105,299	56,569	55,487	112,056
15-19	34,631	34,538	69,169	38,018	37,915	75,933	41,735	41,623	83,359	44,414	44,295	88,708
20-24	22,949	31,662	54,611	25,193	34,758	59,951	27,657	38,157	65,814	29,432	40,606	70,038
25-29	20,245	26,447	46,692	22,225	29,033	51,258	24,398	31,872	56,271	25,964	33,918	59,882
30-34	18,197	21,379	39,576	19,976	23,470	43,446	21,930	25,765	47,695	23,337	27,418	50,756
35-39	14,875	15,519	30,394	16,330	17,037	33,366	17,927	18,703	36,630	19,077	19,903	38,980
40-44	11,143	10,750	21,893	12,233	11,801	24,034	13,429	12,955	26,384	14,291	13,787	28,078
45-49	9,469	9,350	18,819	10,395	10,264	20,659	11,412	11,268	22,680	12,144	11,991	24,135
50-54	7,889	9,123	17,012	8,660	10,015	18,676	9,507	10,995	20,502	10,118	11,700	21,818
55-59	6,380	5,902	12,282	7,004	6,479	13,483	7,689	7,113	14,802	8,182	7,569	15,751
60-64	5,103	5,415	10,518	5,602	5,945	11,547	6,150	6,526	12,676	6,545	6,945	13,489
65-69	3,458	3,376	6,834	3,796	3,706	7,502	4,167	4,069	8,236	4,435	4,330	8,765
70-74	2,973	2,890	5,863	3,264	3,173	6,437	3,583	3,483	7,066	3,813	3,706	7,519
75-79	1,703	1,697	3,400	1,870	1,863	3,733	2,052	2,045	4,097	2,184	2,176	4,360
80+	2,593	3,322	5,915	2,846	3,647	6,493	3,124	4,002	7,126	3,334	4,261	7,595
Total	315,997	333,934	649,931	346,898	366,589	713,488	380,822	402,439	783,261	405,262	428,266	833,527

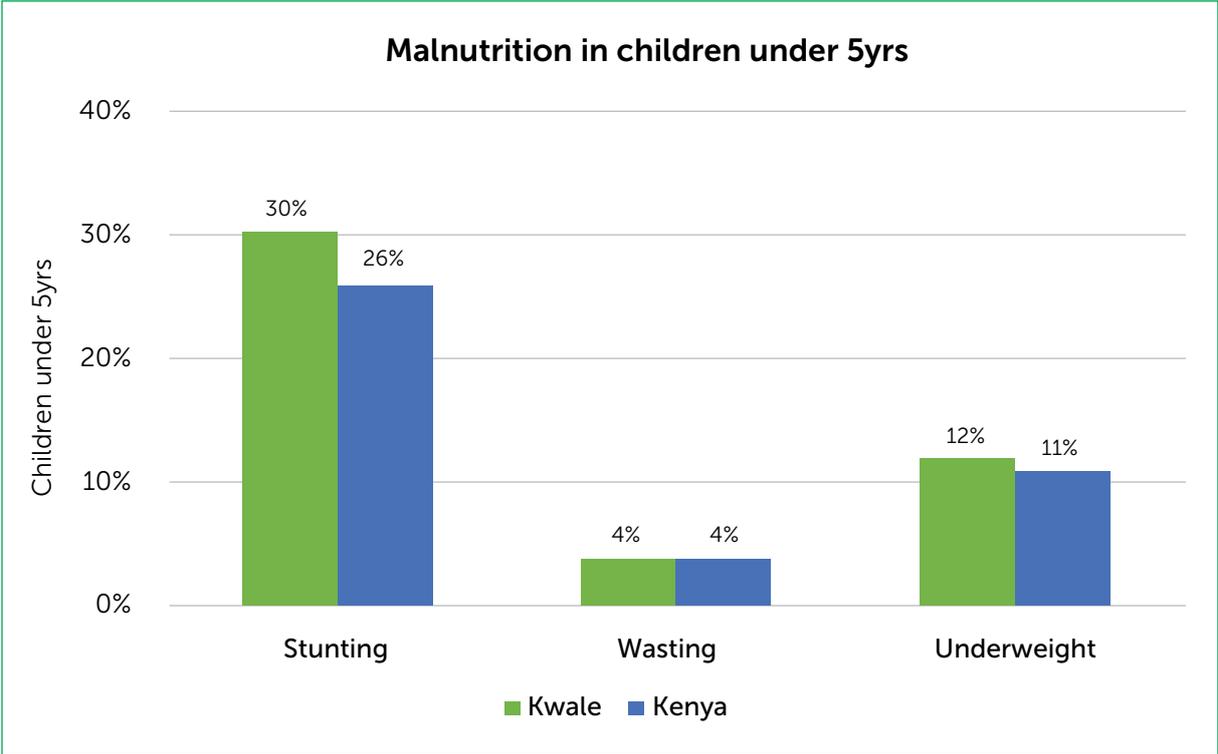
Source: Kwale County Integrated Development plan.

1. Exploring Kenya's Inequality; pulling apart or pooling together. KNBS & SID, 2013. <http://inequalities.sidint.net/kenya/county/kwale/>

Kwale County has a child-rich population, where 0-14 year olds constitute 48% of the total population (KNBS & SID 2015). In cognizance of this fact, the county has acknowledged in its inaugural CIDP that childcare, immunization and improving maternal health should be prioritized in the health sector.

The Kenya Demographic and Health Survey from 2014 has stunting in Kwale at 30%, Wasting at 4% and Underweight at 12%, with the national level rates for the same being 26%, 4% and 11% respectively. The comparison among those indicators on Maternal, Infant and Young Child Nutrition (MIYCN) show that Kwale county rates for children aged below five years are higher than the national indicators for stunting and underweight, and have parity to national indicators for wasting.

Figure 1: County Nutrition Status for children under 5 years



Data Source: Kenya Demographic and Health Survey, 2014.

According to the 2013 CIDP, stunting at the time was 35%, underweight at 21% and wasting at 6%. A comparison between the earlier CIDP data and the most recent KDHS data reflects a significant drop particularly in stunting in the county, reflecting positive strides being made under the devolved county structures to address malnutrition in line with the county plans under the CIDP.



Picture 2: Kwale County Health and nutrition officials planning for nutrition advocacy in Ukunda. CISP 2016.

2.2 Barriers to a vibrant Nutrition Sector

Laudable attempts at elevating the status of nutrition, have shown Kenya's increasing commitment to respond to malnutrition: joining the global SUN Movement in 2012, through events such as the first National Nutrition Symposium in February 2015, and securing the First Lady as a nutrition champion are just some of the indicators for this shift.

However, there are anticipated barriers to the establishment of a strong nutrition sector at national and county levels, including: a lack of direct funding to support pro-active planning; the absence of fully functional and sustained citizen participation systems; intra-sectoral and inter--sectoral activities that, when uncoordinated, may not fully harness existing actors for maximum benefits; low awareness and demand for health and nutrition services from communities; quality and quantity of nutrition staff in the county that requires further investment; lack of contextualized regulatory frameworks, guidelines and legislation; and lack of appropriate tools, or knowledge of the tools for data collection and evidence-based researches to inform practice.

Given the nutrition statistics for Kwale, approximately 30 % of children in Kwale County are at high risk for impaired growth and learning ability and reduced school achievement. The same population will, as adults have reduced and lifetime earnings, limited economic productivity and constitute an adult population that will be unable to fully participate in economic and developmental activities in the County due to malnutrition.

2.3 The policy Framework

Kenya's first National Food Policy (Sessional Paper No. 4 of 1981), which was consolidated into Sessional Paper No. 1 of 1986 on Economic Management for Renewed Growth, aimed to maintain broad self-sufficiency in major foodstuffs and ensure equitable distribution of food of nutritional value to all citizens through government interventions, such as setting grain prices, state monopoly of input distribution, and across the board fertilizer subsidies. Agriculture and rural development were ranked as the topmost government priority, with

food security listed as one of five key sub-sectors in the Kenya's Poverty Reduction Strategy Paper (PRSP) of 2001.

Following the 1991-94 drought, Kenya's second National Food Policy (Sessional Paper No. 2 of 1994) promoted a market driven approach, but on a limited scope. The National Plan of Action on Nutrition of 1994 aimed at addressing nutrition problems in the country through involvement of various sectors and was developed through a consultative process. However, it lacked an implementation framework with clear coordination mechanisms and commitment to fund implementation of the planned activities.

Government's initiatives to revive the economy and the agricultural sector are fully in line with its international commitments and declarations to end hunger and extreme poverty, including the World Food Summit of 1996, the United Nations Millennium Development Goals (MDGs), and the Comprehensive Africa Agriculture Development Programme (CAADP) of the New Partnership for Africa's Development (NEPAD) prepared in 2002. Efforts so far have not successfully managed to address issues of malnutrition comprehensively, therefore the need to have an overarching policy that integrates food and nutrition security initiatives.

The Economic Recovery Strategy (ERS) was supported by the Strategy for Revitalizing Agriculture (SRA) 2004-2014 which evolved into the Agriculture Sector Development Strategy, ASDS (2010-2020). The mission of the ASDS is to create an innovative, commercially-oriented and modern agriculture to ensure a food-secure and prosperous nation. The Vision 2030, under the economic and social pillars emphasizes the enhancement of productivity of crops and livestock, incomes, and food security and nutrition.

The successful implementation of ERS paved way for Vision 2030, whose aims are to transform Kenya into a globally competitive and prosperous nation with a high quality of life. In the Vision 2030, under the social pillar, the health sector is identified as critical in maintaining a healthy working population, necessary for the increased labor production that Kenya requires in order to match its global competitors

Under the economic and social bill of rights, every Kenyan has a right to adequate food of acceptable quality as well as clean and safe water in adequate quantities. Further, the constitution stipulates that every child has the right to basic nutrition, shelter and healthcare. The government takes greater responsibility in ensuring that the right is enjoyed by all Kenyans. The Government of Kenya has developed in 2011 the Food and Nutrition Security Policy to address nutrition security in the country. This policy places nutrition central to human development in the country; emphasizes the need to ensure of right to nutrition as a constitutional right, recognizes disparities in nutrition and provides relevant policy directions; ensures multi-sectoral approach to addressing malnutrition in the country; ensures life-cycle approach to nutrition security and ensures evidence based planning and resource allocation.

The Kenya Constitution Article 53(a) stipulates that every child has the right to basic nutrition, shelter and healthcare. Enshrining the right to food, basic nutrition and healthcare in the constitution marks a radical shift in programme development and implementation around these issues, and the government takes greater responsibility in ensuring that the right is enjoyed by all Kenyans.

The National Food and Nutrition Security Policy then commits the government to ensure that ***"all Kenyans, throughout their life-cycle enjoy at all times safe food in sufficient quantity and quality to satisfy their nutritional needs for optimal health"*** (FNSP, 2011).The Food

Security bill (2014) further acknowledges the right of every Kenyan to be free from hunger, and to have adequate food of an acceptable quality, and provides that both national and county governments, among others, take reasonable measures to monitor and evaluate strategies and programmes for the realization of the right to be free from hunger and the right to adequate food. Consequently, the bill obligates national and county governments to promote childhood nutrition to their extent of their mandate as set out under the constitution.



The national government has developed several policies and programmatic efforts aimed at addressing the nutrition problems and addressing poverty reduction and food security in the country. These include:

- Sessional paper no.10 of 1965 on African socialism and its application to planning in Kenya – This paper emphasized on the eradication of poverty, disease and ignorance
- National food policy (sessional paper no. 4 of 1981) –It was Kenya’s first food policy and aimed to maintain broad self-sufficiency in major foodstuffs and to ensure equitable distribution of food of nutritional value to all citizens
- National food policy (sessional paper No.2 of 1994) – It was Kenya’s second food policy developed following the 1991-94 drought. It promoted a market –driven approach to food security
- Kenya Rural Development Strategy (KRDS) 2002-2017 – It was a long-term framework outline, with a broad range of strategies for the improvement of rural Kenya over the next 15 years. It emphasized food security as the initial step towards poverty alleviation/reduction and rural development
- Economic Recovery Strategy (ERS) for wealth and employment creation, 2003 -2007 which focused on achieving good governance, transparency and accountability and providing a lasting solution to hunger, poverty and unemployment
- Strategy for Revitalizing Agriculture (SRA 2004-2014). Cascaded from ERS, its primary objective was to provide a framework to increase agricultural productivity, to promote investment and encourage private sector involvement in agriculture
- Then came Kenya Vision 2030 which was launched in 2007 to further consolidate the economic recovery momentum gained from implementation of the ERS. The vision identifies agriculture as the key mover of raising Kenya’s GDP to 100%. The vision recommends devolved funds targeting communities with high incidence of poverty, unemployed youth, women and all vulnerable groups and investments in arid and semi-arid districts
- The Agriculture Sector Development Strategy (ASDS) of 2009 has been developed by the agricultural sector to align sector initiatives to vision 2030
- The National Food Security and Nutrition Policy (NFSNP) of 2009 addresses the need for enhanced food and nutrition security, information management systems and coordination of the roles of various ministries and agencies to achieve food security

- Other policy instruments that support national food security initiatives include; the Land policy (2009), The National Agricultural Sector Extension Policy (NASEP) of June 2012, Environment, Water and Irrigation, livestock, Oceans and Fisheries Policy, and ASAL Policy among others.

The Food and Nutrition Security Policy (FNSP) – 2011 provides an overarching national framework covering the multiple dimensions of food security and nutrition improvement. The FNSP commits the government to ensure that efficient and effective institutional and legal frameworks are established for the implementation of food and nutrition security strategies. Legal frameworks provide obligations and parameters of action that actors are required to operate within.



The Food and Nutrition Security Policy Implementation Framework (FNSP-IF) and the National Nutrition Action Plan were developed from the FNSP as implementation tools for the same. The three broad objectives of the FNSP are:

- To achieve good nutrition for optimum health of all Kenyans
- To increase the quantity and quality of food available, accessible and affordable to all Kenyans at all times
- To protect vulnerable populations using innovative and cost-effective safety nets linked to long-term development.

As per the Kenya Nutrition Action Plan (KNAP, 2012- 2017) policy makers and programmers need sensitization on the causal factors of malnutrition and influence them to address malnutrition in a holistic approach. The Action plan also acknowledges that pieces of legislation, nutrition-related policies, strategies and guidelines need urgent review to align them to the current Constitution.



Picture 3: A media representative contributing to nutrition discussions with county nutritionists in Kwale. CISP 2016.

The Kwale County Integrated Development Plan acknowledges the existence of poorly formulated public policies and pegs this to their initial formulation at national government level with limited relevance to county governance concerns. The community has poor access to the existing national level policies, which also weakens their implementation.

Whereas the burden of malnutrition tends to lie heavily on the health sector, the study found no policy, laws or legislation that supported nutrition in Kwale County despite the acknowledgement of relatively high levels of malnutrition. With no legislation, there is neither obligation to support nutrition outcomes, nor adequate contextual legal backing for any emerging county commitments. This in turn causes a consistent lack of deliberate action in alleviating malnutrition.

A county-specific food and nutrition security policy would target the challenges for the sector at county level and help articulate what the county government commits to do. From this commitment, a requisite budget would be developed based on the objectives and the activities envisioned under them. A county policy would also acknowledge the specific range of actors in the county and leverage their input, so that clear coordination mechanisms are put in place to maximize the effect of all activities in the county.

There was a disconnect in awareness on malnutrition-related issues between county nutrition stakeholders and the County assembly, where legislation is done. This could partly explain the absence of legislation introduced to support nutrition in Kwale County despite the high prevalence of malnutrition. Kwale County has no legal framework within which to operationalize the nutrition sector at the county level and hence the lack of a legal binding commitment to support nutrition making it easy to overlook nutrition and slow to push the nutrition agenda.

During the period of the study, the County was processing the development of a draft County Nutrition Action Plan, bringing together county government actors and development partners in the process. Through the County Nutrition Technical Forum (CNTF), areas related to nutrition, including research, monitoring and evaluation, maternal, infant and young child nutrition, integrated management of acute malnutrition, are receiving technical attention from the Department of Health Services.

This gap for a county-specific policy is further supported by a similar gap in the National FNSP policy statement that reads: Subject to availability of requisite resources, the Government will ensure that every Kenyan is free from hunger, has adequate supply of food of acceptable quality, has an interrupted supply of clean and safe water in adequate quantities, at all times.

The policy statement therefore appears to absolve the National government from committing itself to freedom from hunger as it subjects a constitutional right to the chance of fund availability. The County Government of Kwale has not yet contextualized this policy to strengthen its application at county level, though great strides in increasing funding for health have been made.

The alleviation of malnutrition in Kwale is a decision with financial, policy and technical resource implications, and therefore ultimately is a political decision. The political leadership in the county has shown its will to target and support nutrition efforts through its core county planning document, the CIDP. This political will, coupled with advocacy and funding, should merge in joint efforts to mainstream nutrition into the county agenda. There is need for county specific policies and legislation that support nutrition, policies that mirror the national vision, but are contextualized to address Kwale County's needs.

Another potential contextualization opportunity for Kwale County lies in the national government FNSP policy objective ***to ensure an adequate institutional and legal framework, and to mobilize sufficient resources in order to achieve the objectives of the national Food and Nutrition Security Policy (FNSP)***. The policy statement emphasizes that existing institutional coordinating mechanisms, including at national and sub-national levels, will be strengthened and broadened to support the FNSP and related strategies and programmes. A multi-sectoral Food Security and Nutrition Secretariat should be created to ensure broad, cross-sectoral implementation, coordination and monitoring mechanisms. The government should commit financial resources through its Medium-Term Expenditure Framework (MTEF) to meet the goals of the FNSP. Policy implementation will consider government budget allocation and staffing constraints, and will be appropriately phased within this context.

Kwale County could benefit from this by domesticating the FNSP and elaborating on an already existing variety of partners, coordinate their inputs and channel scarce resources towards a common goal. The office of the County Nutrition Coordinator currently leads planning and sharing meetings with a range of stakeholders in nutrition, and such coordination can be leveraged for improved financial, technical and commodity support for nutrition through relevant policies and legislation.



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CHAPTER 3: GOVERNANCE

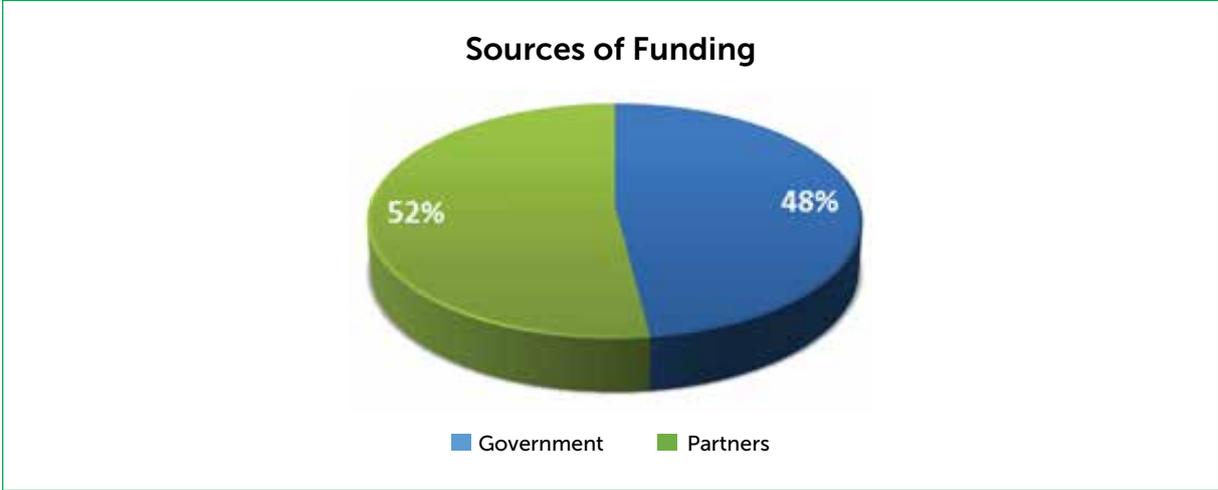
This chapter briefly reviews bottlenecks in Governance and the enabling environment in the delivery of nutrition services, it reviews the legal framework and the extent to which legislation and policies are developed and implemented in practice to support nutrition at the County.

3.1 Funding for health and nutrition

The government policy objective is **to ensure an adequate institutional and legal framework, and to mobilize sufficient resources in order to achieve the objectives of the national Food and Nutrition Security Policy (FNSP).**

The national government budget for health currently stands at 7% of the total government budget despite Kenya being a signatory to the Abuja declaration that commits at least 15% of the total government budget to health. The latest data on health expenditure is from the Kenya National Health Accounts (KNHA) of the 2012/2013, that was published in 2015. In this data, the total health expenditure on nutritional deficiency was Kshs. 896 million (US\$10.5 million) in 2012/13. This amount accounted for 2% of the health budget, corresponding to 0.4% of overall health expenditure and 0.09% of the Gross Domestic Product for the same year. From the same data, approximately 52% of funds used for nutrition activities come from and are managed by other non-government stakeholders, while about 48% was government funded. Moreover, seventy-five (75%) of this budget was marked for human resource needs and administration.

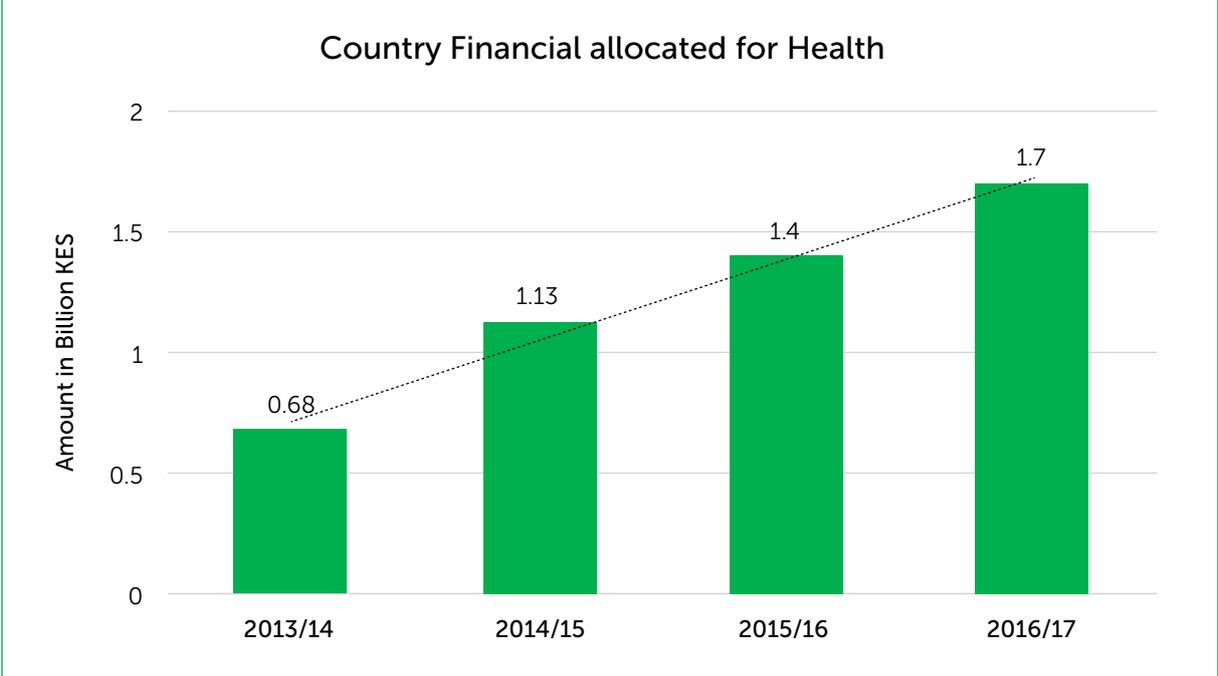
Figure 2: Source of Nutrition Funding



From county budget documents reviewed, the county has nearly doubled allocation for health from KES. 678.9m (2013/14) to KES. 1.13B (2014/15) and has steadily continued to increase the health budget from KES. 1.4B (2015/16) and KES 1.7B (2016/17). However, increase in funding for health has not automatically translated to increase in funding for the nutrition sector in the County.

Asked if the funds allocated for nutrition were adequate, all stakeholders agreed that the funds available were insufficient. The County nutrition sector reportedly receives an average of Ksh. 800,000 from the County Budget annually for Nutritionists salaries in Kwale County. This translates to less than 1% of the total health budget.

Figure 3: Health Budget for Kwale County



There are no specific financial resources allocated for nutrition or a vote line assigned for nutrition activities; instead all funds were pooled together in one basket of promotive and preventive programmes. To access these funds, the nutrition coordinator raises a proposal for a specific activity and is provided with the funds subject to their availability. While the method has been working, the challenge has been in prioritizing nutrition during fund allocation. Chances are that funds are more likely to be channeled to curative programmes rather than preventive, as the latter would be an emergency. "Requisite Resources" to address nutrition in the county are subject to availability as stated by the national policy. The nutrition programmes implemented largely tend to be reactive rather than pro-active in the current finance access structure.

The CIDP, 2013- 2017 for Kwale County, though acknowledging that the nutrition status in the county was very low, does not adequately address Malnutrition as an area of priority. Despite the steady increase in funds allocated for health over the last three years since devolution, none of the seven strategies for promoting health in Kwale County addresses nutrition. Adequate funding for nutrition is imperative if meaningful gains are to be made to alleviate malnutrition in the county, and translate the commendable continued investment in health to similar, trackable investment in nutrition.

However, in the interim, the existence of partners has been instrumental in supporting nutrition in Kwale County. These include, UNICEF, Peace Corps, Population Services Kenya, European Union, International Medical Corps, and the International Committee for the Development of Peoples - CISP among others. These partners have contributed significantly in narrowing the funding and structural gaps to some extent, however both the entry and exit strategies of partners have been a sore point of reference, according to the County officials. The validation

exercise carried out in Kwale revealed discontent among the health workers with regards to financial transparency, continuity of projects, and terms of engagement with nutrition partners. An example they gave was that when some health projects were discontinued, sometimes the result would be a complete reversal of achievements made during the period of project implementations, therefore eventually wasting time and scarce resources.

Whereas the FNSP proposes that “subject to availability of **requisite resources**, *the Government will ensure that every Kenyan is free from hunger, has adequate supply of food of acceptable quality, has an uninterrupted supply of clean and safe water in adequate quantities, at all times*”. The policy statement assures the citizens of Kenya that the Government will ensure that the citizens shall be freed from hunger but denies the same right by absolving themselves in the same statement by saying all this will be subject to requisite resources. The lack of commitment to support adequate nutrition has also resulted in the lack of adequate funding for nutrition nationally, a shortfall at the National level that the county of Kwale could improve on to both fit the context of the county, and establish tangible commitment to further nutrition and health for Kwale.

Respondents were also asked how a nutritionist would access funds for day-to-day running of activities, and they agreed that usually they would go to the hospital administrators and hand in a requisition form based on what was needed. Once the administrator approved the requisition, the nutritionist would then go to the accounts office for the funds.

The respondents agreed the funds flowed to the health centers and that they had received some funds for nutrition activities. It was however, not clear on exactly how much was spent on nutrition activities, as amounts varied across the respondents. There isn't a clear communicated specific budget line for nutrition.

In a validation exercise carried out in Kwale county among the Department of Health stakeholders, members explained that the National Treasury had coded line items in county budgets, and the counties were not at liberty to include nutrition as one of the budget lines. An alternative position was that the counties were expected to use the National Treasury codes up to the 2014/2015 financial year. After that, counties were at liberty to create programs and sub programs within the county budget. It was therefore up to the department of health to advise the County Budget Committee accordingly.

Whereas majority of the respondents (80%) felt that the funds available were insufficient, the lack of a budget line on nutrition in Kwale County has made it difficult to analyze the amount of funds committed and spent on nutrition specific activities. This translates into an unclear picture of what is required to achieve specific results in nutrition, hence denying Kwale County an opportunity to implement evidence-based decision-making around nutrition.

Though the platforms for sharing nutrition information were in existence, they were not very effective given that the meetings/forums were not held to specifically address nutrition but simply provided an avenue for sharing information since it gathered communities together. The forums were also likely to be gender biased e.g. the *Maendeleo ya Wanawake*, and were not consistent in representativeness, hence not always reliable.

A population that is informed about their own current nutritional status and trends can make informed decisions and choices about their own health and development. They are more likely to seek further information and demand for services that meet their needs, and will find value in contributing through participation in the decision-making and planning in their

community processes. This requires that counties have effective structures for information sharing and citizen participation which are critical for social and economic development. The Kenyan constitution (articles 10, 33, 174) supports this participation and community engagement in issues affecting them.



The County Governments Act (Sections 89, 91, 94) similarly supports this engagement through information where counties provide platforms for citizen information and feedback. The sections also provide for county governments to respond to issues raised by the citizens, as well as use mechanisms with the widest outreach to pass information to citizens.

Kwale County has shared information using local radio in some instances, and is online with a website at <http://www.kwalecounty.gov.com/> that provides information including the county structures, ministries, and press releases. It also has social media presence on various pages including Twitter presence online at <https://twitter.com/ourkwalecounty> where the county has also shared relevant health information. The county website however lacks some key documents in relation to health.

For example, the only downloads available at the end of 2016 were tenders (uploaded), press releases and budgets and plans (tabs, but no documents uploaded). The site mentions a range of health statistics, whose source documents would be useful to add as links to the website. The County Integrated Development Plan itself is not available on the website. It is also written exclusively in English.

However, some of the platforms outside of the urban centers for information sharing cover a limited audience. Twitter, for example, requires a smartphone with a little more complex operation knowledge as compared to basic Short Message Service (SMS) that still utilizes the phone but has no limitations on phone type. Written messages however, require that the local community is literate and this might not be the case all over the county. The CIDP cited an average of 57% literacy in the county, meaning nearly a half of the population may not benefit from written communication materials. Even more important to nutrition interventions using information materials is the fact that the literacy levels are lower for women (47%) as compared to men (66.6%).



Picture 4: The County nutrition coordinator (right) awards a certificate to a social editor after completing training in Kwale, CISP 2017.

There is need for Kwale County to strengthen existing communication structures, by adapting them to be easily available to the service users. Downloadable IEC materials should be uploaded for those who can access the website, and the language options expanded from English. Media use and traditional community *barazas* can still be useful avenues to support effective information sharing on new and ongoing nutrition and health interventions by the county.

Health and nutrition data is collected through comprehensive SMART surveys, the Kenya National Bureau of Statistics (KNBS), the principal Government agency for official statistics through the Kenya Demographic and Health Survey (KDHS). The survey collects information on, among others, maternal health and mortality; antenatal and postnatal care; infant and child mortality; nutrition; breastfeeding; child health; family planning; fertility and fertility preferences; HIV/Aids knowledge, attitude and practice; malaria; household and respondent characteristics, and other health related issues. This is done in partnership with the Ministry of Health, National Council for Population and Development and development partners.

However, whereas the FNSP reported that information sources and health information databases were poorly managed, and data collected in the national sample frame was not disaggregated to lower administrative levels, the 2014 KDHS was the first survey designed to provide demographic and health indicators at the county level.

County health officers were asked who was responsible for ensuring the data collected was of good quality. Some respondents said it was the nutrition officer-in-charge's responsibility, and others suggested it was a collective responsibility since they have data review meetings before sending reports to the sub county. It wasn't clear to the respondents who was responsible for quality assurance in data collection. The respondents also said that the data collected was stored either manually or electronically. Manual storage utilized hard copy registers, while the electronic storage included a soft copy file, and the District Health Information System (DHIS).

Table 2: Information storage and access in health facilities in Kwale

Information Storage methods	
Electronic System	Manual System
Soft copies online	Hard Copy registers
DHIS	

The mode of storing information mentioned by respondents at facility level was manual registers kept by the records officer in the facility. The method, should it be the main one, may sometimes prove cumbersome and inconvenient, as different registers exist for different purposes e.g. registers for: Antenatal care (MoH 405), Child welfare Clinic (MoH 511, Inpatient Register (MoH 301), Maternity register (MoH 333), Outpatient Under 5 register (MoH204b), Immunization (MoH 510), Postnatal Care (MoH 406), just to name a few. Without a clear method for collating the different data and prompt sharing and retrieval across the service delivery chain, this may discourage the use of evidence for decision making in nutrition.

When asked how to access health information in the county, the health officers' responses included access granted by the administrator, and the DHIS data through the records officer. The County Nutritionist and sub county Nutritionist similarly had access to nutrition data at county level.

Information retrieved is used for monitoring patient's progress, reviewing and changing regimens, checking differences between the levels of malnutrition to determine trends of malnutrition and analyze the ongoing interventions. It is evident that there is existence of Nutrition data though there is need for regular reviews to ensure efficiency and updated information. . This data should, at its very core, support counties through providing evidence to inform decisions in support of better nutrition.

3.2 Process of Decision making

The devolved governance structure advocates for the participation of people in processes and decisions that affect them. Currently, the county structure, as concerns nutrition, utilizes existing processes like community strategy, *Nyumba Kumi* and *Maendeleo ya Wanawake* as highlighted above as avenues to share information with the communities and collect feedback from them. The county also uses these platforms to collect information on a range of issues of concern, aside from using the usual public participation forums related to the budget that are more common and county-led. These processes inform the community of existing nutrition strategies and allow for the incorporation of the community in the decision-making process.

However, given that both initiatives were originally in support of different issues, i.e. Security for *Nyumba Kumi*, and Women Empowerment for *Maendeleo ya Wanawake*, there still is a need for a nutrition-specific community platform or forum that would strengthen participation in nutrition and health. The county structure for decision making does not explicitly provide for involvement of the community in decision making except for budget preparation in accordance with the County Governments Act and the Public Finance Management Act.

Aside from the constitutional provisions for greater public participation, the importance of involving the stakeholders in decision making is that it allows for active participation in the process eliciting ownership and responsibility for actions taken by the decision makers for improving the community. It also allows the community to better understand the objectives

and creates positive synergy between the officials and the community leading to expected outputs. Decisions reached are therefore sustainable with a wide range of active stakeholders. When communities are not involved in decision making, adoption of the recommended practices becomes slow and are prone to resistance.



Picture 5: County Nutrition actors after an advocacy training by the county government and partners, CISP 2016.

3.3 Regulatory Body

The national government policy on food and nutrition states as one of the objectives, to ensure safe, high quality food by creating public awareness on relevant issues, and by setting, promoting **and enforcing appropriate guidelines, standards and a regulatory framework, (Kenya National Food and Nutrition Security Policy, 2011)**. Guidelines and standards are used to ensure that beneficiaries receive quality services and that there are Standard Operating Procedures guiding the delivery of each service. The absence of a dedicated regulatory framework may result into varied standards of service delivery within the same location, causing undue disadvantage to the beneficiaries of the nutrition service.

There are no less than 20 legislative acts that govern food safety and quality in Kenya. However, county specific guidelines and standards, based on the national and international standards, should be discussed, and where found to add value, developed, revised or updated. These standards and guidelines will focus not only on food and food products but also service delivery in various sectors in response to Kwale County's needs. The private sector as well as development partners will be significant allies to further County efforts to improve food product quality, regulations and safety.

Kwale County is yet to establish a contextualized regulatory framework for nutrition. A regulatory framework would ensure that standards of service are always maintained, and guidelines followed. Without standards, the quality of services provided is likely to vary from time to time and from place to place compromising the health of the population. Whereas the county health actors at facility level have access to a range of nutrition-specific guidelines and Standard Operating Procedures (counseling, young child feeding, hygiene and sanitation,

IMAM and, Guidelines on Nutrition in HIV), overall county-level, county-specific regulations for nutrition are yet to be formulated.

The national regulatory body for nutrition is the Kenya Nutritionist and Dieticians Institute (KNDI) enacted by an act of parliament. The body has been effective in the regulation of nutrition curriculums at institutions of learning but has not supported regulating service delivery outside these institutions. Other institutions that may be of support to establishing regulatory frameworks and guidelines include the Kenya School of Government (KSG), Kenya Medical Training College (KMTC) and Kenya Medical Research Institute (KEMRI) which the Department of Health in Kwale County reports to have existing institutional engagements with, to assist with, among others, meeting the human resource gap at the health centers.

Institutional engagements strengthen partnerships, improve productivity and efficiency. Kwale County may need to strengthen engagements with current and new institutions in promoting nutrition given that the causes of malnutrition are multi-faceted. Institutions such as universities, government ministries, research, development and private entities are likely to significantly support the county to positively influence nutritional outcomes in Kwale County.

3.4 Sector Coordination

Priority area number XI in the National Nutrition Action Plan addresses commitment to strengthening coordination and partnerships among the key nutrition actors. The food and nutrition security secretariats that will be formed in the future will bring together all relevant ministries to ensure broad, multi-sectoral implementation, coordination and monitoring mechanisms. The process of alleviating malnutrition must be approached by addressing all the underlying causes that originate from different sectors of the economy. The education sector, for example, is important in promoting nutrition education while the agriculture sector is important in promoting food security. One sector can be used to strengthen the other.

At national level, the nutrition sector is coordinated through Nutrition Interagency Coordinating Committee (NICC) with four sub-committees, namely Maternal Infant and Young Child Nutrition, Nutrition Technical Forum, National Micronutrient Deficiency Control Council, Healthy Diets and Lifestyle plus Research, Monitoring and Evaluation.

There exist platforms for sector coordination in Kwale County; most notable being the County Nutrition Technical Forum (CNTF) under the County Steering Group (CSG). The CSG is coordinated by the County Commissioner with the NDMA as the secretariat. However; the CNTF faces challenges given that it has no budget for operations. By the time of the interviews the (CNTF) had done a total of 5 meetings out of the expected four meetings yearly, reflecting a willingness to coordinate County Nutrition issues, but such meetings need financial support, which could be catered for under a nutrition budget line.

On collaboration, the different sectors impacting nutrition have met before, but the meetings are irregular, especially due to the different sectors implementing their own agenda independently. This poses a risk that some efforts would be duplicated by other actors, diluting the value the county derives from current resources for nutrition. The causes of malnutrition are multi-sectoral in nature requiring a broad range of actors including: Planning (human development), Agriculture (food security), Industry and Trade (food availability), Economy (purchasing power), Women and Children Development (family empowerment), Education (knowledge and skill), Manpower/Workforce (productivity) and Socio-culture (nutritional behavior). Nutrition decision-makers therefore need to look beyond the health sector and consider an integrated approach for successful achievement of goal.

Kwale County has several agencies working in nutrition, supported by donors and implementing partners working towards better health and nutrition. With many stakeholders and partners in nutrition, the actions are yielding results, though not at the pace envisioned by the county actors in nutrition. Through the coordination role of the County Nutrition Coordinator's office under the Health Department, partnerships from different sectors with actions towards nutrition are currently guided, backed and driven by the county government to ensure sustainability and avoiding future eroding of gains made. There is a need to further strengthen this office as a coordination unit so that all varied actors, objectives, action, experiences, technical, financial and other support would be harnessed for Kwale County objectives in nutrition and help break the vicious cycle of malnutrition.

3.5 Enabling Environment

There is a clear and intentional shift from the hitherto existing focus on infrastructural responses to health and nutrition issues towards understanding the enabling environment that promises better results in nutrition at national level. The international conference on nutrition held in Rome (1992) emphasized that slow progress in solving nutrition problems reflected the lack of human and financial resources, institutional capacity and policy commitment needed to assess the nature, magnitude and causes of nutrition problems and implement concerted programmes to overcome them.

Nationally, some of these reflections still hold true, examples including the budget for health through grants, ratio of nutritionists to populations, and intermittent industrial actions by health workers. The most recent (2013) International Conference of Nutrition noted a special role for public and private sectors to work together to control malnutrition. The conference also noted the role of nutrition in prevention and treatment of other diseases such as Malaria.

With the devolution of the health services to counties, there is need for Kwale County to consider developing its own, effective legal framework for nutrition to guide the actions aimed at solving of nutrition problems, and bring to bear the wide range of public and private sector actors to join hands in this process. To do this, however, the county government may first need to make even firmer social, economic and political commitments to achieve the objective of promoting the nutritional well-being of all its people as an integral part of its development policies, plans and programmes in the short and long run.

While most of the key informants did agree that malnutrition should be addressed, there was more emphasis placed on malaria and HIV/AIDS in terms of priority. Kwale County did have a high disease burden which would explain this prioritization by the county, though the strain of malnutrition is also acknowledged but lacks a similar concerted effort like Malaria and HIV/AIDS.



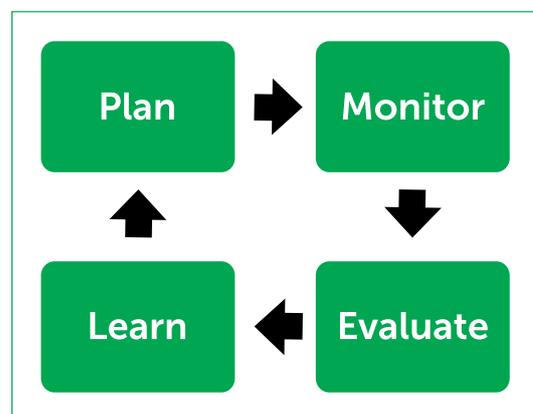
Picture 6: Civil Society and county government representatives in a session on communicating nutrition information to different actors, CISP 2016.

Under devolution, the county has shown commitment to improve nutrition in schools, by allocating 7 million shillings for school feeding programmes (The Institute of Economic Affairs, 2015). Advocacy for appropriate nutrition in Kwale County will play a crucial role in furthering this agenda, not only across the range of high level political decision makers, but also to policy decision implementers and service users for a holistic platform for the nutrition agenda in the county.

3.6 Monitoring and Evaluation system for nutrition

The 2011 Food and Nutrition Security Policy tasks the government with building into the strategic framework an effective Monitoring and Evaluation System whose main work will be to monitor programme implementation and performance against a set of pre-determined indicators. The policy promises to support line ministries in their efforts to monitor their contributions towards attaining food and nutrition security goals and objectives through their own sectoral plans and technical programmes. The vital role of Monitoring and evaluation in achieving the Food Security strategy is therefore recognized at national level

Kwale County does not have a specific nutrition monitoring and evaluation system in place, and largely relies on the DHIS in getting relevant information, and nutrition tracking data for decision making. However, the county, through its Health Department, is in the process of developing a County Nutrition Action Plan which would have a monitoring and evaluation component. The current lack of a localized monitoring and evaluation system in place for county nutrition actions means that County interventions may not all be captured to reflect the real level of interventions and consequent



results achieved. A potential result is lower use of evidence in identifying specific nutrition requirements and timely provision of services to the areas of greatest need.

Whereas the application of the DHIS data is helping the county in current action towards nutrition interventions, there are some gaps in knowledge on the indicators and data tools from the DHIS among the health care workers. The county health and nutrition officers interviewed mentioned a range of monitoring and evaluation tools, including Child Welfare Clinic registers, Daily activity register, Supplementary Food Programme register, OTP register, Adult Nutrition registers for HIV Patients, Children Nutrition registers for HIV Patient, and MOH 407, 713, 733 A, and 734 B). However, how all this raw data is collected, analyzed and incorporated into a final decision-making process was unclear to the respondents.

It is noteworthy, however, that the ministry of health has developed a National Nutrition Monitoring and Evaluation Framework (2013) to monitor implementation of nutrition activities in the country. The framework is expected to provide a benchmark for planning, budgeting, reporting and re-strategizing of nutrition interventions for counties and the country to ensure sharing and scaling up of best practices.

2. National Nutrition Monitoring and Evaluation Framework available at <http://www.nutritionhealth.or.ke/wp-content/uploads/Downloads/National-Nutrition-Monitoring-Evaluation-Framework.pdf>

Umri wa miezi 6-12

Wakati mtoto wako anapotimiza miezi sita, anza kumpatia vyakula vingine vilivyo safi, lishe bora na vimeandaliwa kwa njia salama.



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1-2 kwa siku

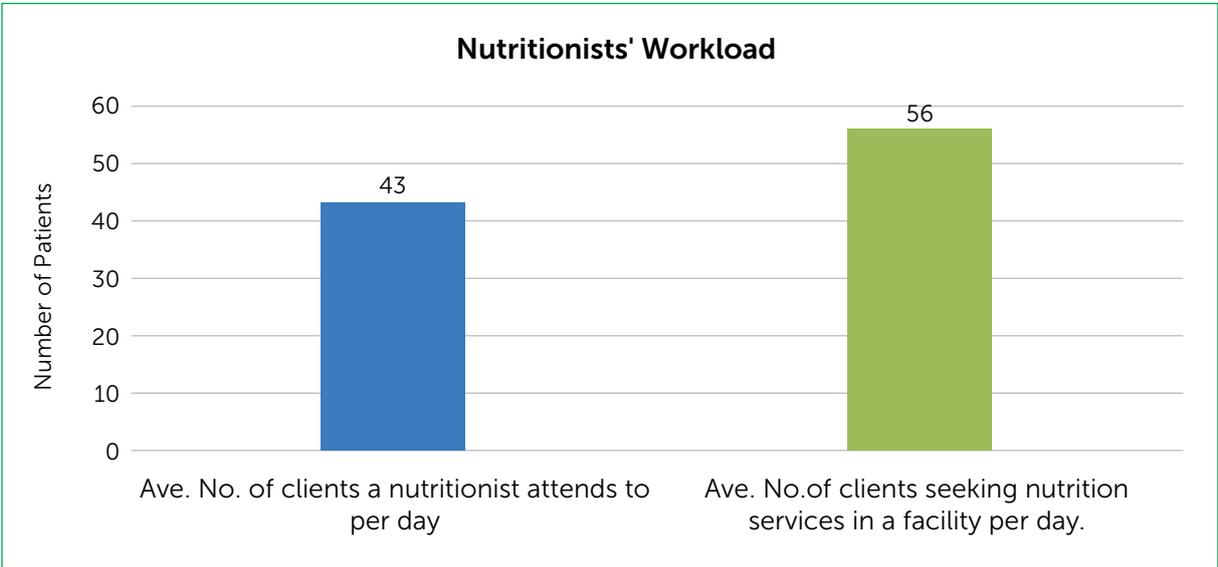
CHAPTER 4: CAPACITY TO DELIVER

4.1 Staffing and Recruitment

The Kenya Nutrition Action Plan (KNAP, 2012–2017) reports that human resource gap for nutritionists and dieticians within public health facilities and at community level is critical and needs immediate action. According to the Kenya Nutrition and Dieticians Institute, there are 1,290 nutritionists, with 600 of them in public health facilities. This translates to 1 nutritionist for every 31,000 people nationally. Kwale County has employed a total of 17 nutritionists cutting across all cadres, and with the CIDP projecting a total population of 783,261 by 2015, this presents a ratio of 1 nutritionist to 46,074 people at the county. This number remains low for the population and may not effectively respond to the nutrition challenges faced by Kwale County. The current ratio of nutritionists to health facilities means each nutritionist serves at least 4 health facilities. The CIDP cites 73 health facilities as at 2013, meaning the current number 17 nutritionists would have to serve at least four facilities to cover them all.

Using the Standard Norms and Practices for Health Workers Manual (2015) Kwale County needs more nutritionists. The current shortage in human resources has resulted in to a heavy work load for nutritionists, with nurses, CHEWs, CHWs assisting in nutrition responses. This strategy’s weak point is that those assisting may not necessarily have expertise in nutrition. Similarly, when any other actor in health is seen to be able to take up nutritionists’ work, an impression is inadvertently created that nutritionists are unnecessary as their roles can be picked up by other actors with different qualifications.

Figure 4: Nutritionists’ workload at facility level



The average number of clients seeking nutrition services in a facility was approximately 56 clients per day while the average number of clients a nutritionist attended to was 43, reflecting a gap in service provision in response to service seeking by the community.

The county's CIDP acknowledged a low nutrition status in the county, and the track record in hiring nutritionists together with other recruitments in health reflects a marked improvement over the last few years. Sustaining this expansion in nutrition service providers in the county will strengthen the county's efforts to respond to the high disease burden and malnutrition in Kwale.

4.2 Roles of the nutritionists

The role of nutritionists in the health sector cannot be overstated. At county level, the county health and nutrition officers mentioned a range of roles executed by nutritionists in the county, including managing the nutrition programme in the county; responsibility for nutrition indicator tracking, assist in training students studying nutrition; provision of nutritional services to people living with HIV/AIDS; nutrition commodity management; nutrition and supplementation and outreach, diet calculations and ensuring all patients get adequate meals; nutrition assessments, diagnosis and interventions.

The range of work carried out by nutritionists is both vital and sometimes the county has engaged nurses to do the work of nutritionists in case of increased demand of nutrition services. However, noting that the nurses have their own workload, and not as adequately informed or trained with nutrition-specific knowledge, their engagement may potentially take away crucial from much-needed nursing services. Moreover, given the temporary nature of this support, present sustainability challenges when the surge in services is not maintained.

4.3 Trainings

Kwale County supports capacity development of its health staff according to the respondents in the study. 56% of the respondents said that they had received training within the last two years. Most of the training received (73%) was through seminars and workshops. Trainings enhance skills and update the health workers on emerging knowledge in the health sector. This enhanced competence further helps to motivate the workforce towards better performance in service provision.



Picture 7: Coast region county officials in a nutrition tracking training in Mombasa. CISP, 2017.

Among the staff interviewed, 10 nutritionists, 8 nursing officers and 5 health administrators indicated having received training specific to nutrition. 5 nutritionists, 6 nursing officers, 5 health administrators and one records officer said they had not received any training specific to nutrition within the last two years. Therefore, whereas trainings on nutrition have involved most of health workers, there are still gaps among the staff whose work has a bearing on nutrition outcomes.

In terms of academic training, majority of the nutritionists interviewed (80%) had a diploma level qualification, while the rest held a certificate in nutrition.



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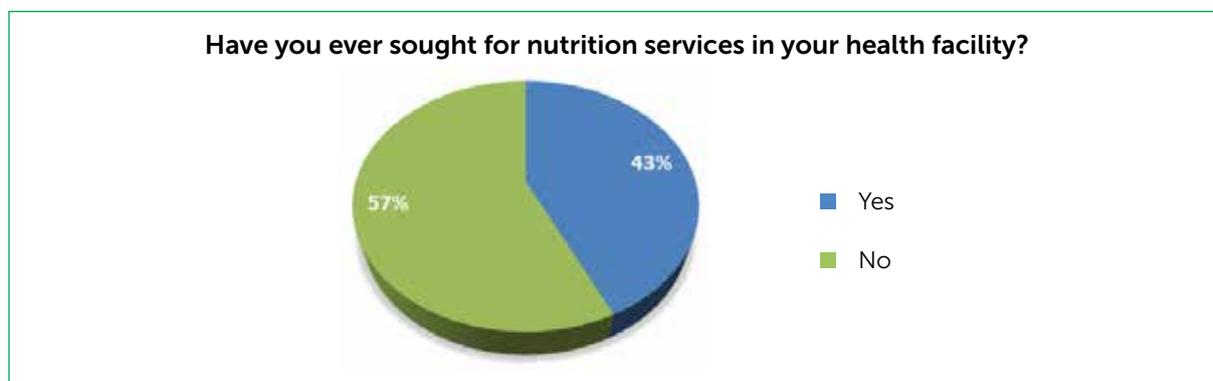
CHAPTER 5: AWARENESS AND DEMAND

5.1 Awareness & Demand for Nutrition Services

Kwale County has been implementing a range of programs and offering services in facilities, a fact that was acknowledged by the service users that participated in the study. However, the level of awareness on nutrition services in Kwale County generally remains low; despite service users describing nutrition services, most did not recognize them as nutrition services. They also referred to nutritionists as *daktari* (doctors) meaning they associated the nutrition services with curative/medical services. The implication is that they would potentially not seek nutrition services unless they were physically sick. This low level of awareness on nutrition services contributes to a lower level of demand for nutrition services painting a false picture of low need. Patients did not deliberately seek nutrition services at the health center but instead came for treatment for a range of diseases, or routine maternal child health clinic, and mostly ended up accessing the nutritionists for services upon referral from medical doctors.

The county actors mentioned that they had access to IEC materials, though these were inadequate given the challenge of malnutrition in the county. In health facilities, materials and equipment mentioned as available included height boards, weight scales, Mid-Upper Arm Circumference (MUAC) tapes, bathroom weighing scales, and stadiometers. Equipment at the health centers was acquired through tendering. Almost all the nutritionists (89%) interviewed could use the equipment, and there was consensus that trainings are usually conducted on the use of the new equipment when these were availed to the facilities.

Figure 5: Survey Response on service-seeking



The community respondents suggested how the county could enhance the nutrition services available, and the proposals from the communities reached include:

- Making more efforts to prevent malnutrition
- Where possible secure a distinct office space for nutrition
- Recruit more Nutrition staff
- Ensure all health facilities have adequate Provision of nutrition equipment
- Increase food supplements to be offered to the population

Only 57% of the interviewed community members said they has ever sought for nutrition services in the county. All of those were satisfied with nutrition services offered in the various health facilities. Services sought included information on feeding for infants, balanced diet, children’s weight, and weaning. However, they said they were yet to be invited to share their opinions with the service provider on the services offered, and when asked what changes they wanted to see in the health facilities about nutrition, they suggested an improvement in the change of attitude by health staff, more staff for better health and nutrition, and more knowledge to improve services.

Respondents also cited cases where they had only one person taking anthropometric measurements, little communication on services available for the community, lack of nutritionists to get information from sometimes, and a preference for strict guidelines in giving out information in infant and young child feeding, possibly stemming from having wrong nutrition information shared. This is not surprising, given that sources of nutrition information cited by the respondents included, among others, “knowledgeable neighbours” and internet. On the other hand, the health service providers requested for more information to share with the communities, more equipment to support nutrition measurements and tracking, increase in education seminars to keep them informed of current and emerging practice.



Picture 8: A media actor, a county nutritionist, and the County First Lady, who is also the nutrition champion for Kwale County in a joint event, CISP 2017.

5.2 Resilience Approach

Kwale County has faced periodic food shortages, contributing to the notable malnutrition levels, including acute malnutrition among children. Coping strategies in times of crisis such as food shortage can make the difference between malnutrition and optimal nutrition. The very modes of resilience approaches applied by communities have encouraged the existing malnutrition and undermined county-led efforts to improve the situation. Some of the coping strategies used during food shortages included:

- Reliance on relief food which is sometimes not enough for all
- Taking children to relatives elsewhere, hampering education and vaccination
- Skipping meals
- Engaging in income generating activities e.g. casual labour.
- Borrowing money and food

Some of the mentioned coping strategies in response to food crises however may encourage and sustain malnutrition, e.g. skipping meals results into inadequate food intake, depending on relief food which is inadequate, unreliable and inconsistent, and most times not nutritionally balanced. Considering that the main food crops grown in Kwale are largely maize and cassava, and that the county faces perennial food shortages and food insecurity (CIDP), the prevalence of maize in both household and relief food means the food variety is limited deprives the population of the required diversity, resulting in insufficient food intake and sustaining existing malnutrition.

Support systems available therefore provide a short-term safety net in times of crisis when there is food shortage. However, these stop-gap measures are not the most effective, and the interventions meant to be temporary are beginning to be perceived as long-term solutions for the hunger crisis by the communities. Typically, the average family in rural Kwale County will store maize in temporary wooden semi-open structures rendering it prone to pest infestation. The use of airtight plastic drums is gaining popularity due to its ability to keep away pests.

Kwale County recognizes in its Integrated Development Plan the crucial sector of agriculture, livestock and fisheries as one of the platforms to realize the county vision for a healthy and food secure population. The county elects to ensure more research prospects, extension services and improvements in production, processing and marketing of agricultural related products to ensure the county is food secure. This essentially will ensure the dependent population has the basic needs as enumerated in Chapter Four of the Constitution, including the highest attainable standards of health and to be free from hunger and have adequate food of acceptable quality. The county government has also pointed at climate change effects on food crops, which have reduced yield and compounded food insecurity.

Under the Agriculture Livestock and Fisheries sector, the County of Kwale identifies food security for Kwale residence as a key priority, and suggests a range of integrated interventions including promotion of agriculture, livestock and fisheries, capacity building of stakeholders, rain-water harvesting, and production and conservation of fodder to address key issues that cause food shortages.

Nyonyesha Mtoto Wako

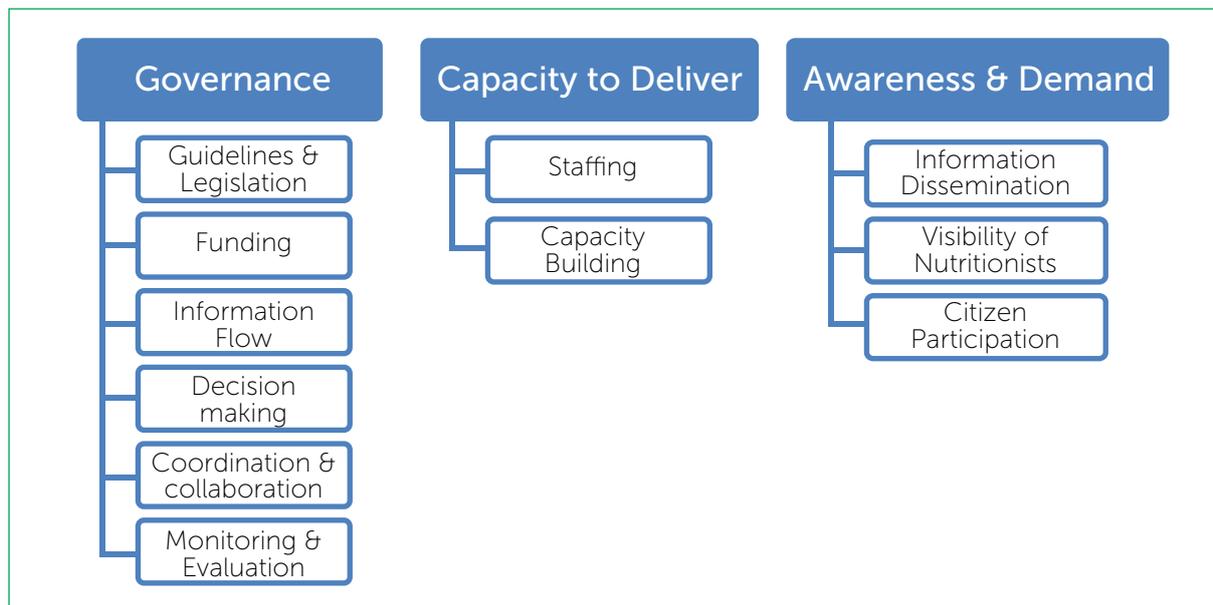
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CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

Figure 6: Priority Areas with bottlenecks in the Nutrition Sector Kwale County



The findings from the assessment largely fall within the strategic pillars in the National Nutrition Advocacy Communication and Social Mobilization (ACSM) strategy. These are governance, capacity to deliver, and behavior and practices.

The findings center around decision making for nutrition, the existing guidelines and legislation and the gaps that have been identified, and the process and mechanisms of coordinating and collaborating around nutrition in the county. The governance pillar, as elaborated in the ACSM strategy, will provide useful entry points in responding to the findings identified.

Similarly, under capacity to deliver as a pillar and that of behavior and practices, the same strategy document presents viable opportunities to support major strides in improving nutrition in Kilifi county.

6.1 Conclusion

Kwale County faces unique challenges in promoting appropriate nutrition, challenges which, if not adequately addressed, will continue rendering a proportion of the population economically unproductive, unable to participate in the development agenda, worse still a social and economic burden for the County in the next fifteen years, and spur an unending poverty cycle. With the county identifying the adverse effects of malnutrition, it acknowledges that the shift from central to county governance may have inadvertently presented counties with uncontextualized and ill-fitting policies for counties in some instances.

With the devolved structure, new opportunities have been created for the county to chart its own path in channeling all political will, social, financial and human resource to address malnutrition. The county government is therefore the lead actor in supporting and promoting appropriate nutrition in the county.

The county government has shown its commitment to respond to health issues in Kwale by steadily increasing the budgetary allocation for health to more than double the initial amount in just 4 years, but there is no explicit allocation of funds for nutrition, which means there can be no articulate proactive planning for nutrition. Nutrition interventions are therefore dependent on good will and the absence of other perceived priorities.

The county government has identified the inadequacies of the national policies to reflect the realities of Kwale County, but is yet to institute county level policies for food security and nutrition.

The information sharing process by the county has leveraged existing community structures such as *Nyumba Kumi* and *Maendeleo ya Wanawake* for engagement with information sharing in nutrition, but its online media (website and twitter) are yet to be crafted to speak to the citizen or for nutrition. The website is entirely in English despite the CIDP noting slightly under 60% literacy level. The website also misses key documents like the County Integrated Development Plan, the County Fiscal Strategy Paper, result reports on past and current processes, and planning documents to enhance community participation. The mechanisms for communication through media platforms are therefore not the best fit for the population in Kwale.

Whereas the county has carried out a variety of activities in promoting nutrition in Kwale, there are no elaborate systems to adequately capture current results. This presents a risk that progress made responding to malnutrition may not be fully captured without a system that monitors the process, and captures results and lessons learned to inform further interventions.

As the need for nutrition responses has persisted, the county has so far increased the number of nutritionists to 17 currently, with training opportunities being offered periodically. However, they are still a small team to adequately offer services at all the health facilities in the county.

The nutritionists and health workers receive capacity building training, mostly through workshops, and more than a half of the respondents working in the health sector in the county had received some training in the past two years. However, there is no structured capacity building plan to systematically identify, address, and evaluate capacity gaps and responses. A system that supports its own service providers' development through progressive assessments and capacity building with the right tools and information to deliver the services effectively will be better placed to drive the county's agenda for nutrition.

Visibility of nutritionists in the county health system is still low, compounded by their small number that the county sometimes uses nurses to offer nutrition services. This has led to an increasing confusion by communities, who perceive nutritionists as doctors, and miss out on advisory services at the expense of doctor-referred visit to a nutritionist. Nutrition services are largely perceived as curative services, accessed only when one is sick.

There is still more to be done to harness current achievements in nutrition and health in the county, and improve existing responses to better handle the levels of malnutrition the county is facing. The achievements already made are testament to the county's commitment to changing the malnutrition trends in the county, and county planning reflects an acknowledgement of the same. The stakeholders coming on board to support county interventions also reflect a recognition of the multi-faceted nature of malnutrition, which, without a similar multi-faceted response, will not fully achieve intended improvements. It is

the combination of the commitment exhibited, and the bringing on board of both evidence and wider actors that will provide stronger support to current efforts ongoing in the county to respond to malnutrition.

6.2 Recommendations

Acknowledging the strides and progress made so far in nutrition and the plans highlighted in the county development plan, the following recommendations are meant to consolidate what has been achieved, and further augment what is being done for even better outcomes in nutrition:

- 1. Funding:** Explore the possibility of a specific budget line for nutrition in the county budget to strengthen active pre-planning for, and monitoring of nutrition actions and interventions. Without a known budget, most actions would be reactive instead of pro-active, and therefore will hold back nutrition programming accompanied by a challenging monitoring process. There is an opportunity for the consistent increase in the Kwale health budget to be reflected in planning around county nutrition actions, that the admirable commitment exhibited in the continually progressive investment in health similarly reflects progressive trackable commitments in nutrition.
- 2. Information Storage & Flow:** Review the system through which information flows from the county's top decision making body to the smallest, most distant health facilities and nutrition actors to ensure two-way real-time communication and information sharing. Information stored in readily accessible forms by those concerned will also support the county efforts in more timely identification and efficient response to emerging nutrition concerns. Further, such information will contribute to the county's building of a body of knowledge and evidence for its planning and implementation purposes.
- 3. Decision-making:** The County structures for decision making in nutrition need to provide for greater involvement of the community in decision making, outside the existing participation in general county budget processes in accordance with the County Governments Act and the Public Finance Management Act. Aside from the constitutional provisions for greater public participation, the importance of involving the stakeholders in decision making will allow for active participation and elicit greater ownership and responsibility for actions taken by the decision makers for improving nutrition in the county. This will also allow the community to better understand the objectives and creates positive synergy between the officials and the community, supporting sustainability of decisions reached by decision makers and stakeholders.
- 4. Regulatory Frameworks:** The field of nutrition actors in Kwale is ever increasing, not only in the number of nutritionists, but also in the number of private, non-state actors in supporting different nutrition outcomes in the county. The Health Department should consider regulatory terms and conditions of service for the nutrition sector in the county, and collaborating with relevant national institutions, determine the scale and application of such frameworks. This also calls for stronger linkages between nutrition frontline actors and the County Assembly that deliberates on the policies and legislation. Without a domestic regulatory body and framework in Kwale County for nutrition service delivery at the county level, specific efforts to ensure the delivery of services may be inadequate in the nutrition sector in the county.

- 5. Monitoring and evaluation system strengthening:** The County needs a clear M&E framework for nutrition to support and consolidate ongoing efforts for better health and nutrition. Stronger tools for collecting information, and stronger feedback mechanisms between community level actors and county level policy and decision makers will go a long way in improving data quality and evidence for nutrition actions, and ensure all programs are monitored and lessons captured to inform future county engagement and sustainability of interventions. There is a clear need to develop a monitoring and evaluation system and train its users for effective surveillance at county level for contextualized action, follow-up, tracking and learning. It may also be useful to explore the scope of responsibility of nutritionists in the county to include a more direct role in collecting nutrition-specific data and actively supporting its validity. This could reduce invalid data interpretations as nutritionists support the larger health system to contribute to the data processing when it is collected, and especially when it relates to nutrition.
- 6. Coordination and Collaboration:** Support the County Nutrition Technical Forum (CNTF) and the County Health Management Team (CHMT) to meet more frequently, and link their activities to the County health committee to keep the County Assembly periodically informed on nutrition progress. The role of coordinating county nutrition activities under the County Nutrition Coordinator is implemented with the support of the County Nutrition Technical Forum. The County Nutrition Technical Forum and the County Health Management Team should be enhanced to further streamline actions in nutrition in the county for achievement of shared goals, and strengthening accountability and transparency among nutrition actors, even when they work through different processes.
- 7. Staffing:** The county should consider further reducing the current ratio of 1 nutritionist to 46,074 people in Kwale County, following its evident past commitment to increasing the workforce across the recommended cadres. The current deficit should be taken as a possible target for a progressive, multi-year incremental plan to respond to the nutrition challenge in the county. This will reduce instances where the work of nutritionists is done by other health cadres and to safeguard professionalism, efficiency and objectivity.
- 8. Capacity building:** With quantity, the staff capacity should be structured to ensure that a continuously updated and knowledgeable workforce is on the frontlines for nutrition planning and responses. A system that periodically assesses the capacity needs of the nutrition staff and engages the county as well as other health actors supporting nutrition services to respond to the identified gaps will strengthen the county's ability to respond more adequately to the county nutrition needs. Such a system should also be able to capture any training provided through the government system as well as partner organization processes in capacity building, and provide a more comprehensive status on the county capacity in relation to nutrition service provision and response.
- 9. Nutrition Information Dissemination:** The county should develop a communication strategy for nutrition that merges the county's online presence with mainstream media, and traditional community information sharing platforms e.g. chief's barazas (local meetings) and cultural dialogues to improve the community awareness on what nutrition services the county can offer its population. An increase in demand due to better information dissemination will further contribute to better tracking of malnutrition cases in the county. The community Health Strategy could be harnessed

to increase coverage during dissemination. In response to the perennial food insecurity in the county, a possible avenue is to include in community information packages a component on resilience and coping mechanisms in face of food shortage and drought. This is the current issue facing communities, and information that supports them to deal with the risks empowers them for the future. Food access, diversification, storage and value chain addition will all be useful parts of an elaborate awareness drive led by the county and supported by both state and non-state actors.

- 10. Visibility:** County Nutritionists should be more visible to encourage community engagement with them. Encouraging a nutrition-specific attire during community outreach or facility rounds will make them easily identifiable. Together with the dissemination of information about nutrition service availability, this will support the communities' shift from seeing nutritionists as doctors "curing" a disease, to sources of information to remain healthy even in the absence of disease. Such health-seeking behaviour will help anchor county efforts to sustain a progressive response to the current malnutrition challenge in Kwale County.

REFERENCE

- Black RE, Morris SS, Bryce J. Where and why are 10 million children dying every year? *Lancet*. 2003; 361:2226–34.
- County Government of Kwale, First County Integrated Development Plan 2013
- Devlin, K. (2012) Stunting Limits Learning and Future Earnings of Children
- Dewey KG & Begum K. Long-term consequences of stunting in early life. *Maternal and Child Nutr.* 2011 Oct; 7 Suppl 3:5-18. doi: 10.1111/j.1740-8709.2011.00349.x
- GoK (2011). National Food and Nutrition Security Policy, 2011, Government of Kenya. [https://extranet.who.int/nutrition/gina/sites/default/files/KEN%202011%20National%20Food%20and%20Nutrition%20Security%20Policy\[1\].pdf](https://extranet.who.int/nutrition/gina/sites/default/files/KEN%202011%20National%20Food%20and%20Nutrition%20Security%20Policy[1].pdf)
- GoK, (2012). Kenya Health Policy 2012–2030.
http://hennet.or.ke/wp-content/uploads/2015/02/KENYA_HEALTH_POLICY_29-01-2014.pdf
- GoK (2012). Kenya National Nutrition Action Plan 2012-2017, http://scalingupnutrition.org/wp-content/uploads/2013/02/Kenya_KNN_Action-Plan_2012_2017.pdf
- GoK (2016) Kenya Reproductive, Maternal, Newborn, Child and Adolescent Health Investment Framework. Ministry of Health Government
- GoK, The 2015 Long Rains Season Assessment Report, Kenya Food Security Steering Group (KFSSG)
- Institute for Economic Affairs (2015). Child Budget Analysis in Kenya; National Government and six county governments. Institute of economic Affairs – IEA. www.ieakenya.or.ke
- MoH, Kenya HIV County Profiles 2014, NASCOP
- MoH. (2015). Kenya National Health Accounts 2012/13. Nairobi: Ministry of Health.
- MoH (2015) National and County Health Budget Analysis Report. 2014/2015 July 2015
- MoH, Nutrition Situation in the Arid and Semi-Arid Areas, February 2015
- MoH (2014) State of Sanitation in Kwale County, Water and Sanitation Programme
- Kenya Inter-Agency Rapid Assessment (KIRA) Report, 2014
<https://www.humanitarianresponse.info/en/operations/kenya/kenya-inter-agency-rapid-assessment-kira>
- KNBS and ICF Macro (2010). Kenya Demographic and Health Survey, 2008-09.
- Kenya Demographic and Health Survey, 2014

- Kenya Reproductive, Maternal, Newborn, Child and Adolescent Health (Rmncah) Investment Framework, Ministry of Health Government of Kenya January 31, 2016
- Mwaniki, EW and Makokha, AN (2013). Nutrition status and associated factors among children in public primary schools in Dagoretti, Nairobi, Kenya. *African Health Sciences*. 13(1): 39–46.
- National Policy on Maternal, Child and Young Infant Nutrition, Government of Kenya, http://scalingupnutrition.org/wp-content/uploads/2013/07/MoPHS-MIYCN-Policy-Document-08_2012.pdf
- NDMA (2014). Early Warning System Bulletin, August 2014. National Drought Management Authority, NDMA. <http://www.ndma.go.ke/index.php/early-warning-bulletins>
- Nutrition Situation in the Arid and Semi-Arid Areas, February 2015
- Olaf Müller and Michael Krawinkel (2005). Malnutrition and health in developing countries. *Canadian Medical Association Journal* vol. 173 (3) 279 – 286.
- Republic of Kenya: National Food and Nutrition Security Policy: 2011
- Republic of Kenya, Human Resources for Health Norms and Standards Guidelines for The Health Sector: 2014
- World Health Organization, (2013), Global nutrition policy review: what does it take to scale up nutrition action?World Health Organization, 2013. http://apps.who.int/iris/bitstream/10665/84408/1/9789241505529_eng.pdf
- UNICEF, Kenya Country Office Humanitarian Situation Report Apr-Jun 2015

About the Nutrition Advocacy Project

About the Project:

The assessment of the nutrition sector in Kwale County was carried out as part of the Maternal and Child Nutrition Programme (MCNP), a UNICEF funded project to support the Counties in: i) Increasing knowledge on current nutrition strategies, needs and best practices at county level; ii) Enhancing community feedback to increase demand for quality nutrition services; iii) Empowerment of duty bearers to better coordinate stakeholders working in nutrition and nutrition cross cutting sectors at county level; and iv) Advocating for increased resource allocation and accountability in nutrition sector.

This assessment is meant to contribute to existing contextual evidence and knowledge to support evidence based decision-making around nutrition and maternal health in Kwele county in line with county and national government priorities and plans.

CISP worked with and benefitted immensely from close collaboration with National and County Government authorities, including the ministry of health, the County Health Department, especially the **County Health Management Teams (CHMT)** and **County Executive Committee (CEC)** Member, the County Nutrition Coordinator's office, local Civil Societies Organizations and other relevant stakeholders on the ground.

Stakeholders in the process have included county departments with nutrition-specific interventions, who have increasingly collaborated to improve the nutrition situation in the county. CISP also benefitted from coordinated action with **Population Services Kenya** and **International Medical Corps (IMC)** through regular quarterly meetings and collaboration in Kwale County.

CISP Profile



CISP Comitato Internazionale per lo Sviluppo dei Popoli (International Committee for the Development of the Peoples) - is a Non-Governmental Organization established in Rome in 1983 and currently active in over 30 countries worldwide.

CISP Kenya carries out projects in area of development by supporting National and county authorities to provide quality, equitable, transparent and accountable services in sectors of health and nutrition, education, child protection and renewable energy through capacity building, promoting active citizenship, shared accountability mechanisms at community, county authorities and National government level.

Specific to Nutrition advocacy programming under the Maternal and Child Nutrition Programme in Kenya, CISP is active in Kilifi, Kwale and Kitui Counties.

ASSESSMENT OF THE NUTRITION SECTOR

Kwale County



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