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PERFORMANCE EVALUATION AND ASSESSMENT OF USAID/KENYA NUTRITION AND HIV PROGRAM (NHP)

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Performance Evaluation and Assessment of USAID/Kenya Nutrition and HIV Program (NHP)

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Acronyms

ABEO	Agriculture, Business & Environment Office
AED	Academy for Educational Development
AIDS	Acquired immune deficiency syndrome
AIDSTAR-One	AIDS Support and Technical Resources
ANC	Antenatal care clinic
ART	Antiretroviral therapy
BMI	Body mass index
CBO	Community based organization
CCC	Comprehensive care centre
CHEW	Community health extension workers
CHW	Community health workers
CME	Continuous medical education
CNO	County nutrition officer
CSB	Corn soya blend
CSI	Corporate social investment
CU	Community unit
DCHS	Division of Community Health Services
DNO	District nutrition officer
FANTA-2	Food and Nutrition Technical Assistance II
FAO	Food and Agricultural Organization
FBF	Fortified blended flour
FBP	Food by Prescription
FGD	Focus group discussion
FTF	Feed the future
GOK	Government of Kenya
HCP	Health care provider
HIV	Human immunodeficiency virus
HMIS	Health management information system
IMAM	Integrated Management of Acute Malnutrition
IT	Information technology
ITC	Information technology and communication
KEMRI	Kenya Medical Research Institute
KEPH	Kenya essential package for health
M&E	Monitoring and evaluation

MAM	Moderate acute malnutrition
MOH	Ministry of Health
MOPHS	Ministry of Public Health and Sanitation
MOU	Memorandum of understanding
MUAC	Mid-upper arm circumference
NACS	Nutrition assessment counselling and support
NASCOP	National AIDS and STI Control Programme
OPH	Office of public health
OR	Operations Research
OVC	Orphans and vulnerable children
PPP	Public private partnership
P/PP	Pregnant and postpartum
PEPFAR	President's Emergency Fund for AIDS Relief
PGH	Provincial general hospital
PLHIV	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PNO	Provincial nutrition officer
PS	Permanent Secretary
QI	Quality improvement
RUTF	Ready-to-use therapeutic food
SAM	Severe Acute Malnutrition
TWG	Technical working group
URC	University research centre
USAID	United States Agency for International Development
USG	United states government
WFP	World Food Programme
WHO	World Health Organization

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The evaluation team would like to thank all key informant stakeholders for their openness and time taken to answer questions. This includes national level stakeholders, provincial and district level government officials, health care facility staff and volunteers, CBO staff and volunteers, and NACS clients. A full list of all interviewees is included in Annex 3.

The evaluation team would like to thank NHP (FHI 360, Insta Products and Phillips Health Care) for their open sharing of information and data, and for organization of field site visits.

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1. Executive summary

This report has four main sections in line with the evaluation Scope of Work. The first section provides background to the NHP programme. The second section is an evaluation of the achievements and limitations of the NHP programme against the cooperative agreement. Key challenges, lesson learned and gaps are also identified here. A summary of key findings is included at the beginning of this section rather than a final conclusion. The third section is an assessment of what needs to be strengthened and supported in the future. The fourth section presents overall recommendations for future direction for nutrition programming. A detailed explanation of the evaluation methodology is included in Annex 4.

Summary of evaluation findings

NHP has exceeded targets set out in the cooperative agreement for a number of key areas including number of sites providing NACS services, numbers of clients treated with FBP and provided with WaterGuard, quantity for FBP delivered to sites, and number of health workers trained (see Table 2 below). NHP, through Insta Products Inc. has succeeded in introducing a locally produced F-100 equivalent RUTF for SAM clients and has recently begun to innovate further to address FBP challenges and needs.

NHP, with NASCOP, have put in place curricula, resources and training to allow the clinical service delivery of NACS. This has been particularly effective in terms of building clinical skills and providing necessary clinical guidance for appropriate prescribing of FBP. Counseling has also been improved. Client and commodity management procedures have been put in place at the health facility level on the whole; however they have not been successfully integrated into Government systems until very recently. Even at this stage, commodity management systems are weak in some key aspects such as forecasting and stock management. Efforts so ensure client compliance has been effective through counseling; however weak bi-referral community linkages has been inadequately developed and partly accounts for relatively poor loss to follow-up data and extended length of time of the FBP by clients.

The rapid expansion of sites supporting NACS service provision from 62 to 619 over the project period has been controlled by the Government led Nutrition Technical Working Group. Although the expansion in the number of sites will have overcome problems of site access for clients and prevented ART site switching by those seeking NACS, the rapid expansion has been at the cost of quality with inadequate capacity and resources available for follow up training and mentorship, supervision, and equipment. This has also posed challenges for NHP in terms of commodity management.

There have been missed opportunities to address some key challenges early in the programme, for example, the community component, quality improvement piloting and tools development, piloting of electronic data capturing tools, and on-going issues relating to lack of storage/container provision.

Summary of assessment findings

Assuming the coordination of nutrition services remains within the remit of the Ministry of Health post elections; technical support will be required to strengthening coordination functions of the Nutrition Technical Working Group and the Interagency Coordination Committee. The likely expansion of NACS services beyond HIV and the future devolution of government both bring significant challenges for the future coordination and resourcing of nutrition services. Constant input will be required to ensure that nutrition remains on the political agenda. Increased assistance is required to strengthen budgeting,

planning and M&E to allow the Government of Kenya to gradually manage NACS service provision and effectively mobilize resources from different partners. In the meantime, the Ministry of Health requires continued technical and financial support to roll-out NACS.

Financial and logistical support for the establishment and maintenance of Community Units as per the Government Community Strategy will be key to the improvement of the 'community component' of NACS. The community component aims to extend the supply chain of commodities to the community, improve client tracking, mitigate loss to follow-up and increase the quality and comprehensiveness of care. This will require increased engagement and resources from USG partners, particularly APHIA Plus, at the community level, and technical and financial support to the Division of Community Health Services at the national, county and district level.

Useful partnerships already exist to build on with new potential opportunities to engage other partners, particularly those that support economic strengthening, livelihoods and food security programmes. Other useful partnerships to pursue include partners with behavior change expertise, quality improvement, and cost-effectiveness tools.

Promising practices from Insta Products Inc and Phillip Health Care have demonstrated the skills and experience that can be tapped within the private sector. The next iteration of the NHP needs to embrace and expand its utilization of public private partnerships (PPPs) to support the scale-up of NACS services provision, for example by expanding NACS services to private health care facilities, working with Information Technology and logistics companies to address existing IT and storage challenges etc. Corporate social Investment (CSI) can also be tapped beyond PPP.

Overall recommendations for future directions

1: Continue to invest in the expansion of NACS programme infrastructure, expand the scope beyond HIV, and increase emphasis and investment in broader 'support' within NACS through economic strengthening, livelihoods and food security
2: Separate RFPs for 'commodity component' for 'service delivery component'
3: Embrace and expand Public Private Partnerships (PPP) for sustainability, promotion of innovation, incorporation of private sector expertise and capitalize on corporate social investment
4: Improve NACS outcomes through efficient and effective use of FBP and increased focus on other kinds of 'support' within NACS
5: Improve quality of NACS service provision by health care providers
6: Clarify and expand the community link component of NACS
7: Support the Government of Kenya to gradually be able to implement all aspects of NACS service provision
8: Incorporate Operations Research into the next iteration of NHP

2. Background[1]

The Nutrition and HIV program was designed to take the two-year Food By Prescription (FBP) pilot project started in 2006, to scale. As a flagship initiative, NHP goal's was to strengthen delivery of nutrition services in and out of hospital settings. Implementation of NHP was guided by the following specific objectives:

- Build on partners expertise in HIV and nutrition, food manufacturing, and logistics, while introducing a new patient-centred concept for clinical service delivery that will improve counselling, patient management and record keeping, and patient and provider compliance with treatment protocol;
- Introduce a locally produced F-100 equivalent RUTF for severely malnourished HIV+ patients and OVC
- Link Insta (the food partner) and health facilities with community-based and home-based care programs for HIV+ patients and OVC to extend the supply chain, improve client tracking, mitigate loss to follow-up, and increase the quality and comprehensive care.
- Scale up interventions while maintaining high quality through performance monitoring and quality assurance systems.
- Strengthen the capacity of local partners, particularly NASCOP.

The process indicators included principally scaling up site coverage from 60 sites to 250 sites, increasing the number of beneficiaries from 6,000 during the first year to 25,000 during the fifth year and correspondingly increasing the amount of therapeutic foods distributed from 432 tons to 1800 tons and training between 200 and 300 health workers on nutrition and HIV per year. The main reporting indicators are the number of HIV+ pregnant women who received food and nutritional supplementation in a PMTCT setting, the number of OVC receiving food and nutritional supplementation through OVC programs and the number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food.

The design of the NHP was informed by several clinical scientific finding, among them, low body mass index (BMI) at Antiretroviral Therapy (ART) initiation was associated with increased mortality, ART initiation was associated with weight gain and that early weight gain on ART initiation was associated with improved survival, particularly when baseline BMI is low. The core of NHP was therefore supported by three interdependent pillars, namely, effective nutritional products, robust supply chain and health facility commitment and performance. The three-pronged implementation strategy strengthens capacity of health providers in delivering nutrition services as an adjunct in care and treatment of HIV and AIDS; catalyses local capacity development to produce supplemental and therapeutic foods; and supports creating a supply chain system for nutritional commodities. In October 2009, PEPFAR's Care and Support Technical Working Group (TWG) with participation of the USAID Kenya commissioned an assessment of NHP's strengths and challenges, and documentation of lessons learned and promising practices. The assessment, by AIDSTAR-One, reported that the FBP service in Kenya is an excellent intervention, well-appreciated by clients and providers alike in terms of improving nutritional status and health outcomes and supporting adherence to and efficacy of ART.

[1] This background information has been drawn directly from the background provided with the evaluation Scope of Work

To improve effectiveness and sustainability of the program this assessment identified six critical areas for quality improvement in order to facilitate graduation from the program, reduce re-entry (re-lapse), enhance integration and encourage sustainability. These areas involve: training, supervision, referrals, community linkages, reporting and data management, and policy. Consistent with these recommendations, the five-year Implementation Framework[2] for the Health Sector provided rationale and structure for programming of USAID/Kenya's resources for the period 2010-2015. USAID/Kenya is working towards the Strategic Goal of supporting its partners to meet the Assistance Objective *"Improved health outcomes and impacts through sustainable country-led programs and partnerships"*. The Assistance Objective, building on the successes of NHP, emphasizes two aspects: 1) that USAID/Kenya's assistance seeks to improve the health of Kenyans; and 2) that this assistance should promote the development of organizations and programs that will continue to provide benefits for the health of Kenyan's even without continued USG support. USAID/Kenya support is based on a two-pronged approach: continuing to support programs which provide immediate health impact, while increasingly focusing on strengthening public and private sector Kenyan institutions to provide a sustained health impact. In this regard, USAID/Kenya's Implementation Framework supports partnerships with the Government of Kenya (GoK) across the health system at all levels of service delivery as well as the private sector to expand access. In order to increase efficiency and synergies, NHP collaborates with USG implementing partners in the delivery of nutrition services.

In order to improve the scientific knowledge and skill in delivering nutrition interventions in care and treatment, USAID supported implementation of an operations research on effectiveness of food by prescription. This activity was implemented alongside the pilot food by prescription interventions by Kenya Medical Research Institute, FANTA, Insta Product, Ministry of Health (MoH) and USAID Kenya. The study was a randomized, controlled, open-labeled trial. The randomized controlled study by KEMRI and FANTA begun in June 2008 and a final report was produced in June 2010.The aim of the study was to evaluate the impact of six months of supplementary food on nutritional and clinical outcomes for malnourished adult ART clients and for malnourished and nutritionally vulnerable HIV-infected adults not yet eligible for ART at six health facilities in Kenya. Based on nutrition counseling and 300 g/day of a fortified blended food or nutrition counseling alone, pre-ART clients receiving food achieved significantly greater increases in body mass index (BMI) during six months of food supplementation. Food supplementation (FBP) was associated with stabilization of immune cells (CD4) and hemoglobin. Control sites experienced high rates of attrition, and while food supplementation only had modest effects on attrition among pre-ART clients, the food did increase clinic attendance among both pre-ART and ART clients.

In 2011, the University Research Company (URC) was contracted by USAID/Washington to support quality improvement (QI) activities in nutrition service delivery in collaboration with the Kenyan Mission and NHP. The general objective of the URC-NHP collaborative activities was to improve the quality of nutrition care services through application of effective process improvement techniques. The QI activities started in mid-2011 at pilot scale in selected districts in Nyanza province. At each site, multi-disciplinary teams were formed to implement quality improvement activities using the model for improvement.

[2] The guiding principles of this framework are closely aligned to those of the Global Health Initiative (GHI) and mirror the reauthorized PEPFAR II. The Framework is consistent with multilateral policy declarations including the 2005 Paris Declaration on AID Effectiveness and the Millennium Development Goals.

3. Evaluation key findings

Summary of the evaluation findings

NHP has exceeded targets set out in the cooperative agreement for a number of key areas including number of sites providing NACS services, numbers of clients treated with FBP and provided with WaterGuard, quantity of FBP delivered to sites, and number of health workers trained (see Table 2 below). NHP, through Insta Products Inc. has succeeded in introducing a locally produced F-100 equivalent RUTF for SAM clients and has recently begun to innovate further to address FBP challenges and needs.

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The table summarizing the overall achievements NHP follows.

Table 1: NHP overall achievements summary

Coop. agreement targets	NHP achievement up to March 2012
Expand to 250 sites	Currently 619 sites provide NACS including FBP - 189 central sites, 431 satellite sites (March 2012). Sites selection well established within Government system. Proportion by KEPH Level: District/Sub-District= 31.2%, Health Centers=30.5%, Dispensaries= 36.5%. Ownership: Mission/FBO=15.4%, Private approx 1%
Reach 25,000 clients	Currently 190,913 clients have been assessed and provided commodities; 46.3% being adult PLHIV, 9.1% Pregnant and post partum women, and 44.6% OVC clients
No SPHERE % for attainment of discharge was included in the cooperative agreement	74,231 clients attained discharge: - 24,298 adult PLWHA attained discharge - 2,407 pregnant and postpartum women attained discharge - 47,526 index and linked OVC attained discharge Calculated successful treatment outcome for adults clients is approximately 56%.
Building on HCP capacity	320 foundation trainings, 698 refresher trainings, DVD for HCP to be disseminated
Locally produced F-100 equivalent RUTF for SAM	Local version of RUTF, trade name (*Plumpy Nut*), has been available since September 2009 for children and February 2010 for adults. A higher density RUSF, potential trade name *Rebound*, has also been developed but not approved. A savory RUTF is planned.
10,000 OVC reached through 15 CBOs with direct FBP services	7 CBOs are engaged (16 CBOs assessed and engaged), 1 CBO prescribing and issuing FBP to adults and OVC (approximately 500 OVC and adults enrolled) Note: due to rapid decentralization, the original CBOs identified and targets are no longer relevant
Bi-directional linkage with CBOs for referral /follow-up	Some facilities have strong linkages and outreach approaches for follow-up, some sites have minimal follow-up mechanisms or partnerships in place
Improved counselling resources	A range of nutrition pamphlets for clients produced, translated and disseminated; desktop counselling flipcharts updated and food demonstration models disseminated; food preparation demonstration conducted at some sites
Influence on policy, mechanisms for practice, and provision of FBP/NACS services	Provide technical input into the improvement of national level guidelines and policies, advocacy for NACS funding, establishment of Kenya Nutrition Day, developed practical tools for client and commodity management (being piloted) and quality tools (being piloted - yet to be rolled out), put national policy on HIV and nutrition into practice
Production and distribution of FBP	Established systems and track record for production and distribution of Fortified Blended Flour and RUTF to 189 central sites (with some stock-outs), totalling 527,381 prescriptions amounting to 3,897.5 metric tonnes (MT) of commodities by March 2012 (see Annex 7). 530,931 bottles of WaterGuard were also dispensed.

3.1 What contribution has NHP made towards the improved nutrition status of HIV+ patients and malnourished OVC, reduced onset of opportunistic disease and infections, and improved AIDS treatment outcomes?

3.1.1 What contribution has NHP made towards the improved nutrition status of HIV+ patients and malnourished OVC?

Contributions to improved nutrition status by NHP have been achieved through a combination of elements within Nutrition, Assessment, Counseling and Support (NACS) services provided. Counseling and community support make a significant contribution to improved nutrition in addition to the Food By Prescription (FBP) products, particularly in regard to the long-term nutrition status of clients.

As the overall summary of achievement table shows NHP assessed and provided commodities to 190,913 clients up to March 2012. 24,298 adults (27.5%), 2,407 pregnant and postpartum women (13.9%) and 47,526 OVC (55.8%) have been successfully treated for malnutrition and discharged. In total, 55,697 clients enrolled with Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM) (i.e. not including linked children)[3] have been successfully treated. With approximately 15% of the 190,913 clients still in the programme, NHP has clearly improved the nutrition status of HIV positive clients and malnourished OVC, and exceeded its initial targets.

On average 47% of clients are lost to follow-up or have died. Although on average 47% of clients are lost to follow-up this does not necessarily equate to 'failure in terms of improved nutrition status' or 'loss' to the programme. For example, reasons for loss to follow-up include clients absorbed into new sites supporting NACS provision; some clients may have left the programme due to barriers such as high transport costs or are reluctance to queue after previous stock-outs; lack of follow-up; clinical failure; and some sites are simply not reporting their data. Overall, NHP estimate that the proportion of successful treatment outcomes for adult NHP clients to be 56%.

Between April 2008 and March 2012 NHP has supported treatment of 190,913 new client beneficiaries and 245,322 revisiting clients. Since the length of time of FBP treatment is a minimum of three months, client revisit numbers should be roughly double the number of new cases. As will the loss to follow-up statistics discussed above, this data does highlight some problems, either with barriers to service provision, site switching or data collection.

The successful treatment of 55,697 clients over 4 years is a huge achievement. However, sustainability of nutrition status is important. Although neither NHP or NACS has official relapse rates for clients, data collected from clients during the evaluation suggested a relapse rate of about 1 in 5 adults and 1 in 6 OVC. Relapse can be due to a number of factors including episodes of poor health, consumption of insufficient quantities of food, availability of food with poor nutritional value, lack of nutrition education etc.

Nutrition counseling is a key strategy for long-term nutrition outcomes. An attempt to separate the impact of FBP and counseling has not been systematically pursued by NHP. However clients interviewed during the evaluation said they were received regular counseling, with 72.9% of clients stating that they had received counselling on their last visit. Clients could list a range of topics that had been discussed of which the mostly commonly cited was improved knowledge of how to use local nutritious foods. The

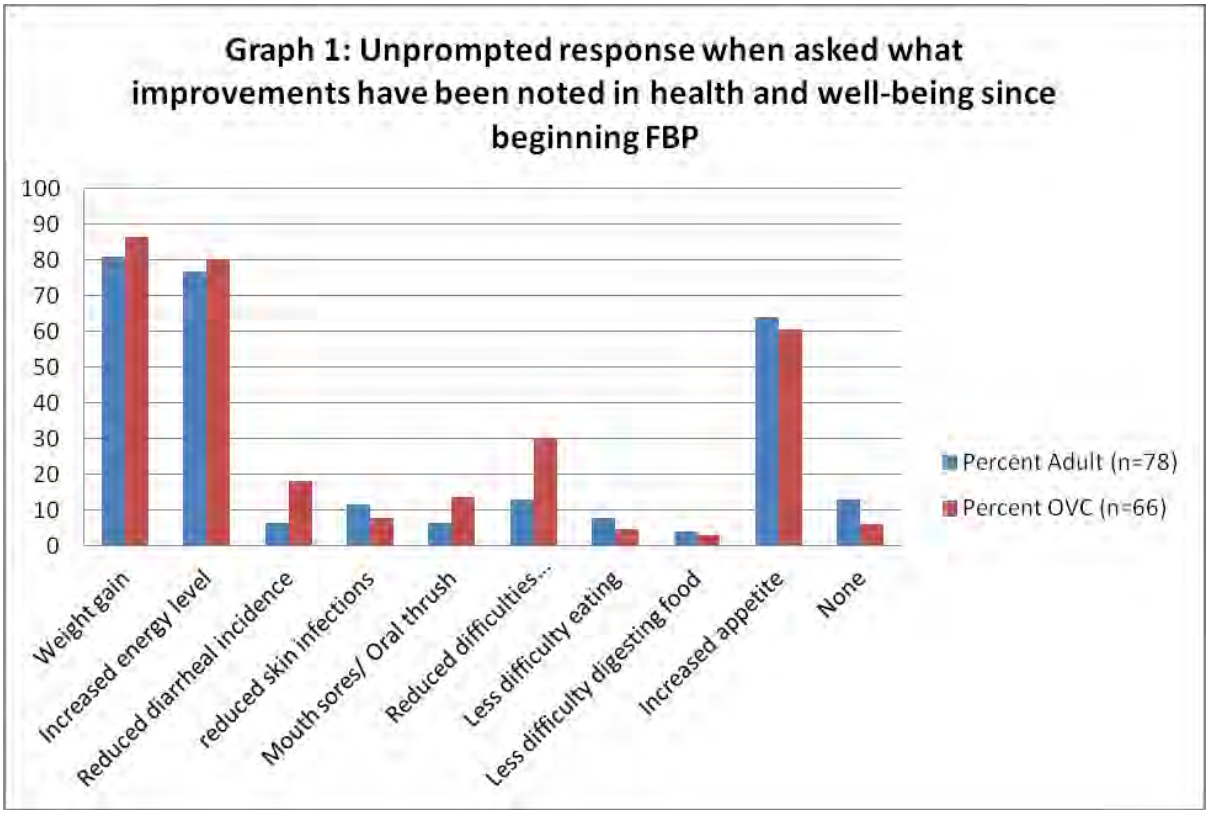
[3] Approximately 39% of OVC enrolled are 'linked' children who are not malnourished, therefore approximately 28, 991 malnourished OVC have been successfully treated.

regularity of counseling cited by clients, the quality of counseling aides, flow of nutrition services including counseling, and the value placed on counseling by service providers indicates that the counseling /education aspects of nutrition sustainability is well established and beneficial.

The gap in terms of improved long-term nutrition status of clients seems to be inadequate linkages and/or availability of economic strengthening, livelihood and food security in the community, and follow-up to ensure correct FBP consumption. This is illustrated by the fact that 1 in 4 adults and 1 in 3 OVC caregivers said they or their children had been on FBP longer than 4 months due to sharing FBP, inconsistent supply and consumption of product, and use of FBP as the main source of food in the household. 39.7% of adults and 36.7% of OVC caregivers admitted sharing the FBP products.

3.1.2 What contribution has NHP made to the reduced onset of opportunistic disease and infections, and improved AIDS treatment outcomes?

There is insufficient data to make a judgment on this impact indicator, so the evidence is inconclusive. NHP only receives data from 30-35% of sites regarding Opportunistic Infections (OI); of these, 10% have OIs. However, clients and health care providers interviewed during the evaluation attributed FBP to a range of improvements in terms of clients well-being and a reduction in health problems (see graph 1 from client perspective).



Although it is not possible to separate the impact of the ART and the FBP, the introduction of FBP clearly supports ART adherence and improves client nutritional status, both of which contribute to improved immune response which leads to reduced onset of opportunistic disease and infections, and improved AIDS treatment outcomes (see Annex 8 for *Scientific evidence for NHP contributions to improved outcomes*).

3.1.3 What key informants said regarding what contribution NHP through NACS has made towards the improved nutrition status of HIV+ patients and malnourished OVC, reduced onset of opportunistic disease and infections, and improved AIDS treatment outcomes?

Overall, the **provincial and district government officer, health facility managers and health care providers'** perceptions of the NHP was very positive with attribution of impact. In all the sites visited, health care providers cited NHP through NACS as having made the following significant impacts:

- Improved nutrition status of clients e.g. In Nyanza, the evaluation team met a woman who had been a bedridden severely wasted client who was enrolled into the NACS program weighing 30 kgs - after 6 months the client weighed 80 kgs. The improved nutritional status was attributed to FBP provided within the context of broader NACS service provision.
- Reduction in the number of severely wasted bedridden HIV infected clients resulting in reduced bed occupancy and mortality due to HIV
- Improved adherence to ART[4] because the FBP reduced side effects of taking the drugs on an empty stomach
- reduced incidence of opportunist infections
- reduced recovery time for severely wasted clients.

Health facility managers' perceptions on the impact of NHP:

- ***"NHP is transforming lives - sick, bedridden clients with no hope, are now healthy and being used as role models to give hope and encouragement to clients who have yet to recover"***
- ***"Nutrition is the key to the management of HIV/AIDS"***
- ***"NHP has put nutrition on the HIV agenda".***

Before the introduction of the RUTF -[5], the recovery rate of severely - malnourished children was slow[6] and consequently it was recommended by the FANTA II evaluation that RUTF be introduced to treat severe wasting. Since then a marked reduction in the number of bed-ridden clients and reduced mortality rates especially for the HIV infected clients from low socio-economic status was noted[7].

National level stakeholders close to the issue of nutrition were unanimous in their opinion that NACS had improved the nutritional status of the clients who had been successfully retained on the programme. Evidence for improved nutritional status was cited as weight gain, and improved strength to resume normal working life and become more food secure (anecdotal evidence provided). When asked more specifically about whether NHP through NACS had reduced the onset of OIs and improve AIDS treatment outcomes again there was unanimous agreement with the most commonly cited indicators being a) better adherence to ART (due to improved tolerance, more frequent site visits motivated by food collection and additional benefit of reinforced counseling), b) better survival rates for PLWHA (reduced mortality), c) and improved general well being and fewer incidences of sickness. 'Evidence' for these outcomes were attributed to feedback from the health care workers at sites, observation on site visits, and report from DNOs providing nutrition and HIV management at the site level. Government stakeholders at all level expressed a strong desire for more impact data to be collected to prove this impact and to justify their advocacy for NACS resources.

The **clients** interviewed during the evaluation attributed FBP (NACS) to improved health and well-being as shown in Graph 1 above. The clients also suggested ways in which the NACS service delivery can be

[4] Adherence in this context was defined as keeping appointments for the collection of ARV drugs and not compliance to taking the drugs as prescribed.

[5] September 2009 for children and in February 2010 for adults (Sept 2009 – Clinton foundation donated RUTF for OVC use, Feb 2012 Insta started producing RUTF for NHP)

[6] FANTA-2 July 2009. Review of Kenya's Food by Prescription Program

[7] Noted by the Medical Doctor in Charge of CCC Kisumu PGH, health care providers from the majority of the sites, and the PNO in Kisumu

strengthened to achieve improved long-term nutrition outcomes for clients. Their suggestion included: Introduce new products to aid in drug adherence (-i.e. the RUTF is too sweet); provide income generating activities; provide food baskets (including beans, rice, millet flour); increase the number of home visits; provide Corn Soya Blend (CSB) to all HIV patients irrespective of their nutritional status for drug adherence and transport allowance; provide more counseling and support groups; strengthen community outreach; prevent stock-outs which require revisits within the month; reduce waiting time in clinics; reduce the weight of the FBP to make transportation easier; ensure the quality of FBP products as it is sometimes rancid or infested with weevils; and more sensitization on the admission and discharge criteria.

3.2 What has been NHP's contribution in strengthening the capacities of partner NGOs, CBOs, and APHIA II partners in nutrition and HIV through training, orientation, and provision of materials?

3.2.1 What has been NHP's contribution in strengthening the capacities of partner NGOs, CBOs training, orientation, and provision of materials?

Strengthening the capacity of NGOs and CBO refers to a specific component within the cooperative agreement for bi-directional referrals between health facilities and NGO/CBOs. This is described as one of the key strategies within the NHP cooperative agreement as follows:

'Link Insta (the Food Partner) and health facilities with community-based and home-based care programmes for HIV+ patients and OVC to extend the supply chain, improve client tracking, mitigate loss to follow-up , and increase the quality and comprehensiveness of care'.

The original purpose of this 'community component' is still valid. Indeed, its expansion and further development is essential for the future of NACS service provision in Kenya. The community component was originally designed to have two key elements: a) direct provision of project services to OVC, b) community follow-up of health facility NACS clients, referrals and linkages to services. NHP has initiated efforts to address both elements although challenges have been faced and this aspect of the NHP does not seem to have been prioritized.

The first element was intended to be delivered by 15 NGOs to serve at least 10,000 OVC. Of the six suggested NGOs listed in the cooperative agreement none were appropriate organizations to engage for the community component. Two of the six, Nazareth Hospital and St. Camilus Mission Hospital Karungu, have been engaged as a site supporting NACS service provision with community outreach services. To establish a more appropriate list of CBOs for the community component USAID Kenya highlighted the opportunity to piggyback nutrition support on OVC APHIA II supported CBOs. A decision was made to select two APHIA II supported CBOs per province. The findings from a rapid assessment of the status of these CBOs are shown in Annex 9. A few of the CBOs assessed to be in a good position to take on this role were successfully mobilized before APHIA II project phase came to an end. Annex 10 shows details of their current status of engagement. It quickly became apparent that with changes in the APHIA implementing partners, continuity was a problem. This has been supported by the fact that continuity between the APHIA II and APHIA Plus partner (FHI) in the Rift Valley province has allowed more successful 'capacity building' of CBOs for NHP in this province. Under the circumstances, *"NHP adopted a strategy to work with partners who were able to quickly see opportunities and whose operations strategies permit easy engagement of the Community System"* – David Mwaniki, NHP, Chief of Party.

Seven CBOs have been activity orientated, trained and resourced to be able to contribute to the community component of NHP. The CBO FAIR was successfully engaged in community capacity strengthening between July and September 2011. Three hundred community healthcare workers (CHWs) supporting FAIR from six Drop In Centres were trained on screening and referral of malnourished orphans and vulnerable children (OVC), and pregnant and post partum women in the community. In Nyanza and Western Provinces, four CBO's were transitioned to NHP after Speak for the Child (SFC)

closed out in July 2011. It is expected that the transition to NHP is for the short term and will allow continuity of community nutrition services pending entry of the APHIA Plus partner or other longer term mechanisms. Nyumbani village in Kwa Vonza, Kitui District has also recently been oriented and trained to conduct screening through their outreach programme and provide referrals. Nyumbani village is likely to eventually become a prescribing facility.

Some limited lessons can be drawn from the community component during the final year of this project period. The evaluation team sense some reluctance from the NHP through NACS to invest in CBO engagement as originally designed as the recent development of Community Units (CU) does mean that CBOs are not necessarily the key referral points in the community[8]. Community units are discussed in more detail with this assessment under section 4.2. CBOs may therefore be additional, larger, organizations or support groups near to health facilities that CU CHWs can refer clients to for economic strengthening, livelihood and food security programmes, support group IGA initiatives, training and seed funding etc. Certainly until CUs are rolled-out nationally, the engagement of CBOs is an urgent task which will improve the effectiveness of the 'Support' component of NACS.

Engagement of NGOs and CBOs: lessons learned by NHP

- Establishment of CUs and county mechanism of health service delivery could be very helpful in accelerating delivery of Community Nutrition Service through CBOs as an integrated activity with water, sanitation and hygiene and non-communicable lifestyle diseases i.e. beyond HIV
- The National AIDS Council has a list of CBOs that identifies whether nutrition is a key area of focus for the CBO - this could be a useful resource for selecting CBOs to increase community engagement in the future.
- Leadership is a pivotal factor across the board (within the CBO, health facility and local supporting government staff)
- Support from local health facility staff is critical
- Religious affiliation is a major stabilizing factor but not without complications
- Extreme humanitarianism approach to food and nutrition does not favor separation of FBP and food aid

[8] Community units are discussed in more detail within the Assessment section 4.2.

Box 1. Overall status of the 'community component':

- 16 CBOs have been oriented in the programme (7 remain), CHWs have received training, and tools have been designed for community screening and referral, however support is still needed for M&E, further training for CHWs, and provision of resources for CHWs including MUAC tapes particularly for adults, bags, incentives etc
- One CBO, Family Aids Initiative (FAIR) based in Nakuru prescribes FBP through 10 Drop-In-Centres for MAM clients. SAM clients who may require more specialized attention are referred to health facilities. Approximately 500 OVC and adults have been enrolled by FAIR.
- All seven CBOs are providing community follow-up of health facility FBP clients, referrals and linkages to services
- Some CBOs previously engaged by NHP may continue to fulfill a NACS role in supporting a health facility but may simply not be reporting to NHP
- Community tools for assessment and referral have been successfully developed
- There is close monitoring of the work of CBOs to see the effectiveness of this approach however this would benefit from a more rigorous 'operations research' (OR) approach
- Community Units are starting to get established in some Districts with CHWs trained by local CBOs are being successfully elected as CU CHWs; APHIA partners have helped to facilitate this link in some districts
- There is high level of understanding and support for the engagement of Community Units – however it is not clear how effectively and consistently CU CHW curriculum training on nutrition screening will be implemented and whether MUAC tapes will be provided
- Capacity building on NGOs/CBOs for the 'community component' of the NHP has been late in the life of the project – the development of the 'community component' for the next iteration of the NHP is important but should be based on OR and its expansion staged to allow for further learning, particularly in the engagement of the Community Units.
- APHIA Plus partners have started to understand and take up their role in the development of the community component – they have a big potential role particularly in:
  - mobilising CBOs and supporting Community Units
  - providing supervisory support for community component and lower KEPH level health facilities to supplement supervision from NHP
  - linking clients (indirectly) to local partners and Ministry of Agriculture for increase food security and livelihood programming
  - providing training on nutrition, WASH, PMTCT community component

3.2.2 What has been NHP's contribution in strengthening the capacities of APHIA II partners in nutrition and HIV through training, orientation, and provision of materials?

APHIA II and APHIA Plus partners have been orientated to the NHP.

In terms of training, NHP has engaged local partners including APHIA Plus, CDC, DOD to support capacity building through PNO, DNOs training and cascade training etc. Here some of the APHIA Plus partners sponsor Continuous Medical Education (CMEs) on nutrition and help central sites to conduct supervisory visits to satellite sites. This model works reasonable well but is considered to work based on 'good will' and commitment of government staff and local partners as insufficient importance and resources are currently put towards nutrition. USG partners, including APHIA Plus, have been encouraged to recruit nutritionists as resource personnel to support nutrition programming.

The APHIA Plus implementing mechanism has so far proved difficult for NHP to work with as NHP continues to be incorrectly viewed as an independent implementing partner despite orientation sessions explaining the contrary. NHP believes that the engagement of APHIA Plus partners will improve with the inclusion of interventions to address the social determinants of health as a key activity of the APHIA Plus programs as stipulated by USAID Kenya. The Ministries of Health engagement to integrate nutrition programming in the community strategy will reinforce linkages at the local level. Local level supervision and support will become practical when APHIA Plus partners fully roll out the national mentorship activities which include nutrition services.

3.3 NHP's influence on policy, strategy and services at health facility and community services in the health sector

3.3.1 NHP's influence on national level policy and strategy

At the national level, policy decisions concerning nutrition, and nutrition and HIV are mainly driven from global agendas and research. Within Kenya, KEMRI conducted a randomized controlled trial of the impacts of food supplementation on malnourished adult ART clients and adult pre-Art clients. NHP has helped to disseminate this data providing scientific evidence to push the agenda of HIV and nutrition, and the importance of nutrition service provision.

Key national level stakeholders interviewed for the evaluation (GoK and non-government) agreed that NHP has been influential in policy, strategy and guideline development. They agreed that NHP is a key stakeholder and expert resource on 'FBP' and 'NACS', with practical experience and data from the implementation of NHP, and up-to-date knowledge on scientific research and global policy and opinion on this subject.

NHP has conducted sensitization of the stakeholders at national, provincial and district levels on NACS i.e. relevant officials from NASCOP, Ministry of Medical Services, Ministry of Public Health and Sanitation, Provincial Nutrition Officers, Provincial Clinical Nutrition Officers. Sensitization has helped to catalyze the need to invest in nutrition as part of HIV programming and has helped broader efforts to get nutrition on the national agenda.

> ***"In terms of influencing policy implementation, NHP has been the first programme to actually systematically implement the Kenya National Guidelines on Nutrition and HIV/AIDS. Without support for implementation, policies can remain on the shelf. NHP therefore has become a source of practical experience that can inform national level policy and strategy."***
>
> **Department of Family Health, Food Security and Emergency Nutrition**

Some national level key informants, particularly among the development partner community, felt that although nutrition was on the agenda within Kenya, that NACS (and within this FBP) was not well understood or discussed in public fora.

The contribution of NHP's influence on policy at the national level is therefore considered by national level stakeholders to be significant. NHP staff are key advisors at the national level as well as key players in translating national level policy into practice. Although NHP is credited with being the first programme to implement the HIV and nutrition guidelines systematically, this has not been fully integrated through the Government systems, with M&E and commodity provision seen as parallel systems. However this practical experience and government engagement has provided a platform for 'advocacy from the ground-up' – helping to influence policy formulation and opinions by impact seen in practice.

The influence of NHP on national and broader regional policy and strategy would likely be greater had more comprehensive impact data been successfully generated and disseminated. NHP have faced some

challenges in generating impact data, but also dissemination of data seems to be have been limited to USG meetings, facilities themselves and, lately, to NASCOP. NASCOP and other government departments should and can receive their own data from health facilities through government systems; challenges in strengthening these systems have hindered M&E and frustrated the government which as a resulting has limited access to data.

In practical terms:

- NHP is widely credited and praised by national level stakeholders for drafting two chapters of the new Guidelines for Antiretroviral Therapy in Kenya (a chapter each for the care of adults and children)

- NHP has also worked with the Ministry of Medical Services to push the Kenya Medical Training College (KMTC) to start training middle level cadres of medical staff on nutrition, rather than solely focus on curricula for nutritionist

- NHP has supported NASCOP to introduce an annual Nutrition Day by providing intensive support for the first year. NASCOP has successfully taken this up, focuses on a different theme each year, and is now supported by other partners.

- NHP has advocated at regional level on the reduction of taxes on vitamins

- As much as possible NHP has worked with Government protocols and guidelines to strengthen existing health service facility processes and strategies. Key to this is the Nutrition TWG whose subcommittees decide how NHP sites are rolled-out and capacity building implemented.

The following table provides a summary of NASCOP's perspective of the NHP and its relationship with the NASCOP/Government of Kenya as a key collaborating partner and (implementation partner).

Table 2: NASCOP's opinion of the Nutrition and HIV Programme (NHP) – NHP's key strengths and areas that need to be strengthened

NHP Strengths	NHP areas in need of improvement
• NHP has helped to raise the profile and put a face to nutrition in Kenya • Clients appreciate the food and have benefitted from it • NHP provided technical input in materials development (wall charts, counseling cards, protocols, guidelines etc) • NHP were very supportive in the establishment of first Kenyan Nutrition Day which now all partners have bought into • FBP (NACS) has been implemented well – food is getting to clients with good procedure • NHP has conducted recent regional sensitization forums on NACS spearheaded by NASCOP – reinforcing on-going assessment and counseling • NHP staff listen to concerns and address them – e.g. packaging issues resolved after alerting NHP to the problem *"When we (GoK & NHP) work together we achieve success – NHP are better collaborators than most"* *"Please continue the programme otherwise Kenyans will strike like they did in Mombasa during stock-out!"*	• M&E - indicators need to be reworded to be more easily measureable or more attention needs to be paid to how indicators are measured, joint support supervision, improved data sharing– NASCOP have not been receiving NHP reports consistently from NHP • Initial NHP training focused too much on commodities; this has improved over time with NACS training • PDAs were not rolled-out as promised early on which has limited data management and ownership, however Net Books are being piloted in nine sites • QI/QA gap for commodity and service provision • Weak community component which has been initiated late and with no involvement of NASCOP • No clear plan for who among the GoK and partners is responsible for the supply and replacement of anthropometric equipment • Support supervision is supposed to be joint between NHP and GoK, although some joint support supervision is conducted with provincial GoK staff, NHP staff do their own limited supervisory support resulting in facilities seeing NACS as a USAID/NHP programs, rather than GoK

3.3.2 NHP's influence on the integration of nutrition services at health facility

One of the key objectives within the NHP cooperative agreement is to provide technical guidance and coordination to integrate nutrition services in HIV management. On the whole, secondary reporting and field visits have shown that NHP has successfully facilitated the integration of nutrition into the provision of HIV services at NHP sites, not just within Comprehensive Care Centres (CCCs), but throughout relevant units at larger facilities.

One indicator of the influence that the NHP programme has had on the delivery of nutrition services within health facilities in Kenya, is sheer demand and push for expansion of HIV and Nutrition services that has been driven by the Nutrition TWG. Over the project duration, sites supporting NACS service provision have scaled up from 62 central sites in 2008 to 189 central sites across all nine provinces of Kenya by March 2012. This reflects the level of support for NACS and desire within the TWG for its rapid roll-out. To strengthen effective decentralization, NHP successfully aligned decentralization of NACS service with ART Decentralization Guidelines (2009). NACS service provision was decentralized to satellite sites where ART is being provided to improve access for clients and reduce the incidence of clients switching ART sites to access FBP/NACS.

Through NHP the FBP protocol was developed providing the first rationale for FBP for health facilities. This has been printed for all NHP sites (central and satellite) and has been disseminated since mid 2010. It has not been disseminated outside NHP sites due to financial limitations however partners have disseminated it as a cost sharing approach (e.g. Walter Reed Project donated 500 protocols to NASCOP to disseminate) and it is accessible as a soft version file for ease of information dissemination. FBP protocol could be a standard tool for all health facilities to facilitate NACS including assessments, categorization, counseling and referral for community support and to sites that offer FBP. It is not clear to what extent this is currently the case.

In the majority of the sites visited, nutrition has been integrated into the "Integrated Care and Support Models" currently being emphasized. Anthropometric assessments are conducted for all ART and pre-ART clients visiting the CCC, to establish their nutritional status, need for FBP and counseling on how to use and adhere to the food. Nutrition services are also integrated into clinical services in the various service provision sites; MCH, ANC, PMTCT and well baby clinics. Whereas there are variations from one health facility to another, the flow of processes in the provision of services allow for the majority of clients to access nutrition services. In the majority of the sites, registration, clients go to the TRIAGE room where nutrition assessment and categorization is conducted before the client is referred to the clinician. The clinician then refers clients needing FBP services to the nutritionist/nutrition office. In the larger sites such as the PGHs, nutrition status assessment and categorization is done at each of the service provision units and then clients are referred to the nutritionist in the CCC.

The integration of nutrition services in HIV management has been supported by the increased numbers of nutritionist staff a health facilitates facilitated by USG partners. CDC addressed this gap by employing nutritionists at sites. In Nyanza PGH for example, two out of the four nutritionists were CDC staff and the other two were government employees. Similarly, in Kombewa District Hospital in Kisumu West district, two of the four nutritionists were employees of DOD. Despite these efforts, the government health facilities do not have adequate nutritionists. The provision of nutrition services more widely is currently constrained by the limited number of nutritionists in the majority of the government facilities. The deficit in employed nutritionists is due to a lack of allocated resources as there is a surplus in trained nutritionists in Kenya. APHIAPlus takes a different approach, working through Capacity Kenya to identify staffing needs, and then negotiating their placement through central government.

Box 2: Specific achievements in the provision of training and anthropometric equipment to facilitate the integration of nutrition services in health facilities

The majority of the health care providers in the CCCs in NHP supported sites have received training to provide NACS services. Their capacity to provide NACS service was reported to have significantly improved according to health care providers, NASCOP, Kisumu PNO and NHP quarterly reports. NHP and NASCOP spearheaded the roll-out of the 5-day NASCOP training nationally. In addition, NHP provided programmes-specific training to 5 staff from each of the health facilities (nutritionists, clinicians, pharmacists, nurses, counselors and food storage and distribution personnel) participating in the programme. So far, the number of health care providers who have received foundation training is 320, with 698 receiving refresher training. Those who received the initial training were expected to train other staff through on-the-job training (OJT) and Continuous Medical Education (CME). NHP has provided material to central sites to facilitate OJT and supportive supervision. NHP together with NASCOP has provided limited supportive supervision and monitoring of the NHP services. Training enabled other cadres of health care providers (not only nutritionists) to accurately assess, categorize and prescribe FBP to clients thereby increasing the capacity of the health facilities, many of which have inadequate staffing of nutritionists, to provide these services. The training also created interest in nutrition among all cadres of health workers and improved appreciation of nutrition in the management of HIV. A DVD for health care providers has also been developed and will soon be disseminated to sites.

To facilitate integration of nutrition into HIV services provision, NHP provided anthropometric equipment and materials vital for professional implementation of NACS service sites. The equipment provided during the initial phase of the programme included height/length measuring boards and stadiometres, weighing scales and MUAC tapes. The availability of such equipment makes professional nutritional status assessment and categorization of clients possible. Nevertheless, many of the sites visited during the evaluation had inadequate and/or old equipment in a state of disrepair. According to NASCOP, it is not clear whose responsibility it is to purchase, maintain and audit the equipment to ensure the provision of NACS services are not constrained by lack of anthropometric equipment.

3.3.3 NHP's influence on the integration of nutrition services in community services

The influence of NHP on the integration of nutrition services in the community services has been discussed in some detail in section 3.3. Beyond the recruitment of NGOs/CBOs to support the community component of NACS, however it is clear from counseling content and from interviews with health care providers that referrals and linkages with community services do currently exist at some health facilities. For example, health facility volunteer peer educators (expert clients) and social workers follow-up clients in the community and provide advice and support. In a few of the larger health facility sites, small shambas had been developed for education purposes and for food production. In some cases these where managed by PLHIV support groups and in one case by a group of NACS clients themselves (Kisumu PGH). NHP has made some contribution to this by supporting the FBP focal person/ nutritionist to train CHWs, incorporating the use of mobile telephony to refer SAM/MAM clients to facilities, and harmonizing referral tools through the use of MoH client community/facility referral forms. However, the community follow-up of health facility FBP clients, referrals and linkages to services so clearly described in the cooperative agreement has not been effectively put in place nor has a systematic approach to strengthening this aspect been devised. For many sites visited no community linkages exist

and health care providers were not aware of services or programmes in the surrounding area that might be able to support the long-term nutrition status of clients.

3.4 What capacity building contributions on technical, scientific, clinical and leadership skills has NHP made?

3.4.1 NHP's contribution to capacity building of technical capacity

Areas for technological capacity building discussed below include a) new FBP products, b) client data management systems c) and commodity management systems, d) electronic data capturing tools, and e) storage provision. NHP has achieved varying success in these areas with some key missed opportunities for early technical advancement.

a) Technology and scientific capacity advancement has been achieved through the development of a Kenyan RUTF commodity and three Insta supplementary foods that are more client-focused. Insta has developed an alternative cheaper energy-dense product called 'REBOUND' with higher palatability. The efficacy of this product has yet to be tested. In the future, Insta Products also proposes to develop a savory RUTF, and NHP is also collaborating with KEMRI to establish whether enzyme technology can be used for future product development.

b) NHP capacity building in terms of client data management has also been intensive over the project duration. There have been three versions of the data collection tools for client i) used by Insta before 2008, ii) NHP version produced end of 2008/early 2009, and iii) version three in November 2011. Tools have been continually improved to align to Kenya HMIS indicators, PEPFAR and District Health Information System (DHIS II). As the forms have been improved over time to collect relevant data to support the measurement of nutrition indicators, the form has become lengthy for health care providers to complete. At the same time, to support reporting from facility to District, Province and National offices, NHP introduced data tally tools in health facilities; however the tools were partially adopted. NHP recognized that in the absence of a universal register it would be difficult to enforce the use of tally sheets. Consequently, NHP has provided technical and financial support to develop a daily nutrition activity register (GoK 407 awaiting feedback from NASCOP) which will replace the NHP form version 3 and all other donor forms at health facilities. Again, if successful this will help to overcome challenges faced by health care workers and help the government to collect and own data. Focused capacity building and supervision will be necessary to ensure the correct and reliable use the register which will feed into DHIS II.

c) NHP capacity building in commodity management has been intensive but challenging over the duration of the project. Although a commodity management system has been put in place which has enabled the delivery of products to sites, the commodity management chain has only really been working effectively for the last 5 months according to NHP staff. The two major limitations have been a) problems with commodities themselves in terms of varying quality and stock outs, and b) weak stock management systems at facility/site level (forecasting, ordering, issuing, storage). As an illustration of the challenges faced, the deadline for reporting is the fifth of the next month, however central sites are often 10-15 days late in reporting which affects not only their facility but also the satellite sites they support. Consequently, NHP has provided NASCOP with technical and financial support to develop and field-test a new LMIS and tools. If the LMIS and tools are successfully piloted and rolled out with adequate training, this will not only support the facilitation of commodity management by GoK systems, but also strengthens government ownership of data which will feed through the LMIS. The development of the daily nutrition activity register (GoK 407), awaiting feedback from NASCOP, and LMIS tools for commodity management (currently being piloted) will replace all tools by the end of the NHP project (March 2013). This will be a considerable achievement of the NHP programme and significant technical

capacity building of the Government of Kenya client and commodity management system for nutrition.

A training unit on commodity management has been included within the NACS training resources (Module 4 unit 2- inventory). By the end of the current NHP, it was anticipated that KEMSA would be handling the commodity management. However KEMSA is evolving and is currently being supported by USAID/Deloitte to build their capacity and therefore handover of nutrition commodity management should be gradually achieve during the next iteration of the NHP.

d) In addition to supporting the development, piloting and roll out of tools to support the LMIS and revised nutrition register, NHP is in the process of testing the feasibility of Electronic Manufacturing Technology for electronic data capture and transmission in nine sites which have been provided with NetBook computers with customized software. Two sites have also been provided with customized software to install in their systems. The development of customized software is a good innovation by NHP and goes beyond the scope of the cooperative agreement, showing a willingness by NHP to work with what is practical at the health care facility level. Where sites have been supported with a NoteBook and/or computer software to enable them to generate their own data, improved leadership and management capacity has been developed. Once the sites own their data, their potential to lead the nutrition team and advocate within the facility is reported to increase. The field-testing of electronic data capturing tools is a good advancement but has come late in the project. Many issues concerning data ownership could have been alleviated if such tools had been piloted earlier with the subsequent progression toward roll-out of electronic data capturing tools.

e) There has been a missed opportunity concerning technological solutions regarding storage at health facility sites. The Cooperative Agreement promised containers for storage which would have helped storage issues witnessed by the evaluation team e.g. Ahero Sub-District Hospital deliberately under-orders FBP commodities due to lack of adequate storage – this results in the use their own inappropriate client prioritisation and graduation criteria. A specially designed and standardized container could have been developed for this purpose and purchased on mass. Opportunities to tap into broader USG expertise and supply chains may have been missed e.g. DOD may have been able to provide technical expertise and resources to help address this challenge; similarly, expertise across Kenyan Government Ministries could have been tapped e.g. Ministry of Defence.

3.4.2 NHP's contribution to capacity building of scientific knowledge

As discussed above under 3.3, NHP is widely considered to be an expert in terms of scientific knowledge concerning HIV and nutrition and FBP. The KEMRI randomized control study provided scientific data to support FBP which NHP helped to communicated widely. NHP has provided technical input into a range of policy, guidelines and services delivery tools (e.g.to comply with WHO and PEPFAR guidelines on end points in all the protocols, guidelines and training materials). This practical input is effective capacity building. NHP continues to share accumulated knowledge from NACS programming with various stakeholders as well as during training of health care staff. A number of national level stakeholders did however comment that NHP could have contributed more to scientific knowledge through more rigorous M&E and presentation of findings.

3.4.3 NHP's contribution to capacity building of clinical skills

NHP's contribution with regards to clinical skills capacity building include a) the financial and technical contribution to the development of practical tools for NACS service provision b) clinical skills training c) mandatory inclusion of anthropometric measure in HIV service provision d) improve counseling, and e) provision of guidance on the use of RUTF.

a) NASCOP credits NHP as being a key partner in making financial and technical contributions to development, production and dissemination of practical tools for NACS clinical management including the Kenya Clinical Nutrition and Dietetics Reference Manual; Protocol for Food by Prescription, Reference charts including BMI for Age 5-17 years, counseling cards, IEC materials, guidelines and posters for drug and food interaction, and strengthening of the Government owned HIV and Nutrition training curriculum through the TWG capacity building work group(including revisions to conform with national guidelines e.g. Integrated Management of Acute Malnutrition (IMAM), PMTCT, ART, Out-patient Therapeutic Programme). BMI for Age for categorization of nutritional status for children 5-17 years of age was not used previously. As a result, malnourished children older than 5 years can be accurately categorized and those who qualify for FBP benefit from the service. FBP guidelines clearly indicate the admission and discharge criteria, the type and amounts of foods to prescribe for the various groups of people. The evaluation team noted that although the BMI charts can be visibly placed on the walls for easy referral the BMI desk flipcharts are easier to use and can be moved from room to room.

b) One of the NHP key objectives is to build capacity to strengthen technical and management capacities for FBP services. NHP is the first to offer capacity strengthening in clinical nutrition on a large scale in Kenya. NHP has provided very effective training in clinical skills development for health care providers in NACS. Initially the training focused on nutritionists but now sensitization is conducted for multi-disciplinary teams because of the shortage of nutritionists in the majority of the sites and the need to integrate of nutrition across HIV clinical services. It was reported by NASCOP and verified by the evaluation team that health care providers are knowledgeable and the majority have the appropriate skills to assess, categorize, provide counseling and prescribe FBP appropriately. Nonetheless, continuous refresher courses, OJT, CMEs and mentorship are necessary to update knowledge and skills because of high staff turnover and rotation of health care providers in service provider sites. Refresher training has been provided to all central sites, however the effectiveness of cascade training and mentoring is questionable considering the workload and supervisory limitations of the provincial and district government officers and central site staff.

c) Anthropometric measurements are included in the HIV Care Patient Card (MOH 257) better known as the "*Blue Card"* making it mandatory to perform nutrition assessment for all PLHIV. In addition, a food security assessment has been introduced as part of nutrition assessment for all patients (see prescription form and page 33 job aid – HHS) to help health care professionals respond to clients who are food insecure.

d) Since the FANTA 2 Evaluation in July 2009, improvements in counselling as part of NACS service provision has been achieved by a) incorporating data capturing of counselling activities on FBP prescription form which implies it is a standard part of the service, b) strengthening the counselling component of the 5 day health care worker training curriculum, c) the redevelopment and availability of a range of nutrition pamphlets for clients translated into various languages, d) use of food demonstration models, e) food preparation demonstrations, and f) development of a desktop flip chart as job aid for health workers which emphasize the importance of counselling and provides practical counselling information. Health workers appreciated IEC materials such as pamphlets and flyers which clients could read at home as sometimes clients are distracted during the visits at the health facility. In most of the sites, however, it was reported that pamphlets and flyers had run out and new supplies had not been received. It was also reported that IEC materials in local languages were appreciated by clients although they too were in short supply. It was also recommended that a DVD focusing on the therapeutic aspect of FBP and education concerning economic strengthening, livelihoods and food security be shown in the waiting bays at the facilities, many of which have television screens.

Consistent provision and high quality of counselling skills was cited by clients interviewed. The majority (72.9%) of the clients reported having received counselling during the last visit at the site. One-on-one counselling was the most common form reported by 86.7% of the clients and

30.5% reported to have received group counselling. The majority of the clients (94.6%) interviewed during the evaluation knew the amount of FBP to eat on a daily basis and 82.2% said they ate the food daily. These findings show an improvement over the findings of the FBP assessment conducted in 2009 (AIDSTAR). During the interviews with clients, the majority reported that what they liked most about the 'FBP' (NACS) was the food, counselling and the respect and warmth offered by the health care providers offering the service. This finding is indicative of the quality of counselling provided. In addition 70.8% of adults and OVC caregivers said they visited FBP facility once a month, only 5.6% said they visited less frequently than this, the remainder visited every two weeks or one week for special care. This shows a consistent policy of requiring clients to return to the health facility every month rather than giving FBP supplies for longer. Increasing return appoints for ART are being aligned with NACS service provision. Both these aspects demonstrate improved clinical management skills.

e) The use of RUTF has been effectively managed through adjustments to FBP guidance, for example the FBP protocol was revised allowing for combination dosing (RUTF+FBF) for adults and older children who identified the sweetness of RUTF as a challenge for consumption as prescribed, and also to reduce cost. Client interviews during the evaluation revealed that 12% of adult clients found the sweetness of RUTF as a challenge for consumption. This shows NHP's ability (along with its partners) to identify and respond to clinical challenges.

3.4.4 NHP's contribution to capacity building of leadership skills

Capacity building in leadership has been relatively successful at the national level although frustrated by the lack of available M&E data to support advocacy and service improvement. The evaluation team found leadership skills to be weak at the health facility level with lack of quality improvement and assurance tools being a contributing factor to otherwise systemic problems. There is some evidence that NHP has strengthened the leadership capacity of PNOs.

a) The design of the NHP programme requires that NHP work through the existing government structures, cascading training and information through each government level. NHP therefore mainly works with national level stakeholders, mainly through the nutrition TWG, and with provincial nutrition officers and district nutrition officers. NHP has supported one workshop to build capacity of provincial nutrition services managers to plan NACS/FBP service, however it is difficult to ascertain to what extent NHP has contributed to capacity building of leadership skills during this workshop. The evaluation team, however, met with one Provincial Nutrition Officer who was highly motivated, provided strong leadership in her province, and who praised NHP for providing her with the support she needed (apart from supervisory transport support and data). To the extent to which NHP actively attempts to build capacity in leadership, it does so by supporting those in leadership roles by working within Government systems wherever possible, listening to problems, and providing technical input. A key contribution NHP could make to leadership capacity building would be to ensure that NHP reports are circulated widely and help ensure that data is available for use by those in leadership positions to advocate for NACS, and improve NACS service provision. Data is not currently flowing through the GoK monitoring and evaluation systems. This is needs to be addressed.

b) The field visits to health care facility sites showed weak leadership amongst local government nutrition staff. This was exacerbated by overstretched DNO/DCNOs attempting to provide nutrition service themselves. From the small sample of sites visited, the FBO staff tended to be more motivated, organized and better resources. Although a systemic problem, focused efforts to strengthen leadership skills among government site managers and senior nutritionist would likely improve the quality of NACS service provision and be a worthwhile investment.

c) A key aspect of leadership is the ability to manage the quality of services provided. A lack of ownership and use of data to improve quality of services at sites and at all levels of government has been exacerbated by lack of IT facilities, training on the use of data, and over reliance on

NHP reports in the absence of effective vertical government reporting systems. Although this is the case generally, it should be noted that for a few sites, the reports generated by NHP have helped some nutrition managers to be more analytical and reflective of the NACS service provision. This is evidenced by the fact that some respond to the reports issued and in some cases challenge the report data by explaining anomalies. In these incidences, NHP is facilitating improved leadership. Needs scale up.

The field sites visited during the evaluation did not have written quality assurance/ improvement (QA/QI) policy with clear guidelines, procedures and tools (QI tools were included in the cooperative agreement). The majority did not operate effective and active systems of performance measurement to monitor achievement of plans, build knowledge, make decisions, and improve quality. This lack of performance audit and review has meant that most sites visited did not learn from past challenges and constraints, and were fire-fighting problems on a day-to-day basis. At Bondo District Hospital where a QI approach facilitated by URC is currently being piloted, appreciation of major quality themes were noted during group discussion with health care providers and clearly some improvements have resulted even during this pilot. However, in order to improve NACS service provision, the quality improvements approach needs to go beyond the specifics of the NACS intervention to examination relationships between and among individual professional staff, their motivation, groups/team processes, as well as broader organization-wide issues involving organizational culture, leadership, decision support systems and incentives. The quality improvement approach being piloted is a step in the right direction and would benefit from wider application once piloting lessons have been learned. This would support leadership development at the facility level.

3.5 How has this resulted into creating a strong platform for therapeutic interventions (ART) and helping prevent the onset of life-threatening infection in Kenya?

There is strong scientific evidence for the impact of therapeutic foods in improving nutritional and health outcomes of HIV infected people. The overall rate of adult treatment outcomes for NHP nationally is 56.0% with some of the more efficient sites reporting higher rates (EDARP 64.0% for all clients). Although these rates should be improved, they demonstrate the significant impact of NHP's NACS programme in improving the health and well being of HIV infected clients. NHP is the first large scale nutrition intervention in HIV management in Kenya. The target of the current programme to scale up has been surpassed to 619 sites providing FBP to 189 central sites and 431 satellite sites. The current platform covers a range of KEPH level including district/sub-district (31.2%); health centers (30.5%); and dispensaries (36.5%). Of these sites; 15.4% are faith-based organizations (FBOs), and approximately 1% are private while the rest are government health facilities. Physically, a string platform already exists for improved care for PLHIV with further potential to decentralise to all 1,731 ART sites.

Sites selection is well established within Government systems therefore providing the potential for sustainability and ownership of the programme. Decentralization of NHP services from primary to satellites sites and the some involvement of CBOs have led to many people accessing the services. Tentative links have been made by NHP between health facility sites and CBOs in the surrounding communities to ensure follow-up of FBP clients through volunteer CHWs. Although the majority of CBOs engaged with NHP (6 out of 7 CBOS) providing screening, referral and follow-up services with NACS, presently, one of the CBOs is prescribing FBP. This process is under pilot and if successful will be rolled out to other CBOs meeting the criteria for provision of FBP. There is high potential for increased accessibility to NACS services by scaling up and strengthening of the community linkage through engagement with more CBOs and Community Units.

The integrated approach to the provision of NACS services has created a strong platform for therapeutic interventions to treat and prevent life-threatening infections related to HIV. Integration of nutrition services has sensitized, created interest and appreciation of nutrition in the management of HIV and

beyond by health facility site managers, all cadres of health care providers not only nutritionists, and clients.

NHP together with NASCOP has trained a critical mass of health care providers (both nutritionists and non-nutritionists) with the capacity to provide NACS services with a relatively high level of success. Capacity building have been achieved conducted with health workers to provide NACS services in a range of health care sites - government, FBOs, CBOs and is currently expanding to private health facilities. NACS has improved the capacity to manage malnutrition and the introduction of a local RUTF (for adults has resulted in significant improvement in the understanding and management of SAM. However, to strengthen the platform some key challenges need to be resolved:

a) More nutritionists should be employed especially in level 6-3 health facilities to coordinate and provide leadership in NACS service provision. Continuous training, refresher courses, OJT and CMEs should be scaled up/accelerated because of the high staff turnover and shortage of nutritionists especially in the government health facilities.

b) improved availability of anthropometric equipment and nutritional status reference materials at the health facilities has enhanced assessment and categorization of clients' nutritional status and the introduction of BMI for age for children 5-17 years of age has facilitated categorization of children older than 5. However, there is need for provision of more anthropometric equipment and maintenance of those in disrepair.

c) Loss to follow up continues to be a major challenge. Currently, the manual system of recording NHP data does not allow for easy identification of clients who do not keep appointments. A few of the sites have introduced the use of Diaries in which clients' return dates are recorded and therefore follow up can be addressed for those who do not keep appointments.

d) Relapse rates continue to be a challenge across sites. Based on the evaluation data, the relapse rates of 21.8% for adults and 16.5% for OVC even though the majority of the clients (82.4%) had been initially discharged having attained the discharge criteria/gained adequate weight. High relapse rates were attributed to household food insecurity, inadequate or lack of linkage to livelihood projects and community strategies for follow-up.

e) A key weak link in the platform is the community follow-up and linkages to economic strengthening, livelihood and food security. In addition to tentative steps in the engagement of CBOs and Community Units, health workers have been encouraged to develop district level nutrition and food security forums.

3.6 Summary of key challenges, lessons learned and gaps identified for NHP implementation

3.6.1 Key challenges during the NHP period

- Transition of from AED to FHI360 caused some staffing issues and financial limitations.
- Stock-outs caused by inconsistent supply from Insta production (first half and part of the second half of 2011) and weak commodity forecasting / management at the site level.
- Loss to follow up continues to be a major challenge.
- Relapse rates continue to be a challenge across sites.
- Lack of solutions offered concerning storage at health facility sites.

- Lack of ownership and use of data to improve quality of services at sites and at all levels of government.

- Relatively weak leadership skills and motivation amongst some Government facility health care providers, and to a lesser extent, Mission/FBO facilities has been difficult for NHP & PNOs to overcome to achieve quality NACS service provision.

- Inadequate availability of staff, especially nutritionists in government institutions.

- Lack of nutritionists at some sites means DNOs are spending their time providing hands on nutrition service provision/ management instead of offering supervisory support, quality control across their district which is so needed.

- PNOs/PCNOs and DNOs/DCNOs have inadequate resources to provide supervisory support to sites supporting NACS service provision.

- The arrival of a large consignment of Plumpy Soy from GoK at sites (without guidelines) has meant that sites have substituted RUTF for Plumpy Soy affecting commodity usage data and procurement. This is incorrect protocol as Plumpy Nut is for SAM and Plumpy Soy is for MAM.

- Site expansion was agreed by NASCOP/TWG ; this has impacted on the quality of service provision due to inadequate training and resources.

- Initial training only provided to nutritionist has meant that in some sites cross-team sensitisation came late and attitudes are entrenched 'that nutrition is a side-service by nutritionists'. Refresher trainings have attempted to bridge this gap.

- Some messages concerning new eligibility criteria are not being included in guidelines or reaching some sites e.g. Inclusion of non-HIV TB clients, and the importance of provision of FBP to linked children to overcome sharing.

- Dependency on FBP as household food due to insufficient economic strengthening, livelihoods and food security support, and in a limited number of cases, inadequate explanation of the FBP aims during initial counselling when the programme was first rolled-out at some sites.

- High staff turnover and rotation of staff to different health care service provision sites.

- Distinction between food aid/FBP can be hard for clients to understand; and overlap of responses, strategies and messages from different partners can be difficult for the GoK to manage/coordinate.

- 39.7% of adults and 36.7% of OVC caregivers said they shared the FBP products (this is probably an underestimation). The main reasons given were that sharing food is expected and /or there was no other food in the household.

- Inconsistent availability of anthropometric equipment (particularly adult MUAC tapes) and equipment in poor state of repair (especially weighing scales). This has been confirmed by NASCOP based on their recent Data Quality Assessment Sites.

- Confusion over the provision of infant formula, and need for clear infant feeding policy in the context of HIV for all partners to follow.

- Insufficient senior staff at NHP (not mentioned by NHP itself), for example, perhaps an operations manager or programs could support the Chief of Party.

- USG partners' terms of employment for nutritionists in health facilities are contractual. There may be gaps in staffing of nutritionists under such employment terms when the contract is over, leading to compromised sustainability and reduced quality of the provision of nutrition services.

- Weak supervision and monitoring of services by NHP and NASCOP.

- Multiple reporting systems for different donors means the government does not get an adequate overall data picture for decision-making and policy formulation. The nutrition register soon to be rolled out and the LMIS should address this issue.

3.6.2 Key lessons learned during the NHP period

- Reasonably poor overall data for graduation attainment of clients and average loss to follow up of 47% can be attributed to a mixture of programme challenges including:
  - stock-out on the supply side and poor pull commodity management system
  - loss-to-follow up due to client barriers, weak health facility follow-up and community referral systems, death
  - incomplete data reporting to NHP
  - client site switching
  - inconsistent prescribing/graduation before appropriate BMI attainment etc. due to lack of training, rationing of products
  - clinical failure.

- Stock-outs have been due to both inconsistent supply from Insta production Inc. (first half and part of the second half of 2011) and weak commodity management at the site level. A pull system is planned to be rolled out in June 2012 (the evaluation team feel that this will only partly rectify the situation with further commodity management training required)

- The length of stay in the programme for many clients to reach the exit criteria is longer than3 months. Out of the 144 clients interviewed during the evaluation, 42.9% had stayed in the FBP for more than 3 months.

- Health care providers, CHW and clients consistently attributed NACS (particularly FBP and counselling) with improved well-being, health outcomes, fewer SAM and bedridden clients, improve appetite etc – it is difficult to separate these outcomes from the benefits of ART (however FBP is reported to have increased ART drug adherence and nutritional status which both contribute to improve immune responses).

- Counselling for new clients must emphasis the short-term therapeutic nature of the FBP and that it is intended to supplement other food sources – this will help to prevent dependency and emphasize need to address food insecurity.

- Quality improvement (QI) through URC has helped Bondo DH appreciate the importance of team work, integration of services, and need to improve service provision. QI ideas however need to be actioned and also need to be tested before implementation.

- Training and sensitization of all health care providers on nutrition service provision is vital for onsite referral and flow, and provide backstop in the absence of a nutritionist; however adding nutrition to their already over-stretched workloads risks poor service delivery.

- Some of the health facility site managers interviewed were not conversant with the implementation of the NHP programme, apart from the knowledge that FBP was provided for HIV infected clients. This can be detrimental as health facility managers' decisions can influence

the success of the implementation of the NHP, for example, the allocation of rooms for the provision of services and for storage of FBP, particularly where there is scarcity of these facilities.

- Whether CHWs are supported by CBOs or Community Units the sustainability of their role is largely be dependent on whether they receive adequate incentives.

- Most mothers do not take their infants back to health facilities after their last inoculations at 9 months. Therefore community outreach and community support and referral is essential, especially for malnourished children who are perceived to be well and are not taken to a health facilities.

- Stigma is still an issue in some areas. Stigma can prevent some clients accessing services and some clients deliberately travel long distances to access NACS services away from their community. This exacerbates transport as a barrier to NACS service access.

- Integration of nutrition services at the health facility is enhanced when all the services (MCH, ANC, PMTCT) and CCC are offered in close physical proximity to one another otherwise some of the clients do not visit the nutrition office after referral by the clinician - either because they do not want to be seen walking to the CCC due to stigma, or they do not inadequately understand the role of nutrition in the management of HIV (as reported in Bondo and Kisumu PGH).

- Nutritionists recruited through USG partners in response to NHP have been vital for many sites to implement NACS. The engagement of external partners including NHP and USG has encouraged the integration of nutrition across units beyond CCCs as part of a move to integrated health services. This has been good for integration but has resource implications (thinly spread human resources, anthropometric equipment, counselling resources etc).

- The following aspects are critical for efficient integration of nutrition into clinical services:
  - availability of trained nutritionists enhances quality of NACS services provided
  - adequate training for all health care providers providing NACS services
  - team spirit among health care providers improves the quality of services provided
  - regular meetings for the team members to review procedures, identify strengths, gaps and challenges and make recommendations for improvement of service provision.

- Health facilities run by FBO often have existing strong linkages with community structures and outreach programmes.

3.6.3 Gaps that should be addressed in the future design of NACS service provision

- Provision of commodity inventory management tools – this is currently being addressed but will require further investment and strengthening in the next iteration of the NHP.

- Inclusion of malnourished clients who are not affected by HIV, particularly non-HIV positive pregnant women and non-HIV+ TB clients and others suffering from wasting conditions. GoK aims to broaden its criteria for those eligible for NACS services, however prioritisation will be necessarily to ensure that it is well understood which clients are the most critical to treat where there are insufficient resources for all that are eligible.

- Inclusion/scale-up of NACS service provision in private health facilities. This should be relatively straight forward for CCCs where services and treatments are provided for free, but may be more complex for services in private health facilities that carry a great charge than in GoK health facilities. However, even with this limitation, reach will be improved and clients can choose to access private facilities and pay more if they wish.

- Provision of NACS services by CBOs for adults as well as OVC where strong links to ART health facilities exist. This is currently being strengthen and will be a key component of the next iteration of the NHP

- Operations research to improve NACS service provision particularly for new aspects such as the community component and the potential integration of nutrition services as a core service rather than a referral service would be beneficial.

- Baseline, M&E milestones and agreed measurable indicators at the start of the programme.

- The programme reports mainly on process indicators but not on impact of the programme. Eight impact indicators have been developed but the programme has not started reporting on some of them. An omission in the list of impact indicators is the percentage of clients with improved ARV treatment outcomes. Some of the data necessary for computation of these indicators are not collected or analyzed.

- A unique identifier for clients on FBP would help to prevent loss to follow-up due to site switching and aid client data management and improved NACS service provision (i.e. help facilitate follow-up).

4. Assessment key findings

Summary of assessment findings

Assuming the coordination of nutrition services remains within the remit of the Ministry of Health post elections; technical support will be required to strengthening coordination functions of the Nutrition TWG and the ICC. The likely expansion of NACS services beyond HIV and the future devolution of government both bring significant challenges for the future coordination and resourcing of nutrition services. Constant input will be required to ensure that nutrition remains on the political agenda. Increased assistance is required to strengthen budgeting, planning and M&E to allow the Government of Kenya to gradually manage NACS service provision and effectively mobilize resources from different partners. In the meantime, the Ministry of Health requires continued technical and financial support to roll-out NACS.

Financial and logistical support for the establishment and maintenance of Community Units as per the Government Community Strategy will be key to the improvement of the 'community component'[9] of NACS. The community component aims to extend the supply chain of commodities to the community, improve client tracking, mitigate loss to follow-up and increase the quality and comprehensiveness of care. This will require increased engagement and resources from USG partners, particularly APHIA Plus, at the community level, and technical and financial support to the Division of Community Health Services at the national, county, and district level.

Useful partnerships already exist to build on with new potential opportunities to engage other partners, particularly those that support economic strengthening, livelihoods and food security programmes. Other useful partnerships to pursue include partners with behavior change expertise, quality improvement, and cost-effectiveness tools. For example, the World Bank has a set of questions which help to establish the cost-effectiveness of a program. It may be interesting to review these questions to see if they might be helpful in improving the cost-effectiveness of the NACS program as a whole or a specific part e.g. regional commodity manufacturing and/or distribution.

Promising practices from Insta Products Inc and Phillip Health Care have demonstrated the skills and experience that can be tapped within the private sector. The next iteration of the NHP needs to embrace and expand its utilization of public private partnerships (PPPs) to support the scale-up of NACS services provision, for example by expanding NACS services to private health care facilities, working with Information Technology and logistics companies to address existing IT and storage challenges etc. Corporate social investment can also be tapped beyond PPP.

[9] The 'community component' as it is referred to in Kenya is termed 'community nutrition services' (CNS) within NACS programming more widely

4.1 What level of technical support would key service delivery departments in the ministry of Health require in the future to improve on the delivery of nutrition services to HIV+ clients in the country?

Overall for all ministries

There is a need to:

- Increase recognition that nutrition is not purely a health issue through the engagement of more GoK ministries. Perhaps as one small example some of the other GoK ministries could be encouraged to support the National Nutrition Day – this would both help to engage these ministries and give them an opportunity to explain their role.

- Plan ahead to ensure nutrition is not lost during the county level prioritization and allocation of resources post devolution – District stakeholder forums will be key to this as well as the sensitization of the current Provincial and District Medical officers for Health. It will be important for APHIA Plus partners to support the county level after devolution.

- Develop a handover strategy to the Government of Kenya with some key milestones set for the next iteration of the NHP. Other donors will need to cost-share the delivering of NACS through government systems. The Department of Family Health, Food Security and Emergency Nutrition (MoPHS) were very clear that financial estimates as Appropriation-in-AID would help this process.

- Support the Government to better coordinate programs/components/activities and prevent isolated nutrition interventions being established. This will be critical moving forward to a NACS agenda beyond HIV. With more intense engagement and technical support, USAID could help to improve the coordination and sharing of information between the ICC and the Nutrition TWG. If NACS service are to be implemented beyond HIV, then coordination beyond NASCOP will be critical and require some considerable adjustment from NASCOP. The recently passed National Food Security and Nutrition Policy sets the tone for cross ministerial engagement and an opportunity for broader nutrition programming outside Health (NASCOP). Expanding USAID technical support provision and engagement across relevant ministries, including support for cross-ministerial nutrition coordination, will be key.

- Conduct a multi-stakeholder comprehensive needs assessment to establish what support the relevant GoK departments require, particularly with devolution in the future, and mindful of the need for rationalization of which partners support which division/ departments to avoid duplication and contradictory messages.

- Establish minimum performance standards for partners in nutrition. This would need to be defined, developed and coordinated by the Nutrition TWG.

- Ensure the strategic placement of nutritionists and food technologists e.g. in addition to consideration of funding the placement of nutritionists at health care sites and as county CNOs, placement of a food technologists in KEMSA in mid-term may be beneficial as KEMSA takes on a bigger role in the distribution of nutrition commodities

Within the Ministries of Health

- Support to Ministry of Health (MOMS and MoPHS) nutrition divisions to make realistic plans for adequate resourcing of GoK facilities - human resources (not forgetting HR for data entry and analysis), equipments, ITC, M&E tools & procedures to support nutrition service provision.

- To enable integration and alignment of the next iteration of the nutrition and HIV programme with Government of Kenya infrastructure will require technical support in forecasting, quantification, procurement, distribution, budgeting, accurate documentation, and monitoring and evaluation. Currently the Government has money for procurement but not for distribution etc. Although improved tools for clients and commodity data management are currently being piloted, considerable investment will need to be made during the next phase to gradually support the government to take over the role of planning, funding and delivering NACS services. With increased Government ownership and accessibility to NACS data, attention to its appropriate use will be required.

- Continue to support and engage with Nutrition TWG which is attended by development partners, implementing partners and Government. The Nutrition TWG has four working groups on Nutrition information, Capacity building, Urban nutrition, and Preparedness and response advocacy group. NHP is currently well engaged and active participant of the Nutrition TWG.

- Continue to support and engage with Nutrition Interagency Coordination Committee (ICC) which includes partners such as UNICEF, WHO, GAIN, WFP etc which has quarterly meetings. The Nutrition ICC focuses on maternal, infant and young child feeding; food security, malnutrition and emergency aid; micro-nutrients; healthy diets and lifestyle.

- If the Ministry of Health (post 2013 elections) is to coordinate nutrition it will be essential to strengthen mechanisms and capacity for the MoH to sensitize other key ministries concerning their role in nutrition prevention and engagement in cross ministerial planning and financing to achieve joint goals, for example in the consistent use and support for the community strategy. The MoH needs to leverage support from other ministries to bring their skills and resources to the table e.g. the Ministry of Education to increase their role in health promotion in schools and potentially with parents, policy change to ensure the nutritional assessment of children on school enrolment, improve feeding programmes ; the Ministry of Agriculture for improved linkages with community units for better use of resources to support locally identified needs, increase food security through increase production and food diversity etc [10].

- The Capacity Building Working Group of the TWG is linked to Human Resources for health – they could be supported to coordinate a performance needs assessment and training needs assessment.

- The Permanent Secretary (PS) for the Ministry of Health and Head of Departments have a performance contract indicator of % of children under 5 who received vitamin supplement. It may be possible to also revisit this performance indicator in relation to nutrition more widely. NASCOP could have a performance indicator for NACS for malnourished clients (clients would need to be defined). Performance contracts will need to be developed for county level staff where it will be important to include some measurable nutrition indicators.

[10] For further details see 'An Integrated Nutrition Investment Framework for Kenya - analyses and recommendations, IT Shows Inc, March 2011'

- The capacity building of the Division of Nutrition is already being supported by WFP. It will be important to focus on the county level before, during and after devolution. At this level, greater information sharing and coordination should be encouraged to ensure that nutrition is seen as a cross-sectoral issue requiring joint planning and financing.

- Increased transport allowance and per diem for supervision support for Provincial Nutrition Officers (PNOs) and District Nutrition Officers (DNOs) is necessary assuming the two ministries are merged and only one such officer is in place for each of these posts. Post devolution DNOs and County Nutrition Officers (CNOs) will require these resources.

Observations from health facilities in the provinces showed the need for:

- Increased numbers of nutrition coordinators in health facilities who can adequately supervise the work of those proving nutrition services and analysis data for quality management.

- Expansion of computerization within health facilities to support data management and analysis, reduced paper work, improve follow-up for defaulting clients, identification of clients that are staying on the programs for longer than expect and subsequent investigation.

- Improved availability, size, security and quality of storage facilities for food products, particularly at central sites – perhaps a specially designed container could be produced by a USG partner en mass or by GoK through a Ministry with relevant expertise (Ministry of Defense perhaps).

- Increased space within health facilities for nutrition assessment, appetite test, and counseling.

Support for the Division of Community Health Services is described below.

4.2 What strategies should USAID Kenya use to strengthen the implementation of the community strategy, with special focus on nutrition and HIV/AIDS services through the division of community health services?

Division of Community Health Services (DCHS) is responsible for the implementation of the community strategy. DCHS within Ministry of Public Health and Sanitation believes that the community component of the NHP has been weak and needs to be scaled up rapidly with Community Units (CU) as the core approach in line with the national Community Strategy (see Annex 11)[11]. NHP has been engaging directly with the DCHS for the past year. Discussions have been held concerning collaboration and joint use of tools.

How to support the Division of Community Health Services (DCHS) to strengthen the implementation of the community strategy:

- Recognize the community unit as a key strategic partner in the CNS of NACS for the future. The work of CU can be supported by CBOs in addition to the health facilities they are linked to.

- An orientation in each province between APHIA Plus partners and the community strategy coordinators would help facilitate and strengthening this relationship. Clarification of the role of

[11] See Annex 10 for a full description of Community Units and their role in support health facilities and communities

APHIA Plus partners and who to contact within APHIA Plus consortiums would help facilitate this relationship.

- APHIA Plus partners are currently supporting the development of community units but they need to invest more resources/ prioritize this. There needs to be clearer communication between APHIA Plus partners and Division of Community Health Services about what APHIA Plus are contributing and doing on the ground.

- APHIA Plus partners will need to support training on the community nutrition module (using the CHW curriculum) and assist with the distribution of dialogue tools, CHW curriculum, log books and manuals during these trainings. APHIA Plus partners need to ensure that the CBO they support are aware of CU CHW elections to ensure well trained CHWs are elected /selected etc. Overall the DCHS needs APHIA Plus partners to help scale-up and strengthen Community Units.

- In addition to community units (where they exist) health care facilities and local CBOs also have CHWs and social workers that visit houses and make referrals as part of NACS service provision. Coordination is required to prevent duplication and ensure those that are more remotely located are reached.

- Support DCHS to work more closely with the Ministry of Agriculture to harness resources and support to address improved livelihood and food security. This relationship has improved in the last two years through the inclusion of the DCHS in the MALEZI BORA programme but needs further strengthening. Likewise, ensure that the Division of Community Health Services is sensitized to Feed The Future, and linkages between FTF and NACS.

- Support the DCHS to raise the profile of the community strategy and ensure it is utilized as a mechanism by other ministries. This integration and explicit citation of the use of CUs as a core strategy for the roll-out and increased effectiveness of NACS will hopefully help this process.

- The DCHS at national level lacks funding and resources to support nutrition – DCHS has no budget line for supporting malnutrition prevention (i.e. livelihoods programs?) unlike the Ministry of Agriculture which can fund the development of fish ponds etc. The DCHS would like its own partners to help achieve its goals. The DCHS would benefit from a community nutrition and HIV advisor who would know how to work across sectors/ministries and have specialist knowledge in nutrition. A core element of the work of the DCHS' performance contract with the Government is supervisory support and yet DCHS does not have money for per diems or have a vehicle which would give them greater access to the provinces for supervision.

- The DCHS is already working with MEASURE on M&E but the development of data collection tools needs expediting.

- There has been inclusion of nutrition in community unit CHW curriculum; however, it is important to check that training in nutrition screening and provision of MUAC tapes is put in practice.

As the use of community units under the community strategy are strengthened for the provision o NACS it is important to consider that CHW are key to the ability of CUs (or CBOs) to support NACS service provision. Whether CHWs are supported by CBOs or Community Units, the sustainability of their role will largely depend on whether they receive adequate incentives. CHW interviewed during the evaluation consistently cited their connection with the CBOs, its training, resources (including stipends) and shared objectives as their motivation. It is not clear whether connectivity to a Community Unit and health facilities through CHEWs will provide the same motivation. It is important to note that the CHWs

interviewed said much of their stipend is spent on transport costs associated with their role, so in its absence, CHW work would be compromised and is unsustainable.

4.3 What kinds of partnership should USAID Kenya support to ensure accelerated scale up implementation of nutrition services using NACS strategy?

A comprehensive assessment of potential partners to support the accelerated scale up of nutrition services using NACS strategy was not conducted, however this was a key question incorporated into national and provincial level stakeholder interviews. The following suggestions were made for partnerships to support and suggestions for why:

- Continued and expanded support to the Government of Kenya, not just through NASCOP and Ministries of Health, but through broader ministry engagement as Kenya applies NACS beyond HIV.

- USAID already supports the Kenya Community Development Foundation through the Global Give Back Circle which is part of the Clinton Global Initiative. The partnership could be strengthened to scale-up support food, security livelihoods and economic strengthening.

- JICA has a livelihoods pilot on Taita in Coast Province for slum, nomadic, and agrarian communities which could be a useful linkage and learning point.

- The World Bank is currently working with the efficiency and effectiveness working group within NASCOP on cost-effectiveness. It may be possible to use the World Bank cost-effectiveness methodology and questions to ensure the continued roll-out of NACS services is as cost-effective as possible.

- Reinforce partnerships with MCHIP particularly concerning GoK strengthening of Division of Child and Adolescent Health to avoid capacity building duplication amongst USG partners.

- Capacity Project in terms of GoK human resource management and planning ahead to ensure nutrition human resources during devolution.

- GAIN in terms of product availability, commercial marketing and behaviour change communication (BCC) for fortified foods.

- PSI for their BCC expertise.

- UNICEF and WFP in terms of coordination around emergency food and other commodity placement.

- URC in terms of quality improvement.

4.4 What are the strategic roles of the private sector – particularly those that are related to scaling up private sector nutrition and HIV/AIDS service delivery in the country?

The strategic role of the private sector in scaling up private sector nutrition and HIV/AIDS service delivery in the Kenya are two-fold:

- Expand the number of private health care facilities currently providing NACS services. Currently only 1% of sites supporting NACS service provision are private health care facilities. NACS can be introduced to support free CCC service provision within private sector clinics. The inclusion

of nutrition services beyond HIV would need to be negotiated by GoK with private sector clinics and may not be easily integrated as a free service.

- Embrace and expand Public Private Partnerships (PPP) for sustainability, promotion of innovation, incorporation of private sector expertise and capitalize on corporate social investment. Possible avenues for PPPs in support of NACS are listed within overall recommendation 3, section 5, and are not repeated here.

4.5 What are the promising practices to engage the private sector in contributing to government led nutrition and HIV/AIDS service delivery initiatives?

Current promising practices include:

- National insurance providers could include ARVs and nutritional support/supplements in the health care package e.g. National Health Insurance companies

- Corporate social investment – there is a strong commitment from the private sector in Kenya towards social causes

- Buying in corporate expertise, for example:

  a) Phillips Health Care is an example of a promising practice in terms of utilization of the private sector. Phillips have managed the warehouse storage, packaging, and logistics aspects of the NHP extremely effectively. They have good warehouse facilities, handling and logistical management that track where products have gone, how many to the site, which sites didn't order and why.

  b) Insta Products Inc, have ultimately achieved what was set out in the cooperative agreement – to develop a locally produce RUTF. Other products have also been developed for specific clients. Stock-outs during 2011 have shown the weakness is reliance one manufacturing company (whether private or not) and ultimately the NHP agreement and project design created a monopoly in Insta, which once it got into difficulties, could not be supported by the broader industry. Were there to be a more open market, another company may have had sufficient investment and resources to be able to meet the shortfall of this supplier.

5. Recommendations for future directions

The following overall recommendations may not all form part of the next iteration of the NHP as some may already be part of other broader initiatives supported in Kenya by USG and others.

Overall recommendation 1: Continue to invest in the expansion of NACS programme infrastructure, expand the scope beyond HIV, and increase emphasis and investment in broader 'support' within NACS through economic strengthening, livelihoods and food security.

a) USG should recognize that the Kenyan NACS response includes all malnourished individuals.
b) USG should continue to invest in NACS programme infrastructural expansion and quality improvement through further coverage and decentralization through GoK, FBO, and private health facilities, and CBOs.
c) USG continue to fund FBP for HIV infected and affected clients and all non-HIV positive MCH and TB clients. FBP within NACS for other malnourished clients can be supported by the government and other resource providers using the NACS platform and GoK established prioritization criteria.
d) Within USAID, the next iteration of the NHP should be a joint program across Office of Public Health (OPH) and Agriculture, Business & Environment Office (ABEO)/Feed the Future (FTF). Collaboration between OPH and ABEO is already indicated within FTF strategy for intermediary results (IR) 4 & 5, and NACS is evident in IR 6 (see Annex 12). Practical links can be made through the new flagship programme Kenya Agricultural Value Chain Enterprise (KAVCE) of which 15% of funding is focused on nutrition, as well as on-going programmes focused on horticulture (3 more years of current programme) and dairy (one year of current programme).
e) Expand the provision of NACS 'support' through economic strengthening/livelihoods/food security by:
    - Linking with and supporting existing local partners that are able to offer this support to clients,
    - Linking to FTF initiatives,
    - Additional investments which go beyond FTF (which is only focused on agriculture and is not country-wide).
f) Actively seek linkages with and leverage other USG initiatives to support NACS.
g) Expand USG technical support provision and engagement with the Government of Kenya across ministries to match the broader scope of the next programme e.g. Closer engagement with Ministry of Agriculture, Ministry of Education etc.

Overall recommendation 2: Separate RFPs for 'commodity component' and 'service delivery component[12]'.

Separation of commodity and service provision components will:
a) enable regional (within Kenya) supply of products,
b) facilitate competition and provision of open tenders,
c) increase transparency and possibility for problem-solving,

[12] The 'service delivery' component would include the commodity management and distribution aspects of the program.

d) prevents the *"all eggs in one basket"* scenario which can impact on consistent supply and quality, provides a more open playing field and potential for innovation and new partnerships for the future,

Overall recommendation 3: Embrace and expand Public Private Partnerships (PPP) for sustainability, promotion of innovation, incorporation of private sector expertise and capitalize on corporate social investment.

Possible avenues for PPPs in support of NACS:

a) Expansion of quality raw material production for supplementary / therapeutic foods since there is unmet need in Kenya and the region (value chain development under FTF).
b) Expand manufacturing base for FBP (2 other manufacturing companies would now pass quality standards). NHP is currently creating a monopoly through sole sourcing from Insta Products; this goes against government procurement procedures and currently prevents KEMSA taking on a future role.
c) Encourage affordable product innovation and design (savory RUTF denser product to reduce storage and weight, ready to eat formulations to reduce sharing etc).
d) Support a national nutrition behavior change communication campaign through mass media.
e) Support improved availability, accessibility and affordability of diversified foods within Kenya and FTF for malnourished individuals and those at risk of malnutrition.
f) Supply of anthropometric equipment (corporate social investment).
g) Support for innovation in data management software and provision of IT equipment (corporate social investment).
h) Engagement of companies with large workforces (e.g. commercial farms) to help with economic strengthening, livelihoods, food security of vulnerable households. For example, commercial farm owners could set aside land (shambas) for employees to farm for the benefit of their own families/community. Workers can be supported with water supplies, tools, farm inputs and knowledge to ensure that nutritious crops are grown successfully.
i) Private engagement of the broad network of universities in Kenya to support Health Care Improvement at site level. Universities now have sites across Kenya providing a network of institution with staff and students with knowledge, skills and experience that could be harnessed to support Health Care Improvement. The next iteration of NHP could have an agreement with a number of universities to teach students on Health Care Improvement and offer placements in the health sector to support Health Care Improvement. This could potentially provide a free (or cheap) service for the health sector whilst providing an opportunity for work experience for students.

Overall recommendation 4: Improve NACS outcomes through efficient and effective use of FBP and increased focus on other kinds of 'support' within NACS.

a) Support early referral of malnourished clients leading to reduced overall investment in FBP support. This can be achieved through a strengthen community component and referral systems with the health sector.
b) Provide prevention support to households at risk of malnutrition. Individual and households at risk of malnutrition can be established from health conditions as well as household situation. Effective prevention will require more attention and resources to be placed on the community component and establish health care facility / community links and follow up systems in place.
c) Ensure that PMTCT infants between the ages of 6 and 24 months automatically receive FBP regardless of their nutrition assessment/status – this cohort should be seen as a priority relative

to older exposed or 'linked' children. A clear prioritisation criteria based on evidence needs to be agreed and documented by GoK.

d) Support the new WHO guidelines for PMTCT concerning extended breast feeding to provide mothers with FBP for the duration of breastfeeding (at least one year) and ensure infants receive complimentary feeding support up to two years of age.
e) Align appointments for ART and NACS to i) establish NACS service as standard of care (core service), ii) reduce the number of visits / time investment by clients, and iii) facilitate on-going nutrition counselling and other forms of support beyond FBP graduation.
f) Change the flow of nutrition services at site level to encourage nutrition to be a core service rather than referral service (review progress at EDARP and Walter Reed).
g) Ensure that the next iteration of the NHP supports and complies with GoK coordination of partners offering food packages and food aid to vulnerable clients.
h) Improve graduation attainment rate by establishing a target standard (in term of length of time) for FBP graduation for those successfully retained within the programme – sites not meeting these targets can receive additional supervision / problem solving support.
i) Continue to promote the strategy to link index children to other household children (particularly those under 5 years of age in food insecure households).
j) Continue to emphasise the therapeutic nature of FBP - 'food as medicine' – within NACs counselling to prevent dependency and sharing.
k) Encourage adult family members to attend health facility and community visits for education concerning the therapeutic nature of FBP and broader avenues of support.
l) Strengthen community support structures for follow-up, bi-directional referral, and community health education and support.
m) Increase investment in local programmes for economic strengthening/livelihoods/food security and establish mechanisms to link clients to these programmes.
n) Develop an RUTF that is more tolerated by adults as current RUTF formulation is very sweet and makes some clients nauseous.
o) Encourage and support the development of a DVD for clients to show in waiting rooms – emphasizing the short-term treatment aspect of FBP and emphasizing strategies for improved food security / balanced diet with local foods.

Overall recommendation 5: Improve quality of NACS service provision by health care providers

a) Support Kenya Nutrition and Dietetics Institute (KNDI) and MoH to be able to conduct a needs assessment and development of a nutrition HR power plan.
b) Ensure nutrition is included in the future devolved county plans, in terms of human resource requirement at the facility level, county and district levels.
c) USG partners continue to fund human resourcing of nutritionists at site level, and also cost-share the recruitment of nutritionists at county level where necessary.
d) Incorporate Health Care Improvement in all NACS/FBP sites - ensure this is owned by health facilities/sites with training, support and supervision provided by local partners including government staff, APHIA Plus partners, local NGOs, local universities.
e) Establishing learning sites at different levels for shared best practices – benchmarking, documentation of good practice, site exchange visits (e.g. EDARP could be a learning site).
f) Strengthen supervision and monitoring of NACS activities, and identify sites needing closer attention – supervisory visits should be conducted jointly between NHP staff and government staff for ownership, shared logistical costs, and different skills to supervisory visits.

g) Ensure NACS is adequately incorporated into pre-service training for nutritionist and other health care provider cadres.
h) Ensure standardization of on-job-training and nutrition Continuous Medical /nutrition Education (also create a Kenya specific webpage with up-dates of NACS for HCP).
i) Ensure adequate sensitization of health facility management for the integration of nutrition into facility plans and development of leadership skills among site managers and senior nutritionist to improve the quality of NACS service provision.
j) Improve systems for following up clients and identifying relapsed clients – computerization, diaries etc.
k) Establish who is responsible for the on-going auditing of nutrition resources; presumably this would be the GoK, but some clarification of which specific department / program is necessary.
l) Ensure there is a clear plan for who is responsible for the provision of NACS resources/facilities e.g. storage space, quality anthropometric equipment and counselling resources, and establish a process to ensure resources are in place and replaced as necessary, and contribute as necessary.
m) Ensure availability of nutrition pamphlets/flyers for clients and CHP DVD and clarify process for reproduction and distribution of these resources.
n) Establish links with universities, colleges and institutes to place nutrition students for attachment and internship for work experience and to support service provision.
o) All sites should have an FBP protocol so that they can conduct assessments, categorization, counseling and referral, particularly in Comprehensive Care Centres (CCCs) and patient support centres (PSCs). This builds on existing normal practice of assessing weight and height (BMI) and/or Mid-Upper Arm Circumference (MUAC).

Overall recommendation 6: Clarify and expand the community link component of NACS

a) The objectives of the community link component of NACS should be:
   - To facilitate community level screening for early identification of malnourished clients or clients at risk of malnutrition and referral to health facility support NACS service provision,
   - To follow-up clients that have missed FBP/ART appointments,
   - To link food insecure households with economic strengthening /livelihoods/food security programmes and initiatives,
   - To provide on-going direct community level counseling, education and support for improved economic strengthening /livelihoods/food insecurity (including establishing IGA groups) and water and sanitation, FBP and drug adherence, food preparation and balanced diet,
   - To provide links to home-based care,
   - To provide links to, and help establishing, support groups,
   - To provide links to broader OVC package of support,
   - To support to KEPH level 1 facilities (dispensaries) to provide NACS services by prescribing and issuing FBP (with strict procedures and limitations – see below).
b) The key local level partners for the community link component should be the Community Units, CU and health facility CHEWs, local CBOs/support groups, facility outreach services providers e.g. social workers, peer educators/expert clients/CHWs, Agriculture extension workers. The local level partners need to be supported by APHIA Plus partners and their NGO/CBO implementing partners, health facility management, and district government officers.
c) Ensure that some research is conducted to establish what motivates CHWs and what needs to be put in place and by whom to ensure their continued engagement.

d) USG need to provide financial and technical support to Division of Community Health Services to cost-share the establishment, resourcing and M&E of Community Units and ensure they are adequately resourced and CHW incentivized (in line with the GoK/ USG partnership agreement pillars 2 and 3, objective 4.2).

e) Work with the GoK and other partners to create strict community level prescribing and issuing guidance for the engagement of CBOs in supporting KEPH level 1 dispensaries (see Box 3).

Box 3: Suggested guidance for community level prescribing and issuing of FBP

1. There should be procedures to ensure that clients requiring referral to higher level health facilities are in place
2. There must be clear guidance on when to stop consuming FBP products even if discharge weight is not achieved
3. There must be clear guidance on which malnourished individuals should be referred rather than treated in the community i.e. all malnourished pregnant or postpartum women, severely malnourished clients and moderately malnourished clients that are ill should be automatically referred to a higher level health facility
4. Adequate resources, guidance, reporting and supervision from the link medical facility needs to be established before community prescribing can take place to avoid duplication of services, and appropriate client management
5. Prescribing by CBOs should be restricted to uncomplicated MAM
6. CHWs should be discouraged from 'accessing' FBP on behalf of SAM clients in the community; rather these clients should be assisted to be taken to an appropriate health care facility
7. Overall FBP should continue to be an incentive for clients to visit health facilities at least every month – CBOs issuing FBP should not break this incentive

f) USG partners should help to establish linkages with existing economic strengthening/ livelihoods/food security initiatives and contribute to address gaps where they exist.

g) USG should provide financial and technical support to local CBOs (through APHIA Plus partners and other USG partners):
   - To help CBOs to build the capacity of, and mentor, Community Units (ensure CBO trained CHW are present during CU elections),
   - To engage effectively with partners to develop innovative systems in the community to improve economic strengthening/livelihoods/food security, dietary diversification, etc (FTF linkages and beyond),
   - To support KEPH level 1 health facilities to prescribe and issue FBP commodities and ensure full NACS service.

h) Ensure CHEWs are adequately supported to facilitate the link with Community Unit CHWs and health facilities.

i) Encourage and support the health facilities and CHEWs to conduct joint mapping of local programmes and partners providing economic strengthening/ livelihoods/food security support (USG partners and DNOs supporting health facilities should be able help encourage and support this).

j) Encourage the health facilities (through support groups and/or CBOs) to establish shambas/ small farms for education/demonstration, production of seedlings for client gardens, and provision of vegetables for most food insecure houses. Health facilities can also work with support groups and CBOs to address micronutrient deficiency and support malnutrition prevention needs of families and individuals.

k) Stagger the expansion of the community component to allow for learning; use of operations research would help to establish the most effective model for the community component in different settings (e.g. urban/ rural, in support of different types of health care facilities i.e. GoK v's FBO).

l) Encourage the establishment of a number of nutrition focal persons within Community Units; this would assist with sharing of new information, provide a link for CHEWs and Nutrition Focal person at the health facility.

Overall recommendation 7: Support the Government of Kenya to gradually be able to implement all aspects of NACS service provision

a) Ensure technical, financial (cost-share) and logistical support to the GoK for:
   - Finalization and roll-out the software for LMIS (Logistical Management Information System – for commodity data) to central sites and on-going improvement to software,
   - Finalization and roll-out the data collection tools for LMIS and the new nutrition service register to all sites and on-going improvement of tools,
   - Procurement and training of appropriate information technology solutions (e.g. desktop computers, NoteBooks, (even PDAs and cell phones where appropriate)) to support data entry across all types and levels of sites,
   - Improved data collection, entry/cleaning, analysis and utilization at the site level,
   - National level partner analysis and utilization of NACS data for improved national level service delivery for nutrition.

b) Facilitate the gradual handover of FBP procurement and distribution to KEMSA. Three pipelines can co-exist for a while whilst lessons continue to be earned and mechanisms and tools put in place.

c) Build the capacity of key ministries in budgeting, M&E, supervision and human resourcing, coordination of partners and cross-ministry collaboration.

d) NHP programme summary and data be shared at development partner meetings, and more documented information be available for circulation, particularly including impact data, to help future joint strategy development and coordinated donor support.

Overall recommendation 8: Incorporate Operations Research into the next iteration of NHP

a) Budget for operations research (OR) for NACS.

b) Work with the Nutrition TWG to define potential areas of OR, select, plan and fund operations research for improved NACS service delivery.

c) Examples of potential areas for OR include:
   - different models for the community component in different settings e.g. rural v's urban, connected to different types of health facility (e.g. Government v's FBO v's Private),
   - Integration of nutrition services as a core service rather than a referral service.

6. Annexes

Annex 1: Scope of Work

PERFORMANCE EVALUATION of USAID/Kenya Nutrition and HIV PROGRAM (NHP) and design of follow-on project

Evaluation Purpose and Use

USAID/Kenya's Office of Population and Health (OPH), in collaboration with the Government of Kenya (GOK) and other development partners, wish to undertake an evaluation of the approaches, management, design and impact of the USAID funded Nutrition and HIV Program (NHP) that will end in March 2013. NHP consists of both national level advocacy and support for nutrition programming and targeted service delivery (information and commodities) to facilities.

The purpose of this end-of-project performance evaluation is 1) to identify accomplishments and constraints of the program with a focus on opportunities and needs for the future, and 2) to assess Government of Kenya needs related to improving delivery of nutrition services. The findings of both the evaluation and assessment will serve as the basis for development of a program description(s) for a five-year national nutrition project.

Background

USAID/Kenya Nutrition and HIV Program (NHP) (2008-2013)

The Nutrition and HIV program was designed to take the two-year Food By Prescription (FBP) pilot project started in 2006, to scale. As a flagship initiative, NHP goal's was to **strengthen delivery of nutrition services in and out of hospital settings**. Implementation of NHP was guided by the following specific objectives;

- Build on partners expertise in HIV and nutrition, food manufacturing, and logistics, while introducing a new patient-centered concept for clinical service delivery that will improve counselling, patient management and record keeping, and patient and provider compliance with treatment protocol;
- Introduce a locally produced F-100 equivalent RUTF for severely malnourished HIV+ patients and OVC
- Link Insta (the food partner) and health facilities with community-based and home-based care programs for HIV+ patients and OVC to extend the supply chain, improve client tracking, mitigate loss to follow-up, and increase the quality and comprehensive care.
- Scale up interventions while maintaining high quality through performance monitoring and quality assurance systems.
- Strengthen the capacity of local partners, particularly NASCOP.

The process indicators included principally scaling up site coverage from 60 sites to 250 sites, increasing the number of beneficiaries from 6,000 during the first year to 25,000 during the fifth year and correspondingly increasing the amount of therapeutic foods distributed from 432 tons to 1800 tons and training between 200 and 300 health workers on nutrition and HIV per year. The main reporting indicators are the number of HIV+ pregnant women who received food and nutritional supplementation in a PMTCT setting, the number

of OVC receiving food and nutritional supplementation through OVC programs and the number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food

The design of the NHP was informed by several clinical scientific findings, among them, low body mass index (BMI) at ART initiation was associated with increased mortality, ART initiation was associated with weight gain and that early weight gain on ART initiation was associated with improved survival, particularly when baseline BMI is low. The core of NHP was therefore supported by three interdependent pillars, namely, effective nutritional products, robust supply chain and health facility commitment and performance. The three-pronged implementation strategy strengthens capacity of health providers in delivering nutrition services as an adjunct in care and treatment of HIV and AIDS; catalyses local capacity development to produce supplemental and therapeutic foods; and supports creating a supply chain system for nutritional commodities. In October 2009, PEPFAR's Care and Support Technical Working Group (TWG) with participation of the USAID Kenya commissioned an assessment of NHP's strengths and challenges, and documentation of lessons learned and promising practices. The assessment, by AIDSTAR-One, reported that the FBP service in Kenya is an excellent intervention, well-appreciated by clients and providers alike in terms of improving nutritional status and health outcomes and supporting adherence to and efficacy of ART.

To improve effectiveness and sustainability of the program this assessment identified six critical areas for quality improvement in order to facilitate graduation from the program, reduce re-entry (re-lapse), enhance integration and encourage sustainability. These areas involve: training, supervision, referrals, community linkages, reporting and data management, and policy. Consistent with these recommendations, the five-year Implementation Framework[13] for the Health Sector provided rationale and structure for programming of USAID/Kenya's resources for the period 2010-2015. USAID/Kenya is working towards the Strategic Goal of supporting its partners to meet the Assistance Objective ***"Improved health outcomes and impacts through sustainable country-led programs and partnerships."*** The Assistance Objective, building on the successes of NHP, emphasizes two aspects: 1) that USAID/Kenya's assistance seeks to improve the health of Kenyans; and 2) that this assistance should promote the development of organizations and programs that will continue to provide benefits for the health of Kenyan's even without continued USG support. USAID/Kenya support is based on a two-pronged approach: continuing to support programs which provide immediate health impact, while increasingly focusing on strengthening public and private sector Kenyan institutions to provide a sustained health impact. In this regard, USAID/Kenya's Implementation Framework supports partnerships with the GOK across the health system at all levels of service delivery as well as the private sector to expand access. In order to increase efficiency and synergies, NHP collaborates with USG implementing partners in the delivery of nutrition services.

In order to improve the scientific knowledge and skill in delivering nutrition interventions in care and treatment, USAID supported implementation of an operations research on effectiveness of food by

[13] The guiding principles of this framework are closely aligned to those of the Global Health Initiative (GHI) and mirror the reauthorized PEPFAR II. The Framework is consistent with multilateral policy declarations including the 2005 Paris Declaration on AID Effectiveness and the Millennium Development Goals.

prescription. This activity was implemented alongside the pilot food by prescription interventions by Kenya Medical Research Institute, FANTA, INSTA, MOH and USAID/K. The study was a randomized, controlled, open-labeled trial. The randomized controlled study by KEMRI and FANTA begun in June 2008 and a final report was produced in June 2010.The aim of the study was to evaluate the impact of six months of supplementary food on nutritional and clinical outcomes for malnourished adult antiretroviral therapy (ART) clients and for malnourished and nutritionally vulnerable HIV-infected adults not yet eligible for ART at six health facilities in Kenya. Based on nutrition counseling and 300 g/day of a fortified blended food or nutrition counseling alone, pre-ART clients receiving food achieved significantly greater increases in body mass index (BMI) during six months of food supplementation. Food supplementation (FBP) was associated with stabilization of immune cells (CD4) and hemoglobin. Control sites experienced high rates of attrition, and while food supplementation only had modest effects on attrition among pre-ART clients, the food did increase clinic attendance among both pre-ART and ART clients.

In 2011, the University Research Company (URC) was contracted by USAID/Washington to support quality improvement (QI) activities in nutrition service delivery in collaboration with the Kenyan Mission and NHP. The general objective of the URC-NHP collaborative activities was to improve the quality of nutrition care services through application of effective process improvement techniques. The QI activities started in mid-2011 at pilot scale in selected districts in Nyanza province. At each site, multi-disciplinary teams were formed to implement quality improvement activities using the model for improvement (Plan – Do – Study – Act).

Evaluation SOW

Evaluation Overview

This evaluation and assessment will help shape USAID/Kenya's support to delivery of HIV and nutrition services at the national level and lead to the development of a Program Description for the anticipated Five-Year Project In developing the program description, the following contextual issues will be taken into account:

- Changes in the external environment in Kenya such as the split of the Ministry of Health into the Ministry of Medical Services and the Ministry of Public Health and Sanitation, and implementation of the new constitution.
- The improved information regarding the health sector from recent surveys such as: the 2009/10 National Health Accounts; the 2007 Household Health Expenditure and Utilization Survey; the 2007 Kenya AIDS Indicator Survey; the 2008 Kenya Demographic and Health Survey; the 2009 National Census; Kenya Service Provision Assessment; the Health Systems Assessment; the Private Sector Assessment; the Service Delivery assessment done during the development of USAID's Implementation Framework; and Vision 2030; and the output data from the program monitoring system.
- Changes within the PEPFAR II re-authorization and the new Global Health and Feed the Future Initiatives.

The evaluation is organized in three phases starting first with an evaluation of the NHP project, followed by an assessment of key departments at the national and regional level to help determine their needs related to

improving delivery of nutrition services, and thereafter the development of a program description(s)/scope(s) of work for the national program plus a two to five pager document that provides a strategic concept note under the National Service Delivery rubric.

Evaluation Questions

Project Performance

1. What contribution has NHP made towards the improved nutritional status of HIV+ patients and malnourished orphans and vulnerable children, reduced onset of opportunistic diseases and infections, and improved AIDS treatment outcomes?

2. What has been NHP's contribution in strengthening the capacities of partner NGOs, CBOs, and APHIA II partners in nutrition and HIV through training, orientation, and provision of materials?

3. To what extent has NHP influenced the integration of food and nutrition into HIV policies, strategies, and services at health facility and community services in the health sector?

4. What capacity building contributions on new technical, scientific knowledge, clinical and leadership skills has NHP made to the targeted (health facilities, community organizations, and national, provincial, and district government systems and staff) in the implementation of HIV and nutrition services in the country? How has this resulted into creating a strong platform for therapeutic interventions (ART) and helping prevent the onset of life-threatening infection in Kenya?

5. What are the key challenges that the project faced over the course of implementation? Explore and document key lessons learned during the NHP's implementation. Recommend how the follow-on project should address them

In addition to evaluating this partner's performance, the team will identify any existing gaps that should be addressed in USAID's design of future Nutrition Sector programming.

Needs Assessment Questions

1. What level of technical support would key service delivery departments in the Ministries of Health require in future to improve on the delivery of nutrition services to HIV+ clients in the country?

2. What strategies should USAID Kenya use to strengthen the implementation of the community strategy, with special focus on nutrition and HIV/AIDS services through the division of community health services? What kinds of partnerships should USAID Kenya support to ensure accelerated scale up implementation of nutrition services using NACS strategy? Determine the best models for linking national level to county level nutrition and HIV/AIDS activities.

3. What are the strategic roles of the private sector – particularly those that are related to scaling up private sector nutrition and HIV/AIDS service delivery in the country? What are the promising practices to engage the private sector in contributing to government led nutrition and HIV/AIDS service delivery initiatives?

Project Design Questions

1. What has been NHP's responsiveness to Ministry of Health's focus in system strengthening and delivery of comprehensive priority clinical and preventive and promotive nutrition services?

2. What strategies should be adopted to optimize the supply chain for therapeutic and prophylactic/supplemental nutritional commodities?

3. What opportunities exist for impacting on other key functions in the health-nutrition value chains i.e. beyond HIV/AIDS and beyond the health sector (MoA)?

Evaluation Design and Methodology

Evaluation Design:

A participatory performance evaluation design, with mixed method of approaches that employ the use of limited-quantitative and qualitative data collection tools and techniques will be used. As much as possible available secondary data from study reports including program performance data will be used. A participatory performance evaluation design using a mixed data collection approaches is selected so as to allow broad-level stakeholders' participation and the much needed flexibility in the use of different qualitative approaches mid-stream the evaluation process based on emerging thematic areas of evaluation interest.

While no formal baseline information was collected, the project in close collaboration with USAID/Kenya will reconstruct baseline data from the existing project records and MOH service statistics. Precautions will be taken by USAID/Kenya to ensure that project records and MOH service statistics are accurate and complete to avoid any potential threats to internal validity. A multi-stage sampling design will be used to sample health facilities and key respondents for both structured and unstructured interviews and documents reviews. This will allow for inclusion of a representative sample of all levels of health facilities, health managers and clients while providing room for maximum triangulation of findings emerging from different data collection approaches.

Data sources and collection methods

Key data sources will include program performance data, available secondary data on HIV and nutrition from national surveys and studies, and key respondents drawn from MOH national programs and departments, implementing partners and sampled CBOs. Outputs from program monitoring systems and facility level records will provide quantitative data, while interviews – focus groups, key informant and large group interviews will provide qualitative data. The details on the comprehensive data sources and data collection approaches will be discussed and firmed up during the initial planning meeting with USAID/Kenya team. The consultants will be expected upon review of the scope of work, to come up with appropriate data collection methods, some additional detailed questions drawn from the broad evaluation/assessment questions and possible data sources.

The team leader and his/her team will plan their program and schedules; finalize data collection tools; conduct interviews, meetings, and field visits to collect information; analyze data; and present findings and key recommendations.

The following are some of the potential data sources that among others will be used to gather the evaluation data:

1) USAID/Kenya Five Year Implementation Framework for the Health Sector (2010-2015)
2) USAID Nutrition and HIV Program RFA, annual work plans and quarterly reports
3) USAID Nutrition and HIV Program Cooperative Agreement
4) USAID AIDSTAR-One, Food By Prescription in Kenya, 2010
5) Kenya Feed the Future Strategy
6) Kenya's new Constitution
7) PEPFAR Country Operational Plan (COP) and Strategy Statement
8) GOK health strategies, policies, guidelines, protocols e.g. Kenya National AIDS Strategic Plan (KNASP), National Health Sector Strategic Plan (NHSSP), Comprehensive national health policy Kenya Health Sector Policy Framework 2011-2030, National Nutrition guidelines
9) KEMRI_FANTA Study Report, 2010
10) AIDSTAR_FBP_Assessment_Final Report, 2009
11) FBP_Kenya_Final Report, 2009
12) Outputs from program monitoring systems
13) Service statistics reports from MOH
14) Study reports on HIV/AIDS and Nutrition in Kenya
15) KDHS 2009 report
16) The Kenya AIDS Indicator Survey 2007

Interviews: The consultants will collect qualitative data through key informant interviews, focus group discussions and in-depth interviews with key stakeholders, partners and the intended beneficiaries. A preliminary list of stakeholders and partners will be developed by IT Shows Inc. in consultation with USAID/Kenya/OPH. Groups of intended

beneficiaries will be organized around the sampled health facilities for either focus or large group interviews. The consultants will develop a priority list of questions for each data collection method/technique for each key stakeholders/partners and present for discussion and finalization with USAID/Kenya team during initial planning team meeting. USAID/Kenya will provide formal approval for all completed data collection instruments.

Key informants and other participants for focus group discussions may include:

Relevant NHP representatives

- ☐ MOH personnel
- ☐ Provincial health authorities
- ☐ Other Cooperating Agencies
- ☐ USAID staff
- ☐ Other donors, as appropriate
- ☐ Intended beneficiaries including nutritionists, nurses, doctors and administrators

Field Visits: The coordination and management of field logistics and Nairobi meetings will be managed the by the USAID/Kenya contractor, IT Shows, Inc. Field visits to the provinces/districts/health facilities/communities will be planned to help the consultants conduct key informant interviews, focus group discussions, to review health facility level data and where possible conduct clients' exit interviews.

Data analysis

As the team reviews the documents available and interview lists and develops the data collection tools, they will ensure that they collect the data they need to adequately respond to the evaluation questions. Once field visits are complete, the teams will compile, review and identify key findings and recommendations, prior to presenting preliminary findings to the USAID. Consultants will be expected on a daily basis to develop a matrix of emerging thematic issues critical for answering evaluation/assessment objectives and questions. Quantitative data presented in studies' and national surveys reports will further be analyzed, compared with output statistics from program monitoring systems and conclusions drawn to answers certain performance evaluation questions. Triangulation of emerging thematic issues from different data collection approaches will be used to develop valid and reliable findings and conclusions.

Strengths and limitations of the evaluation design/data collection methodology:

Evaluation design strengths include the availability of clearly defined questions that can be addressed by a performance evaluation, and the adoption of participatory evaluation using mixed data collection approaches. This provides room for better triangulation of emerging thematic issues and consolidation of findings and conclusions. A sampling frame of health facilities by level type and patients' volume will be used and this ensures representativeness of the findings and conclusions. The main limitations of the evaluation design is the fact that baseline data will have to be reconstructed from the output data from the program monitoring system, quarterly progress reports and facility supervision and capacity building reports.

Evaluation logistics

IT Shows will work closely with the evaluation team to develop the detailed schedule for meetings and will provide logistical support in terms of arranging and scheduling meetings and will assist with hotel reservations and in-country

travel arrangements. They will identify and fund a working space outside of the Mission, assure availability of computers and printing, photocopying and translation services, if needed they will arrange and cover cost for local transportation and will pay for in-country travel, including petrol if vehicles are provided by local contractors for site visits.

Evaluation Team Composition

There will be a one 3-person team that will be recruited through IT Shows, Inc, a USAID/Kenya contractor that solicits and matches the SOW requirements with the skills and work experience of potential consultants. Once identified, IT Shows, Inc. will send CVs of the potential consultants to USAID/Kenya for review and final approval. The team leader will be an international consultant while the other two members will be national consultants. The team must have the requisite mix of technical expertise defined in the skills mix below:

Team Leader

The team leader will have overall responsibility for fulfilling the Statement of Work. S/he will coordinate and supervise the evaluation. Essential Qualifications:

- The team leader will be a senior level consultant with 15 or more years' experience designing, managing and evaluating interventions in HIV/AIDS and Nutrition.
- Master's degree or above in public health, nutrition, demography, population, evaluation, or statistics or with specialization in survey methodologies.
- Ten or more years' experience evaluating U.S. Government or other donor programs. Experience in developing countries; experience in Sub-Saharan Africa is preferred.
- S/he should have an excellent understanding of project administration, financing and management and knowledge of how USAID functions. S/he should have excellent writing and communication skills and a proven track record in leading evaluations or assessment teams, supervising teams in the field and producing reports.
- Previous team leader experience leading an evaluation of this nature.

The Team Leader will be responsible for the overall management of the evaluation/assessment exercise, including its implementation and delivery of quality and timely work products and deliverables. S/he will establish roles, responsibilities, and tasks of team members. S/he will facilitate all necessary meetings in the course of the evaluation/assessment and PD development session in Kenya. S/he will ensure that the logistics arrangements in the field are complete. S/he will ensure timely production of deliverables and coordinate the process of assembling individual input/findings for the team report and finalizing the report. Team leader will consolidate the findings of the team and prepare and lead the oral and written preparation and presentation of key evaluation/assessment findings and recommendations to USAID/Kenya, appropriate USG teams in Kenya, GoK and selected stakeholders and, if appropriate, USAID/W.

Other Team Members:

The other remaining two team members should include experts in the areas of international health, HIV and nutrition, maternal and child health; infectious diseases (malaria, tuberculosis, vaccine-preventable diseases); health systems strengthening including health financing, logistics management, monitoring and evaluation, including health management information systems, and policy. Duties will be determined in consultation

with the team leader, and will include conducting and documenting interviews with government officials, donors, service providers, clients and key partners, analyzing data, recommending new program directions; and assisting the team leader as directed in all aspects of completing the deliverables.

Essential Qualifications. Each technical expert should have at least seven years working experience in international health, HIV/AIDS and Nutrition, monitoring and evaluation. S/he should have proven proficiency in their technical areas and possess health program evaluation skills. S/he should have excellent computer, writing and communication skills, be proficient in English and have a master's degree in public health or related field. It is expected that each team member will have a working knowledge of health issues affecting Kenyan populations and understanding of the impediments to health within the African context. Knowledge of the food processing industry and food hygiene and standards is an advantage. The content and validity of the findings will be the sole responsibility of the IT Shows, Inc. consultants. USAID/Kenya team will ensure that full independence is accorded to the consultants, and that objectivity is maintained throughout the exercise to give credit and ensure valid and reliable evaluation findings and conclusions.

The 3-person IT Shows consultants will be joined by two AID/W staff as the Subject Matter Experts in HIV and Nutrition programming. The two will particularly be valuable and resourceful during the program description (PD) development by bringing the global perspectives in HIV and nutrition programming. Their participation in this evaluation will also enhance global learning and ensure the use of key lessons learnt and best practices in Kenya at the global HIV and nutrition arena.

All team members must provide written disclosures of any prior conflict of interest, and IT Shows must ensure necessary safeguards are in place to prevent any subsequent conflicts of interest.

Deliverables and Timeline

It is anticipated that the evaluation/assessment and PD development can be completed in five weeks, for a total **29 working days including Saturdays**. The evaluation/assessment and final PD development ideally will begin by May 8, 2012 and end no later than June 8, 2012: See the detailed timeline below:

No.	Deliverables	Duration/Timeline
a	Review of relevant documentation (including project studies, status reports, assessments, USAID strategy documents, and other reports related to nutrition programming in Kenya).	May 8 – May 10 (3 days)
b	Detailed written evaluation work plan, including final evaluation design and data collection methodologies	May 11 – May 14 (3 days)
c	Meetings with MOH officials and other stakeholders; site visits/field work(project staff, service providers, PMO, DHMT, field agents, clients/beneficiaries	May 15 – May 26 (11 days)
d	Dissemination meeting during which the team will present the first draft of the evaluation/assessment report, highlighting key findings	May 28 1 day

	and recommendations and receive input from stakeholders	
e	Project Follow-on PD development/Design Document	May 29 – June 6 (8 days)
f	Final PD/Draft Evaluation Report Submission	June 8 (1day)
g	Mission Feedback to IT Shows on draft evaluation report	June 22 (10 days)
h	Final report submission	July 27***

******* IT Shows will work out the number of days for the team leader, not exceeding 2 working days for incorporating mission feedback into the final report.

Final Report Format

The team leader will submit a draft report and final PD to USAID/Kenya prior to the final debrief and departure from the country. The document will be organized as follows:

I. Executive Summary (3-5 pages summarizing key finding
II. Background
III. Evaluation key findings and conclusions
IV. Assessment key findings
V. Recommendations for future directions
VI. Annexes
   a. Scope of Work
   b. Evaluation Team Members
   c. List of Interviewees
   d. Detailed explanation of Methodology
   e. Questionnaire tools, checklists, survey instruments, and discussion guides
   f. Sources of information, properly identified and listed
   g. "Statement of differences" regarding significant unresolved difference of opinion by funders, implementers and/or members of this team.

The report must meet the following criteria:

- The evaluation report should represent a thoughtful, well-researched and well organized effort to objectively evaluate what worked in the project, what did not and why.
- It shall address all evaluation questions outlined herein.
- Evaluation findings will assess outcomes and impact on beneficiaries (males and females).
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence and data and not based on anecdotes, hearsay or the compilation of people's opinions. Findings should be specific, concise and supported by strong quantitative or qualitative evidence.
- All recommendations need to be supported by a specific set of findings.
- All recommendations should be action-oriented, practical and specific, with defined responsibility for the action.

Upon acceptance by USAID/Kenya, IT Shows, Inc. will submit one report in four bound copies and an electronic copy in MS Word. In addition, all quantitative data collected by the evaluation will be: provided in an electronic file in easily readable format; organized and fully documented for use by those not fully familiar with the project or the evaluation; owned by USAID and made available to the public barring rare exceptions.

Level of Effort:

Team leader – 29 days
Other team members (each) – 27 days

Annex 2: Evaluation Team Members

Core team:

1. Nicky Davies – Team Leader (IT Shows, Inc, International Consultant) (Based in UK)
2. Sophie Ochola – (IT Shows, Inc Consultant) (Based in Kenya)
3. Zipporah N. Kiruthu – (IT Shows, Inc Consultant) (Based in Kenya)
4. Emma Apo – Kenya research student to support data collection and entry (Based in Kenya)

Supporting and advising the team:

1. Amie Heap – USAID Washington, Office of HIV/AIDS (until Wednesday 16 May) (Based in USA)
2. Rebecca Egan - USAID Washington, Health, Infections Disease and Nutrition (from Wednesday 16 May until the team went to the field on 20 May) (Based in USA)
3. Tim Quick - USAID Washington, Senior Technical Advisor for HIV/AIDS & Nutrition; Co-Chair, PEPFAR Food & Nutrition Technical Working Group, USAID Office of HIV/AIDS (from 30 May) (Based in USA)
4. Washington Omwomo – USAID Kenya / M&E
5. Ruth Tiampati – USAID Kenya / OPH
6. Abdi Wardere – Technical backstop, IT SHOWS (Based in Arlington)
7. Sandra Kangai – Logistical support, IT SHOWS ((Based in Kenya)

Annex 3: List of interviewees

National Level Stakeholders

Name	Organization
Mary Wachira	Programme Manager, Nutrition Programme, NASCOP
Ruth Musyoki	Programme Officer, Nutrition Programme, NASCOP
Eunice Mutemi	Technical Assistant, Nutrition Programme, NASCOP
Dr. Meshack Ndolo	Capacity Kenya, Project Director
Eunice Mutemi	Capacity Kenya, seconded to NASCOP, also present in NASCOP meeting
Achim Chiaji	Capacity Kenya, Assistant Director, Organizational Development and HR Policy
Rene Berger	USAID OPH, HIV and AIDS Team Leader
Lillian Mutea	USAID OPH
Maurice Maina	USAID OPH
James Batuka	USAID OPH
Ruth Tiampati	USAID OPH
Millie gadbois	USAID ABEO, Senior Agriculture Advisor
Albert Waudo	USAID ABEO, Program Management Assistant
Mervyn Farroe	USAID ABEO, Director
Makeda Tsegaye	USAID ABEO, Senior Livelihoods Advisor
Harrigan Mukhongo	USAID ABEO, Business and Organisational Development Specialist
Corey Fortin	USAID ABEO, Agricultural Development Officer
David Rogers	USAID ABEO, Private Sector Development Officer
Mark Meassick	USAID Program Office, Supervisory Program Officer
Stephen Ragama	USAID Program Office, Project Development Specialist
Washington Omwomo	USAID M&E
Dr Isaac Malonza	MCHIP, Country Director, Jhpiego Kenya
Evelyn Matiri	MCHIP Nutrition Associate
Prof. Judith Kimiywe	MCHIP Nutrition Consultant
Dr David Mwaniki	NHP, Chief of Party
Anthony Kamigwi	NHP, Monitoring, Evaluation and Research Manager
Brian Njoroge	NHP, Program Officer
Hanna Tadayo	NHP, Training Director
Catherine Michobo	NHP, Commodity Manager
Sachen Chandaria	Insta Products Inc.
Rolf Campbell	Insta Products Inc.
Grace Waiharo	Phillips Health Care
Ndiba Kamau	Phillips Health Care
Katie Bigmore	World Bank
Jack Odek	CDC
Milton Omondi	DOD Kisumu

Dr. John Mwitari	MoPHS, Head of Division of Community Health Services (direct interview and email)
Simon Ndemo	Programme Officer , M&E Community Strategy, Division of Community Health Services
Charity Tauta	Division of Community Health Services (via email – did not response)
Emily Wanja	Intern Division of Community Health Services
Lisa Achieng	Intern Division of Community Health Services
Hilda Kakayon	Intern Division of Community Health Services
Terry Wefwafwa	MoPHS Department of Family Health, Division of Nutrition (email contact)
Valerie Wambani	MoPHS Department of Family Health, Food Security and Emergency Nutrition
C J Jones	GAIN, Country Manager
Daisy Mundia	GAIN, Associate, - Maternal, Infant and Young Child Nutrition, Amsterdam Initiative Against Malnutrition
Peter Mutua	Kenya Bureau of Standards (KEBS)
Christy Lee Hanson	TB Consultant working on Kenya USAID TB strategy (input but no formal interview)
Tim Quick	USAID Washington, Senior Technical Advisor for HIV/AIDS & Nutrition; Co-Chair, PEPFAR Food & Nutrition Technical Working Group, USAID Office of HIV/AIDS (input but no formal interview)
Amie Heap	USAID Washington (input but no formal interview)
Rebecca Egan	USAID Washington (input but no formal interview)
APHIA Plus Kamili	Responded to email questions sent to all APHIA Plus partners
APHIA Plus Nuru Ya Bonde	Responded to email questions sent to all APHIA Plus partners

Site visit key informants

Mbagathi	
Esther Mbithi	Senior clinician (HIV clinic)
Michael Kimuyu	Social worker
Rebecca Kwech	Senior nutrition counselors
Gregory Mwinawu	Administrator CCC
Estha Mwambuka	Assistant Chief Nutrition officer
EDARP	
Rose Simiyu	Deputy Site Team Leader
Carline Musiithi	Pharmaceutical Technologist
Steve Kegosi	Nutrition manager
Jane Kasiuki	Nurse
Ken Mawira	Clinical officer
Joel Mwausa	Nutrition supervisor
Kola Mbangula	Laboratory manager
Nazareth Hospital	
1. Sister Clara	Administrator
2. Winnie Mutinda	Nutrition Officer In-Charge
3. Elizabeth Kungu -	Nurse

4. Gladys Mwaura -	Clinical Officer
Lea Toto	
Nicholas Makau	Lea Toto Manager
Marleen Lwangu	Senior nutritionist – Mukuru Site and overall nutritionist
Matthew Mwaniki	Nutritionist – Kariobangi Centre
Paul Mulonga	East Nairobi centre manager
Francis Ndegwa	West Nairobi centre manager
Moses Mjatha	Monitoring and Evaluation
Rhoda Jemeli	Lea Toto centre manager
Stephen Koro	Lea Toto centre manager
Peninnah Nzioka	Lea Toto centre manager
Thika District Hospital	
Ann Thielta	Nutritionist in charge
Nasri Abdullah	Pharmacist intern
Esther Murira	Nurse (Chest clinic)
Doreen Wanyika	Data Clerk (Records)
Rose Ndevitu	Nurse Counsellor
Geoffrey Githiji	Social worker
Rhoda Chesang	Nutritionist
Nyanza Province	
Dr Lusi	Provincial Director of Medical Services (PDMS)
Rael Mwando	Provincial Clinical Nutrition Officer (PCNO)
Nyanza PGH	
Dr Susan Arodi	CCC Manager
Caroline Aurah	Nutritionist (CCC)
Pamela M. Oteino	Nutritionist assistant (TB/HIV)
June Achieng	Nutritionist (Paedriatrics)
Fatuma M, Athmani	Nutritionist (MCH/OPD)
Edris Oloo	Registered clinical Officer
Bondo District	
Nelly Irangi	District Nutrition Officer (DNO)
Bondo district hospital	
Julius Ooko	Clinician (MCH)
Washington Kariuki	Clinician (CCC/PSC)
Nina Auma	Quality Improvement URC
Victor Anyiko	Data officer for Bondo District
Hilda Odindo	Nurse CCC/PSC
Monica Odunga	Mothers2Mothers
Ntakwaka Herine	Nurse MCH / PMTCT
Issac Mgiendo	Social worker
Martha Opyo	Nurse CCC/PSC
Mercy Juma	Volunteer nutritionist and CHEW
Mary Anyango	Peer educator
Beatrice Apiyo	Peer educator
Jane Jodo	Peer educator
Alphine Amondi	Peer educator
Jamwa Danies	Peer educator
Julie Akoth	Peer educator
Ahero	

Florence Akeyo	District Nutrition Officer (DNO)
Ahero Sub-district Hospital	
Joshua Oseko	Pharmacist
Slovia Ojil	Site Coordinator
Milka Nyakwalar	Nurse
Leah Alianda	Clinician
Jared Obora	Nurse
Isaiah Ogola	P.W.P L.C
Pamela Oketch	P.W.P L.C
Lilian Owour	Peer educator
Margaret Atieno	Nurse/Counsellor
Wilkister Dkall	Nurse
Evelyne Orori	Clinician
Wycliffe Kitangala	Nutritionist
Claris Odinga	Nutritionist counselor
Cecilia Onyango	Adherence counsellor
Millicent Odongo	Peer educator
Claris Yala	Peer educator
Elizabeth Juma	Peer educator
AMPATH	
Moses Mokaya	Nutrition Manager, AMPATH
Jennifer Kigen	Assistant Nutrition Manager, AMPATH
Evans Kibongong	HAART Harvest Initiative, AMPATH
Benjamin Andama	Assistant Programme Manager – Family Preservation Initiative (FPI)
Rebecca Kaile	Pharmacy Supervisor
Nancy Karaka	Social Worker
Angus Kebenei	Nurse
Janet Barosio	Clinical Officer
Rhode Keana	Nutritionist
Maxwell Injendi	Data monitor
Ekawa CBO	
Dina Dolphine Abuor	Liaison Officer
Eighteen	Social workers and Community Health Workers
Moi University Teaching and referral hospital (MTRH)	
Titus Tarus	Chief Nurse
Jane Nyariki	Deputy Chief Nurse
Nelson Kenduiywo	Head of Nutrition Department
Morris Korir	Assistant Nutrition Manager
Irene Koech	Infection Control Coordinator
Gladys C. Kilel	Medical Social Worker
Ruth Bett	Nutritionist - Pediatric Ward
Celestine Talam	Clinical Officer
Julia Kembol	Nutritionist - Medicine
Rael Cupkalum	Nurse - Medicine
Nakuru PGH	
Emmy Keitany	Nutritionist In Charge
Lisa Boiywo	Nutritionist CCC
Lydiah Njuku - Mwangi	Nutritionist Pediatrics

Jerry Okeymo	Senior CMA (procurement)
Carolyn Kenduiwa	Nutrition Officer MCH
Evalyne Koech	Nutritionist Medical wards
FAIR CBO, Lanet Drop-In-Centre	
Joseph Mutua	Social Worker in Charge, Lanet Drop-In-Centre
Joanna Nganga	Lanet Drop-In-Centre Assistant
Eleven	Community Health Workers
Eight	University Attachment Students

Annex 4: Detailed explanation of methodology

A participatory performance evaluation was designed with a mixture of data collection approaches selected to allow representative stakeholders' participation. Semi-structured interview scripts with uniquely formulated questions were developed for different national level stakeholders, provincial and district level government officials and different stakeholders within health care facilities. Qualitative data collection formed the bulk of this exercise. Structured questionnaires for adult clients and caregivers of OVC caregivers receiving NACS services were developed to facilitate the collection of quantitative data and qualitative data that could be quantified. Two-thirds of clients completing questionnaires were also interviewed in-depth in local languages to triangulate findings and explore key themes in more detail.

The key elements of the evaluation methodology are listed below. During the three week evaluation period, the team:

1. conducted thirteen field site visits across four provinces (see field visit site format below)
2. conducted semi-structured interviews with one Nyanza Province Nutrition Officer and two district nutrition officers
3. conducted 19 semi structured interviews with national level stakeholder organisations including USAID, NHP/Insta/Phillips, Government of Kenya departments and programmes, and 8 others organisations (see Annex 3 for full list of key informants)
4. sent email questions to APHIA Plus partners
5. sent questionnaires to 5 CBOs engaged with NHP
6. sent email questions to national stakeholders not available for interview e.g. key staff from the Division of Nutrition, Division of Community Health Services, and UNICEF
7. collected and analysed secondary data from NHP
8. reviewed secondary contextual sources from USAID and Government of Kenya

Field visit site selection process, schedule and visit format

Field visit site selection process: Site selection for field visits included a range of site levels and types in addition to a range of other sampling criteria presented below. The team also charted the most appropriate logistical arrangement given the available time constraint. Ruth Tiampati (KENYA/OPH) and Amie Heap (USAID/Washington) provided advice and guidance for the proposed selection.

Information for site selection – site levels and types:
In the Kenyan Health Care System there are six levels of care provision sites ranked from 6 to 1; level 6 being the highest level of care, level 1 being the lowest. NACS services are currently provided in:

- two level 6 facilities which are also national referral hospitals
- nine level 5 facilities which are provincial hospitals (two are actually district hospitals which are now providing high level care)
- a host of level 4 facilities which are mainly district hospitals
- a host of level 3 facilities which are sub-district hospitals
- a host of level 2 facilities which are health clinics

Level 1 facilities usually CBOs. ART is not currently provided below level 2 facilities. The bulk of NHP sites are found in level 2-5 facilities. Among level 2-5 hospitals are Mission Hospitals run by FBOs. Community relationships have been established in 2 provincial sites supported by NHP (Western and Rift Valley Provinces); one district hospital in Nyanza; and a few level 2-5 sites—many of which are mission hospitals.

Overall field site selection criteria:

In addition to selecting a range of site levels and types, the team also applied to following sampling criteria to finalize the site selection:

- Choose sites with a high volume of clients
- Choose sites with high levels of stunting
- Choose sites with high HIV prevalence
- Choose some sites with a strong community component and some that do not
- Include a balanced representation of urban and rural sites
- Visit as many levels of health facilities as possible – at least levels 6 to 2
- Include central sites and satellite sites
- Include FBO and GoK sites
- Witness the NACS program implemented through CCCs, ANC/MCH and in-patient wards
- Include at least one site where AIDSSTAR evaluators did not go
- Include at least one mission facility, or possibly two (at two different levels)
- Choose sites including a variety of cultures and varying population and food security issues
- Ensure at least one of the sites has a strong quality improvement element

Thirteen sites across Nairobi, Central, Nyanza, Rift Valley provinces were selected and are presented in Table below. The sites included 11 health care facilities including FBO and GoK facilities, and 2 CBOs (one providing screening, counselling and referrals and one also prescribing and issuing). Site visits were conducted between 16 and 29 May 2012.

Field visit site selection - four provinces were chosen and thirteen sites selected to meet the selection criteria and address the SOW questions

Province/Site	HIV Prev	Stunting	Wasting	CS/SS	KEPH	Urban vs. Rural	FBO vs. GoK	CDC/USAID	Linkages
Nyanza	13.9%	30.9%	3.9%	34/191					
Nyanza PGH					Level 5	Urban	GoK	CDC	19 satellites
Bondo DH					Level 4	Rural	GoK	CDC	18 satellites
Ahero Sub-DH					Level 3	Rural	GoK	CDC	11 satellites
EKAWA CBO					Level 1	Rural	CBO	NA	
Nairobi	7%	28.5%	3.8%	28/24					
EDARP					Level 2	Urban	FBO	CDC	12 satellites
Mbagathi DH					Level 4	Urban	GoK	USAID	0 satellite
Lea Toto					Level 1	Urban	FBO	USAID	9 satellites
Central	6.6%	6.6%	2.3%	14/32					
Nazareth Hospital					Level 3	Rural	FBO	USAID	5 satellites
Thika DH					Level 5	Urban	GoK	USAID	8 satellites
Rift Valley	4.7%	35.7%	8.9%	39/47					
AMPATH					Level 3	Urban		USAID	22 satellites
Moi University (MTRH)					Level 6	Urban	GoK	USAID	Referral
Nakuru PGH					Level 5	Rural	GoK	USAID	1 satellite
FAIR CBO DIC Nakuru District (APHIA Plus)					Level 1	Rural	CBO	USAID	0 satellites

Field visit schedule

Day	Field visit
Wednesday 16 May	• Mbagathi District Hospital
Thursday 17 May	• Thika District Hospital (also interview Provincial Nutrition Officer)
Friday 18 May	• EDARP
Saturday 19 May)	• Nazareth Hospital • Lea Toto
Sunday 20 May	Fly to Kisumu
Monday 21 May	• Kisumu PGH (also interview Provincial officer)
Tuesday 22 May	• Bondo District Hospital
Wednesday 23 May	• Ahero Sub-District Hospital • EKAWA CBO
Thursday 24 May	Drive to Eldoret (Rift Valley) • AMPATH
Friday 25 May	• Moi University (MTRH)
Saturday 26 May)	Team data analysis
Sunday 27 May	Team data analysis. Drive to Nakuru
Monday 28 May	• Nakuru PGH (also interview Provincial Nutrition Officer)
Tuesday 29 May	• Visit an APHIA Plus partner CBO (FAIR) in Nakuru to visit one of their Drop-In-Centres providing NACS services. Drive to Nairobi

Site visit formats

Each health facility site visit included:

- Semi-structured interviews with site manager (head of CCC or above)
- Semi-structured interviews with head of nutrition
- FGD with health care providers (nutritionists, clinicians, nurses social workers, peer educator/CHEW/CHWs)
- Fill in 15 questionnaires with clients across all eligibility criteria (see box #) with more than half of these clients also engaged in semi-structured in-depth interviews
- Semi-structured interviews with relevant staff on client and commodity data management, and procurement
- Site tour, understanding of integration of nutrition across units and flow
- Inspection of store, data management systems, anthropometric equipment, and counselling tools

Criteria for client interviews:

a) Male PLWHA+ malnourished
b) Female PLWHA+ malnourished
c) PLWHA+ pregnant
d) PLWHA+ postpartum malnourished
e) Caregiver of OVC under 2 years
f) Caregiver of OVC between 2 and under 5 years
g) Caregiver of OVC 5 years and above

Each CBO site visit included:

- Fill in 15 questionnaires and conduct in-depth interviews with clients on NACS
- Semi-structured focus group discussion with Community Heath Workers/ Social workers
- Semi-structured interview with CBO leadership
- I nspection of store, data management systems, anthropometric equipment, counselling tools and reporting
- Review of NHP community tools

Across all the sites, client questionnaires were completed with one-on-one support for 79 adult clients and 65 caregivers of OVC receiving NACS services including FBP; totally 144 questionnaires filled.

Data collection

Both quantitative and qualitative data was collected as part of the evaluation exercise. The evaluation SOW questions required the collection and analysis of data about program operations, the quality of delivery and content of interventions from the perspective of the program staff, stakeholders and other participants. Qualitative techniques were used to encourage respondents to provide descriptive responses. At the same time quantifiable data was collected to make comparisons and draw inferences on relevant performance measures.

Qualitative data is required to answer the more in-depth questions relating to the impact of the NHP program on the target communities as well as its accomplishments and constraints from the participants' perspective (clients, service providers and program staff). Qualitative methods, such as semi-structured interviews with clients and health care providers, were used to extract information that can be used to assess program appropriateness, implementation, refinement and satisfaction. Individual interviews were conducted for key informants on a face-to-face basis. Open ended questions were used and ample time was provided for the subject to comment, explain and share experiences and attitudes. Interviews helped to establish behavior and attitude changes, participant satisfaction and suggestions for improvement.

Document review was used to capture data about performance of the programme, and provide background and historical context to the program. The documents reviewed included NHP documentation, presentations and past evaluations, and available literature on HIV nutrition delivery services in Kenya.

Data analysis

This process began with a preliminary review of the data collected. This involved reading through the questionnaire responses and interview transcripts and correcting, translating and editing entries as applicable. Notes taken during focus group discussions and other interviews were captured on daily basis using an ideas matrix, including capturing immediate thoughts, reactions and interpretations. The data was then categorized as numerical and non-numerical.

Quantitative data analysis techniques were applied on any numerical data. Numeric data captured in the questionnaires and any other forms were entered into an excel database and then analyzed using SPSS. Most analysis was descriptive using frequencies and percentages.

Qualitative analysis was used for any non-numerical data. The team pooled key learnings from notes taken during field observations summarizing what was seen or heard in terms of common words, phrases, themes or patterns. Good field notes helped to record perceptions of the NACS program at the grass roots and also helped develop a general framework for analyzing the rest of the data. All team members were available for key informant interviews during site visits. Although this made site visits longer it allowed for each team member to ask a specific set of questions related to their area of expertise, while the remaining team members wrote notes.

Content analysis was used to capture and summarize key themes and information contained in the documents and publications reviewed as well as the key themes captured from the open-ended interview questions and questionnaires.

Controlling bias was achieved through the involvement of three team members who collectively engaged in qualitative and quantitative data capturing, analysis and comparisons. As a result, different ways of understanding data were discussed, and bias controlled.

Finally, the qualitative data was summarized and reported in terms of common themes or views of a majority of respondents. In addition, any isolated perspectives, even though not under common themes, were highlighted to increase the richness and broadness of the exercise. "Quotable quotes" from key informants will also be captured and reported.

Evaluation constraints:

1. Due to scheduling issues the team had insufficient time to read background documentation prior to developing the evaluation tools. This compromised the quality of these tools and subsequent data that could be extracted.
2. It is preferable for interview data to be recorded on tape or summarized by a recorder or the interviewer who should take notes during the session. As permission was not sought in advance to record interviews, hand written notes were taken by team members. Although effective for capturing information, there was limited time available to review notes comprehensively.
3. The core team of three consultants needed to split during the first week of the evaluation with the team leader conducting national level stakeholder meetings in Nairobi while the two remaining team members and a data collection assistant visited the first four field sites. The team leader also conducted one field site visit to Lea Toto on her own. This had consequences for both the quality of national level stakeholder interviews and initial sites visits, and site visit problem solving and tool refinement.
4. Site visits were planned in advance with written instructions provided to each site. However, after the first few site visits it became clear that insufficient numbers of clients would be available at sites to interview and that a randomized selection of clients would need to be specially requested to visit the health facility to be interviewed. A transport allowance of Ksh200 was given to each client attending. This was logistically very difficult as some clients live a long way away and contact details were not always available and accurate. Some sites did not manage to organize clients to visit sites in advance. In these cases either fewer clients were interviewed, clients were found in wards, or the team returned the following day to interview clients. The team's data collection assistant revisited the initial three sites to support invited clients to complete questionnaires.
5. Although paired interviews where initially designed for client interviews, clients were reluctant to be interviewed in pairs. This will have had pros and cons in terms of extraction of qualitative information. Paired interviews would have help shorten the process at some sites where clients queued to be interviewed. There are pros and cons of paired interviews in terms of the qualitative information extracted; overall this may have had little impact on the evaluation as the clients did wait to be interviewed.
6. Due to time constraints, field tools were not formally pretested but minor changes were made after the first few field visits.
7. NHP did not have the relevant data for the team to use to establish the effectiveness and consistency of the impact of NACS service provision on clients. At the site level, there was no consistent, gradual (across three months) recording of data and analysis for clients to assess performance impact of FBP for clients. With more time and preparation, the evaluation team could have tracked the documentation for a random sample of clients per site visited to gain a qualitative impression of impact of NACS services including length of time (LOT), relapse etc.
8. It would have been appropriate to have questionnaired and interviewed a larger sample of clients than the team managed given the population size but this was constrained by time shortage. 144 clients were interviewed during the evaluation period.
9. A data collection assistant was drafted in at the last minute to help complete questionnaires on site visits and collate data. Advanced planning for this member of the team would have helped problem-solving earlier in the evaluation design process.
10. A few key informants were not available for interview including Charity Tauta from the Division of Community Health Services (MoPHS); Terry Wefwafwa from the Division of Nutrition (MoPHS); Dr. Francis Kimani, Ministry of Medical Services; and Jane Situma the Provincial Nutrition Officer for Nakuru.
11. Lack of time together to plan the evaluation meant consider concerning the reconstruction of a baseline was not pursued. Comparative data could have been made for GoK programme before and after the NHP began.
12. Although the evaluation was ostensibly an external evaluation, USAID were involved in the development of the evaluation tools, and a USAID member of staff 'observed' during 6 field visits. The biased introduced by both these factors was minimized and is unlikely to have significantly impacted on the evaluation.

Annex 5: Evaluation tools

Evaluation tools are available from USAID Kenya on request.

Key tools include:

1. OVC caregiver client questionnaire
2. Adult client questionnaire
3. Specifically tailored national level stakeholder interview scripts
4. Semi-structured focus group discussion interview script for health care providers
5. Semi-structured interview script for health care facility site manager
6. Semi-structured interview script for principal and district nutrition officers
7. CBO questionnaire

Annex 6: Bibliography

AED, Nutrition and HIV program environmental mitigation and monitoring report, period September 30th 2010 to October 30 2011

FANTA-2. Review of Kenya's Food by Prescription Programme. July 2009.

Government of Kenya - Partnership framework between the Government of the Republic of Kenya and the Government of the United States of America to support implementation of the Kenya national HIV response as articulated in the Kenya National AIDS Strategic Plan III (KNASP III) 2009/10.2012/13

Government of Kenya – Ministry of Health. Kenya AIDS Indicator Survey - Preliminary report 2007

Government of Kenya – Ministry of Health. Kenyan National Guidelines on Nutrition and HIV/AIDS. April 2006.

Government of Kenya – Ministry of Health. Nutrition and HIV/AIDS: A Tool Kit for Service Providers in Comprehensive Care Centres. May 2007.

Government of Kenya – Ministry of Health, Reversing the Trends - The Second National Health Sector Strategic Plan of Kenya, Taking the Kenya Essential Package for Health to the Community - A Strategy for the Delivery of Level One Services, June 2006

Government of Kenya – Ministry of Health, Reversing the Trends, Ministry of Medical Services Strategic Plan 2008 – 2012, July 2008

Government of Kenya – Ministry of Health, Reversing the Trends, Ministry of Public Health and Sanitation, Strategic Plan 2008 – 2012, December 2008

Government of Kenya – Ministry of Health, Reversing the Trends, Strategic Plan of Kenya, NHSSP II – 2005–2010, August 2005

Government of Kenya – Ministry of Medical Services. Nutrition Management in Comprehensive Care Centers in Kenya: A Job Aid on Food by Prescription. March 2009.

Government of Kenya – Ministry of Medical Services. Kenya Nutrition and HIV/AIDS Strategy. 2008.

Government of Kenya – Office of the President. Kenya's National AIDS Strategic Plan 2009/10-20012/13. National AIDS Control Council, October 2009.

Government of Kenya – Kenya Demographic and Health Survey 2008-09, June 2010

IT Shows Inc, An Integrated Nutrition Investment Framework for Kenya - analyses and recommendations, March 2011

KEMRI, Randomized Controlled Trial of the Impacts of Food Supplementation on Malnourished Adult ART Clients and Adult pre-ART Clients in Kenya, Final Report, Draft May 7, 2010

PEPFAR Country Operational Plan (COP) and Strategy Statement

USAID AIDSTAR-One, Food By Prescription in Kenya, 2010

USAID/Kenya, Feed the Future Strategy, Kenya Multi-Year Strategy, April 2011

USAID/Kenya, Five Year Implementation Framework for the Health Sector (2010-2015)

USAID Nutrition and HIV Program annual work plans, quarterly reports, and outputs from program monitoring systems

USAID Nutrition and HIV Program Cooperative Agreement

Annex 7: NHP service delivery data

Number of sites providing NACS services, number of prescriptions issued, new visits v's revisits, and quantity of commodity distributed achieved between April, 2008 and March, 2012.

Client Category	# of prescriptions (NEW+REVISIT)			Total
	Foundation Plus (F+)	First Food (FF)	Advantage (AD)	
Adult PLHIV	234,814	812	3,382	239,008
PPP	3,351	93	44,167	47,611
OVC	23,532	216,723	507	240,762
Total	**261,697**	**217,628**	**48,056**	527,381

Reporting Period (Year/Quarter)		Service Points		Commodities	Client Beneficiaries	
		CS	SS	∑ MT	∑ New	∑ Revisits
2008	Q1			143.6	7,325	15,313
	Q2			294.8	5,835	15,629
	Q3			184.2	10,747	11,802
2009	Q4	62	125	332.3	13,115	17,024
	Q1	61	195	159.4	10,310	17,109
	Q2	84	179	306.3	9,216	12,561
	Q3	106	192	204.8	12,823	14,177
2010	Q4	106	197	256.1	12,855	13,141
	Q1	105	220	324.8	14,752	16,277
	Q2	105	261	173.2	11,792	16,859
	Q3	130	261	171.8	10,664	13,813
2011	Q4	155	286	195.2	14,361	15,264
	Q1	156	332	224.3	14,287	16,788
	Q2	156	256	200.0	11,249	13,302
	Q3	165	392	289.1	12,208	15,218
2012	Q4	188	431	437.8	16,574	20,744
Total				**3,897.5**	**188,113**	**245,021**

Annex 8: Scientific evidence for NACS contributions to improved nutrition outcomes

The primary emphasis of FBP is on the nutrition rehabilitation and/or nutrition support of the patient to improve well-being and treatment outcomes. It is widely accepted that nutritional health is essential for persons living with HIV (PLHIV) to maximize the period of asymptomatic infection, to mount an effective immune response to fight opportunistic infections, and to optimize the benefits of antiretroviral treatment (ART).[14] There is increasing evidence that malnutrition coupled with HIV directly influences survival; significant weight loss in HIV-positive individuals has been associated with increased risk of opportunistic Infections (OIs), complications and early death.[15] Scientific evidence demonstrates the impact of therapeutic foods in improving nutritional and health outcomes of malnourished persons infected by HIV and those not infected[16]. A recent study conducted in Ethiopia[17] to examine mortality and its predictors among a cohort of HIV infected patients on anti-retroviral treatment found that 10% weight loss and bedridden functional status were some of the predictors of mortality among HIV infected patients. The study concluded that provision of nutrition support and strengthening of FBP initiative is recommended to reduce mortality.

The findings of a randomized clinical trial of *Impacts of Food Supplementation on Malnourished Adult ART Clients and Adult pre-ART Clients* participating in the Kenya FBP programme in 2010[18] confirmed the critical role that nutrition plays in the management of HIV. Both Pre-ART and ART clients receiving food supplementation achieved significantly greater increases in BMI that their counter parts not receiving food supplementation. CD4 counts of pre-ART clients receiving supplementary food increased modestly while CD4 counts of their peers who were not receiving food declined, and this effect was statistically significant at three months but not at six or 12 months. CD4 counts of ART clients increased significantly, but there were no significant differences between the food and no-food groups in CD4 counts, presumably because the ART's effect on CD4 counts superseded any effect of the food. Findings suggest that food supplementation delivered in clinical settings can confer significant benefits to malnourished and nutritionally vulnerable adult PLHIV, especially pre-ART clients, and that greater attention and consideration should be given to nutrition care for pre-ART clients.

[14] Marston B, De Cock KM. Multivitamins, nutrition, and antiretroviral therapy for HIV disease in Africa. New England Journal of Medicine, 2004, 351:78-80; Fawzi WW, Msamanga GI, Spiegelman D, et al. A randomized trial of multivitamin supplements and HIV disease progression and mortality. New England Journal of Medicine, 2004;351(1):23-32

[15] Friis H (2006). Micronutrient intervention and HIV infection: a review of current evidence. *Tropical Medicine & International Health*, 11(12):1–9

[16] Effect of Preventive Supplementation with Ready-to-Use Therapeutic Food on the Nutritional Status, Mortality, and Morbidity of Children Aged 6 to 60 Months in Niger: A Cluster Randomized Trial. Isanaka S, BA; Nombela N, Djibo A, Poupard A, Beckhoven Dominique Van, Gaboulaud V, Guerin P.J, Grais R.F. JAMA, January 21, 2009—Vol 301, No. 3

[17] Predictors of mortality among HIV infected patients taking antiretroviral treatment in Ethiopia: a retrospective cohort study, Biadgilign S, Reda A.A, Digaffe T. *AIDS Research and Therapy* 2012, **9**:15 doi:10.1186/1742-6405-9-15

[18] KEMRI-FANTA Study Report, May 2010.

Annex 9: CBO assessment results

CBOs selected by APHIA II partners for proposed inclusion in the NHP community component

APHIA 11 ORGANIZATION	CBO/FBO	Location	Number of OVC	Nearest FBP Facility	Comments
APHIA II Nairobi	Community Implementing Initiative (CII)	Nairobi East	1860	Lunga Lunga HC, Makadara HC, Mbagathi DH	No baseline information on nutrition status of OVCs. APHIA 11 Nairobi procures CSB for distribution to malnourished clients. Others provide dry food rations (DFR)
	Mother/Child Aids Support Organization	Nairobi North	320	Pumwani Hospital	No baseline nutrition data. They do not have equipment. DFR is occasionally provided
APHIA II Coast	Wavizi Community Initiative	Malindi	188	Malindi DH	No Baseline data, no equipment and no trained staff. School feeding program in place; referrals to Malindi
	Bamako Initiative	Changamwe		Port Reitz Mikindani Hospital	No information on nutrition activities provided.
APHIA II Nyanza	Kagwa PLHIV Group	East Rachuonyo	3,076	Kendu DH	No information on nutritional status of the OVCs is available. Weight assessment done but not routinely. DFR + unimix provided at household level
	Kazi Ngumu Women Group	Kisumu East-Winam	2,725	Kisumu DH	Nutrition assessment done weight and MUAC data collected, some CHWs trained, no feeding support. Referrals to facilities for OTP service.
APHIAII Western	Kabras Jua Kali Association	Kakamega North-Kabras	1,000	Malava DH Kakamega PGH	No information on nutritional status for the OVCs. Services offered are aimed at reducing poverty, addressing food insecurity and health management.
	Catholic, Anglican, Muslim, Protestant (CAMP)	Mumias	2,000	St. Marys Mission Hosp., Mumias Disp.	No information on nutritional status. No equipment, staff not trained, and no food interventions. Clients referred to hospital for wet feeding.
APHIA II Rift Valley	Family Aids Initiative Response (FAIR)	Nakuru Molo, Njoro	15,000	Rift Valley PGH	No information on nutritional status of OVCs. Those referred to the PGH benefit from food rations provided by a program initiated by FHI or FBP from the PGH.
	Kenya national Outreach Counseling and Training Program (K-NOTE)	Naivasha	5,000	Naivasha DH	No information on nutritional status of OVCs. No equipment and trained staff. Occasional DFR given. Clients referred to the health facility nutrition services
APHIA II North Eastern Province	5 Home based care programs within Garissa town	Garissa	-	Garissa PGH	There is no OVC program for NEP. The HBC programs operating as decentralized service points for the PGH provide an opportunity to reach OVCs.

Annex 10: Status of CBO operations in Community Nutrition Service

	Region Province/ District	Name of NGO/CBO/FBO	Status	Notes
Nyanza				
1	Migori	St Camillus Dala Kiye (recommended in the CoAg)	Disengaged the OVC village but continued to support NACS/FBP to St Camillus Mission Hospital.	The OVC's were supported through Capable Partners Project (USAID/AED). The OVC's were already receiving nutrition/FBP support through the hospital. The OVC community component was already linked to St Camillus Mission Hospital. NHP considered this to be an atypical relationship because hospital management was already providing care to the OVCs.
2	Rachuonyo	Jolajoli	Disengaged	Became dysfunctional after expiry of APHIA II and departure of ENGEDER Health (Prime partner) and AED as a sub. After take over by the APHIA+ partner (Path), CBO was included as a collaborator. Transition challenges were cited by the APHIA + partner
3	Rachuonyo	Kagwa	Disengaged	As above
4	Kisumu	Kazi Ngumu	Disengaged	As above
5	Rarienda	Rafiki	Disengaged (to be revisited once QI activities reach community level operations)	Proved unreliable due to weak management. Used a consignment of prescription food commodities as food aid. No explanation was given for non-observance of the protocol by given by the central site.
6	Ahero	Ekawa	Active, formerly supported by Speak for the Child (SFC)	SFC was an FHI (formerly AED) project. CBO transitioned to NHP pending entry of the APHIA+ partner. Transition was relatively smooth. APHIA + has not yet expressed willingness to take up the CBO as a grass root partner.
6	Ahero	Kwawakasi	Active, formerly supported by Speak for the Child (SFC)	As for Ekawa
Western				
7	Navaholo	Bumulusi	Active, formerly supported SFC	As for Ekawa
8	Navaholo	Nabunasi	Active, formerly supported by SFC	As for Ekawa
Rift Valley				
9	Nakuru	Family Aids	Active CBO with district	Continuity of coverage by FHI from APHIA II to APHIA plus was helpful. The

		Initiative Response (FAIR)	wide coverage.	APHIA II implementing partner (FHI) continued as the APHIA+ implementing partner
10	Pokot	CCS	Active FBO. Entry was 4th quarter 2011	A choice of APHIA + partner (FHI) because of remoteness and vulnerability factors.
11	Kericho	Live with Hope	Temporary suspended because of supervision challenges	CBO supported by Walter Reed (South Rift) project. With recruitment of a nutritionist, the CHW support for OVC will be activated. Currently CBO supervised by Kericho District Hospital
Central				
12	Muranga	KENWA (recommended in the CoAg)	Disengaged	The NGO mechanism of engagement was to receive support and administer the whole project. Availability of continuous supervisor by health workers from the Central site also proved a challenge
		-	-	NHP is in the process of identifying an alternate CBO or NGO in Central
Eastern				
13	Meru	Ripples	Disengaged	Formerly supported by CAP project. Malnutrition was not considered a problem. CAP project closed down. It was not clear whether APHIA + partner did demonstrate intention to carry on with NGO.
14	Kitui	Nyumbani village	Active. An FBO facility that cares for OVCs (in Nairobi and Kitui districts)	Engagement completed first quarter. Training done and OVC assessments started in April 2012.
North Eastern				
15	Garissa	Police line, home based care units	Disengaged as outreach points for OVCs	Sites established to facilitate access to HBC services because of stigma in a predominantly Muslim community. APHIA II and MOH used the sites as satellites of Garissa provincial hospital. They were not suited to serve as community service points for OVCs.
Nairobi				
16	Nairobi	Eastern Deanery AIDS Relief Project	Slowed down; to be redirected to serve as a more cohesive team	Designed as an outreach with member of small Christian communities serving as community volunteers
Coast				
17	Coast	-	-	Consultations being held at the coast in May 2012. This will lead to identification of suitable candidate CBOs/FBOs

Annex 11: Explanation of the Community Units as part of the national Community Strategy

A Community Unit is to be established within every sub-location. Each Community Unit constitutes of the Community Health Committee, 50 Community Health Workers (CHW) and a Community Health Extension Worker (CHEW). The community units aim to empower members of their communities to take care of the own health with resources available to them in a sustainable way.

The approach of the Community Strategy is a flagship pilot project for the Government of Kenya in response to the failure of the existing primary health care system in Kenya. Mid-term results of the Community Strategy, in 2010, showed very promising data e.g. women were four times more likely to attend antenatal clinics and deliver in a health facility, improved HIV indicators etc. This kind of approach is critical for a response which aims to prevent as well as treat malnutrition. CHWs within community units are allocated 100 households each to support.

Community unit CHWs aim to provide comprehensive service to households rather than specializing in any one disease area or intervention e.g. CHWs will address the needs of people and livestock, sanitation, food security, health etc. In terms of support for nutrition and HIV, CHW are able to make referrals, counsel individuals/families on drug adherence including the correct use of FBP, support the correct use of complementary feeding and complementary foods. They are also trained to provided education concerning food security at the household level, household economic strengthening through IGAs, and to make referrals to HIV support groups and local CBOs / NGOs that also provide this food security and livelihoods support. CHWs are given certificates to demonstrate that they have been trained to provide IGA support, nutritional counseling and support to PLWHA. CHWs also provide referrals to health facilities, government administration for immunizations, advice concerning agricultural approaches and choices. In addition, CHW are expected to know which local partners are in the vicinity for referrals. Community units have not been established nation-wide and the GoK is dependent on external donors to help establish and maintain community units and their associated costs (for example MCHIP is currently funding some community units). PEPFAR has agreed a cost share agreement with the Government of Kenya to fund some community units with matched contribution from the government for others.

Monthly meetings and reporting between community units and health care facilities are already integrated into the design of the community unit. Meeting dialogue tools, CHW curriculum, log books and manual have been designed. They are printed and distribute via TOTs providing trainings at county level. These meetings are organized by the CHEW who are often linked to one or more nearby health facilities. The DCHS is in the process of developing a two way referral form to support community and health care facility referrals. This form will be for any referral as per the holistic integrated services approach.

Annex 12: Feed The Future results framework