Approaches and Lessons from Rapidly Scaling-Up Nutrition Assessment, Counseling and Support (NACS) Services

- AED - Academy for Educational Development
- NASCOP - Ministry of Medical Services/Public Health and Sanitation
- USAID/K

Presentation covers

- Background
  - Rationale of moving from pilot to scale
  - Chronology – Development of NACS Services
- Approaches to Expansion of NACS Service
- Lessons learned
- Pending Matters – Future!

Background facts on the burden of HIV and malnutrition

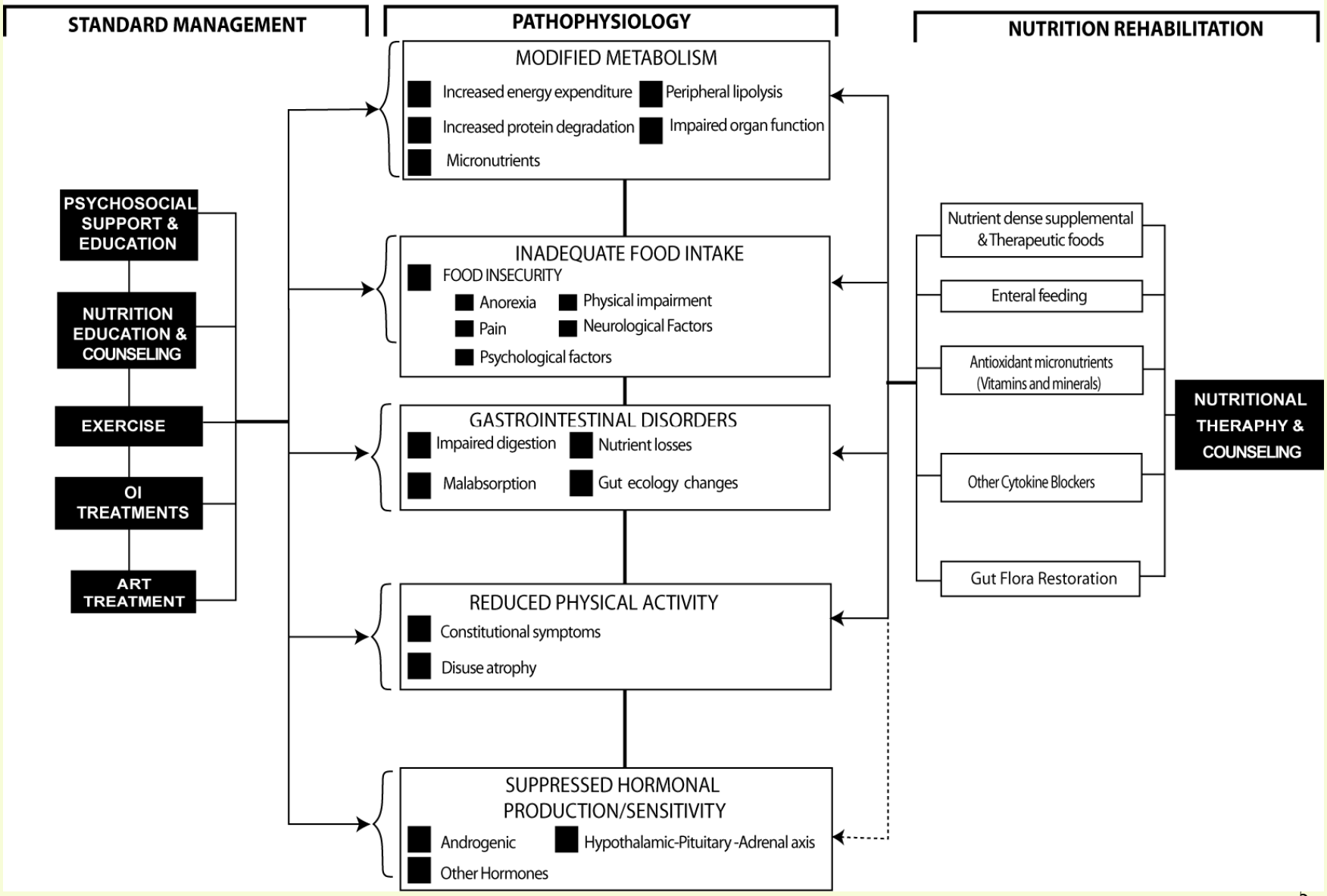
- Kenya has population of 38.6 m people (2009 Census)
- Kenya has ~1.4 m PLHIV; (Kenya AIDS Indicator Survey, 2007; KDHS 2009);
- HIV majority (56%) did not know their status (KAIS, 2007).
- Among PLHIV on care and treatment 10-15% are affected by varying degree of wasting.
- Nutrition status of < 5-yr-olds: Wasting ~ 9%; underweight ~ 20%; stunting ~ 49% (KDHS 2009)
- Food insecurity affects ~ 50% of HH

Expanding NACS Service Delivery – Rationale?

- Contribute to the realization of National Targets as defined in KNASP II & Kenya Nutrition &HIV Strategy (2007-10); KNASP III (2009-13)
  - Coverage
  - Equity and Quality
  - Increase resources – Financial, human & capital
- Achieve full potential of NACS interventions:
  - Optimum strategy for prevention & control of malnutrition among PLHIV & OVC
  - Improve effectiveness of other care & treatment interventions

Scale-Up to New Primary Sites; Decentralize to other service points & Sat. Sites

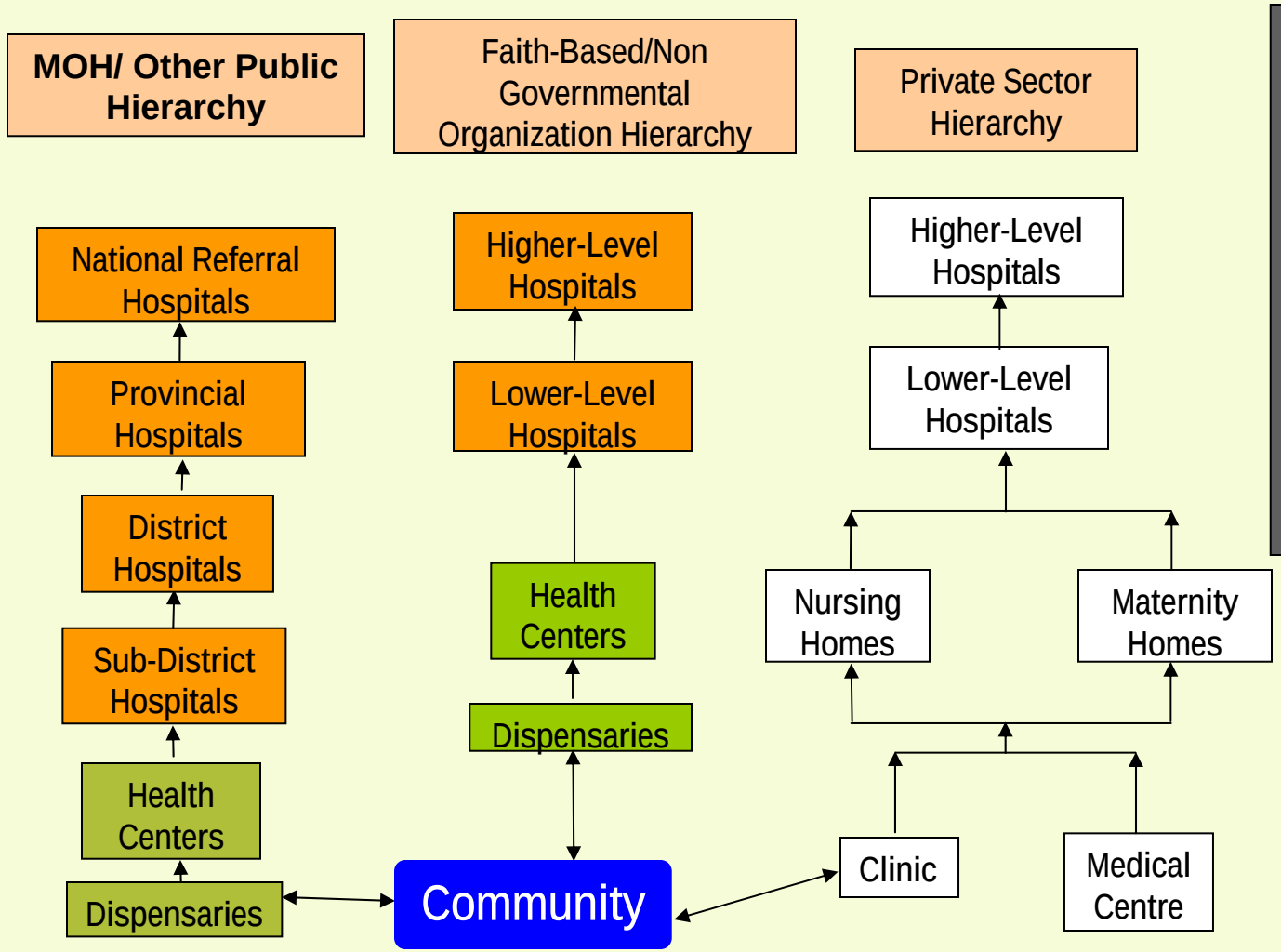
Prevention and Control of Malnutrition in PLHIV



Chronology of NACS Evolution & Service Delivery

2003 -2006	Establishment of Nutrition and HIV TWG at NASCOP Development of Nut.& HIV Guidelines, Infant Feeding Guidelines, Training Materials; TOT; (NASCOP/AED-FANTA/USAID /UNICEF)
2003 -2010	Nutrition Program North Rift/Western Kenya (AMPATH/ WFP) ~ 26 primary sites
2006 -2008	NACS (FBP) Pilot Phase - 58 primary sites (Insta/ NASCOP/USAID)
2006 -2008	Operations Research in 6 sites AED-FANTA/ KEMRI/ MoH/USAID
2007-2010	Key staff hired; Nutritionists & TA (Global Fund, Capacity/USAID, UNICEF)
2008-2013	NACS(FBP) Scale-up to 250 primary sites (NASCOP/ AED/Insta/ USAID; Suba District (Global Fund)

Health Facilities Organizational Hierarchy: NACS Service Delivery

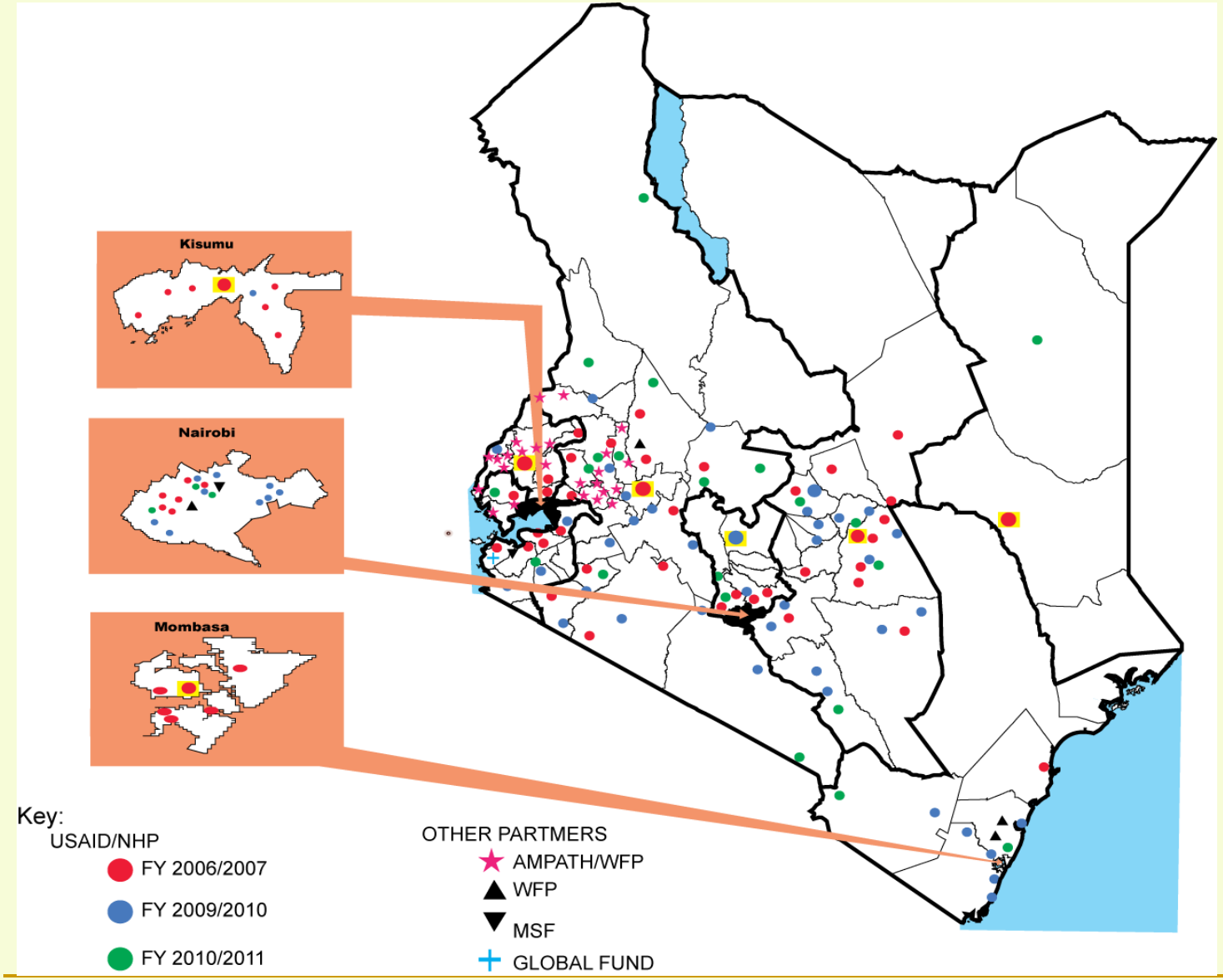


- ❑USG I Partners
  - ▪USAID
  - ▪CDC
- ❑WFP
- ❑Global Fund
- ❑UNICEF
- ❑MSF
- ❑WHO
- ❑Others

Key: **Primary sites** **Satellite sites except Nairobi**

Partner coordination and collaboration

SCALE UP OF NACS SERVICE DELIVERY PRIMARY SITES



Approaches in Expansion of Service Delivery– Issues?

- Agenda Setting – Managing the Policy Process
- Leadership at national and Sub-national levels & Managerial capacity
- Resource Needs (Inputs) – HRH, Equipment, Infrastructure, Financing & Social capital
- Design of Service Package – single intervention vs multiple interventions
- Delivery channels – Vertical vs integrated
- Identify novel approaches – private sector delivery channels vs public sector
- Identify synergies & Partners

Political Commitment; Leadership Planning & Implementation; Resources

Mobilizing Political Support & Resources to Scale Up

Strategies

- Direct engagement of Govt. & Partner Policy Makers
- Sensitize Partners on importance of nutrition services in care and treatment
- Sensitize citizenly on the importance of Nutrition with special reference to HIV

Actions

- National Nutrition Day - Advocacy
- Inform Policy/Program decisions – Evidence?
- Disseminate information in various forums

The USAID NHP Experience

A Public Private Partnership

Implementing Partners:

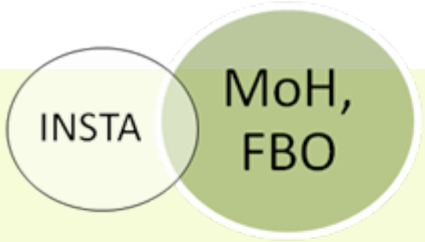
- **Academy for Educational Development**
- **Insta Products (EPZ) Ltd**
- **Ministry of Medical Services/Public Health and Sanitation – NASCOP/DoN**
- **USAID/K**

Responsibilities in the Partnership

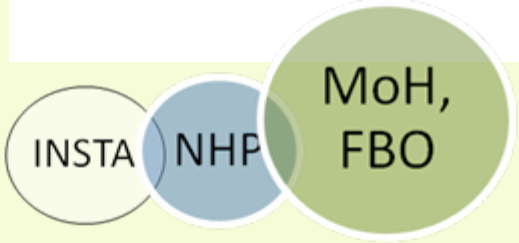
Partner	Roles	Scope/Strategy
Government ***GoK*** ***USG - USAID***	Develop policies, legislation & formulate standards; Provide resources	**Regional/National**
Private Food Company ***Insta as the incubator*** Private SCM Company	Produce Public health goods & deliver to SCM Companies Deliver commodities & assist development of a SCM system for nutritional commodities	**National/international** **National/regional**
NGO –***AED*** ***Prime partner***	Design & deliver interventions/programs; Catalyst/ broker; Advocacy	**Targeting Vulnerable groups**

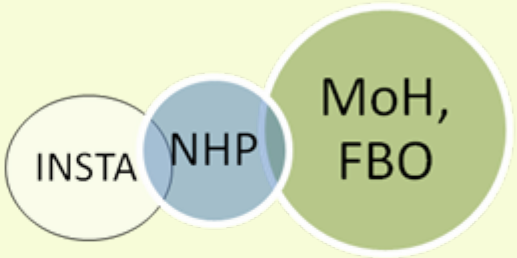
Moving From Pilot to Scale…..

Pilot Phase -2006

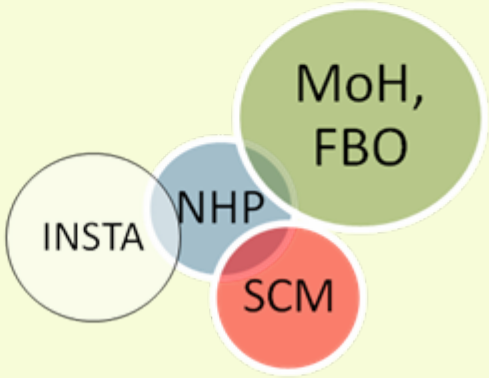


Transition/Adaptation Phase - 2008

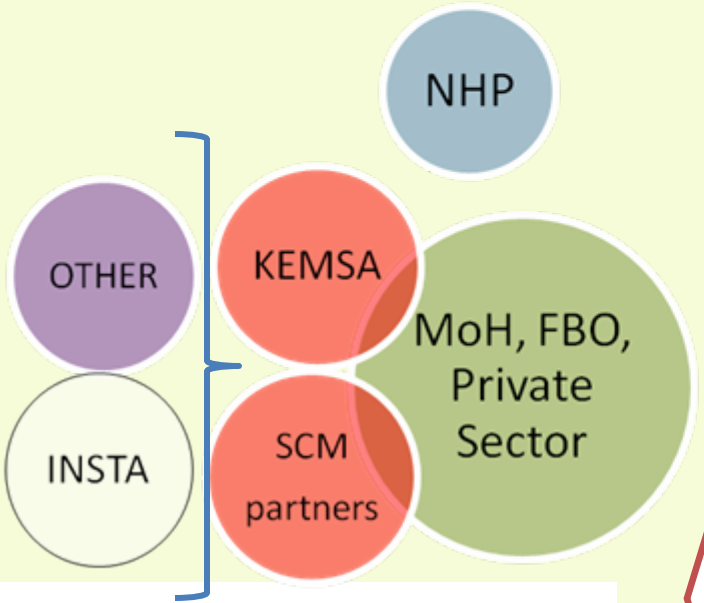




Scale-up Phase -2009



Scale-up Phase -2010/12



Maturation Phase – Post 2013

1st NND -Minister for Medical services, DCM, WR & Officials of GoK &USG Launch USAID NHP

The First National Nutrition Day Walk - 2008

1st NND Walk – "The march to USAID|NHP Launch"

Scaling –Up to New Primary Sites

1. Site Selection Process

- Criteria for selection
- Provincial & Partner consultations
- TWG Review & Consensus

2. Selection of Health Workers

- NASCOP - Criteria for selection of trainees
- Provincial & Sites nominate trainees

3. Training & Post Training actions

- 5 – day residential course
- Site assessment
- Delivery of Ref. materials, tools and commodities

Challenges & Lessons Learned

- Redeployment of trainees to other service points;
- Integration of NACS into other service points eg MCH is slow
- Regional variations in decentralization to satellite sites

Lessons from NACS Service Delivery I-Operations

- High Site Instability in delivery of NACS services -
  - HR - creating a critical mass of HCW & demystify NACS
  - Variations in commodities in the package
- Variations in knowledge of HCW trained on site -
  - Standardize continuing medical /nutrition education mechanism and materials primary and satellite sites
- Gaps in client IEC materials – adult PLHIV
- Equipment – Not calibrated and or faulty
- Lack/inadequate storage space is common
- NACS knowledge & skills weak in pre-service training curricula of other front-line staff

Lessons from NACS Service Delivery II-Operations

Packaging of Commodities

- Pre-packaging of FBF or RUTF sachets is highly appreciated by health workers

Strategies and Channels

- Service points largely limited to CCC; MCH/ PMTCT, Wards, Community – CBOs rare
- Nutrition counseling is not universally done
- Food preparation demonstrations is rarely done.
- Mentorship and site supervision is limited

Lessons from Commodity Management

- A pull system in which sites project needs and use of tracking tools is more suitable.
- A cushion inventory to keep delivery lead time short (<14 d).
- An order forecast (push) in production of commodities along with a pull system of ordering by sites was required to reduce risk of stock outs.
- Quality Assurance – pest infestation, rancidity due to hot weather.
- Raw materials availability & Global economic factors contributed to stock outs.
- Challenges in managing PPP.

Lessons from NACS Service Delivery III-Coordination

- Coordination to facilitate piggybacking on other implementers in delivery of services at community level.
- Harmonization of indicators and data capture tools by partners.
- Observation of the three-ones principle in NACS is required.
- Alignment of NACS service use reporting with ART & Care.

Pending Matters

- Scaling up linkages with other programs – priority -
  - Food security and livelihood support initiatives
  - Food fortification programs
- Social marketing of FBF for better access and sustainability.
- Support for standards to facilitate entry of other investors into the field.
- Policy review: Initiate processes to review taxes & tariffs on Minerals & Vitamins pre-mixes and therapeutic foods within context of public health goods.
- R&D of new formulations and effectiveness trials.

"….If it were not for the services, I would have died"
(FBP client, Nyanza Province)

- Thank You