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Kenya's experience of using the Nutrition Data Value Chain to inform policy and program development

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Q : Can Kenya tell us a little about the institutional anchoring of the information system, especially the data collection and the management of this system; and also on the frequency of data sources?

A : The Kenya Information system is government-led with two dedicated MOH M&E/HIS staff based at the Division of Nutrition and additional technical assistance through 2 staff from UNICEF Kenya. Coordination of NIS/M&E is through the Kenya Nutrition

Information Technical Working Group with a TOR to oversee and support implementation of the NIS Key Result Area in the 2018-2022 Kenya Nutrition Action Plan and the Kenya Nutrition M&E Framework. The M&E Framework provides one agreed country level nutrition M&E framework for the 2018-2022 KNAP. Nutrition indicators are integrated in national surveillance/routine data collection and reporting systems including the DHIS2 and the Kenya Early Warning System. Reporting through the routine and surveillance systems is monthly.

Q : Does the government of Kenya fully fund the information system? Can Kenya also speak on the technical management committee of this system?

A : Funding is a key area requiring improvement as the system is mainly funded by partners with government mainly funding salaries of staff at national and county level. Coordination of NIS/M&E is through the Kenya Nutrition Information Technical Working Group with a TOR to oversee and support implementation of the NIS Key Result Area in the 2018-2022 Kenya Nutrition Action Plan and the Kenya Nutrition M&E Framework.

Q: In Kenya, what was the protocol for caring for children aged 6-59 months under COVID 19 containment and has the protocol changed now?

A : This question is not very clear but assuming this concerns MIYCN and IMAM, some adjustments were made in the national

guidelines as part of preventive measures such as seeking child welfare clinic services during critical services only e.g. seeking services when immunization was scheduled or when a child was sick. There was additional guidance in integrated management of acute malnutrition (IMAM) on disinfecting equipment. Family MUAC was roll out at household level to improve detection of acute malnutrition by caregivers.

Q : I would like to better understand, with regard to Kenya, the periodicity of the data collection, and also the actors involved in the validation of the collected data. I would also like to know how the COVID 19 pandemic could have impacted the very quality of nutrition and the strategies to minimize the risks.

A: Nutrition indicators are integrated in national surveillance/routine data collection and reporting systems including the DHIS2 and the Kenya Early Warning System and are reported monthly. Nutrition Information Technical Working Group validates data and information products. Quartely data review meetings are also held at sub-national level. There is no evidence the quality of the data has changed probably due to pre-COVID capacity strenthening which build system resilience coupled with the fact that COVID-19 has remained within country response capacities across the counties.

Q: To the Kenya team. Congratulations on your comprehensive system. Have you been able to integrate coverage indicators in your DHIS system?

A: Nutrition data elements and indicators are included in DHIS including vitamin A supplementation and IFAS. The numerator for proxy (indirect) coverage for IMAM program is also included in the DHIS (IMAM admissions) with denominators generated through a separate caseload calculation process.

Q : For Kenya: What's the level of multisectoral coordination/ institutional ?

A : Multi-sectoral coordination is relatively developed with food and nutrition analysis well integrated through a multisectoral team. However, the multi-sectoral platform (MSP) has not yet taken off.

Q : For Kenya: is your information system helping for decision making for different sectors other than health sector? For example can it help make decision about large-scale food fortification, agriculture intervention to improve availability and accessibility of some specific foods for long term impact etc.

A : Yes, the system is supporting decision making. For example, products developed during seasonal assessments informs response and contingency planning across sectors. Another

example is the Nutritional Improvements through Cash and Health Education (NICHE) where results from baby friendly community initiative(BFCI) informed scale up of BFCI and NICHE in the country Funding for 5 counties secured.

Q: For Kenya: Can you discuss the activities that were undertaken to provide capacity strengthening on NIS at both the national and sub-national levels?

A: The activities included: training on NIS, data review and feedback, nutrition data clinics which are dedicated times of reflection on grey areas and complex issues, dedicated support from NITWG during surveys and assessments, targeted support through UNICEF roving NIS support officer at sub-national level, harnessing global and regional support based on need etc.

Q: How does nutrition and the food security sector work for you? I am very interested to also understand the indicators selected

A: Information components of food and nutrition are coordinated by the Data and Information Sub-committee of the Kenya Food Security Steering Group. Please find out more here https://www.ndma.go.ke/ .

Contextualization of the Call To Action on the Nutrition Data Value Chain in Liberia (Dr Annette Brima-Davis, Nutrition Director, Ministry of Health)

Q : For Liberia, is DHIS2 already operational? If so, can Liberia share difficulties on the management of this system or share the progress?

A : Yes, the DHIS2 is fully functional and it is being managed by the Director of the health information system, Ministry of Health. The challenge or difficulties on the management of the DHIS2 is that it is only updated once in every five years. Considering this, it is not possible for any program to make changes unless after the five years period.
Progress made: The nutrition program has included 14 standard indicators in the DHIS2 and has disaggregation for some of those indicators, for instance SAM admission data by sex and separated IPF & OTP data. MNP data capture # of children receiving MNP & # of children who have received adequate MNP.

Q : In Liberia, you talked about poor quality data, what do you mean by that?

A : The nutrition indicators are not included into MoH data quality assurance platforms (data validation tools & Facility services Quality tools) which is used to validate the quality of data reported from the health facilities at district, county and national levels and

the quality of services provided. The tools counter verify/validate the quality of care and the quality of monthly reports (data) submitted through the MoH system. Considering this, the credibility of the nutrition data is left questioned. Discussions on the inclusion of the indicators in the validation tools have been held with the HIS & M&E department of the MOH. It is expected that this will be done by end of Q2.
Indicators on adolescent nutrition for schools, Communities & facility routine services are not capture in the present reporting platform (https://dhis2.moh.gov.lr/dhis/dhis-web-dashboard/

Q : The last question is for Kenya and Liberia, how has the COVID pandemic may have impacted the quality of nutrition and strategies to minimize risk.

A : The pandemic has impacted the quality of nutrition negatively:
Low turnover of beneficiaries seeking maternal child health services at the public health facilities
Limited home visits by community health assistants and mother support groups due to COVID 19 restrictions on movement.
To mitigate the risk of COVID 19, behavior changes messages are been available and disseminated using media platform

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Q : To the Liberia and Kenya teams- how are the standard indicators you are collecting in the DHIS been used towards strengthening program coverage at the sub-national levels ?

A : For instance, the standard indicators like: # of children aged 6-23 months receiving MNP, # of children aged 0- 59 months admitted for SAM treatment targets are set from the total under five population of the counties- subnational level.

Nutrition services are being provided in all counties at health facilities and communities' levels and health workers are held accountable to report on nutrition services.