Citizens Voice and Influence for Nutrition Service Delivery in Turkana, Kenya

Report written by Rose Ndolo, Senior Nutrition and Food Security Adviser- World Vision UK with Daniel Muhinja, National Nutrition Specialist- World Vision Kenya

Report published in September 2017

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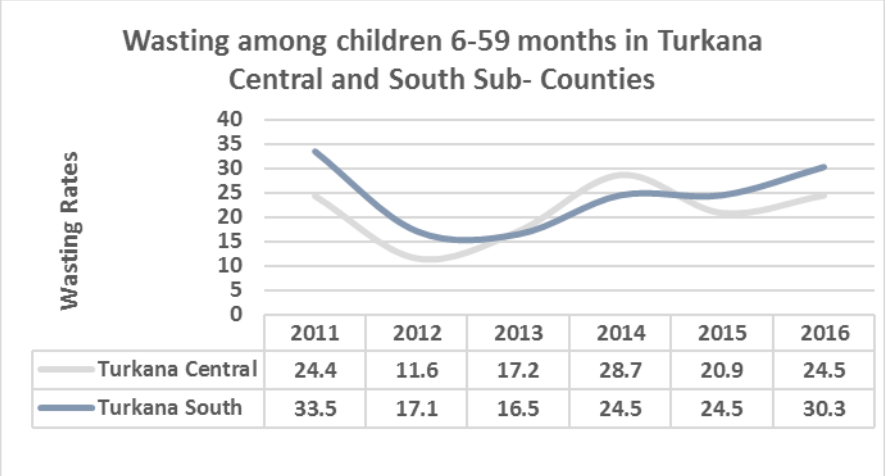
Introduction to the ENSURE project in Turkana

World Vision implemented the ENSURE (Enhancing Nutrition Surveillance and Resilience) project from November 2012 to March 2016 in Turkana Central, South and East sub- counties in Kenya. Turkana County is an arid and semi-arid county located in North of Kenya. It's a county with limited access to quality nutrition services and persistently high levels of child wasting[1] as high as 30% in 2016 and 33.5% in 2011 as shown in the figure 1 below. Malnutrition in Turkana county remains unacceptably high over the last 6 years since the Horn of Africa drought emergency in 2011. Within this context, the ENSURE project aimed to build resilience of the health systems and increase access to treatment for severely malnourished children. Under the devolved system of government in Kenya, health and nutrition services are managed by the 47 counties in the country. ENSURE was a multi- year humanitarian programme funded by the UK Department for International Development to respond to the high levels of global acute malnutrition and build resilience of the health system to treat severe and moderate acute malnutrition [2]in three arid counties i.e. Turkana, Wajir and Mandera. The project duration was 3 years running from November 2012 to March 2016. World Vision Kenya worked with 34 health centres, dispensaries and the Lowdar county referral hospital. The other ENSURE consortium partners were the International Rescue Committee in Turkana and was consortium lead, Save the Children and Islamic Relief Kenya both in Wajir and Mandera.

Figure1: Trends in child wasting



Intended project impact: The overall impact of the project was to contribute to a reduction in mortality and morbidity associated with acute malnutrition amongst children under five and women in these arid and semi-arid lands of Kenya.

Beneficiaries reached: At the end of the 3 years, World Vision reached 20,767 children under five years and 9,983 pregnant and lactating women with outpatient therapeutic and supplementary feeding programmes for treatment of acute malnutrition.

Expected outcomes for social accountability in the project

Citizen Voice Action (CVA), local level advocacy implementation was contributing to one of four project outputs on 'strengthened management and support systems at county level to provide and scale up quality nutritional services'. The indicators to measure this were on proportion of county health budgets allocated for the arid and semi- arid lands and counties with joint government MoH/ partner nutrition workplans and their implementation progress reports

[1] Wasting refers to acute malnutrition. It presents as low weight for height or thinness and is expressed in standard deviation

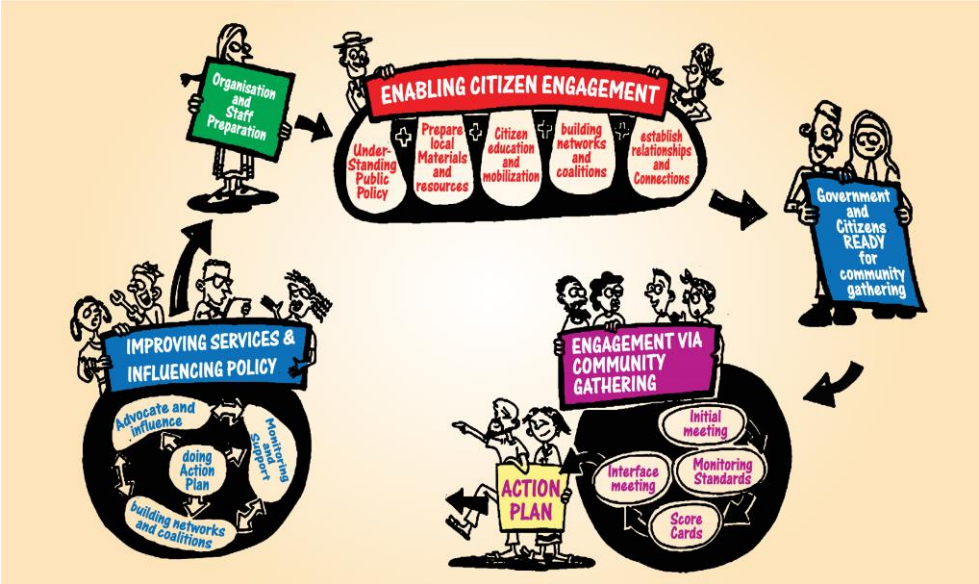
[2] Severe acute malnutrition refers to wasting <-3SD and moderate acute malnutrition is <-2SD

What is the 'Citizen's Voice and Action' approach to social accountability

Citizen Voice and Action (*CVA*) is a social accountability and local level advocacy methodology that aims to address inadequate essential services by improving the relationship between communities and government and empowering communities to hold government to account.

CVA facilitates the transformation of the relationships between citizens, government (civil servants and elected officials), and service providers (like nurses, doctors, principals and teachers) so that everyone in the community can work together towards the well-being of children. CVA works by first informing citizens about their rights and then equipping them with a set of tools, designed to empower them to engage in local advocacy to protect and enforce those rights. First, communities learn about basic human and child rights, and how these rights are expressed under local law. Next, communities work collaboratively with government and service providers to compare reality against their government's own commitments. Communities also have the opportunity to rate government performance against criteria that they themselves generate. Finally, communities work with other stakeholders to influence decision-makers to improve services, using a simple set of advocacy tools.

Here below is a graphic presentation of the standard CVA process in practice.



Summary of main activities carried out during CVA implementation

- **Training on CVA:** 11 staff from the ENSURE partner organisations i.e. World Vision Kenya (WVK), Islamic Relief Kenya (IRK), International Rescue Committee (IRC) and Save the Children (SCI) in Nairobi. These staff were the CVA trainers and supervisors to support county level roll out and implementation.
- **Formation and training of CVA groups:** CVA groups were constituted from existing community health volunteer groups which are locally called community units under the government community health structure.
- **Social audits** on health worker staffing followed by lobbying for deployment of qualified health workers in 5 health facilities
- **Budget analysis** and lobbying for increased budget allocation for nutrition related activities
- **Community dialogue and action days** to demand for increased reach with specific interventions such as integrated outreaches, nutrition surveillance, improved latrine coverage, sensitization on roll out of micro- nutrient powders.

Purpose of Case Study Research

The purpose of this case study was to document the process of implementing CVA in the ENSURE project, assessing how that process was aligned to the standard CVA implementation process. The purpose was to increase understanding of the process and examine results. Of importance, was to document any contextual factors that were made considering the project was humanitarian in nature and in a remote marginalised community.

> **Highlight on nutrition advocacy work in the national office:** World Vision Kenya is a member of the government led national nutrition technical working group at and works with nutrition stakeholders in the counties to develop county level nutrition action plans. World Vision in partnership with other organizations under the Scaling Up Nutrition (SUN) Alliance in Kenya is advocating for the adopting and full implementation of the action plans at the county and Local level. This includes providing technical support to government officials in planning for nutrition interventions in the counties.
>
> World Vision Kenya implements Citizens Voice and Action approach for local level advocacy for nutrition at county level including Turkana, Baringo, Samburu, Migori and Kitui. ENSURE was the first of WV Kenya standalone nutrition project to implement CVA which provided a good learning opportunity for how CVA can be implemented in a project of that nature. Most of the previous CVA programming was for integrated health and nutrition projects. Furthermore, Turkana county where the project was implemented is a marginalised, remote and resource- constrained context.

The Specific objectives for the documentation were;

1. Document the activities that were implemented to empower communities to demand quality health and nutrition services
2. Map out the implementation journey and its key milestones and assess how that aligned the standard CVA implementation process
4. Document experiences in terms of successes, lessons learnt and challenges from WV Kenya staff and the other project consortium partners who implemented CVA
3. Document the intended and unintended results of CVA implementation in the project
5. Make recommendations for future CVA documentation and research

The case study method

Project proposal, reports and CVA specific reports were reviewed to inform drafting of the terms of reference for the case study and development of data collection tools. The same project documents were key sources of secondary data. Primary data was collected through 9 key informant interviews with 5 ENSURE project staff[3], 1 Turkana county government staff, 2 MoH staff in Turkana and 1 DFID staff in Nairobi in addition to 3 focus group discussions with CVA groups in Turkana (see annex).

[3] Four staff from World Vision and one from Islamic Relief Kenya

The CVA Journey in ENSURE								
Activities	Nov 2012- Jan 2013: Preparatory stages and sensitization on CVA	Feb- April 2013: Training of ENSURE partners staff- WVK, IRC, SCI, IRK in Nairobi Training of WV and IRC staff in Turkana County and Community sensitization Formation of 5 CVA groups in Turkana	May- July 2013: CVA groups formally asked county government to allocate budget for community health strategy and environmental services	Aug- Nov 2013: USD 400,000 is allocated for community health strategy and environmental services	Nov2013-April 2014: Community dialogues and action days. CVA groups meeting with health management teams to raise key issues including increases in diarrhoea cases, low case finding for malnutrition, lack of qualified health workers in health facilities, poor practices and services i.e. handwashing, low latrine coverage, lack of MUAC tapes	May – Jul 2014: CVA groups submit social audit report to the County Chief Officer of Health. Asked for posting of qualified staff to the 5 health facilities CVA groups conducted social audits n staffing in 5 health facilities		
Alignment to CVA steps	Organization and staff preparation + enabling citizen engagement		Citizen engagement + Engagement via community dialogue and social audits + action plan					
Activities	Aug- Oct 2014: Use of social audit report to influence county government to post health workers to the five health facilities	Nov'14- Jan2015: Use of social audit report to influence county government to post health workers to the 5 health facilities Community Accountability dialogues in Turkana on need for integrated outreaches	Follow up on health staffing agenda- Namukuse CVA group submitted a memorandum report on health staffing - County government recruited 306 health workers	Feb- April 2015: Follow up on utilization of the USD 40,000 budget allocated to nutrition County government sponsors and organises first hygiene and sanitation advocacy forum. As immediate follow up actions, government purchased 200 bicycles and 8 motorcycles to facilitate community health service. 30 wards with worst latrine coverage were identified and sensitized on community led-total sanitation	May- July 2015: WV and Transparency International jointly held a community dialogue in Nadoto and Katilu to discuss rights to water and high standard of hygiene.	Aug- Oct 2015: CVA group at Katilu health centre s lobby ward administrator, area chief and the member of County Assembly for additional staff	Nov2015- Jan2016: Refresher training for CVA groups as part of exit strategy as project end
Alignment to CVA steps	Engagement via community dialogue and social audits + action plans			Improvement of services	Engagement via community dialogue and social audits + action plans		Staff preparation	

Discussion of Key Findings and Results

Results at project outcome level

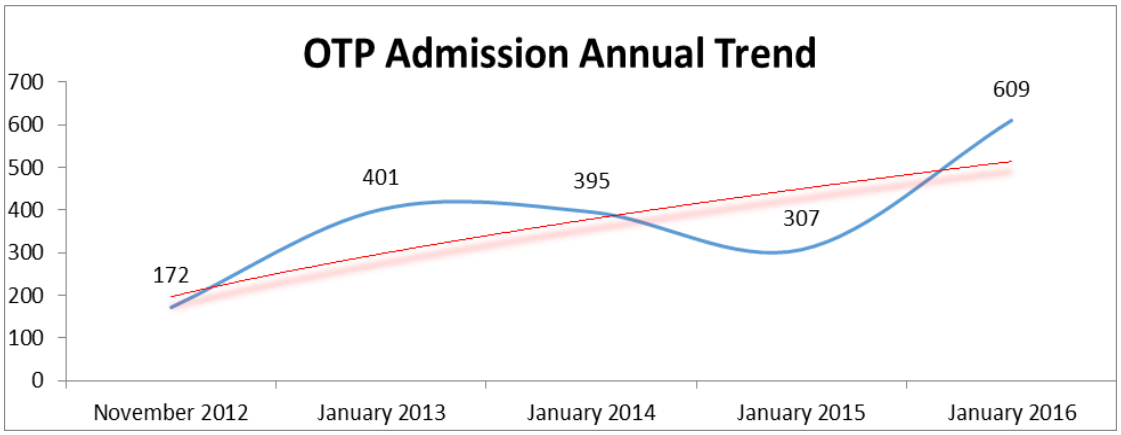
CVA influence resulted in increases in the number of health workers, improved physical access to services and increased resources for community health services and increase in awareness on health and nutrition rights contributing to increased demand and uptake of nutrition services.

It is however important to mention that although there are strong explanations of how CVA influenced change, it is not possible to make direct attribution to that change. This report therefore presents results that CVA would have contributed towards alongside other complementary efforts by ENSURE and other partners.

Uptake of nutrition services for prevention and treatment of acute malnutrition

Outpatient Therapeutic Programme (OTP): Over the three years' project period, the number of severely malnourished children receiving treatment in outpatient therapeutic programme (OTP) increased by 72% from 172 to 609 as shown in figure3 below. In a context like Turkana where wasting is persistently high, it is essential to ensure that malnourished children and those at risk are identified at community level, referred and enrolled in treatment programmes within the health system. As will be reported later in this report, CVA intervention influenced the number of health workers and infrastructure to deliver health and nutrition services.

Figure3: Children with severe acute malnutrition treated in OTP



Although OTP admissions over the 3 years project period correspond to the overall trend of acute malnutrition over the same time, ensuring the continuity of OTP services is crucial to prevent death. Severely malnourished children have an increased risk of death than well-nourished children but those deaths can be prevented when there are well performing services in place.

Supplementary feeding programme (SFP): Children with moderate acute malnutrition and malnourished pregnant and lactating women were enrolled in the programme for treatment and to prevent further deterioration of their nutritional status. A total of 14, 872 children under five years with moderate acute malnutrition were admitted over the 3 years of the project life.

Program coverage: In addition to the OTP and SFP reach as presented above by the number of children admitted in the programme, coverage surveys provide an estimation of the need by a CMAM intervention. The Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) methodology was used to assess the coverage for acute malnutrition in Turkana County. The coverage for severe acute malnutrition ranged from 55.6% in Turkana South Turkana South (57.3%) Turkana East (54.2%) while for moderate acute malnutrition the coverage ranged from 51.3% in Turkana Central, Turkana South (57.1%) and Turkana East (51.1%).

Results at project output level

1. Capacity Building of ENSURE NGO Staff, and government stakeholders

The project made achievements in increasing capacity of the project staff and government workers on social accountability for nutrition by starting off with a training of trainers, followed by cascaded trainings for frontline staff at county levels and eventually to CVA groups at health facility levels. The government staff were drawn from the public health and community services departments which are responsible for delivery of primary health care nutrition services. The WV and MoH staff trained five CVA groups of 10 members each in Turkana Central, South and East sub counties. The training modules covered the CVA approach and exposed the participants to relevant content on the Constitution of Kenya 2010, National government Health Sector Strategic and Development plans, Norms and Standards for Health Service Delivery and National Patients' Rights Charter 2013.

2. Community awareness raised on rights and public service delivery standards for nutrition and health services

Through sensitization, training on CVA and community mobilization, there was increased awareness among communities on their rights to health/ nutrition, gaps in health worker staffing especially inadequate staff at night in health centres, long distances to health facilities and limited support for community health units. The CVA groups were trained on the Kenya constitution 2010 and its article 43 which states that every person has the right to among others (a) the highest attainable standard of health, which includes the right to health care services, including reproductive health care; (b) accessible and adequate housing, and to reasonable standards of sanitation; (c) be free from hunger, and to have adequate food of acceptable quality; (d) clean and safe water in adequate quantities

After the trainings, CVA groups held quarterly **Community dialogue and interface meetings with leaders** to highlight issues that required action like stock outs of drugs, anthropometric equipment, vitamin A, Iron and Folate, poor latrine coverage and poor handwashing practices due to limited access to water. The groups would particularly review nutrition indicators in MoH health information system tools, and identify areas that require attention for community dialogue.

One important new nutrition intervention during this project period was roll out of multiple micronutrient powders (MNPs) supplementation for children 6-23months which required extensive community sensitization to promote uptake. CVA groups played a critical role in sensitizing communities through their leaders on what the MNPs were clear any misconceptions about them being harmful to children, address challenges of stock outs and expiry dates.

Raising awareness on rights and standards was empowering for both the CVA process and communities themselves to engage in development processes.

> **Advocacy with** local **member of county assembly**: The CVA groups increased awareness with communities on their rights for services. For example, in Kawalase the community demanded for increased clean water for household consumption with the local Member of County assembly resulting into construction of a water kiosk in Ilosenget village. The CVA group engaged the community, the County Management who raised the issue with the local water board, Lodwar Water and Sewerage Company(LOWASCO) and demanded for action.

3. Increased influence on health staff deployment

A key activity for CVA under ENSURE project was to undertake social audits in six health facilities and use the findings to demand for more qualified staffing to be posted there. World Vision supported five CVA groups to conduct social audits of the health worker staffing situation in six health facilities

namely: Katilu health centre, Lodwar County Referral hospital and Lopur, Namukuse, and Lokwii dispensaries. The groups were trained on conducting social audits and developed tools based on existing government norms and standards for health service delivery of health centres and dispensaries[4]. Key documents that informed the audit and dialogue processes included; the Constitution of Kenya 2010, National Health Sector Strategic Plans, Norms and Standards for Health Service Delivery for 2006, Turkana County Integrated Development Plan, and the National Patients' Rights Charter 2013.

CVA groups carried out the audits in collaboration with the health facility staff, area chiefs and ward administrators[5] . The audit results depicted an acutely under staffed health system with a 45% gap as shown in the table below. An understaffing situation like this has negative consequences of poor service delivery and uptake related to factors like long waiting times, overworked health workers especially in health centres, compromised quality service to patients and reduced capacity of health workers to engage in community preventive services among others. These factors directly impact negatively on the quality and standard of health care delivery. For example, the one nurse in Lokwii health centre at the time of the social audit was responsible for overall management and coordination, service delivery, community health including defaulter tracing, immunization and mobilization. Being the only staff, they attend to emergencies at night in addition to working during the day.

Health Facility	Staffing standard	Staff available	Staffing gaps
Lowdar county hospital	112	82	30
Lokwii health centre	24	1	23
Lopur dispensary	4	1	3
Katilu health centre	24	8	16
Namukuse dispensary	4	0	4
Total	168	92	**76**
% staffing	100%	55%	45%

To address situations like the one observed in Lokwii health centre, CVA groups presented their social audit findings for discussion with the community members, chiefs and ward administrators in an organised community accountability dialogue.

Based on the findings, the CVA groups made recommendations to the county government to;

- develop a staffing work plan agreed upon with the community members, health facility management committee and the facility health workers.

[4] chrome-extension://oemmndcbldboiebfnladdacbdfmadadm/http://www.health.go.ke/wp-content/uploads/2015/09/16th%20october%20WHO%20Norms%20and%20Standarnds%20%20Book.pdf Accessed on 10th May 2017

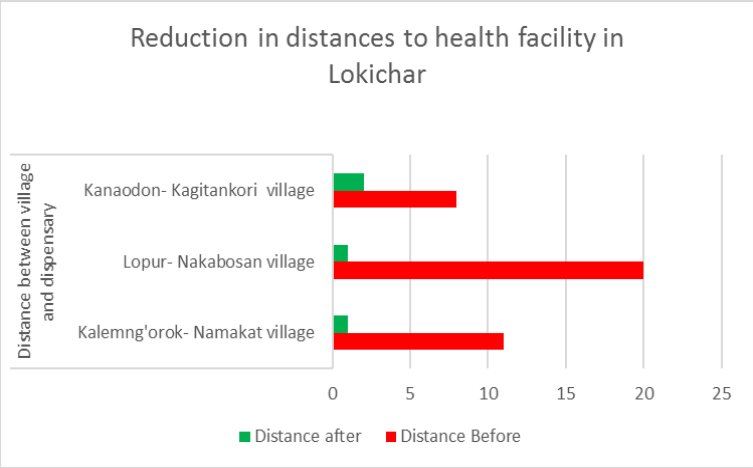
[5] The local political leader at ward level who oversees an area composed of several villages

- prioritize these health facilities for deployment of health workers during the county wide recruitment exercise.
- facilitate communities to come up with a monitoring work plan to track the progress.
- develop a memorandum of understanding with the five communities on how to employ qualified personnel to address the existing gaps.

The CVA social audits were complemented by the county government assessment of the human resource need in the financial year 2013/14 which identified a gap of 2000 health workers in the entire county. Through the process of engaging the county leaders through community dialogues and meetings, CVA accelerated influence for the recruitment of health workers in the five health facilities. Between 2013 and 2015 the county recruited 309 health workers with 98 of them posted to the five health facilities. At the time of this documentation, the county was planning the next deployment of 30 more health workers across the county.

4. Infrastructure Improvements

CVA influenced the construction of three health facilities reducing distances that communities travel to access health and nutrition services as shown in the graph below. *Figure4*



Examples from 3 communities point to CVA contribution towards improved service delivery.

a) The CVA group in Katilu advocated for construction of a new health facility so that residents of Namat village will have a health facility nearer than the 11kms they travelled to the nearest Kalemng'orok Dispensary. They succeeded to have a facility constructed at 1km from the village.
b) The closest health facilities to Nakabosan village were Lopur Dispensary and Lokichar health centre which are 20Kms and 19Kms away respectively. Their advocated resulted in the construction of a static health facility built less than 1km from the village and a qualified nurse was posted. They further advocated for construction of water tank at the dispensary which was facing serious water shortages.
c) The community from Kagitankori village had to travel 8km to the nearest Kanaodon Dispensary. Through CVA influence, a health facility was constructed at less than 2Kms from the village.

In addition to increased number of health facilities constructed, CVA groups demanded for mobile outreach sites for communities far from any static health facility where they can access services. These outreach sites would bring closer for treatment of severe acute malnutrition through outpatient therapeutic program and other integrated mother and child services.

6. Changes in service delivery practices and behaviour

Reduced absenteeism by health workers and waiting time at health facilities were two practice issues that recorded improvements due to citizen participation in service delivery monitoring. As a result of these issues raised by the CVA group in Katilu, a local youth group utilised whatsapp platform for Turkana South professional which is called '*Tukuza- Wasomi wa Turkana'* to report cases of absenteeism and long waiting times at the local health facility. The professional's group includes MoH county and sub- county senior staff and managers who would act on the issues raised. This effort was received positively by the health facility staff because it helped to effectively escalate the challenges they faced regularly at the facility.

Additionalities: Whilst the CVA groups were set up to carry out social accountability directed towards government services, the process empowered them to monitor nutrition services by other non- government actors like World Vision Kenya. They used other accountability platforms like the Integrated Complaints Referral Mechanism called *Uajibikaji Pamoja* implemented by Transparency International with seven other NGOs to demand for action on issues. One of the World Vision nutrition project staff said ''they (the CVA groups) were keeping us on our toes' by demanding for specific services. For example, the CVA group in Lolupe village sent a message to the Uajibikaji Pamoja online platform asking why WV was not providing mobile outreach services to communities around Nayuu dispensary. With this public question, WV provided a response explaining that the government had set up a static health facility to serve that community and therefore it wasn't reasonable to run a mobile health outreach service in the same community''.

5. Increased public participation in the county finance management process

Following three years of CVA introduction in the county, there are observable changes in accountability practice and culture. From the demand side, communities gained more knowledge on their rights for health and nutrition as stipulated in the Kenya constitution, they were more aware of norms and standards as well as service charters. The knowledge and awareness empowered them to engage in community dialogues with their leaders.

On the supply side of service delivery and governance, CVA provided a systematic approach for meaningful participation of communities in the county planning and budget making processes. CVA groups participated in the sub - county public forums to input into the annual budget processes.

As a result of the 3 years engagement, CVA groups are recognised as organised community advocacy groups and are formally invited through the ward admin to participate in county planning processes every year.

Complementary activities: ENSURE partners complemented CVA efforts through lobbying of political leaders for funding of the county nutrition action plan and creating of a budget line for nutrition. WVK, IRC and SCI engaged in focussed roundtable meetings with MCAs. They used tactics of working with MCAs who had a special interest in health and nutrition, and were consistent with their advocacy with their messages and call for action. In 2013/ 2014 they held up to 5 lobbying meetings with MCAs, efforts which were thought to have contributed to increasing awareness on the need to increase nutrition funding over time. At the time of this documentation, August 2016, county health budget was 1.9billion which was an increase from 1.2 billion in 2015/16. Of that 2015/16 health budget, nutrition allocation was 17% of it and there was an explicit nutrition budget line.

Kawalase CVA group engaged with the county planning and budget making process in the year 2013/2014. Their objective was to advocate for increased funding for nutrition and related sectors. WV approached the clerk of the county assembly to get a copy of the proposed budget for 2014/ 2015 which the CVA group analysed. Based on the analysis, the group prioritized community strategy and environmental health as two sectors that required funding for preventive services and prepared a memorandum submission to the county budget and appropriation committee. The memorandum submission which was signed by all the CVA members had a budgetary allocation ask of was Ksh30million for community strategy and Ksh10million of environmental preventive health services respectively. The submission was delivered and received by the chair of the county budget and appropriations committee during a public participation forum. The submission outlined the role of these preventive health services and why it was important to fund them as they had not been funded in the past. The submission itself raised awareness of the county legislators on the role of these sectors beyond funding of Community Health Extension Workers (CHEWs) positions which they were more familiar with.

The MoH point person for community strategy present in the meeting said ''the MCAs hadn't until this time understood the role community health volunteers played within the community strategy and how they work alongside the CHEW. By having the CVA groups present in the budget meeting was useful. It was the first time the CHVs participated in the process and community strategy was funded.'' There was benefit in bringing the community voice into the discussion rather than have the MoH technical people advocate for the funding. The two sectors were funded to the tune of Ksh10 million and Ksh5million respectively in the 2014/2015 financial year. From this total, each community volunteer unit received Ksh20, 000 (about $200) as seed funding to facilitate their formal registration and enable them to initiate income generating ventures to sustain them. The other funding was allocated for assessment of the functionality of community strategy which is critical to improve their services.

Enablers of success and Points of Learning

Several factors were noted to have provided an enabling environment to the citizens social accountability and local level advocacy efforts.

- Existence of government service charters provided a good starting point for CVA groups to engage around standards for services. The MOH service charter is a statement of intent to its clients and customers, which defines the ministry's, core functions, services offered, commitments, obligations, customer's rights and obligations, mechanisms for complaint and redress for any dissatisfied customers.
- Decentralization of health services from national to county governments took effect in 2013 increased the possibility for citizens to interact with key decision makers:
    - The County governments have the responsibility to recruit for health workers based on their need and no longer rely on national government to deploy staff. The place of CVA voice is becoming stronger and stronger with the passing of the county government act 2012 clause 87 that provide framework for citizen participation. It empowers the Citizens to petition the county government on any matter under the responsibility of the county government.

- County governments now make decisions on budget allocation to different sectors. In 2014/15 financial year, the county government allocated the largest budget to health sector, Ksh2.1 billion of the County's Ksh9.4 billion which represents 22% of total budget[6].

- Forming CVA groups from within existing community health committees proved effective because the members were already interested and engaged in the issues. This finding confirms observations from Mandera county where IRK noted that CVA groups which had not previously participated in health and nutrition activities required more training on basic health and nutrition knowledge to grasp the role of CVA within the delivery of those services. *The Lopur CVA group said 'we have community issues at heart; we face the same challenges the community faces like shortage of staff. That motivates us to be the local advocates'. For example, the CVA group presented a case of a village where children as old as 6 years hadn't been immunized at all asking for urgent action from the MoH to bring immunization services to that community by constructing a local health facility.* The CVA process added value in providing tools, methods and skills for monitoring, community engagement and action planning. CVA groups developed skills in presenting the needs of communities in very clear compelling messages that resonated with decision makers
- Having in place a CVA capacity building plan: Training a pool of ToTs enabled effective decentralization of training to the counties where the projects were implemented. Further all the five CVA groups received refresher trainings and ongoing coaching from the project public health nutrition officer who was the CVA lead for the project.
- Commitment from local community leaders and relevant service providers ensured a good loop of social accountability. The local area chief, nurse- in- charge and the MoH public health officer and CVA groups established a mutual collaboration which enabled smooth community dialogue and action planning process as well as further escalation of issues of concern to the county government officials in Lowdar.

Blockers and Challenges

- Due to limited past exposure to social accountability, communities didn't want to come up to raise issues for fear of victimization by their leaders. However, with CVA sensitization and awareness raising communities appreciated the role CVA groups played through participation in in development and service delivery and not 'policing' of service providers.
- Literacy levels affected the uptake of CVA trainings and subsequent implementation. Some of the CVA members needed materials that were translated to local Turkana language which led to reconstitution of the group to include more members who could speak Swahili. The CVA group members in Kawalase which is in the county headquarters were more literate and received closer coaching from the project
- Transfers of MoH staff who were CVA trainers affected roll out and in the end WV staff had to do most of the sub- county trainings.
- Stock out of some essential drugs and supplies was a limitation to meeting the demand for services created by CVA. For example, there was an increase in demand for delivery at Lopur health facility but the facility still lacked a delivery room and there was no privacy in the delivery area at the facility.

[6] http://www.nation.co.ke/counties/Turkana-County-Budget-Health-Education/-/1107872/2368946/-/714xoi/-/index.html

- After the project closure, the groups felt like they hit an advocacy ceiling without a WV staff to link them up to the county level to advocate with the higher-level government leaders. ''Our voice is limited to local community and administration gatherings commonly known as barazas'', they reported.
- Although not reported in the Turkana context which was the primary focus for this case study, IRK reported insecurity in Mandera as a challenge that affected coaching of one of the CVAs group in Lafey area. Beyond the initial three days training IRK couldn't visit the site for further training and support and as a result the group didn't take off. Considering parts of Turkana face sporadic insecurity, this is an important factor to consider in the future.
- Diverse political interests in allocation of resource allocation: In 2015 a dispensary nurse from represented the CVA group at the County Assembly planning meeting to advocate for the construction of a health facility. The group request was honoured at that the time but later the funds were diverted to construct a health facility in a different location which was less needy. At the time of this documentation, the CVA and the nurse were still advocating for the funds to be used for the initial purpose which was to construct the health facility in their location.

Complementary learning and improvement points based on this case study and other experiences

- There is an opportunity for CVA groups to participate in county planning to present the needs for nutrition to be included in the plan during the budgeting process. As the groups demonstrated potential to engage with the district health information system, their capacity can be enhanced to utilise that relevant DHIS nutrition tools to filter the issues that require more focus or need to be prioritised during the budgeting process. Specifically, nutrition- sensitive interventions by agriculture including vegetable and fruit gardening, and promotion of improved small livestock generally not budgeted for by the government with the assumption that NGO partners will fund them.
- As has been presented above, CVA made important contribution into the health system and to specific sectors like the community strategy which deliver nutrition services. However, more could be done to focus some advocacy efforts towards poorly performing nutrition indicators with the overall goal to improve nutrition status. As noted earlier, use of the MoH DHIS community tools could provide the evidence on performance of specific indicators. The use of the DHIS could as well be a starting point for selection of priority communities to implement CVA as a boost to improving the enabling environment.
- Besides the logistical challenges earlier noted the groups had hit 'an advocacy ceiling'. After project closure they lacked the necessary technical support they previously received from WVK in drafting advocacy submission papers and the link to present them in county- public participation fora. Their advocacy is now limited to sub- county and ward levels.
- Explore the potential of youth involvement through social media to amplify the community voice. CVA groups demonstrated the potential using WhatsApp messaging to raise issues to the elite group resulting in quick action. In addition, explore linking CVA with other beneficiary feedback and social accountability mechanisms like the community help desk and WVK hotline that were implemented in Turkana.
- Establish a mechanism for CVA groups to be self- reliant like initiating income generating activities. That way they can run some of their activities without being entirely being dependent on external project funding. The Kawalase group initiated an income activity and this could be extended to other groups to sustain themselves after project closure. During this documentation,

which was seven months after the project closed, three of the five CVA groups still existed. Although they were not actively implementing typical CVA activities, they were recognised as the local advocacy groups and were an entry point for community participation during government planning processes. They however lacked the necessary financial resources to run their day to day plans.

Recommendations for future CVA documentation and research

- Considering nutrition is implemented within a wider health service delivery system, future studies could seek to understand the role CVA plays in the service delivery environment for other MNCH when it is implemented in a nutrition focused project.
- Rigorous studies to estimate the contribution social accountability and CVA has made in improving nutrition outcomes
- Project staff recommended the need to investigate and document the key factors behind success of some of the CVA groups while some groups didn't perform well although all benefited from the same training and roll out support by the project.

Annex: List Key Informant Interviews and Focus Group Discussions

Focus Groups Discussions	Katilu Health Centre CVA group
	Lopur dispensary CVA group + MoH Community Health Extension Worker
	Kawalese CVA group + 2 MoH Community Health Extension Workers
Key Informant Interviews	Government 1. Chief Health Officer- Turkana County Office 2. Community Health Strategy focal point- MoH Turkana 3. Turkana Central sub- county head of Disease Surveillance- MoH
	ENSURE project staff 4. Public Health Nutrition Officer- CVA focal point- WVK 5. Nutrition Officer in charge of Turkana South- WVK 6. Nutrition Officer in charge of Turkana Central- WVK 7. Nutrition Officer in charge of East- WVK 8. Community Liaison Officer in Mandera - Islamic Relief Kenya
	Donor 9. DFID focal point for ENSURE based in Nairobi