WORKSHOP REPORT

DISSEMINATION MEETINGS FOR CAPACITY DEVELOPMENT FOR NUTRITION IN KENYA, UGANDA AND TANZANIA

9 – 17 November 2017

VENUE:
Kenya (Safari Park Hotel)
Uganda (Protea Hotel)
Tanzania
(Julius Nyerere International Conference Centre)

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1.0 INTRODUCTION

1.1 Background

Despite improvement in many health indicators over the last decade, there has been limited progress in improving the nutritional status of children and women in Tanzania, Kenya and Uganda. The loss of human capital associated with malnutrition has been estimated to cost 2-3 per cent of GDP annually while productivity losses to individuals are estimated at more than 10 percent of lifetime earnings. All three countries have high levels of stunting, 34 percent in Tanzania, 29 percent in Uganda and 26 percent in Kenya, which suggest an urgent need to address chronic malnutrition. The Governments of Tanzania, Kenya and Uganda have joined the global Scaling Up Nutrition (SUN) movement and have pledged to scale up the delivery of globally recognized high impact, cost effective nutrition interventions.

One of the main challenges for scaling up nutrition interventions is the lack of technical capacity of front line workers who are not trained or knowledgeable on the "what" and the "how" to deliver key nutrition interventions. Nutrition is a multi-sectoral issue requiring joint actions. Key interventions must be provided at health facility level while the promotion of key behaviors, such as good infant and young child feeding and caring practices, must be followed up with action at the community level across sectors. The capacity assessments of the nutrition workforces in Kenya, Tanzania and Uganda (conducted by Helen Keller International in partnership with the World Bank, UNICEF, and others in 2011) found that insufficient knowledge and practical experience of front line workers is a major barrier to implementing nutrition interventions at both health facility and community level in all three countries. Health and community level workers lack both the knowledge on "what" to deliver, but also on "how" to deliver such services, particular in resource and capacity constraint environments.

To address the mentioned capacity gaps, ECSA Health Community with the support from the World Bank implements a capacity development project for front line workers in Kenya, Tanzania and Uganda. Through the project, ECSA-HC has developed streamlined and harmonized nutrition focused model curricula for pre-service and in-service training packages for facility and community based frontline workers including community health workers/ volunteers, auxiliary cadres, nurses and midwives. In addition, ECSA-HC has produced the report to highlight the economic and social relevance of scaling up nutrition competences of front line workers in the region.

1.2 Purpose

1.2.1 General Objective

The main objective of the meeting is to disseminate the developed regional nutrition in -service packages, pre-service model curriculum and related advocacy tools to country stakeholders. The findings from social return on investment on scaling up nutrition competencies of front line workers was also discussed.

1.2.2 Specific Objective

The workshop achieved the following objectives:

1. Provided opportunity for key stakeholders to listen, critique and give feedback on the findings of Social Return on Investment (SROI) on scaling up nutrition competencies of front line workers for Kenya, Uganda and Tanzania

2. Key stakeholders had opportunity to listen to progress made so far on the adoption and dissemination plans previously developed for purposes of review and improvements considering frequently changing situation and governance structure.
3. Allowed the stakeholders appreciate the development of the project and the process towards development of the products intended for dissemination.
4. Disseminated all the products developed by ECSA to enhance capacity development for nutrition in Kenya, Uganda and Tanzania.
5. Developed a final action plan to guide the implementation, monitoring and evaluation impact of the project in Kenya, Uganda and Tanzania

2.0 METHODOLOGY AND APPROACHES

2.1 Approach

The proceedings of the workshop were guided and moderated through discussions in such a way that effectively and efficiently attained the intended objectives. The meeting activities included presentations, group discussions and plenary sessions. Participants engaged though group guided discussions using feedback and consensus building.

2.2 The Meeting Agenda

The agenda of the meeting was planned within two days' timeframe across Kenya, Uganda and Tanzania with inception meetings in Tanzania and Uganda to have a common understanding on the delivery approaches. The inception meeting involved ECSA project team, SROI technical team from University of Dar es Salaam department of Economic, Facilitator and focal persons from Nutrition Unit/Departments of the MOH.

The main sub-agenda of the meeting was to review the workshop programme for a common understanding. A visual presentation was made on the two-day workshop programme for each Country. The meeting finally agreed on the following areas as being critical for success of the workshop.

i. The feedback session on SROI and MOH presentation on progress made toward adoption plan would include open forum question-answer session, group discussions and plenary.
ii. Primary stakeholder who participated in the SROI evaluation exercise be part of the dissemination team for purposes of validation.

In general, the first day of the workshop across the three countries focused on presentation of Social Return on Investment study where stakeholder had an opportunity to critique the report with a purpose of value addition. Each country team had the opportunity to present the status of the adoption and dissemination plans which were developed in May and update on the progress. With the help of facilitator through positive critique the team had an opportunity to enrich the plan.

The second day focused more on dissemination event, beginning with the background of the project and the process towards development of the products followed by presentation of the products to the guest of honor and other key stakeholders. Open guided discussion session was allowed for participants who suggest the way forward on adoption and utilization of the documents.
(*See Programme Agenda in Annex 1*)

3.0 WORSHOP PROCEEDINGS

3.1 Workshop Preliminaries

The meeting was kicked off by introduction of participants led by Ms. Doreen Marandu from ECSA-HC. The Manager of NCDs, Food Security and Nutrition of programme Ms. Rosemary Mwaisaka gave brief on the Malnutrition status of the Eastern, Central and Southern Africa and re-affirmed the need to emphasize on Human Resource Capacity Development with a focus on frontline health workers. She also welcomes all the participants to the dissemination meeting. The Ministry of Health focal persons in Tanzania, Uganda and Kenya welcomed all the participants and emphasized to participants on the need to intervene on nutrition matters at community level if Scaling up is to be achieved. In Tanzania this message was passed by Dr. Vincent Assey who is acting Director for Tanzania Food and Nutrition Centre.

In Uganda, Prof. Anthony Mbonye gave his welcome remarks that focused on nutrition agenda in Uganda. The remarks re-affirmed the interest in the subject of nutrition and Capacity building of health workers. Other areas of emphasis included maternal and child health, the double burden of diseases, alarming statistics on negative indicators of nutrition status, knowledge and skills, stunting in relation to negative performance and emphasis on nutrition sensitive issues including safety and hygiene. Finally, he applauded ESCA-HC for the good efforts towards nutrition Capacity Strengthening. There was a common understanding on effective service delivery which can only be possible through Capacity Development of frontline cadres. The facilitators stepped in thereafter to re-state the workshop objectives and lead the workshop business as planned.

3.2 Proceedings on SROI Study

The study was introduced by the technical team from the University of Dar es Salaam; department of Economics who were the main consultants for ECSA SROI study for capacity development for nutrition in Kenya, Uganda and Tanzania. Critical outline of the presentation focused on Introduction & Background, methodology, establishing Scope, stakeholders' Mapping, financial proxies, results and conclusion.

3.2.1 Introduction and Background Highlights of the Problem

This section highlighted that 45% (approximately 1.3 million) of infant and child mortality worldwide emanate from poor nutrition. Nutrition status and its impact vary substantially among the three core economies of East Africa. In Uganda (HBS, 2016), one in three women aged 15-49 (32%) are anemic, 53% of children aged 6-59months suffered from some degree of anemia, 33% of children under 5 years of age in Uganda were vitamin A deficient (National Nutrition Guideline for Uganda). In Kenya (DHS 2014), 26% of children under age 5 are stunted, 4% are wasted, and 11% are underweight, 61% of children less than age 6 months are exclusively breastfed and 33% of women are either overweight or obese (BMI ≥25 kg/m2). Tanzania (DHS, 2016) on the other hand has one in three children under five are stunted, 14% of children are underweight or too thin for their age, 58% and 45% of children and women respectively are anaemic.

Lack of specialized workers (Nutritionist), competent and well-trained frontline workers contribute to the nutrition deficiencies across the three Countries. There appears to be absence of relevant competencies on nutrition at the frontline which is a barrier to scaling up nutrition interventions in EA (Hellen Keller international et al. 2011). However, despite efforts by Governments and other stakeholders there are few nutrition specialists deployed by both public and non-public sectors. The current effort by ECSA-HC is therefore essential, timely and necessitated a need for Social Return on

Investment (SROI) analysis to establish prospective return of implementation within the ECSA targeted Countries.

With this background the technical Capacity for Nutrition Programme was designed for three countries aimed at strengthen the ability of the Governments to build the capacity of their front-line workers for the delivery of essential nutrition interventions at health facilities and community level. The programme had three components spelled out which included *building capacity for in-service training on nutrition for community and health workers*. This aimed at supporting development of two in-service nutrition training programmes, one for health facility workers and one for community based workers. Intention was to ensure availability of comprehensive in-service nutrition training packages for health facility workers and community workers. The second aspects focused on *building capacity for pre-service training on nutrition for health workers.* This was to improve the ability of countries to include relevant and high-quality training on nutrition in the pre-service training curricula of the various cadres of health workers. Finally, the third component focused on *knowledge exchanges and advocacy for curricula development and adoption.*

3.2.2 SROI methods

The presentation highlighted that the assignment took four months beginning from 1st of July, 2017 and progressing with close coordination of ECSA team and Ministry of Health Focal Person in three countries. In order to establish the SROI values of the intervention, the team developed a conceptual framework including key assumptions, which informed the process of firming up the theory of change. The preliminary scoping interviews with one of the focal persons in Tanzania were conducted to perfect analytical framework. The scoping exercise assisted in understanding the nature of nutrition trainings and possible attribution issues since the team was informed of the existence of other stakeholders who have been undertaking nutrition trainings made to frontline line workers on specific topics.

The SROI analysis applied multi-methods which included Qualitative interview mainly Focus Group Discussions (FGDs) with community members and Key Informant Interviews (KIIs) with frontline workers. Consultation and discussions, both formal and informal with other people deemed having important information regarding the development and adoption of ECSA's model curriculum was applied successfully. A questionnaire was also administered to frontline workers who could not be reached physically. Finally, desk reviews complemented the results obtained through approaches.

The presentation highlighted that due to limited time large, large sample to assess the willingness to pay by the community was not be feasible, thus the research opted to use the Value Game Technique to obtain the value the community attach to the services provided by the trained frontline workers. The Value Game approach show how stakeholders value the outcomes they expect to experience relative to other items they also value that have market place values (prices) attached.

It appeared that given the nature of intervention approach of this project, it was not easier to observe the true counterfactual, but the best the researchers did was to estimate it by constructing or mimicking it. Attempts were made to ensure that *deadweight* and *attribution effects* are estimated. Thus, the checklist included questions that investigated the extent of attribution of the project. The research process also discounted the stream of benefits to determine a discount rate and time horizon for discounting. Data collection began in Tanzania followed by physical visit in Uganda and due to political tensions, Kenya could not be physically visited during October 2017.

3.2.3 Establishing the Scope of Study

Establishment of Scope and identifying key stakeholders began with a meeting with the focal person in Tanzania and skype discussions with the ECSA-HC Team. The aim of this initial meeting and discussions was to deliberate further on the technical aspects of this task with a view of underpinning the objectives of the work, scope of work and understanding of key elements with regard to implementation of the project. In this case, preliminary mapping of the key stakeholders was drawn.

Additionally, all relevant materials and literatures with regard to the project were mobilized at this stage. Later on, a draft Inception Report was developed and presented to a one-day meeting in Arusha with the ECSA-HC Team. This meeting was useful at concretizing the methodology and list of stakeholders. At this stage, the decision to whether there is a need to include the final (primary) beneficiaries of the project outcome (i.e. people getting the services of the frontline workers) among the stakeholders in SROI analysis was made.

3.2.4 Stakeholder Mapping

The Scope, Stakeholder's mapping and decision-making framework captured possible Stakeholders who included ECSA-HC team; Line Ministries (health); Frontline workers; Community members or users of services; training institutions on nutrition; donor community; Nutritionist/Nutrition Officers/Dieticians who did not attend any of the trainings) all characterized by how do they or are affected by the project. Inclusion/Exclusion criteria and reason for inclusion/exclusion (Rationale) was applied. Method of Involvement (i.e. Interview, KII, FGD, Survey Questionnaire, Workshop, Call, Email) and implementation schedule were considered.

3.2.5 Assigning Financial Proxies

In attempts to obtain the impact per each outcome and stakeholder, the deadweight, displacement, attribution and drop off values were deducted from the financial proxy values. The research process attached the duration in each outcome and this assisted in estimating the Net Present Value (NPV) of the Impact using the following usual formula.

(1) $NPV = \sum_{i}^{n} \frac{\text{Im}\, pactvalue}{(1+r)^n} - inputs$ and,

(2) SROI=Present Value/Value of Inputs

(3) Net SROI=Net Present Value/Value of Inputs

3.2.6 Highlight on critical Results

The critical results in this study was analyzed based on pre-determined outcome. The study gave equal priority to both qualitative and quantitative findings.

3.2.6.1 Qualitative Findings

Outcome 3.1: Increased willingness of government and Donors to Fund Frontline Workers training on Nutrition

> "In Uganda and Tanzania there are few Nutritionists hence the governments are now planning for enhancing the nutrition training for frontline health workers. Plan are there in the countries to employ more people with nutrition knowledge. The countries have adopted the ECSA-HC Model curricula and currently are planning to use the updated manuals for trainings. There is

a very big support from the Governments and donors to support these initiatives" (Interview with Focal Persons in Tanzania and Uganda conducted at different sessions)

Outcome 4.1: Improved communication and practical skills of service delivery.

"The training improved frontline workers communication and practical skills. Before would think he/she knows everything but when we were subjected to practical tests we were surprised that despite our experience our final score was very low hence showing us the weaknesses in handling practical sessions. Thus, after that we have changed our approaches. One frontline worker said –Knowing so much about something is also dangerous as it reduces focus and ending up making mistakes hence the ECSA-HC Manual reminded us on being focused and simplified especially during the practical sessions" (Interview with Frontline Workers in Tanzania and Uganda conducted at different sessions)

3.2.6.2 Quantitative Findings

Highlights of quantitative results focused on all frontline workers (except one who indicated no response) who responded with 'no' to the question as to whether the changes would have occurred without ECSA training. *Deadweight* was established at 5% (except for the Ministries, ECSA and Training institutions). In the changes they experienced, the respondents were asked to give a percentage (%) which they perceived to be a result of ECSA efforts. The average (39%) from all responses formed the attribution factor of the intervention. There was no evidence of any activities displaced by ECSA and the displacement estimated at zero percent. Since the time period given for this analysis was projected to four years, the outcome was expected to be zero in the fourth year and in this case the drop-off was estimated at 25%.

Following the calculations, assumptions and the data given, the total value generated by the investment was USD 3,067,600. The study used a discount rate of 6% which is the average inflation rate across the three countries for September 2017. The Total Present Value for the project was USD 10,483,045 and the Net Present Value is USD 9,662,715. The SROI ratio was therefore USD 10,483,045/820,330 = USD 13: USD 1 which implied that for every dollar of investment in the ECSA Scaling up Nutrition Competency for Frontline Workers project, **USD 13** of social value was created. This information is detailed in the table 4 in the main report as indicated below.

Table 4: SROI Summary Findings

Stakeholders	The Outcomes	Impact	Calculating Social Return				
			Year 0	Year 1	Year 2	Year 3	Year 4
ECSA	Outcome 1.1. Increased recognition by development partners and Member states due to successful implementation of SP	341,613	341,613.15	341,613.15	256,209.87	192,157.40	144,118.05
Training Institutions	Outcome 2.1. Increased recognition by donors and students seeking more nutrition knowledge at higher level	-13,249	-13,249.26	-13,249.26	-9,936.95	-7,452.71	-5,589.53
Ministries	Outcome 3.1: Increased willingness of government and Donors to Fund Frontline Workers training on Nutrition	772,525	772,525.05	772,525.05	579,393.79	434,545.34	325,909.01
Frontline Workers	Outcome 4.1: Improved communication and practical skills of delivery the service	1,822,178	1,822,177.64	1,822,177.64	1,366,633.23	1,024,974.92	768,731.19
	Outcome 4.2: Increased willingness to work to Attend Nutrition Courses	12,775	12,775.18	12,775.18	9,581.38	7,186.04	5,389.53
Community Members	Outcome 5.1: Improved satisfaction of the service delivered by Front line worker	41,162	41,162.06	41,162.06	30,871.55	23,153.66	17,365.24
	Outcome 5.2: Improved Nutrition and Health knowledge	90,596	90,596.27	90,596.27	67,947.21	50,960.40	38,220.30
	TOTAL	3,067,600	3,067,600	3,067,600	2,300,700	1,725,525	1,294,144
	PV of each year		3,067,600	2,893,962	2,047,615	1,448,784	1,025,083
	Total PV						10,483,045
	NPV						9,662,715
	SROI						**13**
	Net SROI						**12**
	Discount Value						6%

Figure 1: Snap shot of computation of SROI at a discounting rate of 6 percent within 4-year period

Further analysis established the impact values. It is usually the case to establish whether the SROI results would have significant variations should the circumstances changes. Under this sensitivity test the research established the sensitivity analysis using some few key impact related variables. Results from the sensitivity analysis indicated the insignificant variation from the original results as follows.

Base and New Case Scenario

	Base Case	New Case	New Ratio
Attribution	39%	25%	USD 20: 1
Drop off	25%	30%	USD 12: 1
Displacement	0%	10%	USD 8: 1

Based on the methodology highlighted in the preceding sections the study concluded that investing 1USD in Capacity Development for frontline health workers would result into USD 13 social value equivalence. This implies that the implementation of this project will have a significant socially verifiable return.

3.2.7 Feedback Matrix for the SROI Study

Participants in the workshop has an opportunity to analyze the strength as well as raise issues on the study outcome. It emerged that triangulation of qualitative and quantitative method makes the study results more accurate with and increases internal consistency of the outcome. FGD from this study was useful in getting more in-depth social value from a stakeholder's perspective. The final outcome can now inform policy makers on the need to invest in Capacity Building of frontline workers.

Additionally, this study has provided good entry point for further interventions. It gives meaning of the capacity development prior to intervention. Somehow, the study has identified and re-affirmed that malnutrition especially undernutrition is a common problem in Kenya, University and Tanzania and could be tackled jointly as common regional problem.

Areas of strengths highlighted by the critiques included involvement of both pre-service and in-service beneficiaries; Engagement of different stakeholders like Nutritionists, extension workers, community members, midwives, training institutions, nutrition service seekers added value to the outcome. The background, situation analysis, mapping was relevant and brought out the gaps and responds to the capacity needs identified by ECSA. The quantitative and qualitative findings justify the feasibility of implementing this project (I dollar spent=13) and robustness. This finding was also found to be comparable with other similar studies in the region. Choice of SROI was a novel approach which introduced economic modelling through SROI into nutrition intervention. Mixing approaches added value on internal consistency of the outcome. However, a number of issues were raised and responses given with a hope to provide some recommendations for improvement of the study outcome.

Table 1. Feedback matrix on SROI study

Issues Raised	Response provided	Recommendations
The study appeared to have had major participation from Uganda, Tanzania with minimal participation from Kenya. The stakeholders were concerned of the reasons.	The SROI team reported constraints that prevented a similar participation level in Kenya as it were in Uganda and Tanzania. Kenya was experiencing political unrest during the period of data collection and therefore only quantitative aspects was captured from a few respondents.	The technical team was advised to make efforts to collect additional information from Kenya for purposes of equality if making inter-country comparisons.
Definition of frontline health worker was raised by some stakeholders.	The consultant made attempt to respond by demonstrating an understanding of the definition. It appeared that the general understanding of the frontline worker referred to any cadre that has firsthand contact with patients or clients.	There was no major recommendation as ECSA-HC clarified that the definition was agreed on in other forums which previously debated on the matter.
Methods of data collection left out observation aspects and relied on the qualitative and survey methods.	This aspect was not considered as the tool had a specific indicator pre-determined as	There is need for the consultants to include this aspect under technical or

	minimum for assigning financial proxies.	methodological limitation within their report.
Representativeness of sample was raised as an issue that would lead to bias in the interpretation of the outcome	Sampling was purposively done based on participants selection criteria during pilot training workshop organized in Nakuru Kenya and validation workshop in Dar es Salaam.	It emerged that there was no harm involving participants who did not take part in the earlier piloting workshop in Nakuru and Dar es Salaam. The general agreements pointed out future control aspect where participants and non-participants target group would be included.
The meeting also questioned the robustness of the outcome which stood at 1USD=13USD return.	The research team reported to have technically included several assumptions. The validity of the outcome fell within the range of other studies which authenticated the outcome range.	This finding would be useful as a basis to adoption of the ECSA products as a bargaining factor in the adoption advocacy.
The study somehow had methodological limitations. The period was found to be short to measure benefit. The approach to measurement of skills acquisition and delivery left out observation methods. Limitations on economic indicators and other issues in implementations, and the weight of assumptions on ruling out counterfactuals somehow demonstrated over assumption. Controlled comparison on ECSA HC trained Vs other to clearly measure attribution would be brought about more weight. Focus on sick persons attending services yet nutrition goes beyond facilities could compromise the results. Issue of increased willingness of community to attend to frontline worker assumes that the community knows which worker got the service or not alluding to over assumption.	The research team responded by agreeing that some of the methodological concerns would be included under the technical limitations of the study.	Generally, the consensus was that based on the unique approaches in SROI which could be different from other baselines surveys.

3.3 Proceedings on Adoption of Action Plan

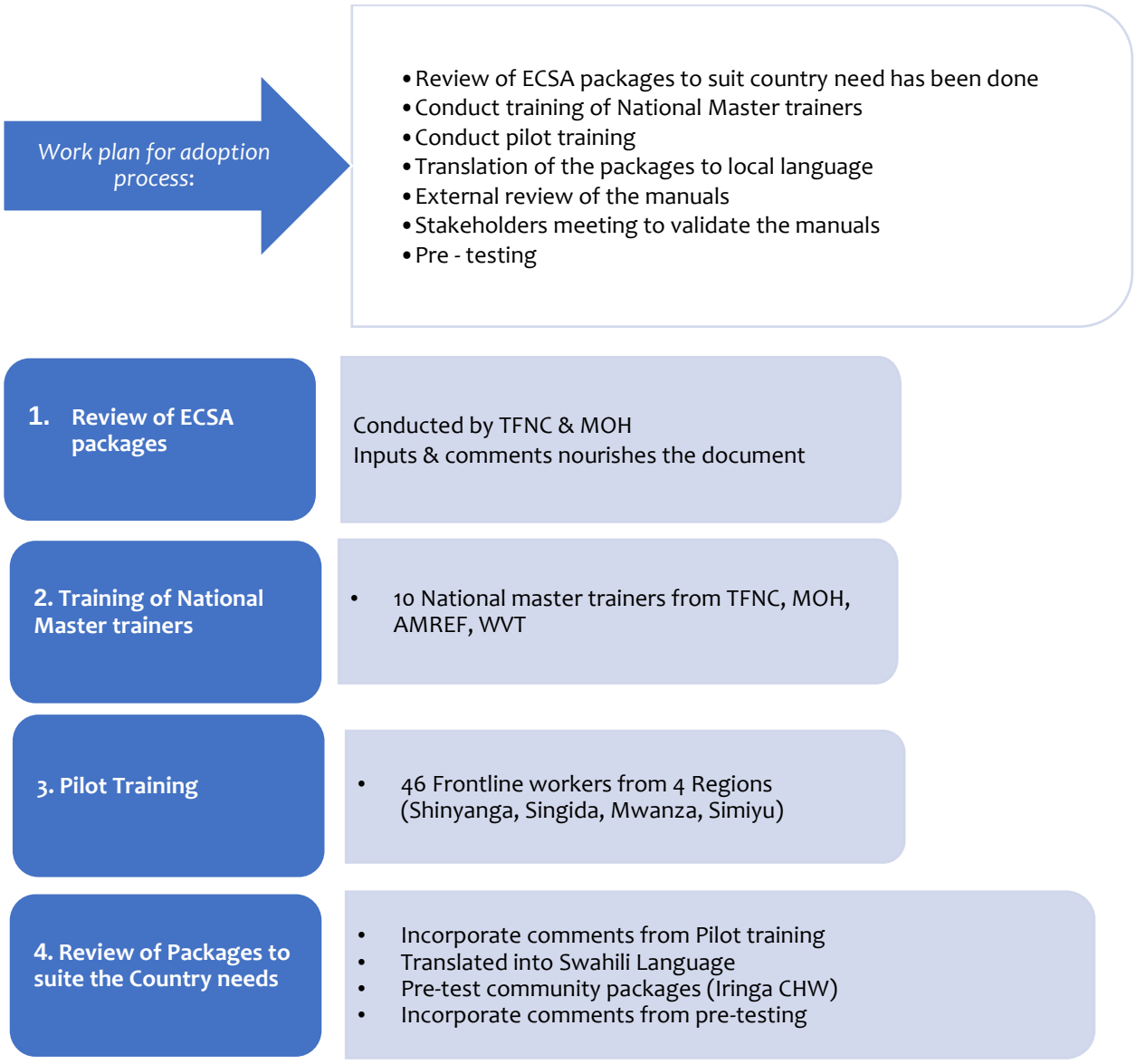
3.4 Tanzania

The Ministry of Health Nutrition Unit was given opportunity to present on the progress made in adoption of in-service and pre-service action plans. The focus on this highlight was based on a malnutrition gap that is common in Tanzania just like any other country in the Eastern and Southern Africa. In the highlights Tanzania, was identified among the countries facing high burden of under nutrition and joined SUN movement to accelerate implementation of high impact nutrition actions. Some of the challenges mentioned in relation to Scaling Up Nutrition in Tanzania included limited knowledge and capacity of existing human resource to effectively deliver nutrition actions across

sectors. Based on the Regional Capacity Assessment of nutrition workforce conducted in 2011 by HKI. The team recognized that the driving factor to focus on nutrition capacity strengthening based the outcome of the Capacity Assessment of nutrition workforce where skills absence was voiced.

3.3.1 Tanzania's Action Plan for Adoption of in-service and pre-service model curriculum

In an attempt to adopt the plan, the Ministry of health recognized ECSA's effort to address the challenges and gap in Capacity strengthening in Tanzania. ECSA-HC therefore supported the development of adoption plan for in-service packages in Tanzania as a guide for moving forward the agenda of nutrition. It appeared that the Ministry has made some efforts to adopt the plan through a piloted module implementation narrowed within a confined scope. The progress details are in figure 1. below.



3.3.1.1 SWOT Analysis of the progress

Participants analyzed the progress made towards the adoption of in-service and preservice model curriculum for purposes of review and developing action plan for roll out of national of the programme. Self-evaluation of the SWOT identified some strengths, weakness, opportunities and threats at the initial pilot stage (Table 2). Analysis of this adoption component revealed no attempt made so far in the pre-service curriculum adoption.

Table 2 SWOT Analysis matrix based on pilot roll out conducted by MOH Tanzania

Action Point	Strength	weakness	opportunity	threats
1. Package translation to Swahili	Universal understanding of Kiswahili language in the context of Tanzania	Challenges on direct translation of certain terms in Kiswahili	Target users are good Kiswahili speakers	Misinterpretation of terminologies
1. Official adoption of trainings packages by MoH	HR availability (trainers)	Insufficient implementing partners	Various Ministries have and partners have bought the idea and ready implement	Difficulty in penetrating other sectors e.g. agriculture
2. Production of materials in Swahili.	Ensure dissemination.	Insufficient financial resources	HR Capacity building	
3. Training of National & Regional level master trainers	Increasing knowledge and competency.	Insufficient financial resources		

3.3.1.2 Action Plan for Adoption of Pre-service Model Curriculum and In-service

Participants were issued with copies of previously developed action plan for reviewed and gaps identification per each Country. The newly thought strategies were identified and populated into a matrix template as a road map for the next course of action in adoption and utilization of the products. The action plan covered roll out for both pre-service model curriculum and in-service packages both with the goal of strengthening capacity building. Details action plans are provided in tables 2a and 2b.

Table 2a. Tanzania Roll Out Action Plan for Adoption of Pre-service Model Curriculum and In-service Packages

Action Steps *What Will Be Done?*	**Responsibilities** *Who Will Do It?*	**Timeline** *By When? (Day/Month)*	**Resources** A. *Resources Available* B. *Resources Needed (financial, human, political & other)*	**Potential Barriers** A. *What individuals or organizations might resist?* B. *How?*	**Communications Plan** *Who is involved? What methods? How often?*
Step 1: Advocate the agenda to training institutions.	MoHCDGEC & MoEVT	June 2018	A. Human, material, political resource B. Financial	A. Training institutions B. Limited resources	MoHCDGEC & MoEVT & policy and decision makers through sensitization, formerly

Step 2: Develop training material to incorporate into existing curricular	Ministry of Health	December, 2018	A. Human resources, B. Fund and political commitment	A. owners training institution B. workload	All stakeholders who deal with nutrition training SWOT TNA Maximum 5 years
Step 3: Review existing curriculum	Ministry of Health Training institutions, TCU, NACTE,	December, 2019	A. Human resources, B. Fund and political commitment	A. owners training institution B. workload	All stakeholders who deal with nutrition training Regulatory board owner Maximum 5 years
Step 4: Develop new nutrition curriculum for certificate and diploma level incorporating the proposed module into the curriculum	Ministry of Health Training institutions, TCU, NACTE,	December, 2020	A. Human resources, B. Fund and political commitment	A. Some of professionals might resist B. They think the program is enough	All stakeholders who deal with nutrition training Regulatory board owner Maximum 5 years
Step 4: Full adoption and Implementation of revised curriculum	All institutions	June 2021	A. Human, Training institutions, material, political resource B. Financial	A. Institutions perception B.	All relevant stakeholders through meetings,
Step 6: M&E progress of implementation	Relevant institutions	Bi-annual after inception of the curriculum review process	A. Human, Training institutions, material, political resource B. Financial	A. B.	Formal process

Table 2b: Tanzania Roll Out Action Plan for Adoption of In-service Packages

Action Steps *What Will Be Done?*	Responsibilities *Who Will Do It?*	Timeline *By When? (Day/Month)*	Resources A. *Resources Available* B. *Resources Needed (financial, human, political & other)*	Potential Barriers A. *What individuals or organizations might resist?* B. *How?*	Communications Plan *Who is involved? What methods? How often?*
Step 1: Adoption process to in-cooperate comment from external reviewer	MoHCDGEC	December, 2017	A. Human, Training institutions, material, political resource B. Financial	A. Local authority B. Resources	All relevant authorities CONTIOUS
Step 3: External review of the manuals	Consultants	February, 2018	A. Human resources B. Fund, political willing	A. owner B. competent consultant	Stakeholders Seminars, training, meeting One year
Step 3: Stakeholders meeting to validate the manuals	Ministry of Health Regulators Professional board	April, 2018	A. Human resources B. Fund, political willing	A. owner B. competent consultant	Stakeholders Seminars, training, meeting One year
Step 4: Pre - testing	Ministry of Health	June, 2018	A. Human resources B. Fund, political willing	A. Owner B. competent consultant	Stakeholders Seminars, training, meeting One year
Step 5: Rollout (scale up)	Ministry of Health	July 2018	A. Human resources B. Fund, political willing	A. Owner B. competent consultant/partners influence	Stakeholders Seminars, training, meeting One year
Step 6: M&E progress of implementation	Ministry of Health	Bi-annual after inception of the manual	C. Human, Training institutions, material, political resource D. Financial	B. B.	Formal process

3.3.2 Uganda Action Plan for adoption of in-service packages and pre-service Curriculum

Participants discussed and deliberated on the adoption strategies for both pre-service model curriculum and in-service training packages. An effective model was agreed on to provide a mechanism for gathering more information. Two categories of participants were engaged based on the practice bias. The academia and representatives from regulatory boards and council agreed to work on the plan of action for adoption of the pre-service curriculum while Ministry of Health, other line ministries represented and partners who were invited worked to action plan for adoption of in-service training packages.

3.3.2.1 Action Plan for adoption of pre-service model curriculum

Pre-service action plan had six proposed strategies with details of who is responsible, timelines, potential barriers and communication plan in a matrix format. Critical issues raised while finalizing this action plan was the entry point for government implementation. It appeared that the Ministry of education is a key stakeholder in the roll out and needed to have been the entry point for the curriculum to be acceptable. Participants had a consensus that the Ministry of education, training institutional heads and academic deans need to be involved for the implementation to be smooth. It was therefore recommended that Ministry of Health to officially write a letter to Ministry of Education and other key stakeholders on the existence of the model curriculum for adoption. The populated matrix of key strategies is in Table 3.

Table 3. Uganda Roll Out Action Plan for Adoption of Pre-service Model Curriculum and In-service Packages.

Action Strategies *What Will Be Done?*	**Responsibilities** *Who Will Do It?*	**Timeline** *By When? (Day/Month)*	**Resources** *A. Resources Available* *B. Resources Needed (financial, human, political & other)*	**Potential Barriers** *A. What individuals or organizations might not be interested* *B. How/ why?*	**Communications Plan** *Who is involved? What methods? How often?*
Strategy 1: Support national and regional dissemination meetings targeting pre-service institutions	• Ministry of Health • Ministry of Education and Sports • ECSA HC • Regulates (National Council for Higher Education (NCHE), Uganda Allied Health Examinations Board (UAHEB), Uganda Nurses and Midwives Examination	January 2018	**A.** human, materials **B.** Finances and Technical support	**A.** Universities and other tertiary institutions **B.** Review is demanding in context of time, logistics, culture and overall "resistance to change"	• Nutrition focal persons who will work with Stakeholders • Courtesy calls to key stakeholders

	Board Council (UNMC), Uganda Allied Health Professional Council (UAHPC), etc. • Professional associations • Champions				
Strategy 2: Situation and gaps analysis to provide evidence for integration	• Independent expert/consultant	Nov-Dec 2017	**A.** Human, materials **B.** Financial and Technical	**A.** Universities and other tertiary institutions **B.** Review is demanding in context of time, logistics, culture and overall "resistance to change"	• Nutrition focal persons who will work with Stakeholders
Strategy 3: Support programmes and curriculum review to support integration	• MOH • MoES • ECSA HC • Regulators (NCHE, UAHEB, UNMEB, UNMC, UAHPC, etc. • Professional associations Champions	January 2018	A. Human, material resources B. Financial and technical resources	**A.** Universities and other tertiary institutions **B.** Review is demanding in context of time, logistics, culture and overall "resistance to change"	• Nutrition focal persons who will work with Stakeholders • Courtesy calls to key stakeholders
Strategy 4: Orientation of institutions and stakeholders	• MOH • MoES • ECSA HC • Regulators (NCHE, UAHEB, UNMEB, UNMC, UAHPC, etc. • Professional associations • Champions	January 2018	**A.** Human, materials **B.** Financial and Technical	**A.** Universities and other tertiary institutions **B.** Review is demanding in context of time, logistics, culture and overall	• Nutrition focal persons who will work with Stakeholders • Courtesy calls to key stakeholders

				"resistance to change"	
Strategy 5: Experience sharing on curriculum implementation	• MOH • MoES • ECSA HC • Regulators (NCHE, UAHEB, UNMEB, UNMC, UAHPC, etc. • Professional associations	January 2019	A. Human, technical B. Financial resources	**A.** Universities and other tertiary institutions **B.** Review is demanding in context of time, logistics, culture and overall "resistance to change"	• Nutrition focal persons who will work with Stakeholders • Courtesy calls to key stakeholders
Strategy 6: Support monitoring and evaluation on the implementation of model curriculum	• MOH • MoES • ECSA HC • Regulators (NCHE, UAHEB, UNMEB, UNMC, UAHPC, etc. • Professional associations	January 2020	A. Human, technical B. Financial resources	**A.** Universities and other tertiary institutions **B.** Review is demanding in context of time, logistics, culture and overall "resistance to change"	• Nutrition focal persons who will work with Stakeholders • Courtesy calls to key stakeholders

3.3.2.2 Action Plan for adoption of in-service packages

Action plan for adoption of in-service packages was anchored on a review of the previously developed adoption plan. The participants in this group had chance to review the previous adoption and dissemination plan and since there were no much progress, the team developed a new action plan and populated a matrix in Table 4.

Table 4: Uganda Roll Out Action Plan for Adoption of In-service Packages

Action Strategies *What Will Be Done?*	Responsibilities *Who Will Do It?*	Timeline *By When? (Day/Month)*	Resources *C. Resources Available* *D. Resources Needed (financial, human, political & other)*	Potential Barriers *C. What individuals or organizations might not be interested* *D. How/ why?*	Communications Plan *Who is involved? What methods? How often?*
Strategy 1: Harmonization & adaption of the facility and	MOH with support of partners	Jan-March 2018	A. • Trained nutritionists in package.	A. Partners & individuals have specific agenda	Nutrition division MOH, regional nutritionist By emails & meetings

community training materials			• Political & Technical will • Existing guidelines B. Logistics.	B. May be seen as duplication of other nutrition package	Quarterly.
Strategy 2: Incorporating the content in the community package into curriculum for CHEWS.	MOH-Nutrition division, Ministry of gender labour & social development , Ministry of Agriculture animal industry and fisheries, Ministry of local government, Ministry of education & sports	March 2018	A. Availability of CHEWs training manual, Human resources B. Funds for meetings	A. None B.	MOH-divisions of: Nutrition, Health education & promotion, Reproductive health, Local government, Human resource development of MOH. Through technical working groups, emails & meeting Monthly.
Strategy 3: MOH to work with other sectors in corporating the content from developed ECSA manual	MOH & other sectors (Education & sports, MAAIF, LGs, KCCA, MTIC	Jan-March 2018	A. Human resources, guidelines & materials for Nutrition-facility & community. B. logistics	None B	Multisectoral technical working group for nutrition. Through meetings and media Quarterly.
Strategy 4: Training of central facilitators to led rollout	MOH-Nutrition division, Regional nutritionists, Ministry of gender labour & social development .	April-June 2018	A. Trained nutritionist, harmonized training materials B. Training Logistics	None B.	MOH & partners Through email, telephone,
Strategy 5: Regional roll out of the training	MOH-Nutrition division, Regional nutritionists,	April – June 2018	A. Trained nutritionist, harmonized training materials	A. None B.	MOH & RRH, DHO's Through email, telephone,

	MGLSD		B. Training Logistics		
Strategy 6: Regional Mentorship & coaching	MOH-nutrition Regional Nutritionist, District local governments	July-Sept 2018	A. Human resources at regional level, mentorship tools B. Logistic	A. None B.	Ministry of health, regional referral hospital (RRH), district local governments.

3.3.2.3 SWOT Analysis of Action Plans

Table 5a SWOT Analysis of pre-service curriculum roll out action Plan in Uganda

Action Strategies	Strengths	Weaknesses	opportunities	Threats
Strategy 1: Support national and regional dissemination meetings targeting pre-service institutions	• Availability of human resource and training materials. • Infrastructure • Existing multispectral system for nutrition	• Lack of financial resources, no specific funding for meetings • Limited technical knowledge among the technical staff	• Existence of institutions • Willingness of institutions to participate • Existing policies & guidelines for collaborations and partnerships	• Time constraint i.e. too many activities • Competing priorities • Inadequate knowledge of importance of nutrition
Strategy 2: Situation and gaps analysis to provide evidence for integration	• Availability of information • Availability of technical staff	• Low priority accorded to nutrition data & its utilization	• Global SUN movement provides an avenue to report • Availability of DHIS2 • Existence of national laws, policies & guidelines to access nutrition data	• Time constraint i.e. too many activities • Competing priorities • Unpredictable catastrophes (disasters and emergencies)
Strategy 3: Support programmes and curriculum review to support integration	• Availability of information • Availability of some	• Lack of finances, • Bureaucracy involved in curriculum	• Availability of Existing curricula at different levels	• Competing issues to be integrated in the existing curricula

	technical staff • Availability of structures e.g. curriculum development center	review & approval		
Strategy 4: Orientation of institutions and stakeholders	• Availability of structures • Availability of laws, policies and guidelines	• Challenges of multi-sectoral coordination & commitment • Lack of finances,	• Existence of nutrition framework at all levels	• Time constraint i.e. too many activities • Competing priorities • Rapid changing political platform
Strategy 5: Experience sharing on curriculum implementation	• Availability of human resource, training materials, • Infrastructure • Existing multispectral system for nutrition	• Lack of finances, no specific funding • Limited technical knowledge among the technical staff	• Existence of institutions • Willingness of institutions to participate • Existing policies & guidelines for collaborations and partnerships	• Time constraint i.e. too many activities • Competing priorities • Inadequate knowledge of importance of nutrition
Strategy 6: Support monitoring and evaluation on the implementation of model curriculum	• Existence of & technical staff • Existence of M & E framework	• Competing priorities • Lack of finances	• Global SUN movement provides an avenue to report • Availability of DHIS2 • Existence on national law, policies & guidelines to access nutrition data	• Time constraint i.e. too many activities

Table 5b. SWOT Analysis of In-service curriculum roll out action Plans in Uganda

Action Strategies	Strengths	Weaknesses	opportunities	Threats

Harmonization & adaption of the facility and community training materials	• Existing materials. • Human resource. • Multi sect - oral frame work for nutrition coordination at national level	• Timeliness in delivery of this task.	• Political will. • Partner support. • Supportive policy environment e.g. integrated services delivery by MOH.	• Differing priorities among government & partners. • Buy in by the nutrition partners. • Limited funds.
Incorporating the content in the community package into curriculum for CHEWS.	• CHEWS to be recruited to handle community curriculum • Key areas already incorporated in the curriculum for the CHEWS.	• Curriculum for the CHEWS available already limited in nutrition content.	• Health workers mentorship and coaching of CHEWS. • Interest of MOH & Partners to support the CHEWS.	• Buy in of this curriculum for the CHEWS
MOH to work other sectors in corpora ting the content from ECSA manual	• National multi-sectoral nutrition coordination secretariat.	• Exclusion of other community based resource persons in other sectors by the curriculum.	• Political will • Nutrition is cross cutting issues.	• Competing priorities by different sectors.
Training of central facilitators to lead rollout	• Team of Experts • Materials.	• Resource pool is inadequate. • We may not reach all the target communities & health facilities	Availability of trained persons in ECSA-nutrition package.	High attrition of expertise.
Regional roll out of the training	• Team of Experts • Materials.	• We may not reach all the target communities & health facilities	• Presence of regional Partners. • Availability of DNCC, MNCC, SCNCC.	• High attrition of trained
Regional Mentorship & coaching	• Wider coverage of frontline health workers. • Availability of regional		• Presence of regional Partners. Availability of DNCC, MNCC, SCNCC.	• High attrition of trained. • Some region lacks regional nutritionist as such some partners have

	Mentors & coaches.			withheld their resources

3.3.3 Kenya Action Plan for adoption of in-service packages and pre-service Curriculum

Following the Adoption meeting stakeholders conducted in May 2017, it was generally agreed that Kenya led by the Ministry of Health would customize the package for Kenya. The Ministry of Health nutrition unit received support from Nutrition International to begin of adoption of in-service packages. The initial focus on this process focused on customization of the packages to fit into the Kenya needs based on existing situation and considering that each County within Kenya have different nutrition demands. So far desk review of existing training materials and ECSA in service package was conducted, followed by key informant interviews conducted targeting MoH departments, Line ministries, Counties, front line health workers, partners. A report of the findings of the desk review and stakeholders' interviews and the proposed framework for the development of the integrated training package was presented to Capacity Development Working Group and draft customized training package will be reviewed by stakeholders. Time schedule to accomplish this pilot process include validation meeting scheduled to take place in January, Training of TOTs (Jan-Feb, 2018), pilot of training material in Elgeyo Marakwet and finalization and Dissemination by March, 2018.

3.3.3.1 Action Plan for adoption of pre-service model curriculum

Pre-service action plan for Kenya identified four proposed strategies with details of who is responsible, timelines, potential barriers and communication plan in a matrix format. This component of dissemination targeted regulatory boards and academia. Critical issues raised while finalizing this action plan were sensitization of key stakeholders, curriculum review, stakeholder active involvement and competency identification. It appears that regulatory authorities being in-charge of training and development of curriculum guidelines will take the lead in the process though coordination at joint-regulatory meetings. The populated matrix of key strategies is in Table 6.

Table 6. Action Plan matrix for adoption of pre-service model curriculum

Action Strategies *What Will Be Done?*	Responsibilities *Who Will Do It?*	Timeline *By When? (Day/Month)*	Resources *A. Resources Available B. Resources Needed financial, human, political & other)*	Potential Barriers *A. What individuals or organizations might not be interested B. How/ why?*	Communications Plan *Who is involved? What methods? How often?*
Strategy 1 Sensitization of Key stakeholders	• Regulatory Bodies • Training institutions	December, 2017	A • Institutional structures B • Qualified Human resource i.e. HR	A • Competing tasks and responsibilities	Training institutions Regulatory bodies ECSA
Strategy 2: Curriculum revision	• Regulatory Bodies • Training institutions	2018/2019	A. • Institutional structures • Qualified Human resource i.e. HR	A. • Internal & External bureaucracy • Institutional and regulatory body policies	All relevant stakeholders Seminars/workshops

			• Institutional policies on curriculum revision / review B. • Finances for infrastructure • Technical personnel	• Resistance from target departments • Disruptions from normal operations • Competing tasks and responsibilities B.	
Strategy 3: Active Stakeholder involvement	• Training institutions • Focal persons • ECSA	February 2018	A. • Institutional infrastructure • Qualified personnel, HR B. • Finances • Support staff • Training materials	A. • Lack of collaboration • Bureaucracies • Staff work load • Disruptions from normal operations • Overloaded curriculum B.	Ministry of Health Ministry of Education Regulatory bodies
Strategy 4: Identifying key competencies	• Regulatory bodies • Specific departments in the institutions	March 2018	A. • Institutional infrastructure • Qualified personnel, HR B. • Finances • Support staff • Training materials	A. • Competing tasks and responsibilities • Bureaucracies / pre-scheduled calendar of events B.	Training institution/ regulatory bodies workshops

3.3.3.2 Action Plan for adoption of in-service packages

In-service training packages was proposed to be rolled out by the Ministry of Health in collaboration with partners. Strategic plan in rolling out the packages included advocacy and sensitization meetings to key stakeholders, development of an implementation plan and mobilization of resources, identifying regional level Master Trainers, actual training of frontline workers at county level and monitoring and evaluation of the entire process.

Table 7. Action Plan matrix for adoption of in-service packages

Action Strategies *What Will Be Done?*	Responsibilities *Who Will Do It?*	Timeline *By When? (Day/Month)*	Resources A. *Resources Available* B. *Resources Needed*	Potential Barriers A. *What individuals or organizations*	Communications Plan *Who is involved?*

			(financial, human, political & other)	*might not be interested* *B. How/ why?*	*What methods? How often?*
Strategy 2: Advocacy and sensitization meetings	MOH /County Health Services /Partners	By end of April 2018	A. Human resource, Training packages / Logistics B. Logistics and political goodwill	A. County Governments priorities B. Bureaucracy	County Govt/Partners
Strategy 1: Develop implementation plan and mobilize resources	MOH /ECSA	By end of March 2018	A. Human resource, Training packages / Logistics B. Financial resources and political goodwill	A. County Govt /COG B. Bureaucracy	Cog/County Govt/Partners
Strategy 3: Regional level Master Trainers	National TOTs, County, Partners	Aug, 2018	A. Training Materials B. Human Resources Logistics	A. Inadequate resources - County governments B. Competing activities- County government-	County govt, CHMT Partners National government
Strategy 4: Trainings of frontline workers at county level	ToTs, National, CHMT, SCHMT, partners	Dec,208	A. Training materials B. Human resources C. Logistics	A. Inadequate resources for nutrition in county- Directors and CHMT B. Competing activities at county level Other cadres e.g. doctors	County govt, CHMT, SCHMT, Emails, phone calls
Strategy 5: Monitoring and evaluation	National capacity office,	Continuous	A. Support supervision tools	A. Inadequate resources for	CHMT, SCHMT, FLWs, partners

	CHMT, partners		B. Logistics Human resource	nutrition in county- CHMT, CEC, National government B. Competing activities at county level – CHMT, Other cadres e.g. doctors Poor prioritization of nutrition -	Email, phone calls Quarterly and on needs basis

3.3.3.3 SWOT Analysis of Action Plans

Table 8a. SWOT Analysis of pre-service curriculum roll out Action Plans in Kenya

Strategy	**Strengths**	**Weaknesses**	**Opportunities**	**Threats**
Strategy 1 Sensitization of key stakeholders	• Consensus and support from stakeholders and institutions • Ability to mobilize resources • Ownership of the curriculum • Sustainability	• Time constraints • Lack of agreements • Lack of budgetary allocation	• Stakeholders ' Goodwill • Exchange program	• Policies • Conflict of interest from different professions
Strategy 2: Curriculum revision	• Ownership of the curriculum • Sustainability • Existing nutrition units in existing curriculum	• Increased workload • Time constraints • Internal Bureaucracies • Lack of budgetary allocation	• Existing infrastructure for curriculum revision • Goodwill • Existing nutrition units in existing curriculum	• Existing Policies (institution and regulatory bodies)
Strategy 3: Stakeholder involvement	• Ownership of the curriculum • Sustainability • Networking	• Lack of budgetary allocation	• Resource mobilization	• Existing Policies (institution and regulatory bodies)

Strategy 4: Identifying key competencies	• Ownership of the curriculum • Sustainability • Existing nutrition units in existing curriculum	• Lack of budgetary allocation	• Resource mobilization	• Policies • Conflict of interest from different professions

Table 8b. SWOT Analysis of In-service curriculum roll out action Plans in Kenya

Strategy	Strengths	Weaknesses	Opportunities	Threats
Strategy 1: Develop implementation plan and mobilize resources	• Training package is place • Multi-sectoral approach/collaboration • Partner support • Kenya National Community Strategic in place • Kenya National and County Action plans	• Inadequate nutrition staff • Reliance on partner support • Programme based budgeting	• Partner support • Support nutrition agenda • Availability of empirical data •	• Donor fatigue • Political uncertainty • Institutional bureaucracy • Delay in release of funds from national to county government
Strategy 2: Advocacy and sensitization meetings	• Well trained human resource/capacity • Training package in place • Partner support • Advocacy, communication and social marketing strategy in place	• Reliance on partner support • Programme based budgeting	• Partner support • Support for nutrition agenda • Availability of empirical data	• Donor fatigue • Political uncertainty • Institutional bureaucracy • Delay in release of funds from national to county government
Strategy 3: Master training of National/regional ToTs	• Training materials • Availability of Master trainers • Pre-existing structures at the national/county level	• Diverse competency capacity • Inadequate number of National ToTs	• Existence of master trainers • Pre-existing structures at the national/county level	• Unwillingness by health workers to carry out additional tasks.
Strategy 4: Cascading of the training to the health workers to the counties	• Trained Master ToT's • Training materials already existing • Existing health workers capacities	• Resources mobilization at county level. • Understaffing	• Availability of training venues • Training materials • willingness of health workers • Counties support the process	• Currently existing SRC categorization of staff • Competing tasks at the county level.

Strategy 5: Monitoring and evaluation	• Already existing support supervisions schedules • Existence of Health information systems	• Resource mobilization • Differences in partner support	• Strengthening existing HIS • Adequate capacity on M&E	• County competing activities • Frequent strikes

3.4 Dissemination proceedings

Dissemination objective was anchored on two objectives of the workshop namely; to allow the stakeholders appreciate the development of the project and the process towards development of the trainings packages intended for dissemination and to disseminate all the products developed by ECSA to enhance capacity development for nutrition to key stakeholders in Kenya, Uganda and Tanzania.

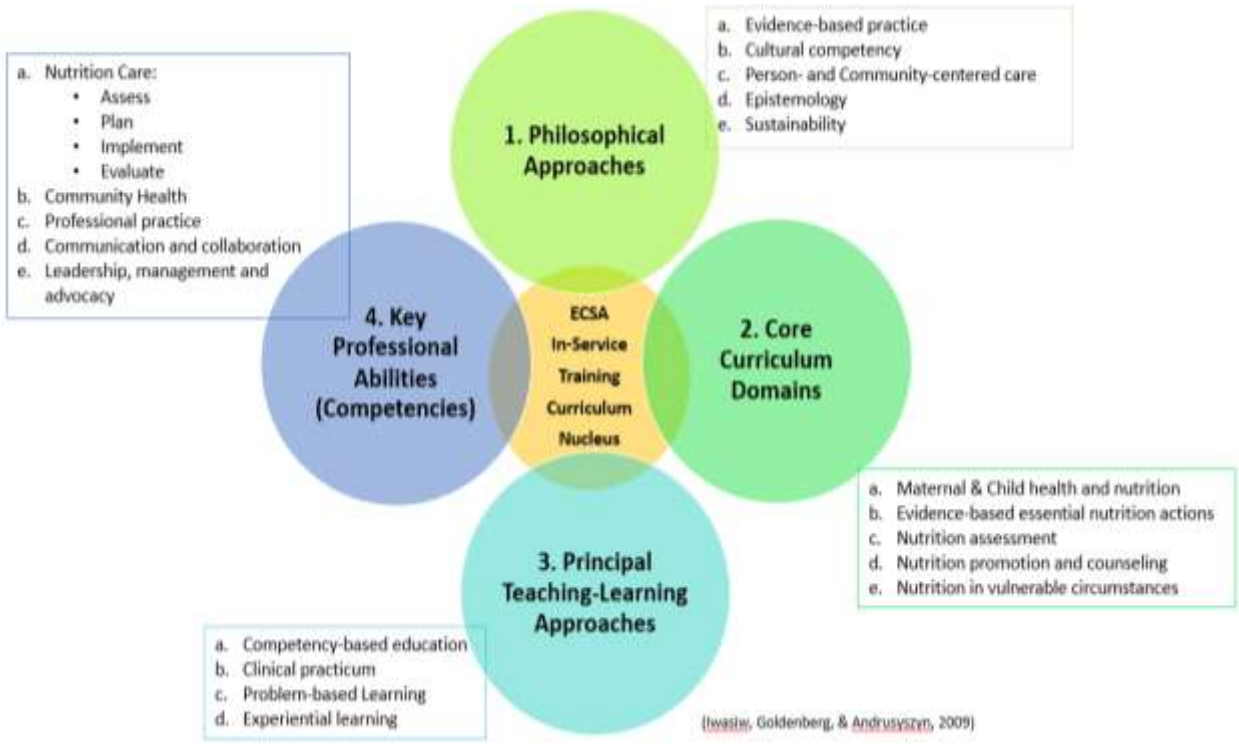
The process of dissemination across the three countries was initialized by giving all participants a background for the ECSA Capacity Development for Nutrition project. ECSA Manager, FSN and NCDs gave overview of the project objectives which included to strengthen ability of Governments of Kenya, Uganda and Tanzania to build the technical capacity of their front-line workers, to strengthen knowledge of frontline workers on *"What to deliver", "How to deliver*" and management and supervision structures needed.

Highlights of project background also outlined core pillars of the project with emphasis on building capacity for in-service training on nutrition for community and health facility workers, building capacity for pre-service training on nutrition for health workers and Knowledge exchanges and advocacy for curricula development and adoption.

In brief the project developed in sequence beginning with regional planning meeting, desk review on, existing pre-service and in-service packages, workforce capacity and nutrition policies, strategies & plans. In country consultative workshops were conducted with a focus on development of framework of action for development of packages and advocacy to decision makers. These were finally followed by regional consultative workshop (draft framework and curriculum nucleus).

Participants were informed that consensus building had to be reached on the definition of frontline health worker. The general agreement defined frontline health worker as one who directly interacts with clientele either at health facility of community level. The focus of these worker was at facility or community level. Health-facility Workers included nutritionists/ dieticians, nurses, midwives, Allied Health Professionals and Clinical officers. Community-based Workers included Agricultural Workers, Social Workers, Community-development Workers, Community-resource Workers, Community-health Workers and Social workers.

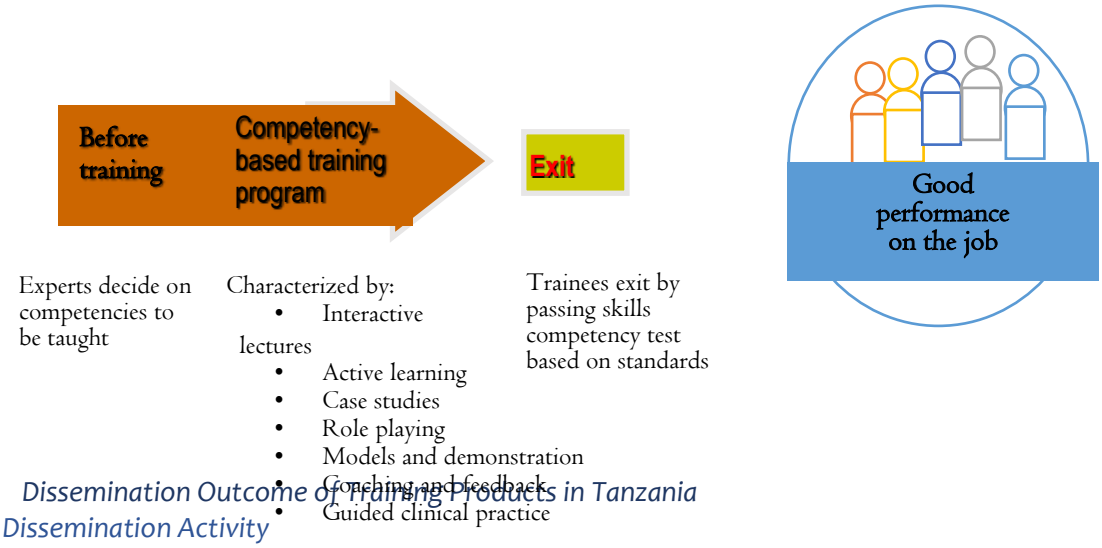
The process of developing competency based training for in-service and pre-service training was based on Curriculum Nucleus for in service Packages model.



Based on the model the project highlighted Minimum components with regard to products which included Trainer of Trainers manual, Facilitator's manual, Participant's manual, sets of PowerPoint presentations corresponding to training materials, additional resource materials (e.g. job aids) and tools to evaluate the trainings. Some of the products are were displayed to the participants.

ECSA project explained to the audience on the development of pre-service curriculum by highlighting the focus. It emphasized the need to incorporate components of the regional model curricula to

existing nurses' curriculum, midwives and other health cadres. The essence is to incorporate basic minimum nutrition and dietetics competencies for such cadres who already are handing nutrition activities with minimal content. The guiding principal for implementation was competency based value chain which illustrates schematic nature of Job performance.



3.4.1 Dissemination Outcome of Training Products in Tanzania

3.4.1.1 Dissemination Activity

Dissemination exercise was conducted upon arrival of the Permanent Secretary Dr. Mpoki Ulisubisya who was the guest of honour. The ministry of health led by Dr. Vincent Assey who is the Acting Managing Director of Tanzania Food and Nutrition Centre and Head of Nutrition Division in the Ministry of Health took over the programme agenda and invited ECSA team and Facilitator to present the project deliverables to the guest of honour and audience. ECSA-Secretariat led by project manager NFSN Ms. Rosemary Mwaisaka gave an overview of the project whose content has been described in the preceding sections. ESCA-facilitator, Dr. David Okeyo gave brief description of the products intended for adoption by outlining the key content and relevance in Capacity Development of the nutrition workforce at frontline.

After all the presentations, the PS was invited to give his remark in the context of Capacity strengthening. Key issues that were addressed by the PS statement to the participants were as follows:

1) Malnutrition especially undernutrition is a big challenge in Tanzania and extends beyond the borders to Southern, Central and Eastern community making is a common enemy to be tackled.
2) Tanzania is already making good progress on various interventions to curtail the menace
3) There is emphasis put on stunting knowledge and a concerned from raised on the need to shift focus from stunting based on stature to brain stunting.
4) The element of inclusiveness emerged where a spanner was thrown in the works to include teachers in nutrition agenda as they play a key role in child development. Emphasis was to put on finding strategies to intervene on nutrition matters at school level.
5) The PS also applauded the ECSA-Health Community and in particular commended the capacity development project manager Mrs. Rosemary Mwaisaka for the good efforts made so far.
6) The emphasis on government commitment to rolling out the adoption of products by calling on multi-sectoral efforts on the matter was evidence from the remarks made.
7) Finally, the PS congratulated the frontline health workers for the spirit of servanthood and encouraged them to continue with their role as primary secondary beneficiary to the nutrition agenda in Tanzania.

Upon delivery of his remark, the PS was presented with a package which included all in-service training packages, the regional model curriculum and other relevant tools accompanying utilization of the products mainly open letter to key stakeholders and flyer for purposes of advocacy. The PS was then asked to deliver a similar package to key stakeholders.

The dissemination ended with a small ceremony of Cake cutting as a symbol of unity of purpose from adoption of ECSA-products. A vote of thanks was given by ECSA Director of programme Mr. Edward Kataika who took chance to applaud the PS for leading by example as a frontline health advocate in Tanzania. The entire process was covered by both print and visual media for purposes of public consumption and branding of the occasion.

3.4.1.2 Critical Analysis of Tanzania's Nutrition Capacity Development Adoption Willingness.

Based on independent evaluation and potential for success in adoption and utilization of Capacity strengthening products in nutrition, it appeared that Tanzania is well prepared for adoption given the support from the government through the Ministry of Health and other partners who have shown interest.

Multi-sectoral involvement of partners in workshops discussing the nutrition agenda, coupled with the results of SROI study which concluded that 1USD invested in capacity development in nutrition results to 13USD social return equivalence, by proxy depicts a healthy and worthy investment. Social return on investment adds to the strength of adoption process. Tanzania can make use of opportunities already created by the Ministry of Health and partners to propel the agenda to another step.

However, some of the weaknesses realized in Tanzania which may affect efficiency is lack of regulatory framework for the nutrition profession. This weakness emerged from the fact that there is limited framework to clearly define who a competent nutritionist is as many cadres still take up this role with minimal content. It appeared that training of trainers who were engaged as master trainers included professionals with different backgrounds which could lead to validity question on competency delivery.

Somehow, there is unforeseen and unexplainable threat in relation to potential increase of workload and chances of other cadres shifting focus on nutrition while neglecting their actual service delivery role. The unanswered question that must be included in the assumption us: *when a nurse shift focuses on nutrition, who covers up for the intended job for that particular nurse?*

3.4.2 Dissemination Outcome of Training Materials in Uganda

3.4.2.1 Dissemination Activity

Dissemination exercise as soon as the representative of the Permanent Secretary's Ministry of Health. Charles Olaro arrived to assume the Chief guests position of honour. The ministry of health led by Deputy Head of Nutrition took over the programme agenda and invited ECSA team and Facilitator to present the project deliverables to the guest of honour and audience. ECSA-Secretariat led by project manager NFSN Ms. Rosemary Mwaisaka gave an overview of the project whose content has been described in the preceding sections. ESCA-facilitator, gave detailed description of the products intended for adoption by outlining the key content and relevance in Capacity Development of the nutrition workforce at frontline.

After all the presentations, the PS was invited to give receive his product package and thereafter officiate handing over of packages to relevant key stakeholders. As soon as all the stakeholders had received their packages the PS representative read the speech of the PS which among other details highlighted the following issues within the dissemination context.

1) Malnutrition is still a major challenge in Uganda despite good climatic conditions and agricultural potential.
2) Stunting still remain at 29% in Uganda against 26% for Kenya within the African region.
3) Strong collaboration with partners in Uganda has pushed the agenda of nutrition as highlighted in Uganda Nutrition Action Plan, Food and Nutrition Policy 2003 and UNDP II 2015/166-2019/20 documents.
4) Emphasized that nutrition agenda has been integrated in other health interventions within the Public Health domain.
5) Identified technical capacity as main challenge to the implementation of nutrition service delivery in Uganda.
6) Promised to equip health care professionals with basic knowledge services as training of nutrition cadre continues.
7) Emphasized on frontline health worker in the fight against malnutrition with proper training.
8) Emphasized that the government of Uganda is committed to invest in Capacity development of health professionals to deliver basic and relevant services in nutrition.
9) Affirmed the position of government with a commitment to engage the ministry of education to take up the pre-service model curriculum for purposes of integration into existing curricula for relevant health professionals.

The dissemination came to an end with a small ceremony of Cake cutting as a symbol of unity of purpose from adoption of ECSA-products. A vote of thanks was given by Ms. Rosemary Mwaisaka on behalf of ECSA health community. Group photo were taken for records and all participants were advised to leave at will.

3.4.2.2 Critical Analysis of Uganda's Nutrition Capacity Development Adoption Willingness.

Based on the action plans for adoption of pre-service model curriculum and in-service training packages, Uganda demonstrated readiness for adoption of use of documents. However, there seems to be serious bureaucratic procedures that must be taken into account. Even though the entry point in the government structure is the Ministry of Health, participants had a feeling that this Ministry is only key for adoption of in-service training packages. However, the guest of honour who echoed sentiments and commitment of MOH took up the matter and confirmed that an official letter to Ministry of education and other stakeholders to inform them on the developed model curriculum and packages and subsequent adoption in their context.

The pre-service model curriculum adoption required ownership by the Ministry of Education as this ministry is in charge of the Curriculum. Additional barriers have to be broken especially within training institutions. Emerged that Universities and colleges must be sensitized to understand the context as they are key stakeholders in the uptake of the curriculum. The voice of protocol in Ministerial dockets was echoed by participants which would require more advocacy and lobbying both internally and by ECSA-HC. Issues of educating top government official emerged as the Ministry of Education seems to have been left in the value chain of products development. Somehow, participants from Uganda in previous meetings that led to development and validation of model curriculum only participated as individuals and experts and may not have represented the opinion other key stakeholders in the education sector.

On the contrary the Ministerial position depicted readiness to pick up the roll out and adoption process recognition that both participants had developed a clear roadmap inform of action plans. Critical analysis of ownership is highly rated among the stakeholders giving the first indication of success. However, close monitoring would be required specially to keep the spirit above expectations.

3.4.3 Dissemination Outcome of Training Products in Kenya

3.4.3.1 Dissemination Activity

Dissemination was officiated by Head of Preventive and Promotive Health in the Ministry of Health Dr. Peter Cherutich representing Permanent Secretary in the Capacity of Chief guests. The ministry of health led by Head of Nutrition unit took over the programme agenda and invited ECSA team and Facilitator to present the project deliverables to the guest of honour and audience. ECSA-Secretariat led by project manager NFSN Ms. Rosemary Mwaisaka gave an overview of the project whose content has been described in the preceding sections. ESCA-facilitator, gave detailed description of the products intended for adoption by outlining the key content and relevance in Capacity Development of the nutrition workforce at frontline.

After all the presentations, the PS representative was invited to read the PS speech which among other details highlighted the following issues within the dissemination context.

1) Malnutrition is still a major challenge in Kenya with emerging issues surrounding obesity and non-communicable diseases.
2) Efforts to reduce the menace require multi-sectoral and multi-disciplinary approaches.
3) Strong collaboration with partners in Kenya and the regional efforts by ECSA Health Community is a positive agenda for the region that Kenya would want to be part of it.
4) The component of capacity building of existing frontline workers is highly welcome in Kenya as regulators especially Kenya Nutritionist and Dieticians Institute make efforts to train adequate number of professionals in nutrition and dietetics in Kenya.
5) The statement recognized the role of KNDI and the Ministry in pushing together the agenda of Nutrition Capacity strengthening in the region.
6) Limited capacity is one of the biggest challenging factors in scaling up nutrition in Kenya, taking into account the multi-sectoral nature of nutrition
7) Human resource for nutrition is also a big challenge in terms of numbers of professionals deployed and knowledge of other frontline workers who complement the delivery of quality nutrition services.
8) Community-based delivery platforms, are promising for scaling up coverage of nutrition interventions and have proofed to be potential in reaching poor populations through demand creation and household service delivery
9) Different cadres of service providers deliver nutrition interventions across the continuum of care.
10) The statement recognized that there are limited capacities by frontline health workers to effectively provide nutrition services.
11) Capacity strengthening for nutrition Frontline workers has been identified as an important factor in the delivery of nutrition services across sectors
12) The statement recommended there is need for ownership of documents and assuming the logos. "*Let's remove logos and operationalize the documents developed by ECSA-HC*"

The dissemination came to an end with a small ceremony of Cake cutting as a symbol of unity of purpose from adoption of ECSA-products. A vote of thanks was given by Director Operations and institutional Development Mr. Sibusiso B. Sibandze on behalf of ECSA health community. Group photo were taken for records and all participants were advised to leave at will.

3.4.3.2 Critical Analysis of Kenya's Nutrition Capacity Development Adoption Willingness.

Workshop proceedings revealed that Kenya is ready to uptake the adoption of pre-service model curriculum and in-service packages. This intention is very clear it the agenda as described in the action plans and statement made by the Ministry of Health. Even though potential barriers are projected from the action plans, the benefit outweighs the threats. It appears that more advocacy and negotiations with training regulatory boards and training institutions would be required for pre-service adoption. The In-service is already in progress and has more potential expect for the competing interests of key players.

4.0 CONCLUSIONS AND RECOMMENDATION

4.1 Conclusions

The workshop agreed on the outcome of SROI study which promises USD 13 in return of USD 1 spent in Capacity strengthening of nutrition frontline workers. The workshop outcome confirmed the need multi-sectoral agenda of the three countries as a commitment towards mitigating malnutrition across the region. Common interests were displayed by the Ministry of Health across Kenya, Uganda and Tanzania with emphasis put on Capacity strengthening of frontline workers as a stop gap measure. The limited resources to engage qualified nutritionists and the fact that malnutrition has etiological complexity that goes beyond nutrition specifics are the driving factors to intergovernmental commitment in the nutrition agenda. The workshop also recognized the differences in the governance operation and protocol matters among the three countries. Utilization of the capacity building products will therefore adopt unique implementation models for each Country.

4.2 Recommendation

A review of the workshop proceedings revealed stakeholder commitment towards Capacity Development in the context of nutrition service delivery. The following four recommendations would push the agenda further.

1. The Ministry of Health and other line Ministries across Kenya, Uganda and Tanzania should refocus on the action plans developed to roll out the adoption of both preserve and in-service curriculum at Country level.
2. The multi-sectoral collaboration with partners should be part of national and regional agenda for both Kenya, Uganda and Tanzania.
3. ECSA Health Community to continue supporting countries through forums where each country would be encouraged to share their progress and best practices.
4. There is need for ECSA-HC to set up overall monitoring and evaluation systems that will establish the impact of the project outputs. An additional SROI focusing on impact assessment would be necessary over four years given the discounting period was set at 4 years by the pilot SROI study.

ANNEXES

Annex 1. Dissemination meeting agenda and programme

Day 1			
Item	**Time**	**Details**	**Person Responsible**
1. Registration	0830-0900		ECSA Team
2. Introductions	0900-0915	Introductions of participants	ECSA Team-Doreen Marandu
3. Welcome remarks	0915-0930	Welcome remarks	ECSA Team – Rosemary Mwaisaka Ministry of Health
4. Workshop objectives	0930-0940	The Facilitator will outline the key objective of the Workshop highlighting the preferable approaches.	Facilitator
5. Presentation of SROI study report	0940-1030	Presentation of Key findings of SROI study including conclusions and recommendations.	Consultants - University of Dar es Salaam department of Economics
Tea Break			
6. Group Discussion of SROI study reports	1100-1300	Participants will be guided to give their concrete feedback to the SROI study report. *Group feedback form shall be availed.*	Facilitator
Lunch			
7. Country team presentation on the adoption and dissemination plans	1400-1515	In-Country implementation team will present on the progress made so far on adoption of in-service packages and pre-service model curriculum.	In-country implementation lead team
8. Group Discussion of the adoption and dissemination progress	1515-1615	○ The participants will be guided to analyze the critical strengths, weakness, opportunities and threats in the implementation framework.	Facilitator

9. Conclusion	1615-1700	○ Summary of the day's work	Facilitator

Day 2			
Item	**Time**	**Details**	**Person Responsible**
1. Introduction	0900-0930	Recap of Days One's Activity	
2. Dissemination objectives	0930-9.45	The Facilitator will outline the key objectives with a focus on products and tools	Facilitator
3. Background of the project	0945-10.30	The Project technical team will outline the project background and steps undertaken to develop the products. ***Media Coverage***	ECSA Team-Rosemary Mwaisaka
Tea break			
4. Description of products and tools	11.00-11.40	Brief outline products shall be made in a presentation outlining critical content. <u>Pre-service model curriculum</u> • Advocacy materials- fliers and open letter to key stakeholders (see attached for Kenya) • Other branded material for advocacy- we will update you on this <u>In service training packages</u> • Training of trainer manual • Facilitator manual (for health facility and community) • Participants manual (for health facility and community) • Hand out/teaching aid for community • Job aid ***Media Coverage***	Facilitator

5. Brief presentation on country adoption plan	11.40-12.00	○ General discussions with a focus on how each country intends to utilize the products for Capacity development in their Countries.	MOH
6. Presentation of Products	12.00-13.00	Guest of honour will be presented with all the project products along with other key stakeholders. ***All documents put together and tied by ribbon.*** ***Media Coverage***	ECSA Team Director of Programs Rosemary Mwaisaka Doreen Marandu
7. Vote of thanks	13.00-13.30	Vote of thanks – Government Representative	
		Lunch Break	

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