REPUBLIC OF KENYA

NATIONAL NUTRITION ACTION PLAN (NNAP) 2012-2017

IMPLEMETATION REVIEW REPORT

DECEMBER 2017

NUTRITION INTERNATIONAL
Nourish Life

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Table of Contents

Abbreviations

AWP	Annual Work Plan
DFID	Department for International development
DHIS	Data Health Information Systems
EAC	East African Community
FAO	Food Agricultural Organization
FGD	Focus Group Discussion
FNSP	Food and Nutrition Security Policy
HiNi	High Impact Nutrition Interventions
ICN	International Conference on Nutrition
ICT	Information Communication and Technology
ID	Iron Deficiency
IDA	Iron Deficiency Anemia
IFAS	Iron Folic Acid Supplementation
KDHS	Kenya Demographic Health Survey
KHSSP	Kenya Health Sector Strategic and Investment Plan
KNMS	Kenya National Micronutrient Survey
MI	Micronutrient Initiative
MOH	Ministry of Health
MTR	Mid Term Review
MoE	Ministry of Education
MDG	Millennium Developmental
MIYCN	Maternal, Infant and Young Child Nutrition
MTEF	Medium Term Expenditure Framework
MTEP	Medium Term Expenditure Plan
MTP	Medium term Plans
NDU	Nutrition and Dietetics Unit
NNAP	National Nutrition Action Plan
NGO	Non-Governmental Organization
NI	Nutrition International
SDG	Sustainable Development Goals
SUN	Scaling Up Nutrition
ToR	Terms of Reference
UNICEF	United Nations Children Fund
UN	United Nations
VAD	Vitamin A Deficiency
WFP	World Food Programme
WHO	World Health Organization

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Executive Summary

Kenya has defined its development agenda under the 'Kenya Vision 2030' framework. The Vision aims at transforming the country into a middle-income country that will ensure high quality of life for its people. Amongst the issues Kenya is addressing in order to achieve the Vision 2030 is the double burden of malnutrition; under-nutrition and over nutrition.

Issues like severe stunting, though over the years has registered remarked reduction, still continues to affect children below five years especially in rural areas. According to the Kenya National Micronutrient Survey of 2011, anemia and iron deficiency among pregnant women and children under five years of age continues to be of major concern to public health. Zinc and B12 and folate deficiency are among other micronutrients affecting different population groups. Overweight and obesity on the other hand has continued to increase especially among women of reproductive age (KDHS 2014).

In 2012, Kenya joined the Scaling Up Nutrition (SUN) Movement and developed a five-year National Nutrition Action Plan (NNAP) 2012 to 2017 to facilitate implementation of evidence based nutrition interventions. NNAP presents a coordinated effort to address malnutrition as outlined in 11 strategic objectives focusing on both under-nutrition and over-nutrition. Kenya's adoption of SDGs especially the Agenda 2030 that domesticates the SDGs presents greater opportunity to refocus, systematically articulate the Scaling Up Nutrition with an integrated approach both for emergencies and sustainable food security and nutrition interventions.

As NNAP comes to a conclusion in 2017, the nutrition sector has undertaken a review of its implementation and will use the findings to inform the next NNAP (2018-2022). The process of reviewing NNAP included desk review of various key documents, policies, laws and regulations governing the nutrition sector. It also involved an interactive inception workshop and consultations with key stakeholders in selected counties covering ASAL, non-ASAL and urban counties. The visits were meant to mine and collate and triangulate information on implementation of the NNAP. This has addressed issues related to enabling environment, identified programmatic issues addressed by the NNAP over its implementation period 2012-2017. The review would also confirm strengths, challenges that affect nutrition interventions and that if addressed, would ensure greater and sustainable outcomes. It will also identify opportunities that may be included in the next NNAP.

Key achievements have been registered under NNAP. Some of the achievements reported include:

1) Improve micronutrient levels of Vitamin A, iron, zinc reducing deficiency among pregnant women, children under five years of age. IFAS supplementation for 90 days in pregnant women has slightly improved
2) Stunting and wasting rates have reduced over the period of NNAP, while the rate of obesity is on the increase during the same period.
3) Implementation of Baby Friendly Community Initiative including establishment of baby friendly environment by private sector is reported.
4) Approximately 2000 health workers trained on diabetes prevention and control while BMI scale up and Waist Circumference measurements at community has been initiated.
5) Activities to improve nutrition knowledge, attitudes and practices undertaken and periodic assessment reports are available.

6) There is noted enhanced government leadership, improved coordination of stakeholders, a more harmonized approach to implementation and monitoring of nutrition programs. The various stakeholders have included government ministries and departments, private sector, civil society, academia, development partners both bilateral and multilaterals.
7) Increased financing of nutrition interventions both at national and county level coupled with support from donors UN agencies and implementing partner.

Looking into the future, the need for multi-sectoral approach and strong coordination cannot be over-emphasized because unlike in 2012 when the NNAP was launched, the county governments are now responsible of implementing 95 percent of nutrition activities. Devolution provides a great opportunity to prioritise nutrition, increase investment, and capacity in skilled human resource (both technical and managerial).

The next NNAP also need greater advocacy to prioritize agriculture and nutrition as part of counties development agenda. There is also need to emphasise on monitoring and evaluation for performance measurement to inform further planning and resource mobilisation.

Chapter 1: Background

Under the Vision 2030, Kenya aims to attain middle income status. Kenya's economic and social development continues to register positive growth but malnutrition is hindering its full potential because malnutrition in the long term impends full productive potential of those affected. The Government of Kenya has demonstrated commitment to address malnutrition situation by putting in place policies, strategies and legislation aimed at improving nutrition situation in the country. These include, National Food and Nutrition Security Policy (FNSP) 2012 that identifies food security as a basic human right, Draft FNSP Implementation Framework 2016-2020, Kenya Health Strategic Plan that includes nutrition, National Nutrition Action Plan (NNAP), East Africa Fortification Standards, Breastmilk substitute Act 2012 among others.

Kenya joined the SUN Movement in 2012 and thereafter launched the NNAP 2012-2017, signaling its commitment to addressing malnutrition and undertaking coordination of all stakeholders. Some of the key achievements since adoption of 2012-2017 NNAP include enhanced government leadership of the nutrition sector, improved coordination of stakeholders, a more harmonized approach to implementation and monitoring of nutrition programs. The various stakeholders have included government ministries and departments, private sector, civil society, academia, development partners both bilateral and multilaterals. It is notable that nutrition interventions are part of the Annual Operational Plans (AOPs), and Medium-Term Expenditure Framework (MTEF). The existence of coordination mechanisms with overall leadership from Nutrition Interagency Coordination Committee (NICC) have enhanced sector wide approach instrumental in overseeing and guiding the implementation of the NNAP since 2012.

NNAP 2012-2017 is coming to an end and the Nutrition Unit of the Ministry of Health has undertaken an in-depth review aimed at understanding and analyzing the nutrition sector policies, strategies and reports and implementation and performance of NNAP 11 strategic objectives. The in-depth review is also meant to draw lessons, identify opportunities and challenges that will inform the new NNAP 2018-2022. The review examines the extent to which NNAP objectives have been achieved, and challenges impacting on the sub-sector works in. In doing so, the review analyzes the roles of stakeholders and that of SUN Movement Focal Point in coordinating the sub-sector. The review also focuses on the changed environment since the new constitution that provides for 47 county governments and their contribution in enhancing nutrition interventions in respective counties. Finally, the review has come up with recommendations and gaps for inclusion in the next NNAP.

Chapter 2: Methodology

The in-depth review involved the following approaches:

2.1 Desk Review

The desk review provided an understanding of the overall objective of the nutrition Programme in Kenya and confirmed regulations, policies and strategies guiding the nutrition sector. These documents also provided the context of the foundation of nutrition interventions and programmes, and the status of implementation of nutrition activities in the country. Information and data from the desk review justified nutrition specific and sensitive interventions and confirmed the documentation of the implementation and achievements to date. The output of the desk review provided a framework for discussions and interrogation of issues within the three identified thematic areas that included; the enabling environment, programmatic issues weaknesses, strengths, opportunities and challenges that impacted on implementation of NNAP 2012-2017.

2.2 Inception Workshop

The inception workshop entrenched participation of stakeholders through technical working groups constituted along three thematic areas namely: enabling environment, programmatic areas and strengths, weaknesses, opportunities and threats.

The participants representing different institutions were divided into six discussion groups. All groups discussed the three thematic areas to enable as wide contribution across all the three thematic areas. In discussing the programmatic issues, stakeholders were divided into the following groups:

i. Maternal, Infant and Young Child nutrition
ii. Micro-nutrient deficiency prevention and control and food fortification
iii. Food Security and Emergency nutrition
iv. Clinical Nutrition
v. Advocacy and Nutrition in Institutions
vi. Monitoring and Evaluation and Research

2.3 Interviews and Field Visits

The review emphasized on a participatory approach that was achieved through wide stakeholder consultation both at national and county levels. At the national level, the stakeholders included key institutions involved in nutrition interventions, public, civil society, donors, UN and private sector. At the county level, stakeholders included county government departments, implementing partners, UN technical personnel. The selection of the six counties was based on representation of ASAL, Non ASAL and urban areas.

Consultations were based on approved tools specific to each level of government and each segment of stakeholders participating (Annex 2). The tools were designed in consultation with nutrition and dietetics unit of MoH. It included in-depth interviews with key informants and round table consultations. The purpose of the consultations and interviews was to triangulate the information collected during the desk review, inception workshop and confirmation of the implementation of the intervention in the counties.

2.4 Stakeholders workshop

The stakeholders' workshop validated findings of the review and approved the identified opportunities and proposed recommendations for inclusion in the next NNAP.

Chapter 3: Nutrition Landscape in Kenya

3.1 Analysis of Legislation, Regulation, Polices and Strategies

Kenya food and nutrition insecurity is often attributed to the low performance of the agricultural sector. Over the years, Kenya has developed a number of documents focusing on performance of agriculture and its role in food security. Some of these documents include Sessional Paper no. 4 (1981) being Kenya's first food policy aiming at sufficiency in foodstuffs production, and ensuring equitable distribution of food of nutritional value to all citizens. Second Session paper of 1994, promoted market driven approach to food security. Kenya Rural Development Strategy of 2002-2017 was developed as a long-term framework emphasizing food security as initial steps towards poverty alleviation and rural development, and the Agriculture Sector Development Strategy focus on aligning agricultural sector initiatives with Vision 2030, the blue print for Kenya development.

In addition, the Food and Nutrition Security Policy and its Implementation Framework defines food and nutrition related issues and how they should be implemented. Further, the sector has defined specific regulation and policies that are specific to nutrition. These include; the food fortification standards, the Breastmilk Substitute (BMS) Act, School feeding policy, the salt iodization standards, the social protection policy, the health ACT, the nutrition in HIV guidelines, healthy lifestyle guidelines to mention but a few.

Whilst the sector has elaborated policies, legislations, regulations and guidelines, the country is yet to achieve optimal nutrition for its population. Some of the reasons discussed further below, include, limited resources, disjointed implementation frameworks by different partners, emphasis on emergencies vis a vis deliberate systematic and developmental approach to nutrition interventions. The FNSP discussed below emphasised more on food security and therefore agriculture sector has focused mainly on interventions that ensure production of foods with less emphasis on nutrition.

Despite the many sectoral participation in nutrition, there has not been a deliberate attempt to confirm the contribution of all these sectors towards improved nutrition. For example, the school feeding programme has no indicators confirming contribution towards nutrition of the children, instead only measures retention of children in schools. Nevertheless, the review confirms that the policies and specifically FNSP remains relevant to the nutrition sector and the focus should mainly be the implementation from an integrated approach to allow contributing sector confirm their performance in relation to nutrition outcomes.

3.2 Food and Nutrition Security Policy

The Food and Nutrition Security Policy (FNSP) 2011 provides an overarching framework covering the multiple dimensions of food security and nutrition interventions. [1] The policy identifies food security as a basic human right. FNSP consolidates all relevant policies and strategies, initiatives and plans included in the Economic Recovery Strategy, Agriculture for Revitalizing Agriculture and vision 2030 that address nutrition. The policy also reflects initiative to revive the economy and revitalize agriculture as cornerstones for nutrition as part of the Sustainable Development Goals.

[1] The Food and Nutrition Security Policy 2011

The FNSP takes into consideration that it is not just sufficient food, but it is food that guarantees nutritious and safe food to support health and growth throughout the life cycle.

The objectives of FNSP include:

i) To achieve adequate nutrition for optimum health of all Kenyans;
ii) To increase the quantity and quality of food available, accessible and affordable to all Kenyans at all times; and
iii) To protect vulnerable populations using innovative and cost-effective safety nets linked to long-term development

To attain its objectives, FNSP is constructed under multiple dimensions including, domestic production, storage and agro-processing, strategic food reserves; access to and quality of markets; food trade; on farm and off farm employment; improving food accessibility for the urban and peri-urban poor; irrigation and food security. It also takes into consideration cultural, social and political factors in accessing food.

The FNSP focuses on:

i) Advocating for increase of quantity and quality of food available and made accessible for adequate and diversified diets for all Kenyans,
ii) Recognizes the effect of poverty on food security and malnutrition.
iii) The policy framework provides for development of appropriate institutional and regulatory framework to ensure safe and high-quality foods
iv) Addressing micronutrient deficiencies through promotion of diversified diets, food fortification, bio fortifications and vitamin and mineral supplementation.
v) Nutrition in schools and institutions.

Although agriculture sector has experienced growth over the years, the sector's strategies have not led to full food security for the country and micronutrient-rich foods have been insufficiently promoted.[2] One of the factors contributing to this minimal achievement is due to lack of linkage with other relevant sectors like water, health and education that play a major role in promoting nutrition.

Kenya's food security and nutrition needs is further complicated by an unstable economic environment, a recent rise in food and fuel prices, adverse weather conditions, insufficient budgetary allocations and weak sector coordination.[3] Kenya still records low agricultural productivity and growth less than 6%, which lower than the Maputo Declaration target of 10%.

It is thus worth noting currently agriculture as a key sector represents 32 % of GDP of Kenya and 27% of GDP indirectly through linkages with manufacturing, distribution and other service related sectors. Despite efforts to support the agriculture sector, hunger still persists. Percentage allocation in the last financial year remains low (4.6% of national budget). According to the Global Hunger index, out of 113 countries of which 27 are from Sub Saharan Africa, Kenya ranks No 86 with a score of 42.2% (GHI 2017) in its support to agriculture leaving a lot to be done.

3.3 Some of the Nutrition Achievements under FNS Policy

The above not withstanding Kenya has made impressive strides in addressing nutritional challenges especially among the most vulnerable segments of the populations, including

[2]Kenya : Situation analysis for Transform Nutrition: Republic of Kenya 2008,-2010 reports-USAID
[3]Ibid

children and women of reproductive age. Figure 1.0. provided a graphical comparison of the trends in stunting, wasting and underweight among children under the age of 5yrs. According to the Kenya National Micronutrient Survey (KNMS) conducted in 2011[4], the prevalence of stunting stood at 26.3% from 35% over a period of over two decades. These statistics are corroborated by the KDHS report of 2014.[5] Wasting is at 4% for children under 5, while severe stunting remained unchanged at 8.1%. [6] It is however worth noting that severe stunting affected more children in rural areas (9.9%) compared to children living in urban areas (3.7%).

The chart below illustrates these key nutrition trends for children under 5 years of age.

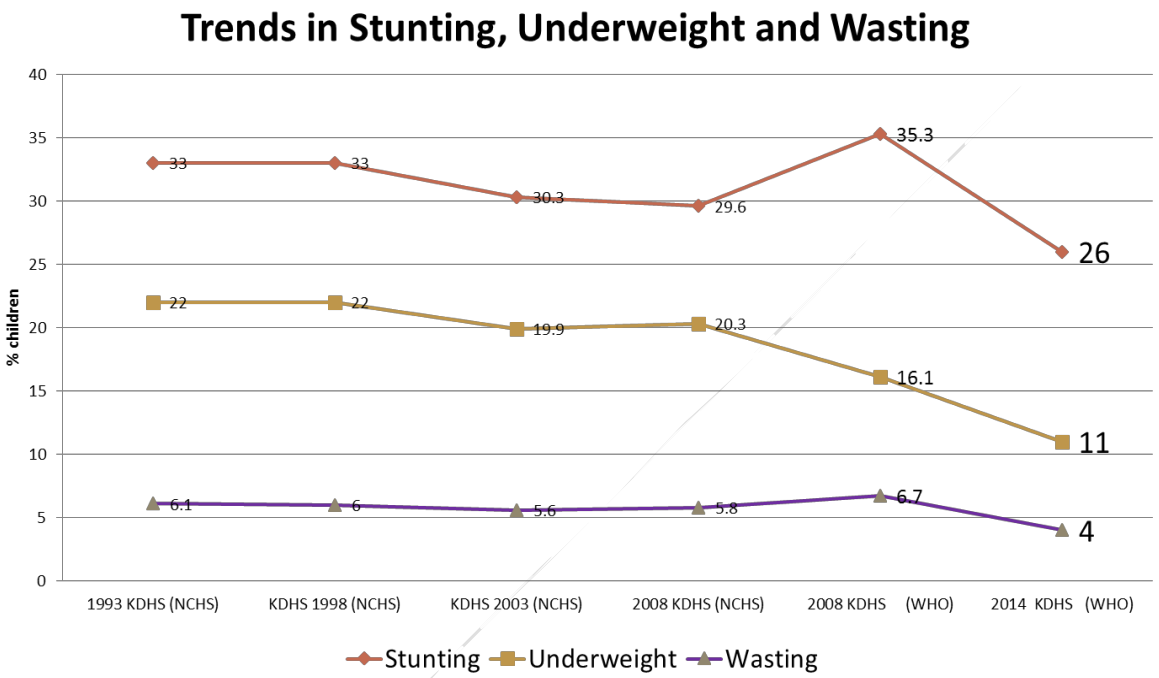


Figure 1: Trends in Stunting, Underweight and Wasting
Source: MOH Nutrition Unit

[4] Kenya National Micronutrient Survey 2011
[5] Kenya National Bureau of Statistics (KNBS) and ICF Macro. 2014. Kenya Demographic and Health Survey 2014. Calverton, Maryland: KNBS and ICF Macro
[6] 2011 survey data corroborated by KDHS 2014

As illustrated in Figure 2 obesity and overweight in the WRA shows an increase over a period of 5 years rising from 25% to 35% for overweight and obesity increased from 7% to 10% from 2008 to 2014.[7] Thinness on the other hand, registered a downward trend from 12% in 2008 to 9% in 2014.

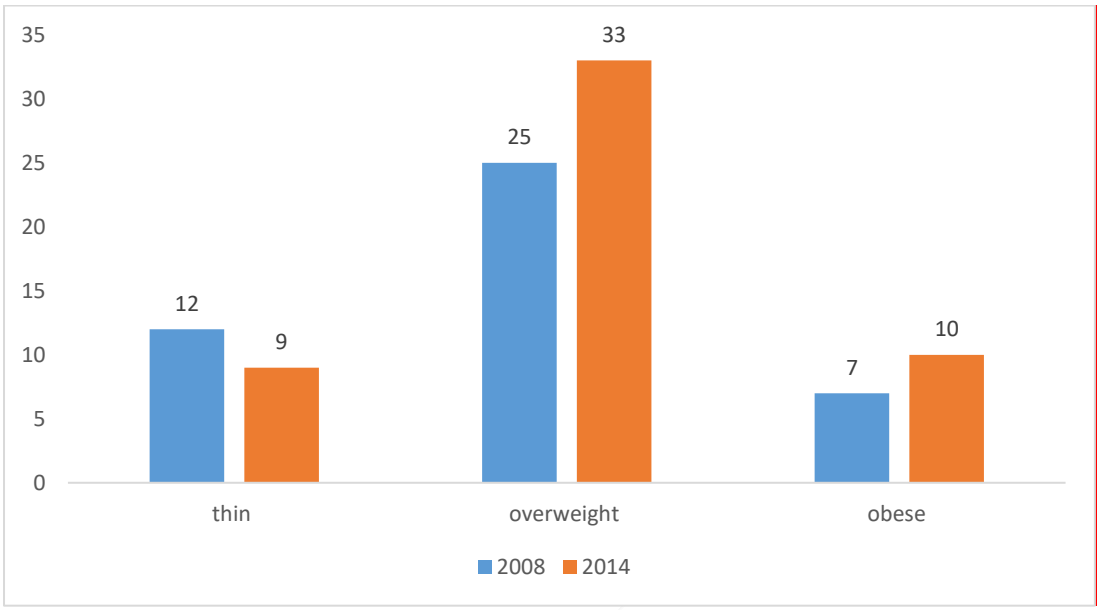


Figure 2: Malnutrition among Women of Reproductive Age. *Source KDHS 2014*

The last demographic health survey of 2014, showed there were more overweight and obese women than men. Overall. 27.9% of the adult population is overweight and obese as illustrates in Figure 3.

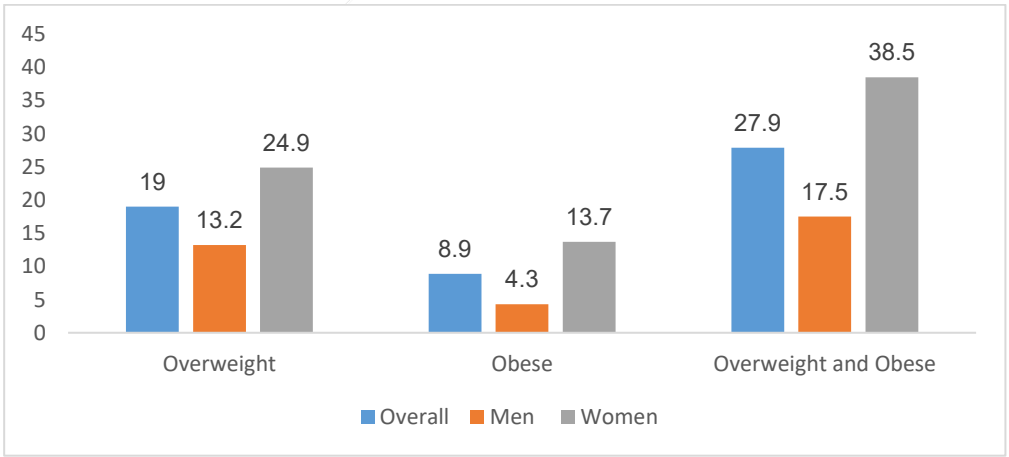


Figure 3: Prevelance of Overweight in General Population. *Source KHDS 2014*.

[7] Kenya National Micronutrient Survey 2011

The trend of overweight and obese children shows a downward trend over the last 20 years as illustrated by Figure 4.

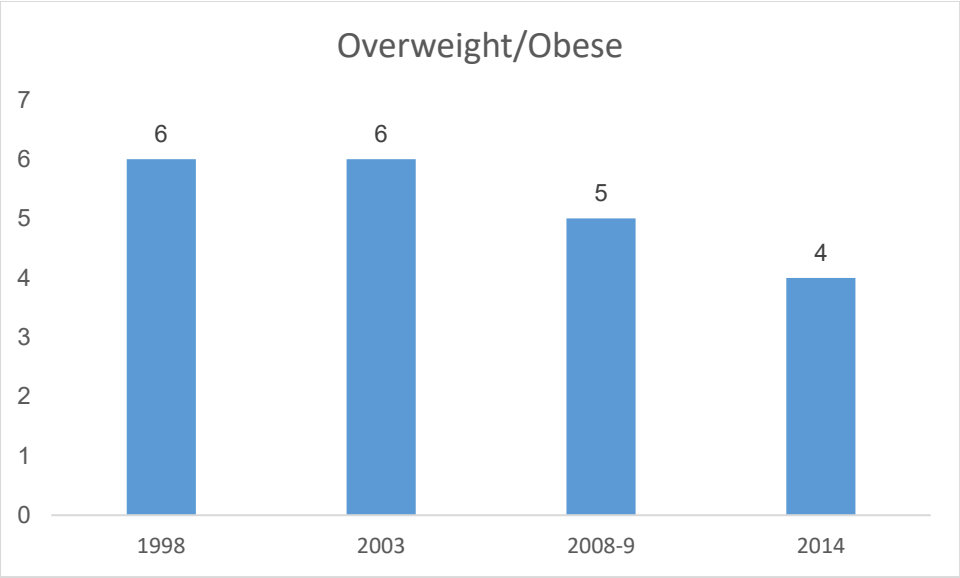


Figure 4: Proportion of Overweight and Obese Children (WHZ +2 scores). *Source: KDHS 2014*

Anemia and iron deficiency are of major public health concern in Kenya. 2011 KNMS showed that pregnant women were the most affected by anemia, predominantly due to iron deficiency. According to the survey, anemia in pregnancy was 41.6%. Based on the high anemia prevalence among women of reproductive age, health and nutrition sector has adopted various strategies to address this deficiency including iron supplementation. It is recommended that all pregnant women receive at least 90 tablets of iron. According to the KDHS 2014, only 8% of the women took at least 90 or more iron tablets while 30% did not take any iron supplementation during pregnancy as shown in Figure 5.

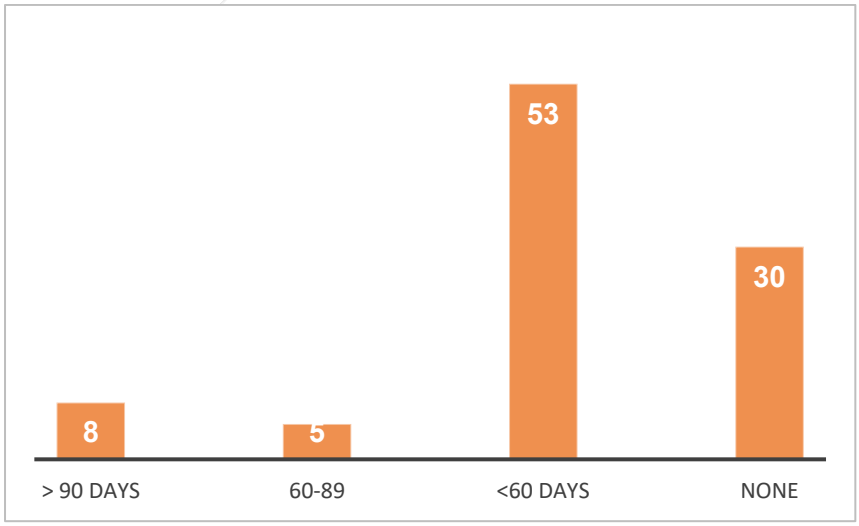


Figure 5: Iron Supplementation among Pregnant Women Source: *KDHS 2014)*

Anemia in children under the age of five years stands at 26.1% while 21.8% of children suffer from iron deficiency. Vitamin A deficiency (VAD) and marginal VAD among school-aged

children was 3.6 percent and 33.9 percent respectively as reported by Kenya National Micronutrient Survey of 2011. High zinc deficiency was observed across the population groups; with the highest deficiency noted in school going children at 83.3% and non-pregnant women at 82.3% by the same report. Children under the age of 5years also reported high level of deficiency at 80.2%, while 74.8% was reported among men and 68.3% in pregnant women. The national prevalence of folate deficiency in pregnant and non-pregnant women was 32.1% and 30.9% respectively. While Vitamin B12 deficiency was higher in non-pregnant women standing at 34.7% compared to pregnant women 7.7%.

Chapter 4 Kenya National Nutrition Action Plan 2012-2017

The Background of developing NNAP dates back to 1992 when the International Conference on Nutrition (ICN) in Rome provided an opportunity to review Kenya's nutrition strategies leading the development of the first Nutrition Action Plan 1994-1997. Learning from lessons of 1994-1997 NNAP, in 2008 the Food Security and Nutrition Policy (FSNP) was developed followed by the Food Security and Nutrition Strategy (FSNS) to operationalize the policy that has been since replaced by implementation frameworks.

The 2012-2017 National Nutrition Action Plan (NNAP) is derived from the FNS Policy. It is important to note that the NNAP was developed when the country was focused on achievement of the MDGs through the implementation of the High Impact Nutrition interventions (HiNi). NNAP, aiming at improving the nutrition status of the Kenya's population, set up 11 strategic objectives that would help address the double burden of malnutrition- the under and over-nutrition. Kenya committed to spend KES. 6 billion over the five-year period to support the scaling up of nutrition interventions outlined in the action plan. The responsibility of implementing NNAP is shared across various ministries including health, agriculture, water and irrigation, fisheries development, and national planning and development.

The NNAP is aligned to the Government Medium Term Planning (MTP) process and has been implemented as a multi-year plan with annual work plans being generated to link to the government budgetary cycle. As the plan come to a conclusion in 2017, the nutrition sector is required to undertake a strategic in-depth review to inform the next (2018-2022) MTP cycle

Some of the NNAP objectives targets to contribute towards reduction of severe and moderate stunting by one-third, eliminate iodine deficiency, and reduce anemia by 30 per cent. [8] Results of successful implementation of the NNAP is expected to contribute to an overall impact of a 30 percent reduction in child mortality and an increase in GDP of up to 3 percent, in the long term.

[8] USAID Report on Kenya Nutrition Profile February 2016

The Ministry of Health Nutrition and Dietetics Unit (NDU) under the Family Health Department is responsible for coordinating the implementation of NNAP including providing guidance on implementation of NNAP interventions by other sectors including Ministries of Agriculture, Education, Water and the counties. A Nutrition Interagency Coordinating Committee serves as the multi-stakeholder and multi-agency platform to coordinate nutrition programs. High-level coordination structures, the National Food Security and Nutrition Steering Committee (NFSNSC) and the National Food and Nutrition Security Secretariat (NFNSS), are established under the Office of the President and the Ministry of Devolution and Planning respectively to provide over-arching coordination of the nutrition sector. Nutrition is also being prioritized within the country's 47 counties, with each expected to develop County Nutrition Action Plans, Among the visited counties Kakamega and Isiolo have developed and operationalised their first plans.

NNAP has an embedded monitoring and evaluation framework. This M&E framework has further been developed into an independent M&E framework 2013 to guide the monitoring and evaluation of activities of the nutrition sector in the country. It also aims at consolidating nutrition data and information from various sources including DHIS and nutrition surveys and assessments. This data is used for planning and coordination of nutrition activities across the two levels of government.

NNAP 11 ambitious objectives for period 2012-2017 are.

i) Improve nutritional status of women of reproductive age (15-49 years)
ii) Improve nutrition status of children under five
iii) Reduce the prevalence of micronutrient deficiencies in the population
iv) Prevent deterioration of nutritional status and save lives of vulnerable groups in emergencies
v) Improve access to quality curative nutrition services
vi) Improve prevention, management and control of diet related NCDs
vii) Improve nutrition in schools and other institutions
viii) Improve knowledge, attitudes and practices on optimal nutrition
ix) Strengthen the nutrition surveillance, monitoring and evaluation systems
x) Enhance evidence-based decision-making through operations research: Evidence-based decision-making through operations research
xi) Strengthen coordination and partnerships among the key nutrition actors

NNAP has an activity implementation matrix providing baselines, targets and indicators to measure the achievements of the NNAP strategic objectives and initiatives. However, reports showing achievements are not conclusive and comprehensive as most are providing reports skewed to areas that have heavy partner presence and funding. Reports corresponding to national outputs as per the targets and indicators provided in the NNAP are not available.

Chapter 5 Key Findings of the NNAP: Achievement in Line with Set Objectives

The following section provides the findings gathered during review of performance of NNAP. The results and findings are structured into, programme related findings based on the outcomes and outputs of the NNAP strategic objectives. In undertaking the review, emphasis on participation of stakeholders helped in deliberating issues that have influenced the achievements of the NNAP. These issues include the enabling environment, confirmed strengths and weaknesses impacting on implementation of interventions. Finally identifying opportunities for inclusion in the next NNAP and challenges that if addressed would lead to greater and sustainable outcomes.

5.1 Programmatic Issues of the NNAP Strategic Objectives

The following section presents findings under the programmatic issues based on the expected outputs of the programme's strategic objectives. The results are based on indicators included in the NNAP 2012-2017. It is important to note that some of the indicators have no baselines and targets, making it difficult to confirm quantitative achievements. However, a lot of work has been done and information is available to provide qualitative data on activities undertaken over NNAP 2012-2017 implementation period. These results are captured as notes in the last column in each table. Reviewing the reported strategic objectives results over the five years confirms that baselines were drawn from different surveys undertaken at different dates. Some of the baselines were dated as early as 1990s while others were drawn from KDHS of 2014. Because of this disparity in baseline data, it is not clear how the targets were arrived at and how they would be measured. The lack of strong baselines weakens the expected outputs and outcomes from the strategic objectives.

The review confirmed that some of the data reported as achievement was derived from the KDHS of 2014. This means that some of the reported data cannot be attributed to the NNAP that started in 2012 and concluded in 2017.

Additionally, most indicators under the outputs do not have baselines or targets making it difficult to confirm level of achievements by end of five years of implementation. However, a lot has been and the achievements are captured as Notes under the programmatic issues. The review recommends that the next NNAP ensure a comprehensive implementation log frame with clearly defined indicators and means of verification. There is need to undertake a baseline study that will establish the baselines for all interventions.

The next NNAP also need to have realistic targets for the implementation period. The lack of clearly defined baselines and targets means inability to measure the extent to which NNAP has achieved its objectives as envisage at time of planning. Nevertheless, looking at other processes including the policies, legislation and regulations and guidelines identified during the review confirms that NNAP has contributed towards improved nutrition.

Strategic Objective 1: To improve the nutritional status of women of reproductive age (15-49 years)

A number of indicators such as iodine and goiter deficiencies, the baseline data is based on surveys undertaken before NNAP was launched. As presented in the tables in the Annexes, the baselines iodine is drawn for KDHS but there is no data to confirm the achievement of the target set.

Strategic Objective 1 had a focus on improving nutritional status of women of reproductive age. Data available for this strategic objective indicate a positive trend towards achieving the target both at outcome and output levels. Vitamin A deficiency reduced from 51% to 5.4% among pregnant women and 1.1% in non-pregnant women against targeted reduction to 15%. Iron deficiency reduced from a prevalence of 55% to 26% and 14% in pregnant and non-pregnant women respectively while it was expected that it would reduce to 25%. In the case of goiter, the prevalence has not been assessed at national level since 2004, but there is no data to confirm performance. The baseline for Zinc deficiency levels was 52% in 1999 and increased to 68.3% in pregnant women and 82.3% in non-pregnant women in 2014, 15 years later. Prevalence of Zinc deficiency seemed to have gotten worse despite interventions.

During development of NNAP, targets for overweight, obesity and underweight in WRA were based on KDHS 2008/09 data. After 5 years in 2014, the national prevalence of overweight and obesity increased from 25% to 35%, while the proportion of the underweight reduced from 12.3% to 8.9%. This shows an inverse relationship, as overweight and obesity among WRA increases while underweight decreases.

Based on the outputs of objective one, in 2008 before the start of NNAP, the proportion of women taking iron and folic acid supplements for at least 90 days during pregnancy was 3%. NNAP targeted to increase the proportion on WRA on Iron and folic acid supplementation to 80%, however by the end of NNAP implementation, this proportion had only creased by 4.5% to 7.5%. Measures of nutrition status by MUAC, monitoring of weight in pregnant women, proportion of health facilities with nutrition commodities and equipment for maternal nutrition interventions were not measured making it difficult to assess performance. Details are presented in Annex 3 Table 1A and B.

Strategic Objective 2: To Improve the Nutritional Status of Children under 5 Years

Outcome and output indicators on improved nutritional status of children under the age of five show slow improvement. All base lines are derived from 2004 KDHS- any changes 2 years prior to NNAP implementation process are not captured. However, arising from the intense activities during the NNAP implementation period, stunting rates are reported to have reduced from 35% to 26%, over a period of more than two decades, however fell short of the MDG target 14%. The decrease in prevalence also applies to wasting (from 6% to 4% against a target of 2%) and underweight (from 16% to 11% against a target of 10%). The scenario is different for obesity, Iron and Vitamin A where the achieved change is higher than the planned targets.

Zinc deficiency on the other hand increased from 51% in 1999 to 83.3% in 20111/2012 showing a somewhat poor achievement when compared to performance of the other micronutrients.

Implementation of Baby Friendly Community Initiative is reported to have been achieved in all community units. While health facilities certified as baby friendly are a quarter of the target set over the NNAP implementation period. Overall, achievements in the output indicators for objective 2 are reported to have improved. Details are presented in Annex 3 Table A and B.

Some of the outputs reported under strategic objective 2 have details of the activities undertaken during NNAP. Some of the activities include studies taken, enactment of the Health Act 2017 requiring all companies to set up lactating rooms. To date 13 companies

including NGOs and banks have been provided with certificates as baby friendly organisations. Details are provided under Annex 3 Table A and B.
In addition, 103 health workers from each county have been trained as trainers (TOTs) on appropriate infant feeding practices and 23 ASAL counties provided with Behavior Change Communication/Information, Education and Communication (BCC/IEC) materials. Complementary feeding framework has been finalized. However, there is no available data to confirm the extent to which dissemination has been done. Further, the Breast-Milk Substitutes ACT has been finalized.

Strategic Objective 3: To Reduce the Prevalence of Micronutrient Deficiencies in the Population

Micronutrient deficiencies interventions reports positive progress; with Vitamin A deficiency reduction reported at 6%. The target for reduction of iron deficiency in non-pregnant and pregnant women is almost met. The iodine indicators showed decrease in iodine deficiency in school age children and women of reproductive age during the period of NNAP implementation.

County specific studies undertaken have findings on specific to micronutrient deficiencies. These include the Large Country Lot Quality Assurance Sampling studies. The studies measure the increase in the population knowledge on micronutrient deficiency and curative and preventive measures. No data for this indicator is available.

Except for three indicators, the rest of outputs indicators for objective 3 (annex 3 Table 3A and B) have reported their achievements as notes because there are no set baselines and target. It is noted that % of children supplemented with Vitamin A increased by 10 percent but below the target of 86%. IFAS supplementation for 90 days in pregnant women continues to under-perform despite a slight increase. Food fortifications as a key intervention that was fully adopted during NNAP implementation has since seen 305 certified brands as private sector participation in fortifying foods products as per the national guidelines.

Strategic Objective 4: To Prevent Deterioration of Nutritional Status and Save Lives of Vulnerable Groups in Emergencies

Interventions in emergencies reduced proportion of wasted children reduced by 2%; from 6% to 4%, missing the target by 2%.
Despite not having baseline indicators for most of the output indicators under this strategic objective, it is noted that a number of activities were initiated to prevent deterioration of nutritional status and save lives of vulnerable groups during emergencies as provided. Annex 3 Table 4 A and B has listed these achievements including drought emergency response in all 23 ASAL counties, contingency plans for the 8 floods prone non ASAL counties.

Strategic Objective 5: To Improve Access to Quality Curative Nutrition Services

This objective did not have baselines and targets to facilitate tracking progress. However lots of work has been done. The achievements are reported as Notes.

As indicated in annex 3 Table 5A and B NCDs, TB and HIV programs have integrated nutrition in their plans. Nutrition and HIV and nutrition and TB guidelines have been developed and disseminated across a number of counties. In 2012, 300 nutritionists were trained on nutrition and Diabetes and 700 healthcare workers trained as ToTs on nutrition and TB.

The curative nutrition services generally has no clear indicators to be monitored, currently, the clinical nutrition and dietetics manual review process is ongoing.

Strategic Objective 6: Halt and Reverse the Prevalence of Diet Related Non-Communicable Diseases

The outcomes on NCDs, have no set baselines or targets. However, achievements over the NNAP implementation period are noted as indicated in annex 3 Table 6A and B. The measures of NCDs have largely relied in other surveys like the stepwise survey conducted in 2015. This survey screened for hypertension, diabetes, cervical cancer. Data shows that there a number of cancer incidences that have been reported though not at national scale. These include, esophageal, prostate, Karposis Sarcoma cancer.

Approximately 2000 health workers have been trained on diabetes prevention and control-about 10% target health workers. BMI is done on ad hoc basis and data is not captured in DHIS. Scale up for BMI and Waist Circumference at community is ongoing but data is not available. With no data, it's difficult to relate any nutrition related activities to the different NCDs. In addition, mapping of partners to measure the proportion of counties implementing nutrition guidelines on NCDs done.

Strategic Objective 7: To Improve Nutrition in Schools, Public and Private Institutions

The outcome on pupils in primary schools with adequate nutrition status has no indicators. The achievements captured is a reflection of amounts of work that has been done under this objective. Situation analysis done for the homegrown school feeding regions, have been documented and disseminated. The home-grown school feeding program is in public primary schools in ASALs and vulnerable populations in urban areas under Ministry of Education (MoE).

With this understanding of multi-sectoral approaches, members of nutrition unit are included in curriculum development. Currently the school health program in the Neo-natal child and adolescent health unit is reviewing the school health policy and guidelines. Specific report on other activities are detailed in Annex 3 Table 7A and B. Lack of indicators linking nutrition and the education sector school feeding programme hinder confirmation of contribution or impacted on nutrition from the feeding programme.

Strategic Objective 8: To Improve Nutrition Knowledge Attitudes and Practices among the Population

Activities to improve nutrition knowledge, attitudes and practices have been undertaken and periodic assessment reports are available. As detailed in annex 3 table 8 A and B these include minimum acceptable diets for children aged 6-23 months, EBF rates, MIYCN KAP surveys covering pregnant and lactating women and children less than 2 years. The stepwise survey on NCD risk factors is providing data for adults aged 18-69 years touching on sugar, salt intake, consumption of fruits and vegetables in terms of servings per day against WHO recommendations. In addition, most counties mark nutrition days, e.g. Malezi bora, breastfeeding week.

Strategic Objective 9: To Strengthen the Nutrition Surveillance, Monitoring and Evaluation Systems

The strategic objective 9 aimed at establishing functional and sustainable nutrition information system. A lot of progress has been made though the objective does not have indicators. National data is available from DHIS, NDMA early warning system and national surveys such as the 2014 KDHS. Small scale surveys and assessments such as integrated SMART surveys, IMAM program coverage assessments, MIYCN KAP surveys and nutrition capacity assessments have been carried out in priority counties to inform programming during the NNAP.

Some of the achievements from this objective are detailed in Table 3 Annex 9 A and B. Notable achievement is improved surveillance, timely response under emergency while M and E is providing data on trends on nutrition hence facilitating programming.

Strategic Objective 10: To Enhance Evidence-Based Decision-Making through Research

This objective was intended to provide evidence through research for purposes of decision making. The research component of NDU has been part of the surveillance and M and E section. As a result, more focus has been on surveillance and M and E and little attention on critical nutrition research. Notably, the major surveillance is skewed to the SMART surveys which have been limited in scope and in-depth. SMART surveys have provide data on anthropometrics but no biochemical data which is critical in identifying the effects of nutrition interventions. Further, county specific studies undertaken have regional limitations. This makes it difficult to make comparisons across counties on similar issues. During implementation of NNAP a number of research studies were carried out among them, Operational research on calcium and iron supplementation during pregnancy in Meru and Kakamega, operational research on multiple micronutrients (90 sachets), Kenya National Micronutrient Survey (KNMS) report; KAP survey on iron folic acid and Vitamin A supplementation and Feasibility study on Baby Friendly Community Initiative just to mention a few, further detail is provided in annex 3 Table 10

Nevertheless, the need to build capacity for research has been identified and NDU has recently disengaged research from M and E components and formed a specific Research Nutrition Technical Working Group open to stakeholders interested in nutrition research.

Strategic Objective 11: To Strengthen Coordination and Partnerships among the Key Nutrition Actors

The review found strong coordination among nutrition specific programmes at the national and county levels. The review also noted that areas with high number of donor funded programmes have stronger coordination. The inter and intra sectoral meetings have been noted particularly under emergency response. The review confirmed existence of large number of committees at the county however, there is nothing to help measure functionality and execution of their mandate.

Importantly, on resource mobilization it is confirmed funding comes from both government and partners for nutrition activities. However, the programmes funded under NNAP did not have clear targets to help measure progress. Nevertheless, a lot of activities have been reported as notes across all the strategic objectives. Funding for emergency support has been consistent and during the last few years of NNAP, it was well coordinated and ensured that all nutrition emergencies were addressed in a timely manner. Further information is detailed in Annex 3 Table 11A and B.

Enabling Environment for Implementation of NNAP 2012-2017

The review identified a number of factors that have influenced the implementation of the NNAP. Some of these factors provided enabling environment and that going forward will be crucial to nutrition interventions. These included:

(i) Availability of policies, legislation and regulations and strategies that have guided the nutrition sector.
(ii) Leadership and governance
(iii) Improved coordination,
(iv) strong political will,
(v) Financing (including public private partnerships),
(vi) Research, Monitoring and Evaluation,
(vii) Strong advocacy,
(viii) Capacity and human resource,
(ix) Accountability,
(x) Social norms,
(xi) Devolution and
(xii) Cross cutting issues which include gender considerations.

The analysis of these factors confirms the impact on the implementation of NNAP and supports findings, weakness and opportunities that exist for improving nutrition.

Policies, Legislation, Regulations and Strategies

The literature review confirmed numerous policies, legislation, regulations and strategies that provide framework for implementation of nutrition activities and interventions across various sectors. The review confirms that FNSP is still relevant as the basic guide for the nutrition sector. Focus should be to intensify implementation of the FNSP objectives and all other strategies developed under specific programmes across all sectors contributing towards improved nutrition.

Furthermore, NNAP is implemented under the context of MDGs 1 and 2 that of reducing poverty and halving the Kenyan population suffering from hunger. To realize these goals, a multi-sectoral and integrated approach was seen as having strong potential especially for children under five and pregnant and lactating women. Kenya's efforts towards achievement of MDG 4 and 5 paid off - Kenya met MDG 4 and made impressive improvements under MDG 5 though the goal was not fully realized. However, overall, improvement have been observed under MDG 1 and 2 as a result of the integrated approach to MDG 4 and 5 which have direct impact on MDG 1 and 2. Nevertheless, despite spirited efforts, Kenya did not meet the targets set for MDG No. 1 and 2 by the deadline of year 2015.

> The nutrition sector has policies, legislation and guidelines and strategies that guide the nutrition interventions. The FNS policy guiding both agriculture and nutrition interventions, is still relevant to the nutrition sector and focus need to shift to intensified implementation of its objectives and other strategies developed under the specific programmes

The next NNAP will be formulated under the Sustainable Development Goals (SDGs) that Kenya has signed to. SDGS 1, 2 and 3 have direct impact on nutrition that future NNAP will need to pay attention to, namely:

i. End poverty in all its forms every where
ii. End hunger, achieve food security and improved nutrition and promote sustainable agriculture
iii. Ensure healthy lives and promote well-being for all at all ages

The following are the laws, policies, plans, guidelines and strategies that are guiding the nutrition interventions, mostly developed during the NNAP review period

Regulations

- Nutritionists and Dietetics Act
- Employment Act (Maternity Protection) 2007
- The salt Iodization Act
- The Breast Milk Substitute ACT
- The food fortification regulation
- Nutritionists & Dietician acts 2007,
- Basic Education Act to guide nutrition issues in Education sector
- The Health Bill

Policies

- The National Food Security and Nutrition policy (NFSNP) and the National Food Security Policy Implementation Framework provide guidance to the multi-sectoral nutrition sector. NNAP objectives are derived from the NFSNP
- Kenya Health Policy Framework (2010)

Strategies

- Kenya National Strategy for the prevention and control of NCDs (2015-20)
- Social Protection Policy (2011).
- Kenya Nutrition and HIV AIDS Strategy (2007-10)

- National Strategy and Infant Feeding (2007-10)
- Child Survival and Development Strategy (2008
- Community involvement through the community Strategy

Plans

- The National Nutrition Action Plan 2012-2017
- Adolescent Reproductive Health Plan of Action (2015)
- National School Health Strategy Implementation Plan (2011-15)
- Nutrition is included in the Government MTP II (Medium Term Plans)
- The County Integrated Development Plans (CIDPs)
- County Nutrition Action Plans

Guidelines

- National School Health Policy and implementation Guideline (2009)
- National micronutrient guidelines, Vit A, MIYCNs, IFAS, IMAM, MMNP
- The Healthy dietary guidelines

In addition, the following are frameworks that also provided guidance on issues related to nutrition:

- The Constitution of Kenya provides for the right to food among other rights.
- The Vision 2030, Kenyan development blue print includes Nutrition among key development factors
- Kenya's MDG targets on nutrition have been translated into SDG to plan for long term and sustainable nutrition goals.
- Inclusion under KHSSP (2013-2017) key specific nutrition programmes positioning for resource allocation. Such programmes include nutrition service provision, counselling in Maternal Nutrition, HR requirements for Nutrition.
- Joining the SUN movement committed Kenya to Scaling up Nutrition in the Country

Furthermore, under the regulatory framework, the Kenya Bureau of Standards (KEBS), the Department of Public Health, the National Public Health Laboratories at the MoH are key stakeholders that provide regular monitoring of compliance with quality standards especially on fortification and other foods manufacturing, processing and handling. KEBS is particularly key in enforcing and regulating the mandatory national fortification of flours, fats and oils and edible salt. This is critical since fortification has strong private sector interest and there is need to establish level playing field for large, medium and small industries.

With the county government structures, KEBS is working out modalities to ensure that fortification compliance for flours, fats and oils at county levels is equally given support.

Other regulatory frameworks include breastfeeding and marketing of milk substitutes, framework for employers to ensure breastfeeding at work places is supported. A number of organization like Safaricom have adopted the breastfeeding framework and has set up baby friendly centers and is practicing breastfeeding at the work place.

With exception of Kakamega County, no other county has initiated own legal framework to support county nutrition interventions.

Leadership

The Nutrition and Dietetics Unit (NDU)[9] has provided leadership and coordination of the nutrition sector in the country. NDU also support coordination of donors, private sector and implementing partners working across the two levels of government. In addition, NDU has ensured roll out of programmes under NNAP to all the 47 counties. As a result NDU in its leadership has played a key role in bringing to fore the importance of nutrition.

NDU has provided strong leadership and coordination of nutrition for both sensitive and specific interventions across both levels of governments. However, with counties, new leadership structures are emerging. Majority of counties have made health their priority, as a result, nutrition specific interventions are benefiting from primary health services that are now more accessible to majority of the population.

It is noted that NDU over the last five years has continued to build its own capacity and in this endeavor, the Unit has received technical support from UNICEF, Nutrition International (NI) and World Food Programme (WFP). This capacity is reflected in the following achievements:

i) Unit's ability to plan,
i) Coordinate nutrition programmes both at MOH and across sectors contributing to nutrition improvement,
ii) Monitor and evaluate performance of the 9 programmes under the NNAP that are directly implemented by the Unit and in coordination with other MOH divisions.
iii) Manage and account for resources mobilized from the various donors working directly with the Unit. The funds have either gone to facilitate procurement of nutrition commodities, capacity building or direct implementation of interventions.
iv) Working with Ministry of Agriculture and supported by partners, the Unit has coordinated the development of an Implementation Framework that seeks to bring stakeholders working in nutrition sensitive and specific under one framework for ease of coordination, coherence and monitoring of nutrition interventions across the two levels of government. In addition, the Unit is supporting Ministry of Agriculture in developing its nutrition strategy that will ensure full implementation of the National Food and Nutrition Security (NFNS).
v) The Unit has further supported development of guidelines for the various interventions across the nutrition sector.
vi) The Unit has spearheaded development of various regulations and legislation to guide and regulate the sector interventions.
vii) The Unit has also managed to work with counties and supported the development of County Nutrition Action Plans (CNAPs)

The counties under devolution, has led to new leadership and governance structures. County nutrition activities are coordinated through the County Nutrition Coordinators Offices in all the 47 counties.

The County government leadership recognition of nutrition as a priority ensured that all counties included nutrition in the County Integrated Development Plans. The county nutrition specific services are also aligned to the national priorities under the NNAP 2012-2017 framework. Majority of counties have also made health a priority leading to increased number of health facilities. As a result this has improved access to primary health care including nutrition services.

Among the counties visited during the review confirmed that, counties are focusing on:

(i) Coordinating all the stakeholders working in nutrition sector aiming at minimizing duplication and reduce resource wastage.
(ii) Aligning nutrition activities to the county priority areas
(iii) Leadership at county level has included nutrition outcomes as part of their Key Performance Indicators (KPIs).

Among the visited counties, integration of nutrition was found in the agriculture, education, community strategy and water sectors. This integrated approach has created opportunities for these sectors to understand their role and contribute towards improving nutrition. In Nyandarua for example, education sector supports schools to ensure availability of adequate drinking water through water harvesting and storage to ensure all the schools have toilets thus addressing issues of sanitation that directly impacts on nutrition. Nyandarua and Kwale counties are focusing on construction of small dams to provide water for domestic use and irrigation towards food security. Kakamega on the other hand, has incorporated water and sanitation into its programmes through community strategy for improved access to clean and safe water for household use. Whilst, Turkana has sunk boreholes for improved water access for domestic use and for irrigation.

Coordination and Multi-Sectoral Approach

Majority of stakeholders interviewed noted that nutrition sector requires a multi-sectoral approach with each sector contributing to different aspects of nutrition. While health sector deals with specific aspects of nutrition, other sectors like agriculture livestock and fisheries, education, water and special programmes address nutrition sensitive issues providing a holistic approach. Other stakeholders that contribute and support nutrition interventions include; donors, UN agencies, private sector, academia and implementing organizations represented by the Civil Society Agencies (CSA) working both at policy and community levels. Strong coordination is thus prerequisite to the success of nutrition interventions.
Over the implementation period of NNAP, it was noted that strong coordination mechanisms have evolved at different levels. Both at national and county levels multi sectoral coordination frameworks have brought various players together.

At the national level, high level steering committee brings together all sectors involved in food and nutrition security. This high-level steering committee chaired by the Head of Civil Service is key especially during emergency response; all sectors involved in food security and nutrition are members. Below this forum is the Multi Sectoral forum convened by the National Drought Management Authority (NDMA) under the Ministry of Planning and Devolution. MOH is represented as a member of this forum by NDU. At technical level, the Linkage Technical

Working Group (TWG) is co-chaired by the Ministry of Agriculture and FAO with NDU as secretary. Members of these TWGs include Ministries Education, Water, Planning and Devolution (special programmes) and NDMA.

The review confirmed that MOH has the largest number of programmes under the NNAP. Other nutrition interventions are integrated in programs like HIV, TB, NCDs and Environmental health. NDU coordinates the nutrition specific programmes and nutrition supplies and commodities particularly the Supplementary and Therapeutic Feeding Programme. NDU also oversights nutrition sensitive programmes across other sectors including Education where NDU has influenced the development of primary school curriculum to ensure integration of nutrition interventions. During stakeholder consultations, it was noted that coordination with Agriculture Livestock and Fisheries is weak making it difficult for NDU to influence the integration of nutrition among agriculture interventions.

At the county level, various stakeholders are organized in different forums, providing opportunity for planning and reporting. These forums also allow for priority setting and resource allocations especially in drought prone areas. In such counties, National Drought Management Authority (NDMA) plays a crucial role in managing emergency response, minimize duplication of services and mitigating against resource wastage.

Suffice to note that county level coordination differs from county to county. Generally, ASAL and Semi ASAL counties with high level of interventions also have strongest coordination both at health department and among sectors that contribute towards nutrition interventions. In this regard, and based on the stakeholders' consultations, three counties with high level of interventions, Isiolo, Turkana and Kwale also, have stronger level of coordination among the different partners.

Multi sectoral coordination framework in these counties brings various players together such as UNICEF, WFP and implementing partners such as Save the Children, Red Cross, Action Against Hunger (ACF), World Vision etc. The coordination forums provide opportunity for planning, accountability and reporting of achievements registered from the various sectors and stakeholders.

Some of the forums in Kwale, Isiolo and Turkana include:

- The nutrition technical working groups,
- Emergency response forum with all sector included- agriculture, water, education, health, National Drought Management Authority (NDMA), the office of county commissioner, partners,
- Sub county nutrition forums including all sectors and stakeholders,
- Turkana, has County Steering Group whose mandates include getting progress reports from all the sectors in the county including partners.

In visited non- ASAL counties characterized by few interventions, there was marked limited coordination across the different sector contributing to nutrition issues. Nyandarua is a good example with few number of nutrition interventions mainly concentrated in the health department, where coordination was observed to be weak. Indeed, it was noted that a fish producing project supported by Agriculture Development Support Programme (ADSP) under the National Ministry of Agriculture, Livestock and Fisheries meant to improve protein consumption in the area collapsed as soon as funding came to an end. Reasons attributed to this collapse was mainly due to poor coordination among different departments that failed to connect fish farmers to the markets. It was noted that where programmes/projects have no common activity across different sectors, coordination is a challenge.

Strong coordination is noted among counties with strong interventions. Thus the 23 ASAL and Semi-ASAL counties with intensified interventions also reports strong coordination while counties with limited interventions have weak coordination

Political Will

The review confirms that Food and nutrition security is an area that has strong political support because of the political impact inadequate food. It is notable that the Food and Nutrition Security Steering Committee is chaired by the Head of Civil Services. Emergency response is coordinated by the NDMA and all sectors in food, nutrition and water participate. Partners like WFP, FAO, UNICEF, are members of response team.

Furthermore, nutrition has government champions at executive level that have supported advocating, developing and enacting of laws such as the Breastmilk Substitute Act, the food fortification Act, the salt Iodization Act, to mention but a few. The high level national nutrition committee once operationalized will assign and coordinate strategic objectives across sectors contributing to improved nutrition. Some of the strategic objectives include nutrition curriculum for schools, irrigation, social protection transfers. County governments too, have shown political will in supporting nutrition sector. Counties of Kakamega and Kwale have allocated county funds to support nutrition interventions. Turkana County is providing an enabling environment for the nutrition sector.

Financing

The Ministries of Education, Agriculture, Social Protection and Health have budgetary allocated to different interventions that contribute to nutrition. However, some of these interventions have no indicators to confirm their linkage and contribution towards nutrition objectives. For example, the school feeding programme under education sector, measures school retention as its key indicator. There is no indicator to measure if financing of school feeding programmes results in improved nutrition of the school pupils.

Suffice to note that although NNAP focuses on improved nutrition countrywide, a lot of support is skewed to 23 ASAL and semi- ASAL counties, leading to concentration of funding from donors and implementing partners. This is due to the long-standing nutrition challenges that have faced these counties. Partners in other counties have initiated different programmes based on the different needs in each county.

During the review, the national Ministry of Agriculture confirmed that all agricultural related interventions such as crop production and large-scale irrigation geared toward food security are funded. However, the nutrition unit's budgetary allocation is mainly for staff remuneration, and no budgetary allocation to ensure integration of nutrition in any other programmes. Under the Education sector, on the other hand, budgetary allocation for school feeding programmes cover mainly ASAL and semi-ASAL counties. These funds are channeled to schools for them to plan and execute the feeding programmes under the home-grown feeding programme.

Additionally, Kenya has adopted a social protection under the Ministry in charge of Special Programmes. The programme provides cash transfers to the elderly. It is anticipated that the transfers to the elderly will help those who are food insecure to access basic food needs. The programme also provides *corn-soya blend* to the elderly who are unable to consume maize.

Further, the national government also provided cash transfers from the emergency funds to households in the ASAL and Semi-ASAL counties under the ***Chakula kwa Njamii programme*** under management of WFP**.** It is worth noting that the same households benefit from other nutrition supplies such as Supplementary and Therapeutic feeds focusing on children under-fives, pregnant and lactating mothers.

The Ministry of Health has budgetary allocation under programmes like HIV, TB and NCDs that have integrated nutrition as part of their interventions. Further, the MoH has budgetary allocation mainly to cover procurement of Supplementary and Therapeutic feeds. NDU has an allocation from Treasury but the funds provided are inadequate for operations.

It is however, worth noting that except for the funds for procurement of Supplementary and Therapeutic feeds, and salaries for staff, all programmes under the NNAP have no operational funding from government. Actual implementation of these programmes is supported by development partners and UN agencies. The over-reliance on donor funding raises the issue of government ownership and the programmes' sustainability in the absence of donor funding. Furthermore, stakeholders noted that lack of flexibility of partners' funds leave out counties with acute malnutrition issues because they are non ASAL. A good example is Nyandarua where the review found no IEC materials and guidelines at health facility level even for programmes like MIYNC that focusses on under-fives and pregnant and lactating mothers while an over- supply of the same was observed in Isiolo.

All counties visited reported to have plans and budgetary allocation for food production interventions in their CIDPs. They also have specific interventions under health sector such as Vitamin A for children under the age of five years, iron and folic acid supplementation for pregnant. In as much as the budgetary allocation remains inadequate, counties like Kwale and Kakamega are making efforts to increase their budgetary allocations towards increased food supply. In Turkana and Kwale, the counties are supporting farmers with tractors and plan micro dams for irrigation. Under nutrition specific, counties rely on NNAP programmes.

Kwale allocated of KES. 184 million during the 2016/2017 financial year. The amount has been increase to KES. 337 million during the current financial year 2017/2018. An additional KES. 1 million is provided for micro-irrigation. Further, the county is providing free tractors, seeds, manure, goats, dairy cows and rehabilitation of cow deeps. Isiolo has provided 10 million for ECD feed programme. In Kakamega the ***Imarisha Maisha ya Mama na Mtoto***, is

a county funded initiative. The county also has a draft bill that once enacted will secure nutrition interventions in future and ensure continuous budgetary allocation. Additionally, the county government of Kakamega spends approximately KES 50 million annually supporting the community health volunteer who are supporting a number of nutrition related activities in the communities.

The NNAP was estimated to cost about KES 70 billion for the five period. The following funding represent the confirmed financial support of NNAP interventions over the implementation period. These funds do not include funds provided directly to counties or CSOs. The figures also do not include cash transfers by the special programmes and for procurement of corn-soya blend. The funds provided fall short of estimated cost of NNAP as shown below.

Source	**Amount in millions**	**Purpose**
GOK 2012/13	KES. 100 (I M USD)	Drought response: Procurement of nutrition commodities including SFP and Therapeutic Feeding
GOK 2015/16	KES. 400 (4M USD)	
GOK 2012/13-	KES. 745 (75.4M USD)	
World Bank	KES. 1.26B (12.6M USD	
Nutrition International	KES. 2.5B (25M USD)	Procurement and distribution of Vitamin A and capacity building and research
UNICEF	KES. 190M (1.9 USD)	For procurement of Vitamin A
UNICEF	KES. 3.0B (USD 30)	Strengthening community resilience in nine counties in the Arid and Semi- Arid Lands (ASAL) Mandera, Wajir, Turkana, West Pokot, Tana River, Samburu, Kitui, Kwale and Kilifi counties.
EU through UNICEF	KES. 1.9B (USD 19)	For Resilience support that is mainly focusing on nutrition

Limited financial support is starting to show in some counties especially non ASAL which are experiencing IFAS inconsistency supply or stock outs. Going forward there is need to advocate for counties to allocate funds to ensure consistent supply of IFAS while at same time mobilizing resources for preventive and promotive intervention.

Financial tracking of the funded programmes has been enhanced as a result of setting up of financial tracking mechanisms and tools at NDU. The development of expenditure reports from partners has enabled decision making regarding resource allocation to the various nutrition programmes. At county level, the importance of CIDPs provided a good entry for all stakeholders to align their interventions with county priorities.

Research, Monitoring and Evaluation

For many years, Kenya Demographic Health Survey (KDHS) has been the main source of national nutrition data providing periodic household surveys to monitor changes of key health and nutrition indicators. Such indicators include, stunting, breast feeding habits, complementary feeding among others. In 2011, the Kenya National Micronutrient Survey was introduced with the purpose of providing comprehensive micronutrient status across population groups.

Under the health sector, the District Health Information System (DHIS) provides all routine data that includes nutrition. Data from emergency interventions depends on M&E to provide caseloads of different categories of malnutrition to support monitor trends. On nutrition commodities, data is available at KEMSA and at facility level. The SUN movement research and academia section has been established, however, needs to be strengthened to support generate research data for evidence based interventions and decision making.

Advocacy

The review confirmed that, there has been strong and sustained advocacy for nutrition at national, county and community level. The efforts of the First Lady, Her Excellence, Mrs. Margaret Kenyatta as the nutrition patron has galvanized all county First Ladies to advocate for improved nutrition. However, a lot needs to be done to streamline coordination among the many players. The role of CSOs in this process should be enhanced to cover all the counties in the country under the next NNAP.

One of the areas that has not received strong advocacy is capacity strengthening of the nutrition services. The trained nutrition workforce is high but not yet absorbed into service. In addition, there is need to advocate at national and county level for both staffing and increased budgetary support for nutrition interventions.

Capacity and Resources

All stakeholders interviewed noted weak capacity for nutrition both at national and county levels. Poor absorption of trained nutrition professionals has led to task-shifting where nurses are providing nutrition services across all health facilities. Some stakeholders noted that as a result, nutrition is becoming more and more curative, losing the preventive and promotive components. It was also noted that the country is gradually loosing home economist as a key cadre in nutrition management and promotion since no institution of higher learning is training them anymore.

Capacity development is the mandate of the national government. Counties also have a role to play in capacity building especially at sub-county levels. There is need to clarify that the national government can only train TOTs focusing at county level managers. The rest of people have to be trained by the counties using county funds. In this regard, counties need to budget for capacity development for all staff.

Under the NNAP, capacity development has been limited to programmes covered by donor funding. The training is also limited to specific areas (both in terms of programmatic and geographic) that donors have interest in. This also applies to printing and dissemination of guidelines and IEC materials covering areas funded by the partners. That is how Isiolo has over supply of IEC and guidelines while Nyandarua with limited donor programmes has no material at facility level. As a result, there are emerging inequalities in terms of capacity development across the counties.

During the NNAP implementation period, NDU has managed to develop the Kenya Capacity Nutrition Framework that guides the national capacity development on nutrition. There is also attempt to work with the Integrated Human Resource Information System (IHRIS) to get data on types and levels of training.

It is further noted that no quality standards for developing capacity across nutrition programmes has been put in place. Each programme is developing own capacity manual. To address this gap, a technical working group has been put in place to come up with a capacity training manual to standardize capacity development across the counties.

Current focus on clinical nutrition is not comprehensive, creating room for confusion and poor services. There is need for concerted effort to improve standards for quality of care by developing standard manuals and guidelines for health facilities across all levels. The standards need to embrace a holistic approach to create linkage between clinical and community services focusing on preventive and promotive approaches including promoting behavior change.

The definition of what nutrition narrow and should include addressing the determinants of malnutrition. This broad definition will help in re-focusing the entire food supply and value chain ensuring linkages with other sectors facilitating a holistic approach. Finally, there will be need to sensitize training institutions to embrace trainings on skills that the country requires to address the many facets of nutrition.

The review nevertheless noted that there are many guidelines developed by individual programmes in relation to specific interventions guiding implementation of programmes like IMAM, MIYCN, BFHI, BFCI, healthy diets and lifestyles.

Accountability

The implementation of NNAP has seen growing expectations of reporting on progress of various indicators to measure performance. The review notes that while nutrition specific has data on performance of key indicators included on DHIS, there is scanty data on emerging NCDs and no linkage indicators from other sectors to confirm their contributions to nutrition in-spite of having nutrition sensitive interventions. Due to lack of data, there is lack of evidence for planning and advocacy for budgetary allocation. There is therefore need to define indicators for routine data collection across all sectors involved in nutrition that would support understanding the need for better planning and financing.

However, the SUN Movement is providing avenues for reporting achievements for local use and for comparison internationally. The adoption of SDGs especially the Agenda 2030 that domesticates the SDGs not only provides new context for the next NNAP, it also re-focuses nutrition as a priority, presenting new opportunity to systematically bringing sectors together to address nutrition issues from a developmental perspective. This will allow the country to articulate the Scaling-Up Nutrition as a cross cutting issue that needs to be integrated across key sectoral strategies and interventions.

Social Norms

Community sensitization has seen promotion and improved uptake of traditional foods. Through behaviour change communication, some communities have dropped negative practices and adopting beneficial food practices including complementary feeding and supplementation in children.

Facility based sensitization, education and advocacy to mothers, has been identified as a key pillar to ensuring women of reproductive age access the correct services. Programmes that promote behaviour change towards breastfeeding have seen the rate improve from 32% to 62% in 5 years according the KDHS.

Therefore, focusing on what is available at the community levels with regards to foods and services couples with community participation, nutrition education and advocacy has proven to be of benefit where nutrition is concerned.

Devolution

Devolution provides opportunities for increased investment for both nutrition specific and sensitive activities. There are key programmes set up in agriculture that are promoting food security and nutrition e.g. dairy and poultry programmes, improved banana culture, horticulture, irrigation schemes and county commitment in water provision through investment in boreholes and dams for micro-irrigation.

Among the nutrition specific investments is the provision of supplements and supplemental foods through the national government, provision of food rations in schools through involvement of community members, planned provision of fresh milk to school children in ECDs. Devolution has also enabled counties to identify their county specific priorities focusing on home grown solutions that will be sustainable. But strong monitoring structures are required to enable confirm performance of supported intervention.

5.2 SWOT ANALYSIS

NNAP 2012-2017 Strengths and Weakness

This section provides details of strengths and weaknesses as identified in both the stakeholders' inception workshop and the county informant interviews and consultations that impacted on the implementation of the NNAP during the last five years.

Strengths

- The FNSP is still relevant to guide nutrition interventions from a multi sectoral approach. Policies, guidelines, legislation and regulation have been developed to support various programmes of the NNAP. These guiding documents provide the nutrition sector with a firm base to build on.
- There is increased private sector participation, indicating existence of an enabling environment for business in nutrition that is enhanced by existence of standards and regulation supporting a level playing field for all players
- There is Increased budget allocation noted over the NNAP period
- Nutrition and Dietetics unit has provided leadership and coordination of nutrition helping create coherence and awareness of importance of nutrition across the two levels of government
- Improved emergency response reducing severe impact of malnutrition as a result of drought
- There has been remarkable strong political and media publicity supporting nutrition advocacy
- The Increased number of partners supporting nutrition both at national and county levels
- Improved public and community participation leading to behavior change, uptake of traditional foods
- Successful inclusion of food and nutrition education in primary and secondary schools' curriculum
- M&E framework developed strengthening measurement for performance and evidence based planning
- Research and surveillance strengthened providing opportunity for timely response to emergencies and applying evidence to operations
- Devolution:
    - Has led to an increase in the Effort on improvement of skilled personnel.
    - Increased availability of health facilities especially at county level improving access to basic nutrition services
    - Devolution and prioritizing nutrition in CIPDs has provided additional investment resulting in accelerated implementation and improved nutrition.

Weaknesses

- Inadequate dissemination of the policies, strategies legislation and regulation thus hindering their use and application at country level.
- Weak knowledge management and translation of research findings into policies to inform programming
- Limited
    - Coordination of agri-nutrition related researches and linkages to health sector
    - Use of evidence in programming
    - Scale –up of piloted innovative strategies and good practices – for example PROPAN, care group models.
- The multi sectoral approach to Nutrition remains weak- No cross cutting indicators to fully measure all nutrition sensitive intervention implemented across sectors exist.
- Weak databases-not all indicators incorporated especially cross cutting that would allow evaluating of the performance of key sectors that are have or are involved in nutrition interventions
- Inadequate funding from the national and county governments leading to over reliance on donor funding for nutrition programmes.

- Counties not prioritizing procurement of micronutrients (even those in essential medical list]
- inadequate technical expertise across both levels of government including institutions (hospitals prisons, schools, children's' homes, etc) for institutional nutrition/feed programmes
- There is limited human resource on nutrition to support implementation of dietary diversification strategies in the agriculture sector
- Negative cultural practices and gender influencing food preferences.
- M&E indicators not SMART for the strategic objective. Indicators not set according to objectives thus difficult to track, monitor and measure performance
- Progressive monitoring of NNAP to measure performance over the 5-year period.
- Inadequate and old nutrition equipment in most facilities creating a break in reporting of key indicators

NNAP 2012-2017 Opportunities and Challenges

Opportunities

- Inclusion of the NNAP programmes in the MTP3 and subsequent planning processes including the ministries' annual plans and the counties CIDPs that provides commitment for funding.
- Availability of guidelines provides an opportunity for consistent implementation of nutrition interventions across all sectors and tow levels of government.
- Kenya has adequate national policies, laws and regulations that nutrition and leveraging on to support implementation of nutrition interventions that would also support Integration of SDGs.
- Social protection programmes provide an opportunity for all vulnerable groups
- Strong laws to assure regulatory process e. g fortification provide an opportunity for increased private sector participation in nutrition interventions
- Devolution presents greater opportunities for prioritization and increased investment in nutrition
- Existence of High level coordination extended to cover and emphasis on a multi-sectoral approach to nutrition
- Nutrition should be positioned at a level that facilitates effective coordination across the multi sectoral players
- A strategy under Agriculture/livestock/fisheries that integrate nutrition sensitive activities in all food production programmes expands nutrition approach beyond what exists tapping into budgeting allocations at national and county levels.
- Scaling-Up Nutrition Movement provides for increased visibility for nutrition
- Existing fora at national and County level provides opportunity for dissemination of nutrition messages
- Capacity Development Framework (CDF) and sensitization of high level training institutions provides an opportunity for the country required skills on nutrition.
- Kenya Nutritionists and Dieticians Institute provides an opportunity to regulate nutrition trainings and curriculum development
- Some counties have very good ecology that should be tapped into to increase and diversify food production

Challenges

- Insufficient implementation/use of existing policies, guidelines and strategies
- Inadequate coordination with other sectors to ensure indicators in the different sectors focus and respond appropriately

- Time and resources spent on sensitization of new leadership in counties on nutrition in order for them to buy in.
- Delay certification process, weak penalties and slow feedback mechanism by responsible regulatory bodies, impacting negatively on the private engagement in supporting nutrition and exposes the public to risk.
- Lack of holistic approach to nutrition interventions leading to more curative approaches leaving out promotive and preventive
- Addressing nutrition from an emergency perspective instead of a systematic, long term developmental approach giving it short term planning perspective.
- Budget allocation for nutrition at both national and county level remains sub optimal including for research.
- Partner driven/over reliance by government on external support to carry out key activities leading to questions of ownership and sustainability of programmes.
- Misconception of micronutrients supplements and unacceptability of certain foods by communities leading to low uptake (e. g MNPs, Vit A and fortified foods),
- Cultural practices and gender factors that hinder adoption of alternatives to improved agricultural and nutrition practices
- Climate change, HIV infections, drug and substance use affecting communities' economies' including food production.
- Weak knowledge management form the existing systems like DHIS etc.

Chapter 6: Conclusion

In concluding, the review confirms that the NNAP provided strategic objectives based on the FNSP. As noted, FNSP remains relevant to the sector as the basis for developing broader engagement in terms interventions and stakeholders' participation. Under devolution, most counties are prioritising nutrition leading to increased investments further creating interest across private and public sectors. Nutrition specific issues are benefiting from increased health investment as more facilities are established making the nutrition services accessible.

During this NNAP implementation, lots of policies, legislations, regulations and strategies have been developed to guide in-depth interventions in the key areas. Because broad focus of interventions and increased number of stakeholders, coordination has broadened and strengthened with a marked government leadership spearheaded by NDU. While nutrition interventions are implemented in all 47 counties, there was marked concentration of interventions in 23 ASAL counties than in non ASAL counties. It was also noted that these 23 counties have stronger coordination structures than the rest of the counties.

The review concluded that the enabling environment, with strengthened leadership, increased finances though inadequate, increased advocacy and political will to mention but a few has played an important role in ensuring the successful implementation of the NNAP.

Going forward, the context for the next NNAP need to change to incorporate SDGs with a sustainable developmental approach. The planning processes need to be articulate with clear measurable indicators to confirm long term outcomes.

Chapter 7: Recommendations for the Next NNAP

1. Next NNAP should ensure interventions are included in the forthcoming MTP and CIDPS to facilitate commitment for nutrition as priority and influence budgetary allocations for the next five years.

2. The next NNAP needs to ensure indicators that will support monitoring of performance across the sectors are defined. Sectoral indicators especially under the health specific need to have their baselines determined. Sources of baselines need to be confirmed and surveys or data collected on time to confirm trends, outputs and outcomes of the selected interventions.

   To achieve this, there is need to strengthen and broaden the existing Monitoring and Evaluation framework and encourage other sectors to develop own M&E systems and enhance data sharing and findings to inform planning and decision making.

3. There is marked commitment to supporting nutrition between the two levels of government. There is need to entrench and elevate the position of NDU to a level where it is able to influence the integration of nutrition interventions across the relevant sectors. Placing the nutrition coordination in a higher office like the Office of President to facilitate stronger coordination is a discussion that need to take place.

4. Lessons from the 2012-2017 NNAP shows nutrition objectives are better realized when nutrition intervention are undertaken from a multi-sectoral approach. There is need therefore, to strengthen coordination structures among all the players including the private sector partners

5. The review confirms the National Food and Nutrition Security Policy is still relevant to the sector. For sustainable outcomes, the change in contextual basis of the next NNAP under SDGs need to be defined with developmental focus incorporating systematically planned interventions.

6. There will be need to establish strong linkages between agriculture and other sectors like education, social protection and health by defining measurable indicators to monitor progress and contribution to nutrition outcomes and general sustainable economic development.

7. There is need to incorporate strong preventive and promotive, behavior change nutrition interventions across the contributing sectors. Addressing the determinants of nutrition in the long run will be the most cost effective.

8. There is need for strong private sector involvement to support promote innovations and investments in technologies that incorporate nutrition along food systems.

9. Leverage on technology for adequate sensitization and advocacy aimed at providing knowledge on access to technologies and innovations to ensure food and nutrition security.

10. Increase food access through enhanced food redistribution between counties through various approaches including government owned food banks.

11. Lessons learning through Inter-county government best practices will allow counties to learn from each other e.g, in the development of CNAPs, resource mobilization and how to advocate for nutrition budget inclusion in the county budget, new innovations on agricultural practices and cross county trade.

12. The need for continuous capacity assessment planned to ensure capacity development for new innovations and technologies.

13. There is need for the next NNAP to take cognizance of emerging funding modalities and mechanisms such as pooled funding, Global Funding facilities and results based financing that would fill the financing gaps for nutrition interventions.

14. Clinical nutrition sub sector need concerted effort that must be linked to preventive and promotive interventions in order to make nutrition interventions efficient and of quality at health facility level.

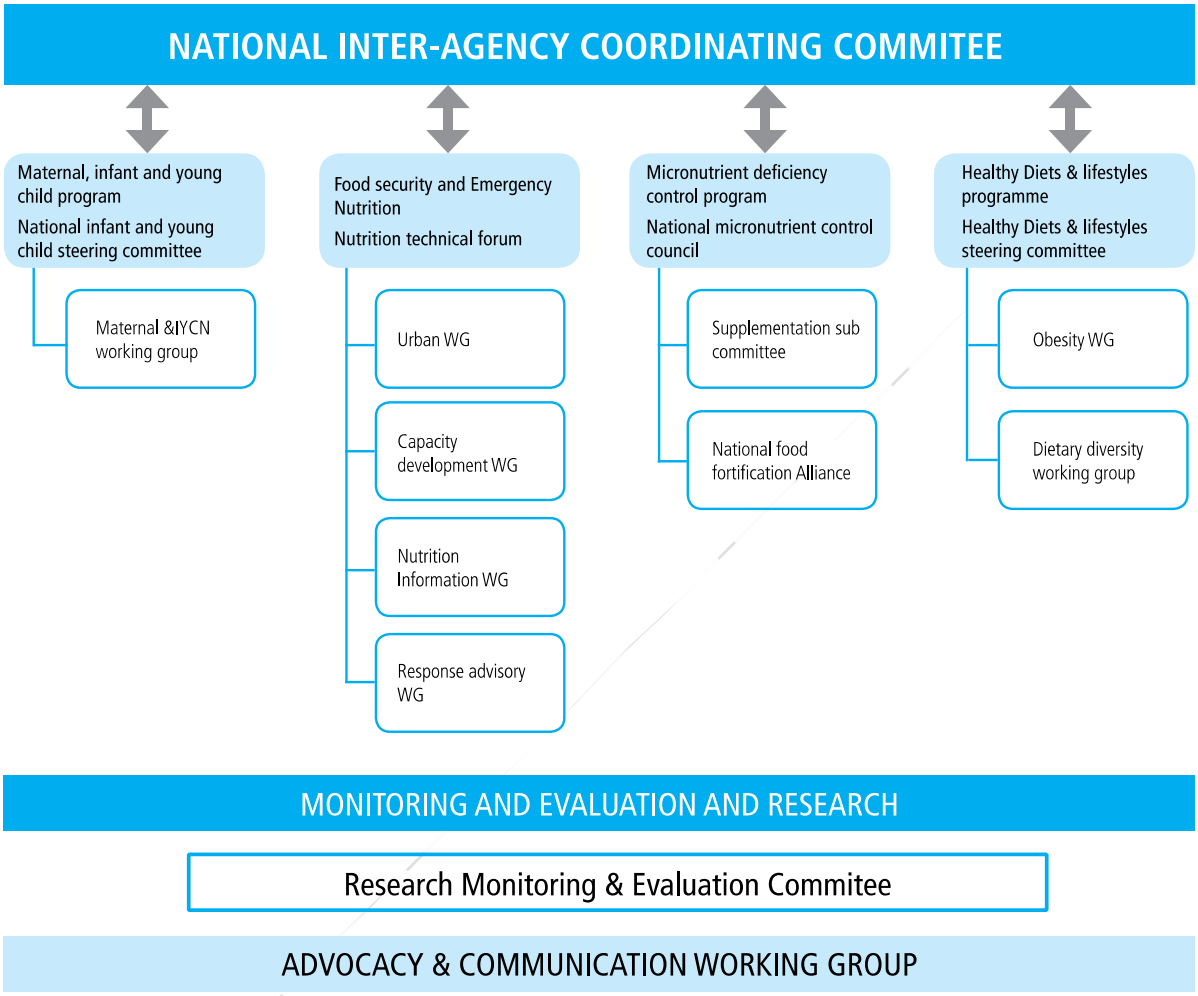
15. Regarding commodities, and in order to improve on efficiency, there is need to review the essential drugs list to include core nutrition commodities to create awareness among counties and facilitate availability through KEMSA. In addition, storage facility challenges must be addressed to ensure safety and sustained supply of commodities.

16. It is important to incorporating research as a cross cutting issue in all sectors dealing with nutrition to generating evidence. Further, there is need for exploration of nutrition issues through utilization of existing data bases such as KDHS and other surveys.

17. Finally, creation of a repository for data and information access is key for knowledge management. This can be enhanced through linkages with NACOSTI, research institutions and universities. A mechanism of translating the research findings to inform policy need to be developed.

8.0 Annexes

Annex 1: Conceptual framework for coordination of nutrition activities



Annex 2: Key Informants Interviews and Consultations Data Collection

Tools for National and Counties

The review of the National Nutrition Action Plan (NNAP) involves undertaking consultations and Key Informant Interviews (KIIs) at national level and Focused Groups (FDGs) at county levels.

The objective of the consultations is to confirm what has been the enabling environment, opportunities programmatic issues and challenges that hamper implementation of NNAP. The consultations will also support identification of opportunities to be included in the next NNAP.

This questions are divided into two sections:

Section One involves identification of Key informants at the national level and focused groups at county levels.

Section 2 includes the questions that will facilitate discussions and participation of the key groups. Participation of these stakeholders during the identification of opportunities for the next NNAP is crucial because this will ensure there is strong ownership, better prioritization and planning of the next Action plan objectives.

Section 1:

The following are identified as key informants and focused groups:

a) i) National level

- Nutrition focus persons in key ministries
- Private sector alliance
- Civil society
- Donor community
- UN focus alliance

1. **National Level : KIIs Questions:**

i) General questions: Policy institutions

1. What is the role of your institution or ministry in nutrition agenda?
2. Is there any policy or guidelines that provide guidance in your nutrition interventions.
3. Is there a coordination mechanism with other sectors
4. Do you have a mechanism of monitoring your outputs of the interventions you are involved
5. How would you rate importance of nutrition sector in the overall national development

ii) Specific questions to Ministries:

Health

1. Does the Ministry of Health prioritize nutrition programmes in its mid-term plan and annual plans?
2. Are the programmes integrated among other health related programmes
3. Are the programmes in the Mid-term the same as those in the National Nutrition Action Plan?
   i) If not why not?
4. Is there a budget line specifically for nutrition programmes
   i) If yes how much is allocated during the current financial year from the national government and donors?
5. Does the Ministry have a nutrition policy that guide nutrition specific interventions?
   i) If yes, is there a strategic plan to implement the policy?
   ii) If not what guides he nutrition specific interventions?
6. How is the nutrition data collected?
   i) Are there indicators
   ii) for routine data collection?
   ii) If yes, who is the custodian of that information?
   ii) What is the information used for?
7. How is data from interventions that have integrated nutrition interventions collected, reported and used

8. Do the Ministry of Health and Ministry of Water coordinate to facilitate addressing issues that impact on health
9. Do the Ministry of Health coordinate with Ministry of Education on nutrition programmes for schools?
   i) If yes explain how and on what programmes
10. Does the Ministry of Health coordinate with Ministry of Youth Gender and Social Services on Social Security Transfers specifically covering elderly? How are the beneficiaries identified?
11. What are some of the opportunities that exist that will further improve nutrition status in the country

Ministry of Education

1. Does the Ministry of Education have nutrition priorities in its mid- term and annual
2. plans?
3. Are the school feeding programmes part of these priorities?
   i) Are schools involved in setting the feeding priorities?
   ii) Are the feeding programmes funded by the Ministry's budget?
   ii) If not where do schools get funds from?
4. How are the schools participating in the feeding programmes selected?
   i) Is there a set criteria for school's selections?
5. How does the Ministry measure results of these feeding programmes?
6. Does the Ministry prioritize deworming and clean drinking water for pupils?
7. How many schools are included in deworming programme?
   Are the funds for deworming provided under the national Ministry of Education budget? Is yes how much
8. Does the deworming cover all the schools?
   i) If not, how are schools selected?
9. Are there other programmes related to nutrition that the Ministry prioritize?
10. Does the Ministry have a data base to capture data on the nutrition results
    i) How does the information flow from across the different levels from the schools to Ministry of Education HQ?
    ii) How is the collected information used and by who?
11. What are some of the opportunities that exist that will further improve nutrition status in the country

Ministry of Agriculture

1. The current Food Security and Nutrition policy is domiciled in Ministry of Agriculture. Does the Ministry have a strategic plan to implement and operationalize the policy?
   i) How does the Ministry coordinate with other ministries that have nutrition programmes
2. What are the plans the Ministry has to ensure there is both food security and nutrition in the country.

3. Does the Ministry have nutrition programmes in the Mid-term plans and annual plans?
4. What is the budgetary allocation for nutrition related programmes during the current financial year?
5.
6. Are there measures in place to support irrigation to increase food production and security?
   i) If yes, do the measure also focusing on nutrition?
7. Does the Ministry have an information system that allows data collection on food production and nutrition
   How is such information used and by who?
8. How do you involve the community in agriculture and nutrition related activities
9. What are the new technologies you are coming up with to improve food and nutrition security
10. does agriculture and nutrition sector coordinator
11. What are some of the opportunities that exist that will further improve nutrition status in the country

Development Partners UN and other Funding Institutions *(Development Partners/bilateral, multi-lateral, INGOs- UNICEF, NI, WFP, USAID, EU)*

1. What type of nutrition projects do your organization support in Kenya:

i) Nutrition specific
ii) Nutrition sensitive
2. What is the budget allocation
3. Are the funds/support projects
   i) in the public sector or
   ii) through civil society
4. Are you satisfied with level of implementation
5. What are the challenges that contribute to poor implementation and if addressed can improve uptake of the funded interventions
6. How can the challenges be addressed
7. What are the opportunities that exist that you would like included in the next plan?

Private Sector Alliance

1. How many companies are members of the network?
2. What are the factors that contribute to private sector successful operations in the food and nutrition sector
3. Are the agricultural sector regulations aiding or hampering private sector contribution to food security
4. Is private sector contribution in nutrition sector adding value?
5. Is regulatory framework adequate to facilitate business in the nutrition sector
6. What other measures would the private sector like to have enacted or implemented in the health sector

Civil Society Alliance

1. How many CSOs are members of the network
2. What is the criteria of joining the network?
3. What are some of the nutrition activities that the CSOs are involved in
4. Where do the CSOs draw their activities from
5. What is their source of funds for the activities
6. How are the CSOs coordinated among themselves and with other stakeholders
7. Is there an information system that you feed the data reported by CSOs and they can also use for their plans?
8. What are some of the challenges that CSOs face while implementing nutrition interventions
9. What are some of the opportunities that exist that nutrition sector should be priorities

1. Counties : Key Informants Interviews and Consultations Data Collection Tools

As indicated above, county level interviews and consultations will be undertaken through both KIIs and consultations as per the identified officers or institutions.

a) The following are identified for KIIs interviews at the County level

- KIIS (3) with Agriculture, Water company and education sector representatives at county level
- County Nutrition Coordinator
- Dispensary and health Centers,

b) The following are identified as focused discussions/consultations groups at county levels:

- County Health Management Teams – (Chief Officer, director of health,(chairs), CNC, Pharmacists (commodities) administrator, chief nurse, nutrition activities)
- Implementers -NGO in the county (6)
- Community nutrition workers /volunteers

i) County Agriculture Officer

1, Are you aware of the National Food Security and Nutrition policy by Ministry of Agriculture?

2. Is the County operationalizing the policy or has the county developed its own?
   i) How does the county coordinate with other county departments that direct or indirect impact on nutrition programmes?

3. Does the Ministry have nutrition programmes in the CIDP and annual plans?
   i) If yes, what informs the decision to include these programmes and how are the outputs measured

4. What is the budgetary allocation for nutrition related programmes during the current financial year?
5. What measures has the County department of agriculture put in place to support increased food production and security in the county?
6. What are the new technologies the county is coming up targeting improved or increased food security and production?
    i) Who is funding these activities?
7. Does the county have an information system that supports data collection on food production and nutrition
    i) How is such information used and by who?
8. How do you involve the community in agriculture and nutrition related activities
9. How could you assess the capacity of the ministry to implement nutrition related activities
10. What are some of the opportunities that exist that will further improve nutrition status in the country

ii. County Department of Water and Company

1. Do you have a county policy that include nutrition related activities? And how is that policy link to the national policy.
    i) If yes what are the indicators of nutrition in that policy
2. How does the Water company link with county department of water?
3. How does the company coordinate with other departments that have nutrition programmes in the implementation of the water and sanitation policy?
4. IS the Water and sanitation plans included in the CIDPs?
    i) If yes, Provide the details of these programmes
5. What informs the decision to include these programmes and how are the outputs measured
6. How does that company collect information to nutrition and health from company activities?
7. How is such information used and by who?
8. How do you involve the community in water sustainability and nutrition and health related activities?
9. How could you assess the capacity of the department to implement nutrition and health related activities?
10. What are some of the opportunities that exist that will further improve nutrition status in the country

iii. Department of Education

1. We are aware that education is not devolved. However, there are nutrition and health related programmes in schools. How does the county government coordinate with the national government to implement these programmes?
2. Are there nutrition and health related programme that are currently being implemented in the county
    i) If yes what has guided the choice of these programmes and the school participation in these programmes?.
    ii) Do you think this should be done differently?
    iii) If yes, how? How are they funded?
3. Which sectors do you collaborate with in addressing nutrition in your county

iv. County Health Management teams including the County Nutrition Coordinator;

1. How does the county identify nutrition priority areas in the county?
2. Do you have any guiding tools such as policies and guidelines?
3. How are they linked to the national policies and guidelines?
4. Are you aware that the Kenya National Nutrition Action Plan exist?
    i) If yes, programmes stipulated in the NNAP implemented in the counties
5. What challenges is your county facing in implementing of nutrition programmes?
6. What mechanisms have you put in place to address these challenges?
    i) Which are other sectors participating in nutrition programmes.

ii) How are these sectors coordinated? How do you coordinate partners working in nutrition?

7. What capacity do you have to support nutrition related activities?
8. What reporting mechanism exit for nutrition related activities?
    ii) How is the data collected? Are there tools to support data collection?
    iii) How do you track your nutrition indicator?
    iv) How are the county nutrition issues linked to the national level?
9. Does the community get involved in nutrition related issues in the county?
    i) If yes, how?
10. What trainings in nutrition are supported by the county?

v. Dispensaries/ health centers

1. Does the facility offer any nutrition services?
    i) If yes, which ones?
2. What are the common nutrition problems you have observed?
3. Who are your target population for nutrition services?
4. What has made implementation of nutrition services possible in the last 5 years
5. Do you have any guidelines to guide your work?
6. Do you have any IEC materials?
    i) Which ones
    ii) Who provides the IEC materials
    iii) How do you collect your data?
    iv) Is your data segregated? How?
7. Have you received training in nutrition in the last 5 years?
8. What challenges do you experience in providing nutrition related services?
9. Do you have enough equipment and supplies for implementation of nutrition related services?
    i) What type of supplies?
10. Which partners do you work with in support nutrition?

vi. Civil Society/NGOs Implementers

1. Are you aware of any policies guideline and strategies the county is using to address nutrition relates challenges?
    i) What are some of the nutrition activities that the CSOs/NGOs are involved in
    ii) Where do the CSOs/NGOs draw their activities from?
    iii) Who is your target?
2. Are you aware of any coordination mechanisms that brings the county sectors together to discuss nutrition?
3. Is there community participation in selection of your interventions?
4. Do you have a coordination forum?
    i) How are the CSOs/NGOs coordinated among themselves and with other stakeholders?
    ii) Do you participate in any coordinated planning session with other partners working on nutrition?
5. What is your source of funds for nutrition related activities?
6. Is there an information system that you feed your data and that you can access when planning?
7. What are some of the challenges that CSOs/NGOs face while implementing nutrition interventions?
8. What are some of the opportunities that exist that nutrition sector should be priorities?

Annex 3: Strategic Objectives Report Tables

Table 1a: **Objective 1-Outcomes**

OUTCOME INDICATORS	Baseline	Target	Achievements
% reduction of Vitamin A deficiency among women of reproductive age.	51%*	15%	Pregnant: 5.4% Non-pregnant: 1.1 % (6.5%)
% reduction of iron deficiency among women of reproductive age.	55%*	25%	Pregnant: 26% Non-pregnant: 14 % (40%)
% reduction of iodine deficiency among women of reproductive age. (This is goiter rate)	6%***	1%	This indicator has never been measured at national level
% reduction of overweight and obesity among women of reproductive age.	25%**	Non-set	Currently at 35%
% reduction of zinc deficiency among women of reproductive age	52%*	15%	Pregnant: 68.3% Non-pregnant:82.3%
% reduction underweight among women of Reproductive age.	12.3%**	Non-set	8.9%

*Baseline based on Micronutrient Survey 1999
** Baseline based on 2008/09 KDHS
*** Based on 2004 IDD Survey

Table 1b: **Objective 1-Outputs:**

OUTPUT INDICATORS	Baseline	Target	Achievements
% of pregnant women who take iron and folic acid supplements for at least 90 days during pregnancy.	3%(2008)	80%	7.5%
% of pregnant and lactating women with MUAC < 21 cm receiving supplementary food.	No data	No data	No data
% of pregnant women monitored for their weight.	Not measured	No data	No data
Proportion of health facilities with nutrition commodities and equipment for maternal nutrition interventions	No data	No data	No data
No. of maternal nutrition guidelines disseminated in use at county level	No data	No data	i. MIYCN policy, ii. strategy 2012-2017 ii. operational guidelines v. Disseminate BFCI tools, printed and disseminated v. Dissemination of MIYCN materials and job aids

Table 2a: Objective 1 Outcomes

OUTCOME INDICATORS	Baseline	Target	Achieved
% reduction of children <5 years with malnutrition (stunting, wasting, underweight, obesity)			
Stunting	35%(2008/9)	14%	26%
Wasting	6%	2%	4%
Underweight	16%	10%	11%
Obesity (Overweight)	22%	19.5%	4.1%
% reduction of children <5 who are micronutrient deficient (Zn, Fe, I, Vit A)			
Fe Deficiency	69%(1999)	25%	21.8%
Vit A Deficiency	84.4%(1999)	15%	9.2%
Zinc Deficiency	51%(1999)	20%	83.3%

Table 2b: Objective 2-Outputs (a)

OUTPUT INDICATORS	Baseline	Target	Achieved
% of health facilities certified as Baby Friendly		28%	7%
% of community units that are implementing Baby Friendly Community Initiative		28%	10%
% of infants who are breastfed within one hour of birth	58%**	78%	62.2%
% of children < 6 months who are breastfed exclusively	32%**	56%	61.4
% of children aged 6-23 months who are consuming 3+ or 4+food groups per day (dietary diversity)	39%**	67%	31%
% of children aged 6-59 months receiving Vitamin A supplements twice a year	62%**	86%	71.1%
% of children < 5 years with diarrhea who are treated with zinc supplements	20%**	80%	8.9%

** KDHS 2014

Table 2b: Objective 2-Outputs (b)

Output Indicators	Baseline	Target	Achieved	Notes
% of companies/ suppliers complying with the Code of Marketing of Breast Milk Substitutes	No data	30%	No data	Study done in 5 counties a regulation framework on Companies complying with the code of Marketing of breast Milk Substitutes in final stage of development
% of agencies/ companies which support breastfeeding in the workplace	No data	35%	No data	• Health Act 2017 enacted requiring all companies

Output Indicators	Baseline	Target	Achieved	Notes
				setting up lactating rooms • 13 companies including NGOs and banks provided with certificates for being baby friendly
% of children < 5 years whose growth is monitored	No data	18%	No data	
% of children < 5 years screened at community level and referred for nutrition management	No data	13%	No data	
Proportion of health facilities equipped with anthropometric equipment and reporting tools	No data	No data	No data	
% of health workers trained on appropriate infant feeding practices per county	No data	No data	No data	103 TOTs trained
% of health facilities per county provided with Behavior Change Communication/ Information, Education and Communication (BCC/IEC) materials	No data	No data	No data	23 ASAL counties provided with (BCC/IEC materials)
% of children aged 6-59 months receiving multiple micronutrient powders as per recommended dose.	No data	No data	No data	
% of health facilities complying with IYCN guidelines	0	32%	No data	• Complementary feeding framework finalized, and disseminated • Regulatory and Implementation Framework for the Code for Monitoring of Breast milk Substitutes act finalized.

** Based on the 2008/09 KDHS survey

Table 3a: Outcomes

OUTCOME INDICATORS	BASELINE	Target	Achievements
Decreased prevalence of micronutrients deficiencies			
Decreased prevalence of Vitamin A deficiency by 5%	51%*	15%	9.2%
Decreased prevalence of iron deficiency by 10%	55%*	25%	Pregnant =21.6% Non-Pregnant =21.3%
Decreased prevalence of iodine (goiter rate) deficiency by 1%	16%*	1%	6%**

OUTCOME INDICATORS	BASELINE	Target	Achievements
Increase in the population knowledge on micronutrient deficiency and curative and Preventive measures	Not set		A number of studies undertaken have findings on knowledge specific to micronutrient deficiencies. These include: the LCLQAS studies

*Based on 1999 micronutrient survey
** iodine study 2004

Table 3b: Outputs

OUTPUT INDICATORS	BASELINE	Target	Achievement
# of health workers at all levels trained on prevention, management and control of micronutrient deficiencies.	Not set	Not set	Trainings of health care providers on IFAS and VAS, MNPs done, Fortification regulatory framework enacted and industries currently fortifying
No. of advocacy workshops on micronutrient interventions conducted at all levels	Not set	Not set	These were Integrated within the key nutrition forums
No. of micronutrient intervention campaigns (Radio, TV, Community etc.) launched.	Not set	Not set	Food fortification program is currently ongoing IFAS and VAS was integrated with Polio campaigns
Proportion of U5 children who receive multiple micronutrient supplements	Not set	Not set	Over 12,000
% U5 children supplemented with vitamin A	62%**	86%	72% (KDHS,2014)
% of women of reproductive age supplemented with iron and folic acid (for 90 days)	3%**	80%	7.5%
% of households consuming adequately fortified foods in the country	Not set	Not set	No information available
Proportion of population that adopt consumption of micronutrient rich foods including the fortified foods	Not set, But 5% in 2014/2015	8%	No data
% of widely consumed basic commodities which are fortified with necessary micronutrients	Not set	Not set	No data
Proportion of fortified foods at the household level with recommended content of fortificants	Not set	100%	no data available to confirm achievement

OUTPUT INDICATORS	BASELINE	Target	Achievement
No. of private sector actors/industries fortifying their foods products as per the national guidelines.	Not set	Not set	#305 certified brands

** Based on 2008/09 KDHS survey

Table 4a: Objective 4 -Outcomes

OUTCOME INDICATORS	Baseline	Target	Achievement
Improved nutritional status of populations in Emergencies.	6%	2%	Wasting-4%
Reduced morbidity and mortality of the affected population			

Table 4b: Objective 4-Outputs

OUTPUT INDICATORS	Achievement
Proportion of counties with emergency nutrition response plans	All 23 ASAL counties have drought emergency response plans. 8 floods prone non ASAL counties have contingency plans
Number of counties reporting on a timely basis on nutrition surveillance	All counties reporting through DHIS. However, there are delays in reporting and quality of data is not ascertained.
% of children screened at community level and referred for nutrition management	
Number of counties holding regular coordination meetings.	16 counties out of 23 ASAL
Proportion of facilities experiencing no stock-outs of essential nutrition commodities	10 out of 23 counties did not experience stock outs
% of pregnant & lactating women with MUAC<21cm receiving supplementary foods	PLW reached (47,429 against a target of 29,500)
Proportion of health facilities offering the essential nutrition services package	68% of health facilities are implementing HINI
Number of health workers in emergency districts trained on essential nutrition services package.	40% of health workers trained from 8 counties
Proportion of counties mobilizing, resources for nutrition emergency response	14 out of 23 ASAL counties were able to mobilize resources through DCF & county government
Number of counties meeting the SPHERE, standards on IMAM and national targets on IFE	7% of counties met sphere standards for SAM 61% for MAM
National nutrition commodities monitoring plan developed and disseminated for use by the counties	No data
Proportion of counties implementing the nutrition commodities monitoring plan used during emergencies	No data

Table 5a: Objective 5 -outputs

OUTPUT INDICATORS	Achievement
Number of agencies integrating nutritional care standards in their plan	• Progress in addressing NCDs, TB and HIV programs. These programmes have integrated nutrition in their plans • Nutrition and HIV guidelines have been developed and disseminated. • Nutrition and TB guidelines developed and disseminated. • Clinical nutrition and dietetics manual review process ongoing.
Proportion of resources committed to nutrition care services	• Some resources have been allocated to vertical programs (NCDs, TB, HIV -diseases of PH concern) Ksh 6M used for nutrition and diabetes trainings in 2012. • Nutrition and TB training Ksh 28M for healthcare workers and 3.88MKsh for National and county TOTs.
Number of health workers trained on curative nutrition services	• Data exists in the vertical disease specific programs • 300 nutritionists trained in nutrition and Diabetes in 2012. • 700 healthcare workers trained on nutrition and TB and 97 ToTs. • Clinical nutrition training package /modules developed and disseminated
Proportion of facilities experiencing no stock-outs of essential nutrition commodities	Commodity committee at facility level formed
Proportion of counties implementing the nutrition commodities monitoring plan	No data available
Number of community individuals and private sector players sensitized on quarterly basis	No data available
Proportion of health facilities providing curative nutrition services	No data available
Reduced inpatient length of stay	Not a nutrition specific objective

Table 6a: Objective 6: Outcomes

OUTCOME INDICATORS	Noted
% Reduction of incidences of NCDs^	There are several studies to measure incidences of NCDs including cancer confirming the following Cancer Incidence rates: • Overall annual cancer incidences at37,000 and annual mortality at 28,000 Types: • Esophageal cance-17.5, • Prostate Cancer- 15.2 • Kaposis Sarcoma- 9.2 per 100,000 men Diabetes • Prevalence -4.6% (750,000 persons; 20,000 deaths annually) • 14% impaired glucose

OUTCOME INDICATORS	Noted
	• Injuries due to assault -prevalence -42% Injuries due to RTC -prevalence 28%
% of population screened for NCDs	• 4500 (95%) of samples households (STEPWise Survey 2015) • 44% never screened for hypertension • 22% ever screened for diabetes • 11% ever screened for cervical cancer
% reduction of population prevalence rates for obesity and overweight	• 2015-Steps Survey • 28% overweight and obese (39% women and18% men) • 2014 -KDHS • 33% overweight and obesity in women (an increase)
% of population with normal BMI range	The current KDHS provides Proportion of women with normal BMI to 33%
% of household consuming diversified diet	No national data available

^ estimated, many go unreported: Source Steps Survey 2015

Table 6b: Objective 6 -Outputs

OUTPUT INDICATORS	Achievement
Proportion of counties implementing nutrition guidelines on NCDs	Mapping of partners done but specific data linking budget to interventions and planning processes not available.
Proportion of the population who are screened for non-communicable diseases	5% target
Proportion of Counties conducting sensitization meetings on healthy diets and physical activity	BMI done on adhoc basis and data not captured in DHIS. Scale up for BMI and Waist Circumference at community is ongoing but data is not available.
% of population whose BMI is monitored regularly	• The target for this indicator was 15% however, no baseline to measure against. • BMI done on adhoc basis and data not captured in DHIS. Scale up for BMI and Waist Circumference at community is ongoing but data is not available.

Table 7b: Objective 7 -Outputs

OUTPUT INDICATORS	Achievement
Situation analysis on school/ institutional feeding conducted, documented and disseminated	Situation analysis done for the homegrown school feeding regions, documented and disseminated. Only home-grown school feeding program in public primary schools in ASALs and vulnerable populations in urban areas under MoE are involved.
Proportion of pupils and in-mates in Institutions each receive nutritionally adequate meals at all times	No data
School/institutional feeding guidelines reviewed and disseminated	• There is a draft guideline and strategy that has been reviewed but not finalized. Noted is that it is solely focused on schools but not all institutions. • Led by Ministry of education, a team of stakeholders have developed a draft school meals and nutrition strategy. • These two have been finalized, awaiting approval, printing and dissemination
Proportion of schools and institutions mainstreaming basic nutrition in their operations	• Curriculum addressing nutrition in primary schools (basic nutrition subjects) on- going.

OUTPUT INDICATORS	Achievement
	• A school nutrition task force was formed within the Food and Nutrition Linkages Working group to direct activities of nutrition in schools • The matrix for content was submitted to the Kenya Institute of Curriculum Development for inclusion of content in the curriculum reform process • The NDU and its partners have engaged in the curriculum review process. • 1 advocacy meeting held to the CEO Kenya Institute of Curriculum Development for the need to include nutrition in the curriculum • 2 advocacy meetings held for curriculum developers • 1 advocacy meeting held with policy makers who included directors in the Ministry OF Education and the permanent secretary • Development of a memorandum to justify inclusion of nutrition in the curriculum • 2 workshops held where a scope and sequence matrix for food and nutrition content for inclusion in the school curriculum developed. • Members of nutrition unit have been included in the subject and course panels for curriculum development in the KICD
Number of ECD centers carrying out growth Monitoring	Target was 10% but no data is available to confirm achievements
Number of counties holding stakeholders' meetings on sustainable institutional feeding programs	• No specific data collated on this indicator. Some stakeholder meetings are happening, but information not available. • Coordination meetings held periodically but no consistent data to confirm not available.
Proportion of counties monitoring nutrition interventions in schools and institutions	• Data available for Vit. A and deworming for ECD and primary schools. No data for secondary schools and other institutions. • Currently the school health program in the Neo-natal child and adolescent health unit is reviewing the school health policy and guidelines. Nutrition is one of the key thematic areas in the document.

Table 8a: Objective 8 -Outcomes

OUTCOME INDICATORS	Target	Achieved
% of population adopting healthy diets and lifestyle	4% of the population adopt positive nutrition practices	No data to confirm the change. The only data available is on consumption of fruits and veg, physical activities and salt and sugar use

Table 8b: -Outputs

OUTPUT INDICATORS	Achievement
Formative and periodic assessment	• Some periodic assessments are available as follows;

OUTPUT INDICATORS	Achievement
reports available and disseminated	• Minimum acceptable diets for children 6-23, EBF rates, this is in KDHS and SMART surveys, MIYCN KAP surveys done in some counties also have data on KAP pregnant and lactating women and children less than 2 years. • The stepwise survey on NCD risk factors is providing data for adults 18-69 years on the following practice aspects • Studies done on sugar, salt intake, consumption of fruits and vegetables in terms of servings per day against WHO recommendations and number of days consumed in a week.
Proportion of Counties implementing ACSM strategy	• Partial implementation due to un-availability of funds, (sensitization done in 27 counties only). The target was all 47 counties
Proportion of service providers trained on nutrition communication and advocacy skills	• Training materials are developed and awaiting finalization and estimated 10% nutrition service providers trained and carrying out IEC/BCC activities (2017)
Number and type of nutrition communication materials developed and disseminated at all levels	Types: infographics, policy briefs, posters, brochures, radio ads, media briefs, and bulletins online, TV ads, banners have been done.
Proportion of counties marking Nutrition Days	Most counties mark nutrition days, e.g. Malezi bora, breastfeeding week but there is no specific data aggregated and simplified for use.
Proportion of media houses disseminating nutrition messages	No specific data aggregated and simplified for use, but there is information disseminated across all media houses on nutrition

Table 9b: Objective 9 -Outputs

OUTPUT INDICATORS	Target	Achieved
Nutrition M&E framework developed and disseminate	M&E framework developed and disseminated, and in use	• M&E framework developed and disseminated and in use. Disseminated through 2 sensitization meetings (County level), and other 4 high level forums
# Core nutrition indicators integrated into HIS, KNBS, MTEF or Vision 2030	core nutrition indicators included in HIS, NMEF, MTEF planning and budgeting framework	• 11 Nutrition indicators integrated in DHIS • 23 Nutrition indicators integrated in KDHS (KNBS) • Nutrition indicators (stunting, HR) included in the KHSSP
Surveillance protocol and reporting formats disseminated and implemented.	Surveillance guideline developed	• SMART guideline reviewed, SMART questionnaire reviewed (Hard copy & ODK) • Coverage • MIYCN field assessment manual • Capacity assessment tools • Nutrition IPC protocol adopted • Mass screening protocol • KAP questionnaire developed

OUTPUT INDICATORS	Target	Achieved
		• IMAM standard training package and tools • DHIS tools (711, 713,710) • Blanket supplementary feeding tools developed
Surveillance protocol and M&E tools (Reporting formats etc.) Available online.	Surveillance protocol and M&E tools (Reporting formats etc.) Available online	• Nutrition survey data base • DHIS-nutrition integrated • Tools available online • SMART and coverage materials available online • Data clinics held annually • DQAs • IMAM data base
Number of nutrition M&E tools disseminated	Number of nutrition M&E tools disseminated	• 10 tools • SMART tools • MIYCN field assessment tools • Capacity assessment tools • Nutrition IPC tools • Mass screening tool • KAP questionnaire • IMAM standard training tools • DHIS tools (711, 713,710) • Nutrition Financial tracking tool • Nutrition costing tool • IMAM Tools • IMAM and GFD/FFA Linkage Tools • CHANIS • DHIS trainings • OJT-number of facilities visited Training on BSFP data collection and reporting
Proportion of health facilities reporting quality nutrition data		
Proportion of counties conducting scheduled support supervision visits		
Proportion of county health facilities equipped with facilities for data entry and analysis	Proportion of sub counties equipped with facilities for data entry and analysis	Proportion of sub counties equipped with facilities for data entry and analysis

Table 10a: Objective 10-Outcomes

OUTCOME INDICATORS	Baseline	Target	Achieved
Evidence based nutrition interventions planned and programmed			Most of the interventions are reviewed and reprogrammed after SMART surveys

Table 10b: Objective 10 -Outputs

OUTPUT INDICATORS	Notes on Achievements
Nutrition Research Coordinating Committee established and executing its appropriate mandate	Fully functional coordinating committee established Research activities were fully integrated into NITWG mandate
Number and type of nutrition priority research studies conducted and disseminated among relevant nutrition stakeholders	2013/2014 • ICCM Vitamin A research • Pilot on complementary feeding assessment • Pilot of Vitamin A (100000 IU) 100 count bottles • Nutrition programs, measures and strategies in various ministries to meet the objectives of adequately acceptable diet in the population, identified and appraised 2014/2015 11 operational researches on nutrition conducted/disseminated • Conduct Integrated Community Case Management Vitamin A Supplementation research • Assessment of adherence to ready to use supplementary feeds (RUSF) among PLW • Finalize the supply chain assessment (IMAM) • Assessments for SUN networks • Operational research on calcium and iron supplementation during pregnancy (Meru and Western) Operational research on multiple micronutrients (90 sachets) • County field visits to offer technical support in the Kenya Demographic and Health survey • Kenya National Micronutrient Survey (KNMS) report finalized and disseminated • KAP survey on iron folic acid and Vitamin A supplementation results disseminated at the national and county level • Feasibility study on Baby Friendly Community Initiative • Study to explore risk factors for acute and chronic under-nutrition • Measuring social returns of nutrition investment: What is the worth of Baby Friendly Community Interventions in Nairobi slums • Establishing innovative community engagement approaches in a baby friendly community initiative. • Social Return on Investment (SROI) assessment of a Baby-Friendly Community Initiative in urban poor settings, Nairobi, Kenya • Voices for Action: Vulnerable and Solutions to food and nutrition insecurity amongst the Maasai Community • Kenya Breastfeeding Workplace Initiative (KBWI) a formative study undertaken in Kericho • Human Milk banking formative study
Number of agencies and institutions making decisions based on empirical evidence for	No specific number available however, all Ministries Departments nutrition interventions, Donor and UN organizations use available data for their interventions

OUTPUT INDICATORS	Notes on Achievements
nutrition intervention programming and planning	
Number and type of best-practices documented and disseminated for evidence-based programming	• Revision of Vitamin A supplementation in children 6-59 months • Work place support in 13 organizations
Facilities equipped with tools for data entry and analysis	all counties country wide

Table 11a: Objective 11 -Outcome

OUTCOME INDICATORS	Achieved
Increased human, financial and material resources allocation by government and partners to support nutrition activities.	Tracking tool for financial resources.

Table 2b: Objective 11 outputs

OUTPUT INDICATORS	BASELINE	TARGET	ACHIEVED
Number of inter and intra-sectoral coordination meetings held at all levels define meaning of "all levels"	No baseline	Work plans have targets, but no established aggregation mechanism	• Inter/intra-sectoral meetings are taking place and are documented at national and county level but there is no readily aggregated information • 54 Meetings held at national level
Number of functional nutrition coordination committees in place and executing their mandates at all level	No Baseline	Target, 100% (48, i.e. 1 national , 47 county level)	• Committees are available at national level, and county level, but there is no aggregated data on functionality and mandate execution for all the counties • 10 are functional across the two levels of government • 3 global/regional nutrition events marked • Advocacy on key nutrition areas conducted • Quarterly and monthly nutrition coordination meetings conducted
Number of new partners supporting nutrition activities at all levels.	N/A	N/A	There is a mapping tool for new partners, SUN and sector coordinators. However, aggregates have not been undertaken
Proportion of counties integrating nutrition priorities in their county plans	No baseline	47 counties	Full information not available
% of the resource mobilized for nutrition activities from government and partners against the budget activities.	Baseline	85% of total NNAP budget.	At national and county level, funds have been allocated by government and partners, but no aggregated amount to show progress against target is available. There are many stakeholders implementing partners undertaking nutrition intervention but do not avail their funding levels.

OUTPUT INDICATORS	BASELINE	TARGET	ACHIEVED
			Emergency can be tracked but not all other components – Funds available from the government is available

Annex 4: Kenya National Nutrition Action Plan Review- Inception Meeting List of Participants

	NAMES	INSTITUTION
1	Ms. Beryl Rose Katiechi	Nutrition for Africa
2	Ms. Joy Kiruntimi	Nutrition International
3	Ms. Assumpta Ndumi	Save the Children
4	Ms. Rose Wambu	Ministry of Health, Nutrition and Dietetics Unit
5	Ms. Christine Mwangi	Kenya Medical Research Institute
6	Mr. Albert Mwangi	Department of Fisheries
7	Ms. Irene Mugo	International Medical Corps
8	Lillian Odhiambo	Emergency Nutrition Network
9	Janet Ntwiga	UNICEF-MoH
10	Dr. Florence Kyallo	JKUAT
11	Fatima Weiss	BIO foods
12	Lucy Maina Gathigi	UNICEF-MoH
13	Sicily Matu	UNICEF
14	Salome Nyakina	Ministry of Health, Nutrition and Dietetics Unit
15	Dr. Rose O. Opiyo	University of Nairobi, School of Public Health
16	Lucy Kinyua	Ministry of Health, Nutrition and Dietetics Unit
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18	Penina Munguti	Terre Des Hommes
19	Clare Orengo	Consultant
20	Francis Odhiambo	Bioversity International
21	Jane Wambugu	Ministry of Agriculture, Livestock and Fisheries
22	Milka Njeri	APHRC
23	Florence Mugo	Ministry of Health, Nutrition and Dietetics Unit
24	Helen Okochil	KEMRI Intern
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26	Leila Akinyi	Ministry of Health, Nutrition and Dietetics Unit
27	Mr. Kevin Sudi	CISP
28	Caroline Chetu	International Medical Corps
29	Dr. Luis Spagtian	Help Age International
30	Julie Rotich	Ministry of Health, Nutrition and Dietetics Unit
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32	Nicholas Kirimi	UNICEF
33	Lucy Waithaka	International Medical Corps
35	Hellen Makau	Ministry of Agriculture
36	D Nyagah	MoH- NITD-Programme
37	Dominic Gordana	GAIN
38	Anthony Mativo	World Vision Kenya
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42	Alexender Mbogo	Kenyatta National Hospital
43	Oliver Agutu	UNICEF
44	Peter Wathigo	DSM
45	Agnes Sitati	Kenyatta National Hospital
46	Charity Tauta	Ministry of Health, Community Health Department
47	Francis Wambua	UNICEF –NDMA
48	Valarie Wambani	KRCS
49	Rachel Wanjigi	MOH-NCD
50	Edga Okoth Onyango	ACF
51	Caroline Chiedo	NSO
53	Martin Mburu	MoH –RHMSU
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55	Audrina Mikhala Makaka	CBCC
56	Denis Osiago	MOH-OSU
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63	Nassah Massaguoi	UNICEF
65	Gladys Mugambi	Ministry of Health- NDU
66	Zipporah Bukania	Consultant
67	Rhoda Njuguna	Consultant

Annex 3 NNAP REVIEW REPORT: STAKEHOLDERS VALIDATION WORKSHOP 14TH NOVEMBER 2017

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50	Wema Adere	AVCD-ILRI
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15th November 2017

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13	Peris Wangui	MOH
14	Daniel Mbogo	CIP
15	Josephine Njoroge	WHO
16	Sicily Matu	UNICEF
17	Joyce Owiga	NIP
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28	Edna K Warentho	KNH
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Annex 9: References

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