EUROPEAN UNION
DELEGATION TO THE REPUBLIC OF KENYA

Report of Workshop on Maternal and Child Nutrition

Sharing Experiences, Best Practices and Lessons Learnt

8 - 10 September 2015

Lake Naivasha Simba Lodge, Naivasha

September 2015

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INTRODUCTION

This report is divided into seven sections namely; the executive summary, background information, methodology, summary of workshop contents, analysis of the workshop contents, conclusions and recommendations. Attached to this report are annexes giving detailed accounts of the presentations by the various speakers, the workshop programme and the list of workshop participants.

EXECUTIVE SUMMARY

A two day workshop was organized by the European Union (EU) in Naivasha to provide a platform for knowledge and information sharing by maternal and child health projects that are funded by the EU. The workshop was attended by 64 participants including representatives of NGOs and partners implementing EU funded Maternal and Child Health (MCH) and nutrition projects, Ministry of Health (MOH), UNICEF, FAO, UNFPA, DFID, GIZ, WHO and the First Lady's Beyond Zero Campaign.

The Naivasha workshop focused on issues aimed at enhancing the impact of nutrition intervention in the EU funded projects in Kenya with the following objectives:

1. Explore ways of effectively integrating nutrition with MCH interventions.
2. Brainstorm on the best ways of enhancing nutrition sensitive interventions in MCH actions.
3. Discuss logical frameworks, baselines and SMART indicators in line with the EU result framework.
4. Share best practices on nutrition interventions and lessons learnt.
5. Enhance networking among the non-state actors.

It was pointed out that nutrition sensitive programming entails addressing the underlying determinants of foetal and childhood malnutrition and incorporating nutrition goals and specific activities in project design. Ensuring that MCH projects are nutrition sensitive therefore entails incorporating nutrition specific interventions that deal with the immediate determinants of nutrition while establishing linkages with other nutrition sensitive programmes that deal with other underlying causes of malnutrition. Enhancing the Nutrition-sensitivity of MCH Interventions will also entail strengthening multi-sectoral linkages across relevant sectors for coordinated programming as well as incorporating nutrition objectives, actions and indicators in MCH's program design, implementation, monitoring and evaluation.

There is anecdotal evidence to suggest that the MCH projects are incorporating nutrition specific interventions within their programmes across the board. What is not clear is the extent of this incorporation in each of the MCH projects in different geographical areas. There is likelihood that some MCH projects are integrating more or less nutrition specific interventions than others. The general feeling in the workshop was that a number of MCH projects have not sufficiently and effectively integrated nutrition.

In consideration of the multiple determinants of nutrition, linkages among the relevant interventions by different players are critical. It was particularly noted during the workshop that promotion of Income Generating Activities (IGA) for women is a central element in improving the health outcomes of households, nutrition included. In overall terms, the MCH programmes seem to be weak in this advocacy agenda.

The following are some of the best practices that emerged from the discussions:

- Considerable momentum by donors and actors towards multi-sectoral programming across sectors.
- Scaling up the role of Social Behaviour Change (SBC) in influencing nutrition outcomes.
- Integrating nutrition in county integrated development plans.
- Conducting nutrition causal analyses to inform and guide programming.
- Some on-going studies to understand the dynamics at play during the budgeting processes at county level.

There was recognition from the discussions that delivering results at scale requires a combination of system resources from different players. Other lessons learnt include the false assumption that nutrition knowledge and information alone is sufficient to affect behavior change beside the fact that sustainable development cannot be realized without innovative ways to engage the private sector.

With regard to increasing nutrition sensitivity of programmes, there is low understanding of modalities of establishing relevant linkages that are a pre-requisite to this kind of programming. Multi-sectoral platforms both at national and county level are required to promote nutrition sensitivity in programming. The Scaling Up Nutrition (SUN) movement is supporting this through:

- Support for establishment of multi-sectoral and multi-stakeholder platforms at national and county level.
- More effective communication and advocacy.

The key recommendations from the workshop hinged on:

- Increasing nutrition sensitivity of MCH programmes.
- Strengthening documentation and experience sharing.
- Investing more in research, advocacy and accountability.
- Increasing awareness and understanding on nutrition sensitive interventions.
- Working with the county governments by bringing on board the relevant accounting officers to facilitate transparency and accountability.

- Engaging the private sector through the Corporate Social Responsibility and Public-Private Partnership (CSR/PPP) arrangements

BACKGROUND

Since 2007 when the thematic programme, currently known as "Civil Society Organizations and Local Authorities" was de-concentrated to EU Delegations, the EU Delegation in Kenya has been supporting health interventions focused on MCH. This was intended to support Kenya to achieve MDG 3 and 4 on reducing child mortality and maternal mortality by 2015. After realizing the importance of the complimentary role nutrition plays in mother and child health, a nutrition component was introduced in the 2010 call for proposals and in the subsequent calls until 2013. In order to align actions with the new EU-Kenya Development Cooperation, EDF 11 for the period 2014-2020, where one of the three focal sectors is Food Security and Resilience to Climate Shocks with enhancing nutrition as one important component, the EU Delegation decided for the first time to launch a call for proposals, targeted purely on maternal and child nutrition in 2014. Seven grants are expected to be awarded to civil society organizations under this call in 2015.

The following are the main expected results in the MCH projects:

1. Child and Maternal mortality ratios reduced.
2. Nutrition status of mothers, new-born and children under five years improved.
3. Family planning uptake improved.
4. Capacities of health-care delivery systems improved.

For the maternal and child nutrition call, the following are the expected results:

1. Enhance mobilization and political commitment for nutrition.
2. Scale up of actions at country level.
3. Strengthening the expertise and the knowledge-base for nutrition.

Under this programme, the EU has given grants to NGOs amounting to about €27 million (including the anticipated €5 million to be contracted before end of 2015 for the nutrition call). In addition, and through EDF, EU is supporting a nutrition programme of €19 million implemented by UNICEF. Overall, since 2007, the EU has committed about €46 million to support nutrition, maternal and child health projects in Kenya. Currently the EU is supporting 18 ongoing projects on MCH with a nutrition component worth €15.4 million in Kenya.

The Nutrition Workshop held on 8th to 10th September 2015 at Lake Naivasha Simba Lodge was attended by 64 participants including representatives of NGOs and partners implementing EU funded MCH and nutrition projects, Ministry of Health, UNICEF, FAO, UNFPA, DFID, GIZ, WHO and Beyond Zero Campaign. This was a follow up of a similar workshop on maternal and child health held in November 2013 at Nakuru, where participants underscored the importance of regular meetings of that nature for purposes of networking, discussion on challenges of EU funded project implementation, sharing best practices and lessons learnt. While the Nakuru workshop focused mostly on MCH, the Naivasha workshop focused on issues aimed at enhancing the impact of nutrition intervention in the EU funded projects with the following objectives:

1. Explore ways of effectively integrating nutrition with maternal and child health interventions.
2. Brainstorm on the best ways of enhancing nutrition sensitive interventions in MCH actions.
3. Discuss logical frameworks, baselines and SMART indicators in line with EU result framework.
4. Share best practices on nutrition interventions and lessons learnt.
5. Enhance networking among the non-state actors.

METHODOLOGY

This was an interactive workshop characterized by robust discussions and active participation by participants. A mix of methods was used in facilitation including: power-point presentations, group work sessions, group work presentations and plenary discussions. The workshop which comprised of a total of 9 sessions was officially opened by Mr. Eric Habers, Head of Cooperation in the EU Delegation in Kenya. An overview of the nutrition situation in the country presented by an officer from the Nutrition and Dietetics unit, MOH provided an overall context for the workshop deliberations by highlighting key achievements and challenges in nutrition programming. Other key presentations on day one included 'Effective Integration of Nutrition in Maternal and Child Health by UNICEF and 'Enhancing Nutrition Sensitive Interventions in MCH actions' by Action Against Hunger.

See detailed workshop programme in Annex 2

SUMMARY OF WORKSHOP CONTENTS

OPENING REMARKS

In his opening remarks, the Head of Cooperation at the EU observed that the main investment of the EU Delegation in Kenya is in infrastructural development particularly the road network with other major investments being in agriculture and governance. With respect to support towards the health sector, the focus has been shifting from MCH interventions to integration with nutrition interventions. In the near future, investments in nutrition should be linked to the agricultural sector and greater emphasis put on achievement of results as well as the visibility of the EU Delegation. As far as the MOH is concerned, the emphasis is on sustainability of interventions and the need for exit strategies from the project initiation.

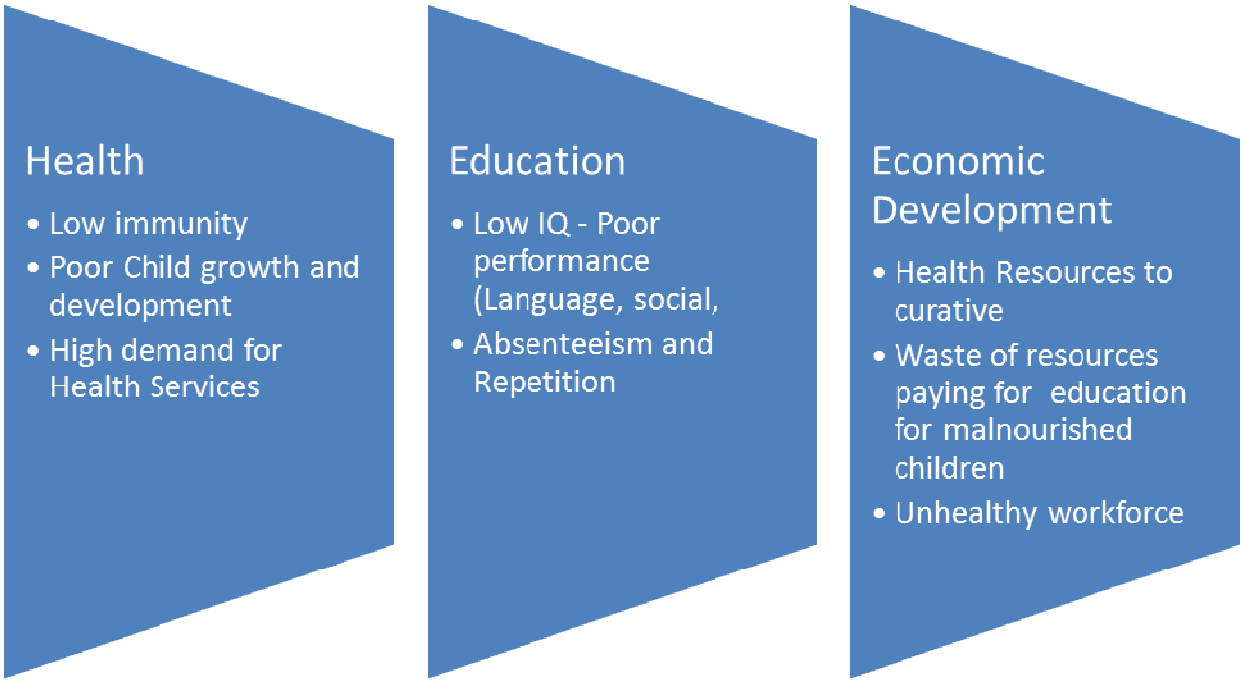
NUTRITION SITUATION OVERVIEW - 2015

In existence are clearly stated policy and legal frameworks as for example exemplified in the Constitution of Kenya (2010), the National Food and Nutrition Security Policy, the National Nutrition Plan of Action 2012-2017 and the Breast Milk Substitutes Act 2012. Key health and nutrition improvements so far include the following;

- Reduction of under-five mortality rate down from 74 deaths per 1,000 live births in 2008-2009 Kenya Demographic and Health Survey (KDHS) to 52 deaths per every 1,000 live births in 2014 KDHS.
- Decrease in underweight from 16% in 2008/9 to 11% in 2014 KDHS, thus achieving one of the indicators for MDG number One.
- Increased exclusive breastfeeding rate to 61% in 2014 KDHS from 33% in 2008-2009 KDHS.
- Delivery in healthcare facilities increased to 61% in 2014 KDHS compared with 43% in the 2008-2009 KDHS.
- Decrease in stunting among children under 5 years old from 35% in 2008-09 KDHS to 26% in 2014 KDHS.

As the levels of stunting, underweight and wasting are steadily going down, over-nutrition is on the rise due to increased consumption of highly refined foods, sugars, salts and fats as well as reduced physical activity and the resultant sedentary lifestyle.

Overall malnutrition has the following effects:



The following challenges are associated with programming to improve nutrition;

- Low understanding of linkage between national food security, basic education, and water and sanitation strategies on one hand and nutrition on the other.
- Vertical program strategies lacking nutrition as an outcome indicator.
- The government's budgetary allocation for the health sector, still falls below the 15% standard stipulated in the Abuja declaration.
- There is a human resource gap for nutritionists and dieticians within public health facilities and at community level.

DISCUSSION

The reasons that predominantly featured in the discussions for explaining the high levels of stunting in Kilifi, Kitui and West-Pokot included; household food insecurity, poor Water, Sanitation and Health (WASH) practices, child illness, low women empowerment, poor Infant and Young Child Feeding (IYCF) practices, inappropriate socio-cultural factors and low education levels.

Devolved government present an opportunity for increased lobbying for increased resources to address nutrition challenges. This agenda has however not been addressed

clearly in most of the County Integrated Plans and budgets. To improve programming around the nutrition agenda, the following suggestions were proposed:

- Document how different players are responding to socio-cultural issues impacting negatively on nutrition and where applicable replicate the different successful models.
- Use cultural/traditional leaders to champion nutrition issues.
- Utilize opportunities that can possibly be availed via the Corporate Social Responsibility and Public-Private Partnership (CSR/PPP) arrangements through effective advocacy strategies.
- In consideration of the multiple determinants of nutrition, link with other relevant interventions such as the Orphans and Vulnerable Children (OVC) programmes, food banking initiatives, gender and development programmes as well as afforestation with appropriate fruit tree species.
- Embrace community participatory approaches so as to foster home grown solutions.

EFFECTIVE INTEGRATION OF NUTRITION IN MATERNAL AND CHILD HEALTH

The need for integration

The framework for Actions to achieve optimal foetal and child nutrition and development according to the Lancet series (Lancet 2008) involves a combination of interventions geared towards nutrition specific interventions and programmes on one hand and nutrition sensitive programmes and approaches on the other hand.

There is evidence to suggest that Kenya's High Impact Nutrition Interventions (HINI) which are in themselves integrated can save at least 15% of child deaths and avert a fifth of all stunting if delivered at scale (Lancet 2008). Delivering at scale on the other hand requires a combination of system resources from different players. It has been established that undernutrition is a key shared risk factor for morbidity and mortality associated with diarrhea and pneumonia (Bloomberg et al April 2013).

Government Actions

Government efforts towards integration of nutrition in maternal and child health interventions entail implementing both specific nutrition and nutrition sensitive interventions with the appropriate governance environment. The specific nutrition interventions include:

- Promotion of exclusive breastfeeding.

- Promotion of optimal complementary feeding.
- Zinc treatment for diarrhea.
- Iron and folic acid supplementation among pregnant women.
- Vitamin A supplementation for children.
- Iodization of table salt.
- Food fortification initiatives.

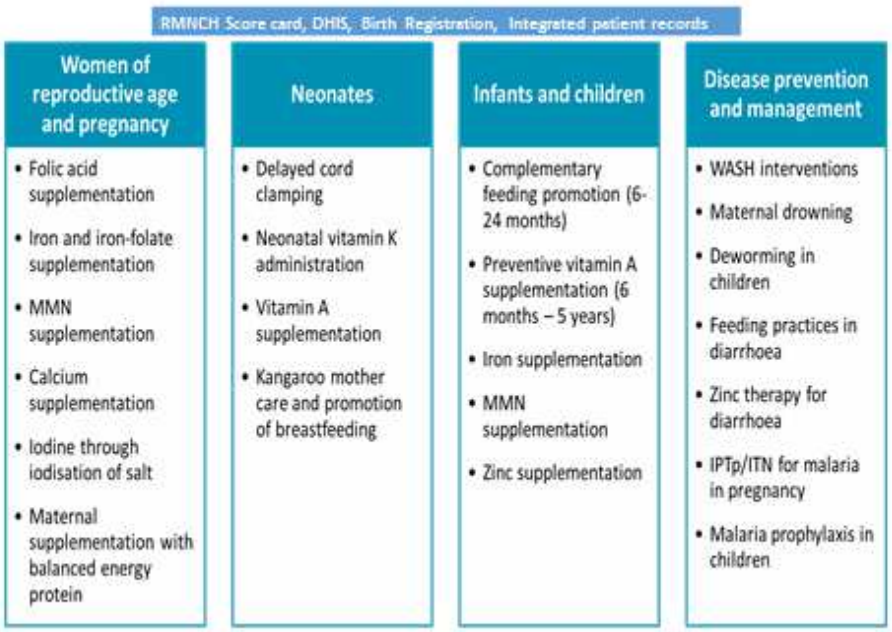
The nutrition sensitive interventions comprise:

- Food security and agriculture programmes.
- Improvement of child care environment.
- Improvements in public health, water and sanitation.
- Women empowerment and support for resilience.

The appropriate governance environment entails:

- Coordination and information management.
- Development of policy and legislation.
- Advocacy and communication.
- Systems building for sustainability.

As illustrated below, the practical implication of nutrition integration into MCH services translates into specific nutrition initiatives targeted towards women of reproductive age and pregnancy, neonates, infants and children as well as dealing with diseases prevention and management.



Health Facility Based Surge Capacity Concept is a good example of an integrated model that is becoming increasingly relevant for supporting health facilities and the Sub-County Health Management Teams when responding to a deteriorating nutrition situation.

GROUP WORK

Group work discussions reflected on the extent to which nutrition is integrated in MCH programmes. The following three questions formed the basis of the discussions:

1. How is nutrition integrated into MCH services in your area?
2. How can this integration be strengthened?
3. Do you think current national policies promote integration?

SUMMARY OUTCOMES OF GROUP WORK

How nutrition is integrated into Maternal and Child Health Services

- Supporting integrated health and nutrition outreach services.
- Integrating nutrition elements in MCH training for Community Health Workers (CHWs) and other staff.
- Integrating Information, Education and Communication (IEC) materials on nutrition at the community and facility level.
- Participating in nutrition stakeholder forums.
- Supporting integrated nutrition surveys.
- Incorporation of specific nutrition objectives in MCH programmes.
- Incorporating nutrition specific activities in the MCH programmes such as;
    - Nutritional education among pregnant and lactating mothers.
    - Nutrition supplementation.
    - Cooking demonstrations.
    - Nutrition assessment, counseling and treatment.
    - Coordination of nutrition reporting by MOH.
    - Promotion of exclusive breast feeding promotion.
    - Working with Traditional Birth Attendants (TBAs) to reduce nutritional myths related to nutrition.
    - Promoting PD[1]/Hearth for nutrition at community is effective and sustainable

- Incorporating nutrition sensitive activities in the MCH programmes such as;
    - Kitchen gardening through Mother to Mother support groups.
    - Promotion of income generating activities to enable target groups access food.

[1] http://www.wvi.org/nutrition/project-models/positive-deviancehearth

Strengthening integration

- Use of diverse media platforms to reach the community including a strong component on SBC and IEC.
- Mapping the critical spheres of influence such as teachers, fathers, grandmothers etc.
- Integrating nutrition in pre- and post-service curriculum.
- Strengthen and improve existing multi-sectoral forums at the county level to improve nutrition.
- Ensure nutrition is integrated in all MCH programs at the design stage including clear specific nutrition objectives.
- Integrate nutrition indicators in performance monitoring for MCH workers/leaders as part of an accountability measure.
- Making Maternal Child Health and Nutrition (MCHN) programming disability friendly.
- Strengthen the MCHN M&E system.
- Strengthening documentation and sharing of experiences in MCHN.
- Ensure continuous engagement/advocacy with the relevant players as well as focusing on system strengthening for MCHN interventions to assure sustainability. This should ideally result in increased allocation of resources to nutrition at the county government level.
- Increase on resource mobilization for MCHN activities including the MCHN human resource base as well as its capacity building.
- Put in place sustainable motivation strategies for CHWs (Community Health Workers)
- Establish and support strong linkages with the Ministry of Agriculture and other relevant line Ministries and departments including the early childhood education institutions.
- Invest in nutrition research to inform and influence advocacy and policy

Does the current national policy promote integration?

There were mixed reactions to this question in the sense that in as much as there was appreciation that the national policy exists on paper (the National Food and Nutrition Security Policy), not much has been done in terms of comprehensively implementing these policies especially at the county level. For these policies to work;

- There must be adequate resources
- There must be a strong citizen's voice to assure accountability
- Government ministries and departments must establish both vertical and horizontal linkages
- There must be harmonized advocacy

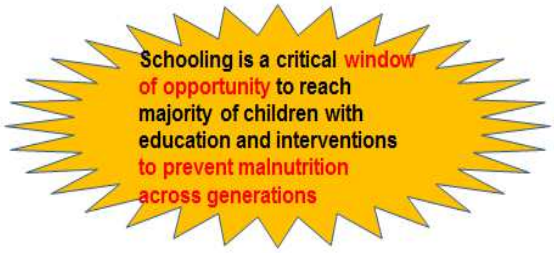
DISCUSSION ON GROUP WORK

- There was a general feeling that a number of MCH projects have not sufficiently integrated nutrition.
- It was noted that 5 Focused Ethnographic Studies (FES) which provide good information on determinants of complementary feeding have been carried out in Kitui, Vihiga, Marsabit, Turkana and Isiolo counties by Global Alliance for Improved Nutrition (GAIN) in partnership with the Nutrition Unit, MOH. These have been disseminated at national and county level. There is need for findings of such studies and others of similar nature to guide programming especially on social behavior change by partners. Other platforms for dissemination could include conferences and workshops organized by state and non-state actors.
- Researches being done in Kenya are generally very elaborate because of the various relevant technical working groups that provide oversight to these researches.
- Borrowing a leaf from successful Behaviour Change and Communication (BCC) programmes and up-scaling the positive aspects is a good practice. Nonetheless, the SBC and IEC materials should be made in local/appropriate languages.
- It was noted that promotion of Income Generating Activities (IGA) for women is critical element in improving the health outcomes of households, nutrition included.
- Capacity building for incorporating nutrition in programmes should not be limited to professionals in the health sector but should spread to other sectors such as agriculture and education. Additionally, the training mode should shift to on-job training.
- Understanding the dynamics at play during the budgeting processes at county level is important. Of critical concern are the political and social interests in the process. Some studies to understand these dynamics are currently on-going. This will go a long way in understanding how sustainability can be mainstreamed.
- Finding out what works and deriving the requisite lessons especially in as far as the health systems and their sustainability are concerned is of paramount importance. Organizationally, the Kenya constitution stipulates that national level does policies and county governments implements them. Partners should therefore focus on the capacity of county government to implement policies developed by the national governments. Some of these policy documents for instance the National Food and Nutrition Security Policy cuts across many ministries (health, agriculture, education etc.) necessitating that their implementation be done in a coordinated manner. The Ministry of Education (MOE) has for instance integrated school management systems that are supposed to bring on board many other partners including those dealing with nutrition.

THE BURDEN OF MALNUTRITION AND ITS IMPLICATION TO SCHOOL CHILDREN

Why Focus on School Children?

1. Education provides the platform for empowering populations to make the right decisions and transfer skills as agents of change.
2. The Constitution of Kenya (2010) through the section on bills of rights makes it mandatory to address the health and nutrition concerns for children.
3. Children are the future hope of any society.
4. Healthy children will contribute to achieving Vision 2030 of educated, healthy and productive population.
5. Children of school going age between 3 -18 years represent over 50% of the entire population.
6. Children spend more than 75% of time in the school environment.
7. Children are excellent change agents.



Why should we integrate nutrition in the school curriculum?

- ✓ Malnourished children in Kenya (too short, too thin or underweight) have;
  - Mothers with no education
  - Mothers who stopped their education at primary school
- ✓ There is a direct link between mothers' nutritional status, their education levels, and child nutritional status[2]

Ongoing strategies to alleviate malnutrition using school platforms

1. Schools health nutrition and meals programme.
2. Deworming and supplementation.
3. Minimal nutrition education and agriculture in the curriculum (formal and co-curriculum) both in theory and practical.

[2] Donald Makoka (2013); The Impact of Maternal Education on Child Nutrition: Evidence from Malawi, Tanzania, and Zimbabwe

A call to action

- ✓ Malnutrition is predictable, preventable and treatable.
- ✓ Malnutrition is the single greatest contributor to child morbidity and mortality.
- ✓ Strengthening nutrition in the curriculum is one of the avenues of winning the battle.

Strategies in short term, medium term and long term

1. Support the inclusion of agriculture and nutrition messaging into the curriculum.
2. Develop well defined engagement and partnership modalities between MOE, MOH and Ministry of Agriculture (MOA) through establishment of a regular coordination mechanism as well as developing modalities for information gathering and sharing.
3. Consider diverse modalities of passing agriculture and nutrition messaging in schools through for example drama, music festivals and school health clubs.
4. Develop a system to roll out, monitor and evaluate nutrition and agriculture interventions in the education sector.
5. Measure the impact of the cohesive partnership between the 3 ministries and the causal relationship between agriculture, nutrition and education.

DISCUSSION ON THE PRESENTATION

There is a possibility of including nutrition at school in children's co-curricular activities such as the children's parliaments and health clubs

With regard to increasing nutrition sensitivity, there is low understanding when it comes to establishing the relevant linkages that are pre-requisite when it comes to this kind of programming. Additionally, the role shifts from direct implementation for some of the aspects to being more facilitative. Relevant multi-sectoral platforms both at national and county level are required in increasing nutrition sensitivity in programming. In as much as nutrition sensitivity programming is a grey area, it has been established that about 75% of donor funding in Kenya is going towards this kind of programming. Generally the momentum towards this kind of programming is impressive by the donor community but will require more input by the government.

It has also been established that birth spacing reduces stunting. This is a situation where family planning combined with appropriate investment in nutrition creates changes in the demographic map leading to positive consequences referred to as demographic dividends. This scenario eventually generates a situation where there is a young productive population that is employable leading to increased economic growth. This clearly becomes a good advocacy tool.

ENHANCING NUTRITION SENSITIVE INTERVENTIONS IN MCH ACTIONS

Understanding the nutrition sensitive agenda

Nutrition sensitive programming entails addressing underlying determinants of foetal and child nutrition and deliberately incorporates nutrition goals and actions. It therefore requires that nutrition is explicitly incorporated within other sector approaches particularly programmes to do with:

- Women and youth empowerment
- Social safety nets
- Child protection
- Classroom education
- Water, sanitation and hygiene
- Agriculture and food security
- Early childhood development
- Health and family planning services

There is ample evidence to show that direct actions to address the immediate determinants of undernutrition can be further enhanced by action on some of the more underlying determinants. Conversely improving nutrition can help nutrition sensitive programmes achieve their own goals. Nutrition sensitive programmes are therefore considered as perfect delivery platforms for nutrition specific interventions as they offer unique opportunities to reach critical population groups e.g. adolescents and children.

On a practical level and in general terms, enhancing the Nutrition-sensitivity of MCH interventions entails strengthening multi-sectoral linkages across other relevant sectors for coordinated programming and incorporating nutrition objectives and indicators consistently in MCH's needs assessment, program design, implementation and monitoring.

Experiences and Best Practices

- There is now considerable momentum by donors and actors towards multi-sectoral programming.
- Scaling up the role of SBC in influencing nutrition outcomes.
- Integrating nutrition in county integrated development plans.
- Development of score card to assess nutrition interventions across sectors.
- Emerging causal analyses methodologies.

Lessons Learnt

- Take advantage of low hanging fruits - 1,000 days window and adolescents as easy entry points.
- Thinking and acting multi-sectoral.
- Social Behaviour Change (SBC) is a vital cross cutting precursor.
- What gets measured gets managed.
- We cannot win without innovative ways to engage the private sector.

What is next in the nutrition sensitive programming front?

- Development of guidelines on how to improve nutrition-sensitivity of programmes.
- Increased use of rigorous, impact and cost-effectiveness assessments including impact pathway analyses.
- Increasing nutrition sensitive of programmes with the development of appropriate nutrition goals and actions.

GROUP WORK

Group work discussions reflected on the extent to which nutrition sensitivity has been enhanced. The following six questions formed the basis of the discussions:

1. What are some of the examples of nutrition sensitive MCH interventions *(meeting ingredient criteria)*?
2. What are some of the barriers/challenges to nutrition sensitive MCH programming?
3. What is the role of the private sector in the nutrition sensitive agenda and how can they be engaged?
4. How can political commitment in nutrition sensitive MCH programming be sustainably increased?
5. How can SBC be used in ensuring nutrition sensitiveness of MCH interventions?
6. What are the roles of SUN in the nutrition sensitivity agenda?

SUMMARY OUTCOMES OF GROUP WORK

Examples of nutrition sensitive MCH interventions

- Integrating nutrition components in the promotion of household hygiene using CHWs, Early Childhood Development (ECD) schools, Ante Natal Clinic (ANC), school health programmes family planning services, MCH disability programmes, immunization programmes and social mobilization.
- Implementation of specific nutrition interventions such as supplementation for pregnant women and children, food preparation demos, deworming.
- Supporting high impact nutrition intervention.

- Promoting the SURGE capacity model.
- Supporting food assistance targeting MCH clients.
- Working with MOA to support livelihood programmes including support to Mother To Mother Support Groups and kitchen gardens.
- Promote community based nutrition programme such as PD/Hearth.

Barriers/challenges

- The nutrition knowledge given to health workers and extension officers does not necessarily translate into action in nutrition.
- There are many incidences where the nutrition messaging is inappropriate. This is compounded by the high illiteracy levels in some communities and the inadequate or lack of relevant IEC materials/tools. On the other hand, CHWs have limited capacities with respect to communication skills.
- Some social norms and cultural as well as religious believes impact negatively on some interventions.
- Some national policies, actions plans and data collection tools are not well customized at the county level.
- Most of the approaches and tools/equipment are not disability friendly.
- There is still poor stakeholder coordination with different sectors and players working vertically/in silos leading to inadequate joint inter-departmental interventions at all levels (designing, planning, implementation, monitoring and evaluation). This is partly informed by the inadequate understanding of what nutrition entails at all levels.
- There is generally shortage of resources (technical staff, material and financial) in the relevant sectors/ministries.
- Intricacies in the implementation of the devolution processes, sometimes presenting dilemmas due to unclear roles.
- There is currently no clear framework on nutrition sensitive programming in the Country.
- High poverty levels at household level, prioritizes spending on non-nutrition items.

Role of private sector in the nutrition sensitive agenda and how to engage them

- Providing opportunities for women in the supply chains thereby leading to women empowerment.
- Financial institutions providing opportunities for economic empowerment of women through access to finances.
- Development and promotion of Public Private Partnership strategies that are nutrition sensitive.

- Contribution of resources including technical expertise towards nutrition sensitive programming.
- Should be on the frontline on advocacy through social marketing as well as innovations e.g. the Safaricom communication platforms.
- Plays a leading role in the food industry especially on food fortification.
- They can leverage on their strengths on communication for accelerating appropriate SBC.

Increasing political commitment in nutrition sensitive MCH programming

- Engage governors' and their spouses and reach out to other critical opinion leaders through the relevant advocacy processes including evidence based advocacy.
- Understand the budgeting cycle especially at the county level in order to influence budgetary allocations. This will include understanding the influencers/interests plus the tools/mechanisms for budget tracking and social accountability. This should go hand in hand with the harmonization of processes between the national and county government levels.
- Document human interest stories and data on cost of inaction and share the stories with key influencers.
- Identify political leaders, teams or nutrition champions at the county level to drive the agenda.
- Strengthen civil society platforms and alliances that champion the interests of the communities in as far as nutrition sensitive MCH programming is concerned. These platforms are also critical for improving on accountability and ensuring sustained appropriate feedbacks.
- Increase awareness, knowledge and understanding on nutrition sensitive interventions among the relevant players at all levels.

Using SBC in ensuring nutrition sensitive MCH interventions

- Identify and utilize evidence that is context specific as well as ensuring relevant messaging that addresses behavioural needs and using appropriate media for communication.
- Strengthen community participation that is already ingrained with SBC to increase ownership.
- Leverage on existing programmes and community channels for efficient and effective delivery of messages.
- Strengthening communication skills and support community dialogues.

Role of SUN in nutrition sensitive agenda

- A good platform for ensuring a common strategy in bringing various players together and having a common results framework to enhance accountability.
- Spearhead coordination of nutrition interventions.
- Advocate and mobilize resources for nutrition.
- Policy engagements at the national level.
- Support the relevant multi-sectoral linkages.
- Ensure SUN[3] is scaled up in different counties.

DEVELOPING SMART INDICATORS FOR EFFECTIVE MONITORING AND EVALUATION FOR AN MCHN PROGRAMME

SMART criteria

- **Specific** to the objective.
- **Measurable** either quantitatively or qualitatively.
- **Achievable** at an acceptable cost.
- **Relevant** to the information needs of decision-makers and the community.
- **Time-bound** so that users know when to expect the objective or target to be achieved.

The main expected results in the MCH/nutrition programmes:

1. Child and maternal mortality ratios reduced.
2. Nutrition status of mothers, new-born and children under five years improved.
3. Family planning uptake improved.
4. Capacities of health-care delivery systems improved.

Indicators in the MCH/Nutrition programmes are derived from:

- Global (MDG) indicators.
- EU result framework level 2 indicators.
- Ministry of Health of Kenya indicators.
- Agency's own indicators.

[3] SUN comprises the government (MOH, MOA, MOE, Gender and Planning), Civil Society Alliance, UN, Business network, Academia and the Donor network

Relevant EU result framework level 2 indicators:

- Number of women of reproductive age and children under 5 benefiting from nutrition related programmes with EU support.
- Number of births attended by skilled health personnel with EU support (MDG 5.2).
- Number of 1-year olds immunized with EU support (MDG 4.3).
- Number of women using any method of contraception with EU supports (MDG 5.3).
- Number of insecticide-treated bed-nets distributed with EU support (MDG 6.7).

MOH indicators for MCH/nutrition

- National Nutrition Action Plan 2012-2017
- Kenya Health Sector Strategic Plan III (KHSSP)
- County Health Sector Strategic Plans
- County Integrated Development Plans (CIDP)
- Kenya Demographic Health Survey

The Tana North log frame (Agency's own indicators)

- Based on EU result framework (2 indicators); https://ec.europa.eu/europeaid/sites/devco/files/swd-2015-80-f1-staff-working-paper-v3-p1-805238_en_0.pdf
- Based on MOH indicators.
- Builds on the community-based health approach and the indicators of the international Red Cross movement.
- CBHFA has a PMER toolkit available at; http://www.ifrc.org/Global/Publications/Health/CBHFA%20PMER%20toolkit.pdf.

Challenges

- There are too many indicators to measure and monitor at different levels.
- The county systems are still emerging hence in some areas there no clear agreed upon county specific indicators.
- There is overlap on some of the indicators.
- The indicators are not disaggregated to track People Living With Disabilities (PWDs).
- Some indicators depend on MOH stock outs.
- Indicators directly linked to activities.
- There are difficulties setting targets particularly for behavior change.
- Not linking activities to the targets.
- There are no beneficiary satisfactory indicators.

BEYOND ZERO CAMPAIGN

The campaign, un-like what is in the public domain, is endeavoring to address the determinants of health as stipulated by WHO particularly access to health services, environment and education. The First Lady for the Republic of Kenya is using her position to push for the implementation of commitments made in the various national policy documents. The campaign is guided by a strategic framework and works in partnership with other relevant players to raise the profiles of some critical issues.

The Secretariat is currently hosted at National Aids and Control Council (NACC) with various technical teams offering oversight. A total of 32 mobile clinics have already been established. Sustainability mechanisms for these clinics are imbedded in the national health sector strategic frameworks. In these frameworks, counties are supposed to make commitments to maintain the mobile clinics. These clinics have been very useful especially in Arid and Semi Arid Lands (ASAL) areas with Samburu County for instance opting to buy two more.

WAY FORWARD AND CLOSING REMARKS

- Every player should make an effort to work with the respective county governments.
- Partner mapping is key at the county government level.
- It was reiterated that the national government makes policies while the corresponding county governments implement the policies.
- The respective accounting officers at the county government level are critical in ensuring transparency and accountability of resources. They therefore should be fully brought on board in all development initiatives. There was a suggestion that a specific workshop be organized for accounting officers to especially discuss issues of coordination and resource allocation.
- The following three summary points were emphasized:
    1. The importance of the multi-sectoral platforms exemplified by the SUN networks on one hand and the national platform with all relevant ministries on the other hand. The SUN movement is particularly keen on this aspect
    2. Multi-sectoral approach.
    3. The need for more effective communication and advocacy.

ANALYSIS OF THE WORKSHOP CONTENTS

ENHANCING NUTRITION SENSITIVITY OF MCH PROGRAMMES

Nutrition sensitive programming (in which MCH is one of them) entails addressing underlying determinants of foetal and child nutrition and deliberately incorporates nutrition goals and actions.

There is ample evidence to show that direct actions to address the immediate determinants of undernutrition can be further enhanced by actions on some of the more underlying determinants the actions of which are normally the preserve of nutrition sensitive programmes. Therefore a perfect scenario is where nutrition sensitive programmes become delivery platforms for nutrition specific interventions. The double advantage in such a setting is the fact that improving nutrition can help nutrition sensitive programmes achieves their own goals. It has been established for example that undernutrition is a key shared risk factor for morbidity and mortality associated with diarrhea and pneumonia (Bloomberg et al April 2013). Therefore dealing with nutrition in an MCH programme enhances other health outcomes.

An MCH service as a nutrition sensitive programme has ideally two broad agendas:

1. Incorporating nutrition specific interventions that deal with the immediate determinants of nutrition and;
2. Establishing linkages with other nutrition sensitive programmes that deal with other underlying causes of malnutrition.

On a practical level and in general terms, enhancing the Nutrition-sensitivity of MCH Interventions entail strengthening multi-sectoral linkages across other relevant sectors for coordinated programming and incorporating nutrition objectives, actions and indicators consistently in MCH's needs assessment, program design, implementation, monitoring and evaluation.

In as much as nutrition sensitivity programming is a grey area, it has been established that about 75% of donor funding in Kenya is going towards this kind of programming. Generally the momentum towards this kind of programming is impressive by the donor community but will require more input by the government.

<u>Nutrition specific interventions</u>

There is sufficient anecdotal evidence to suggest that the MCH projects are incorporating nutrition specific interventions within their programmes across the board. What is not clear is the extent of this incorporation in each of the MCH projects at different geographical areas. There is likelihood that some MCH projects are integrating more

nutrition specific interventions than others. The general feeling in the workshop was that a number of MCH projects have not sufficiently and effectively integrated nutrition.

Establishing linkages

In consideration of the multiple determinants of nutrition, linkages among the relevant interventions by different players are critical. It was particularly noted during the workshop that promotion of IGA for women is a central element in improving the health outcomes of households, nutrition included. Additionally, a few cases were noted of MCH programmes working with the Ministry of Agriculture to support livelihood programmes through Mother To Mother Support Groups. Strong linkages are also at play when it comes to supporting processes for mobilizing resources towards the nutrition agenda. Therefore understanding the dynamics at play during the budgeting processes at county level is important. Of critical concern are the political and social interests because the entire process is normally political. In overall terms, the MCH programmes seem to be weak in this advocacy agenda.

BEST PRACTICES

This part of the report is lacking in-depth understanding and consensus. This is due to minimum evidence reported/presented at the workshop worthy of considering as 'best practice'. For an aspect to be regarded as best practice there must be clear demonstration of results in line with stated objectives. Some of the content as presented below could, with further documentation, pass for best practices but for now they remain emerging best practices and they include:

- Considerable momentum by donors and actors towards multi-sectoral programming across sectors
- Scaling up the role of SBC in influencing nutrition outcomes
- Integrating nutrition in county integrated development plans
- Conducting nutrition causal analyses to inform and guide programming
- Community based nutrition promotion
- On-going studies to understand the dynamics at play during the budgeting processes at county level

LESSONS LEARNT

Delivering at scale requires a combination of system resources from different players. Without collaboration and effective linkages, scaling up programmes generally becomes hampered and not cost effective.

In many incidences, nutrition messaging is inappropriate. In such incidences, either the literacy level is not considered in designing the materials or even when it is, some social, religious or cultural dynamics are ignored. Additionally, it is normally assumed that the CHWs who convey the messages have adequate communication skills. Consequently, some of the IEC materials become irrelevant. Therefore Social Behaviour Change (SBC) as an approach becomes a vital precursor since some social norms, cultural as well as religious believes impact negatively on some interventions.

The assumption that the nutrition knowledge provided to health workers and extension officers translate into action in nutrition is not correct. This bring into question the many capacity building sessions in form of training that most programmes heavily invests in. There could be better ways of utilizing such resources such as on-job training. Besides capacity building, another notion that is normally held is the assumption that there is sufficient number of technical personnel to implement programmes, which is rarely the case. Any programming should therefore clearly plan for these capacity gaps from the design phase.

Sustainable development cannot be realized without innovative ways to engage the private and public sector. When this engagement and partnership is ignored, then development becomes haphazard, disjointed and un-coordinated. The private sector, it has been established, is the engine of development since it is at the forefront with respect to the economic empowerment of the communities, while the public sector is wide and spread promoting equity to access and sustainability.

The need to be rigorous towards effective monitoring and evaluation of on-going interventions and achievement of objectives respectively is summed up in the statement "What gets measured gets managed". Without sufficient and timely information on programmes, operations become a management crisis.

Kenya has been known to have some of the finest national policies, strategies, plans and implementation as well as data collection tools. However these instruments are rarely customized at the county level rendering them impractical tools for the most part in supporting implementation at the grass root level. It is the role of County government to realize the need to adapt such policies to their circumstances and put these policies into relevant practice.

CONCLUSIONS

With regard to increasing nutrition sensitivity, there is low understanding when it comes to establishing the relevant linkages that are a pre-requisite to this kind of programming. Relevant multi-sectoral platforms both at national and county level are required in increasing nutrition sensitivity in programming. There is poor stakeholder coordination with different sectors and players working vertically or in silos leading to inadequate joint

inter-departmental interventions at all levels (designing, planning, implementation, monitoring and evaluation). This is partly informed by the inadequate understanding of what nutrition entails at all levels. The SUN movement is particularly keen on addressing these concerns through:

1. The multi-sectoral platforms exemplified by the SUN networks on one hand and the National platform with all relevant ministries on the other hand.
2. Multi-sectoral approaches.
3. More effective communication and advocacy.

Currently there is no clear framework on nutrition sensitive programming in the country.

RECOMMENDATIONS

Increase nutrition sensitivity of MCH programmes: This can be achieved by ensuring that nutrition is effectively integrated at the design stage through the development of clearer specific nutrition objectives, actions and indicators. This should be followed by a robust monitoring and evaluation system.

Strengthen documentation and experience sharing: Since nutrition sensitive programming is a fairly new experience, clear documentation of what is working will be paramount. This is especially so given that different players will be responding to socio-cultural issues impacting negatively on nutrition differently. Documentation, sharing and where applicable replication of the successful practices/models will be worthwhile.

Strengthen multi-sectoral platforms: Support the relevant multi-sectoral platforms at the county level to improve nutrition outcomes. It will be necessary to establish and support strong linkages with the Ministry of Agriculture in particular and other relevant line Ministries and departments.

Invest in research, advocacy and accountability: Evidence based advocacy will require a strong relevant operational research agenda. This will also entail increased use of rigorous, impact and cost-effectiveness assessments including impact pathway analyses. Armed with strong evidence of what works, critical opinion leaders at all levels should be reached for purposes of influencing resource allocations towards nutrition. Programme personnel should be taken through a process of understanding the budgeting cycle especially at the county level in order to enable them lobby for more funding to nutrition. This will include understanding the influencers/interests plus the tools/mechanisms for budget tracking and social accountability. In a similar vein, strengthen civil society platforms and alliances that champion the interests of the communities in as far as nutrition sensitive MCH programming is concerned. These platforms are also critical for improving on accountability and ensuring sustained appropriate feedbacks.

Increase awareness and understanding on nutrition sensitive interventions: This awareness should be done among the relevant players at all levels. A pre-requisite for this awareness will be the development of guidelines on how to improve nutrition-sensitivity of programmes and the utilization of evidence to develop relevant messages that address behavioural needs using appropriate communication media.

Work with the county governments: Since much of the resources from the national government have been devolved, every other player should make efforts to work with their respective county governments. Towards this end, the relevant accounting officers at the county government level should be broad on board fully to facilitate transparency and accountability. An induction workshop for the relevant accounting officers to especially discuss issues of coordination and resource allocation would be a good idea.

Engage the private sector: Utilize opportunities that can possibly be availed via the Corporate Social Responsibility and Public-Private Partnership (CSR/PPP) arrangements.

ANNEX 1: DETAILED PRESENTATIONS

NUTRITION SITUATION OVERVIEW -2015 by Monica - SHARE Focal Point at MOH

Policy and legal framework

- The Constitution of Kenya (2010): *Article 43 - every person has the right to be free from hunger and article 53 - every child has the right to basic nutrition.*
- National Food and Nutrition Security Policy
- National Nutrition Plan of Action 2012 to 2017
- Policy Statements and Guidelines and Detailed work
- Legislation - Breast Milk Substitutes (Regulation and Control) Act 2012
- Mandatory fortification of cereals and oils - 2012,
- Maternity Protection (3 months for mother, 2 weeks for father)

Nutrition Situation

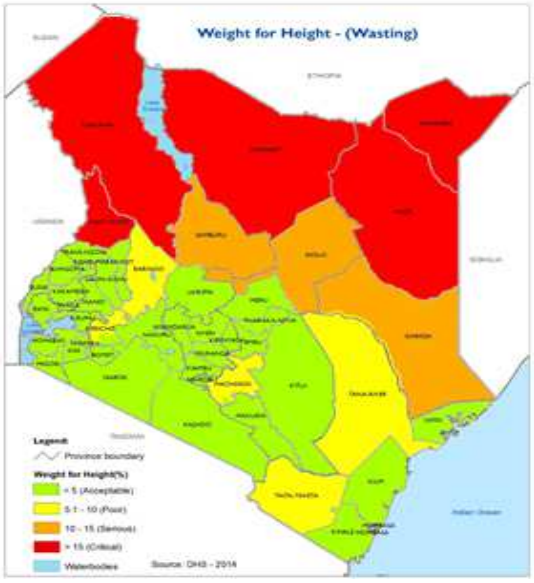
- Child survival has improved since the 2008-2009 KDHS.
- The under-five mortality rate is 52 deaths per every 1,000 live births, down from 74 deaths per 1,000 live births in 2008-2009
- Underweight also decreased from 16% in 2008/9 to 11% in 2014 KDHS, thus achieving one of the indicators for MDG number One.
- Appropriate infant feeding practices are fundamental for health, nutrition, survival and development of children.
- Exclusive breastfeeding rate increased to 61% in 2014 KDHS from 33% in 2008-2009 KDHS.
- More than three in five births (61%) took place in healthcare facilities , compared with 43% in the 2008-2009 KDHS

Stunting

- Childhood malnutrition has also declined, 26% of children under 5 were stunted, a decrease from 35% in 2008-09
- About one-quarter (26 percent) of Kenyan children are stunted, while 8 percent are severely stunted with children 18-23 months being the most affected (12 percent), and those less than 6 months being the least affected

Wasting

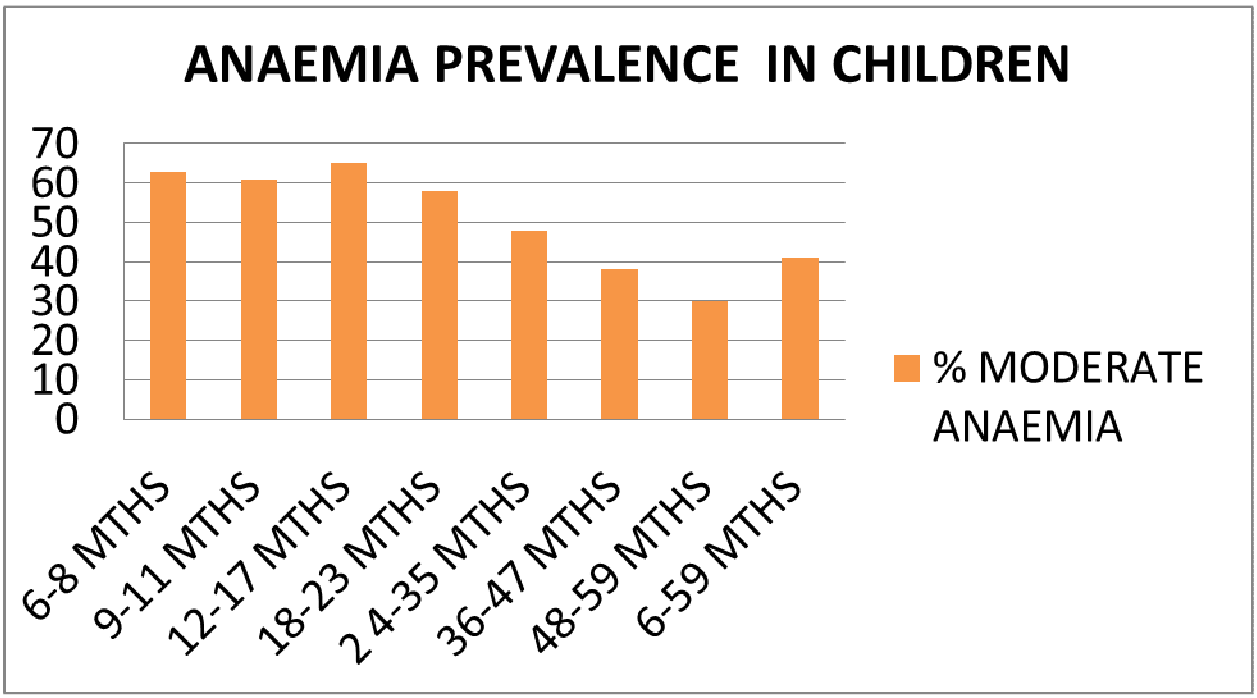
- 4 percent of Kenyan children are wasted and 1 percent are severely wasted
- Wasting is concentrated in the north: Garissa, Wajir, Mandera, Marsabit, Turkana, West Pokot, and Samburu
- More than 11 percent of children are wasted in these counties, with Turkana topping out at 23 percent



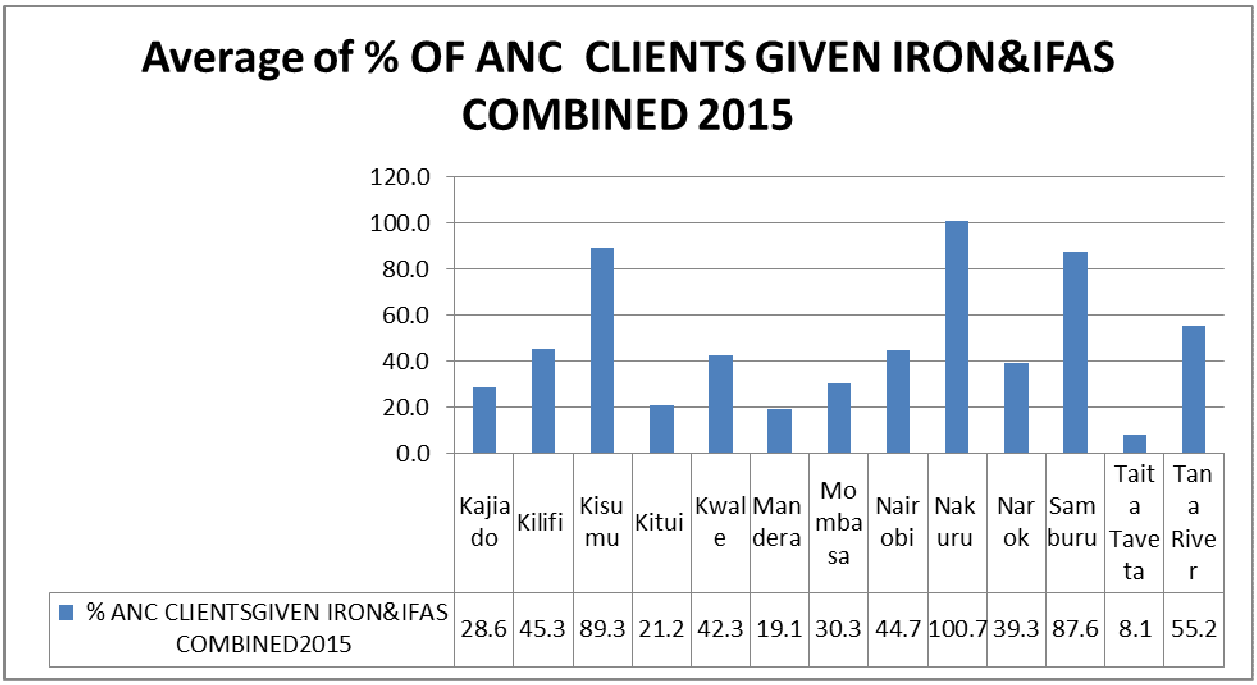
Underweight

- 11 percent of Kenyan children are underweight, with 2 percent classified as severely underweight.
- Peak levels of low weight-for-age are found among children age 24-35 months.
- The percentage underweight is slightly higher among boys (12 percent) than girls (10 percent), and for rural children (13 percent) than urban children (7 percent).
- At the county level, more than one-quarter of children are underweight in five counties:
- Mandera, Marsabit, Turkana, West Pokot, and Samburu

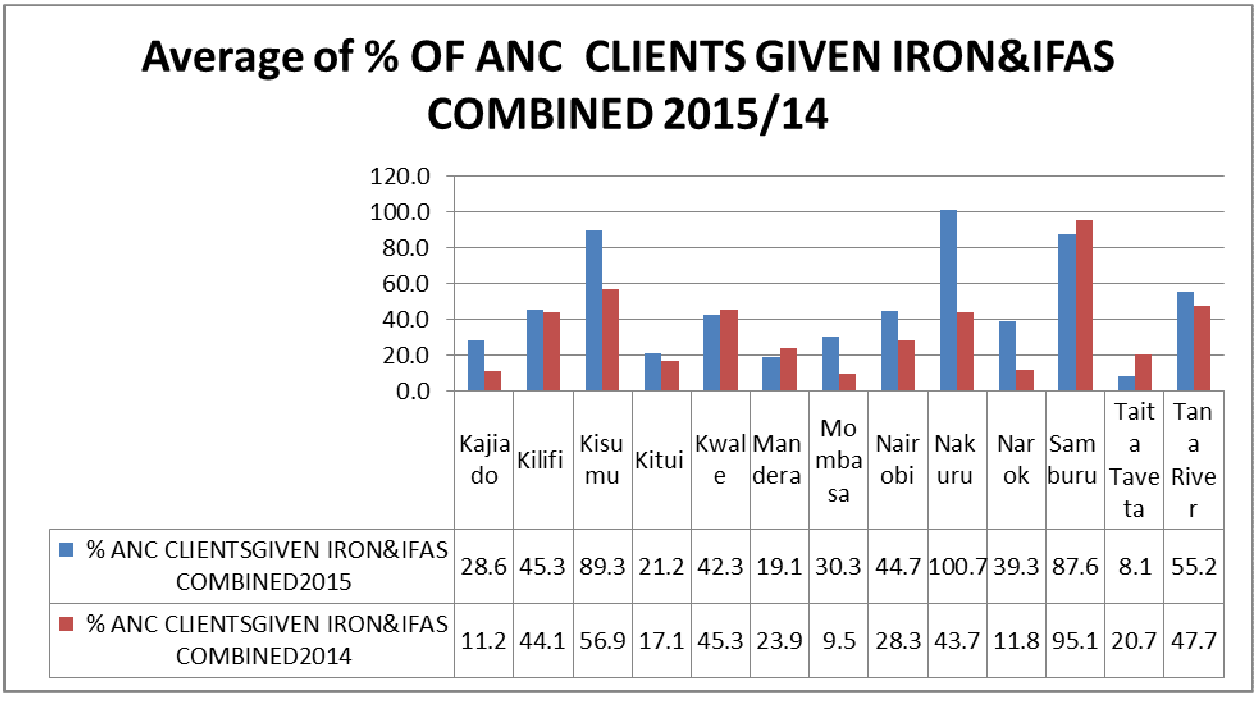
IRON DEFICIENCY ANAEMIA IN CHN < 5 yrs (*Malaria Survey 2010)*



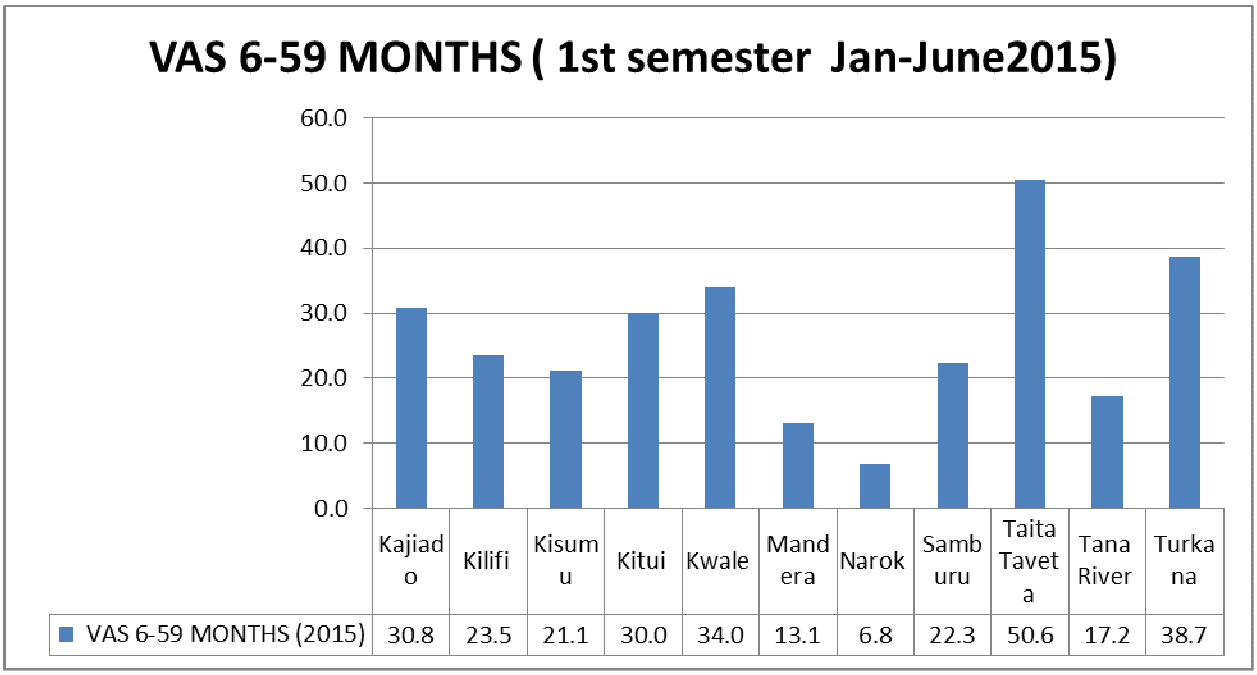
% OF ANC CLIENTS GIVEN IRON&IFAS COMBINED 2015



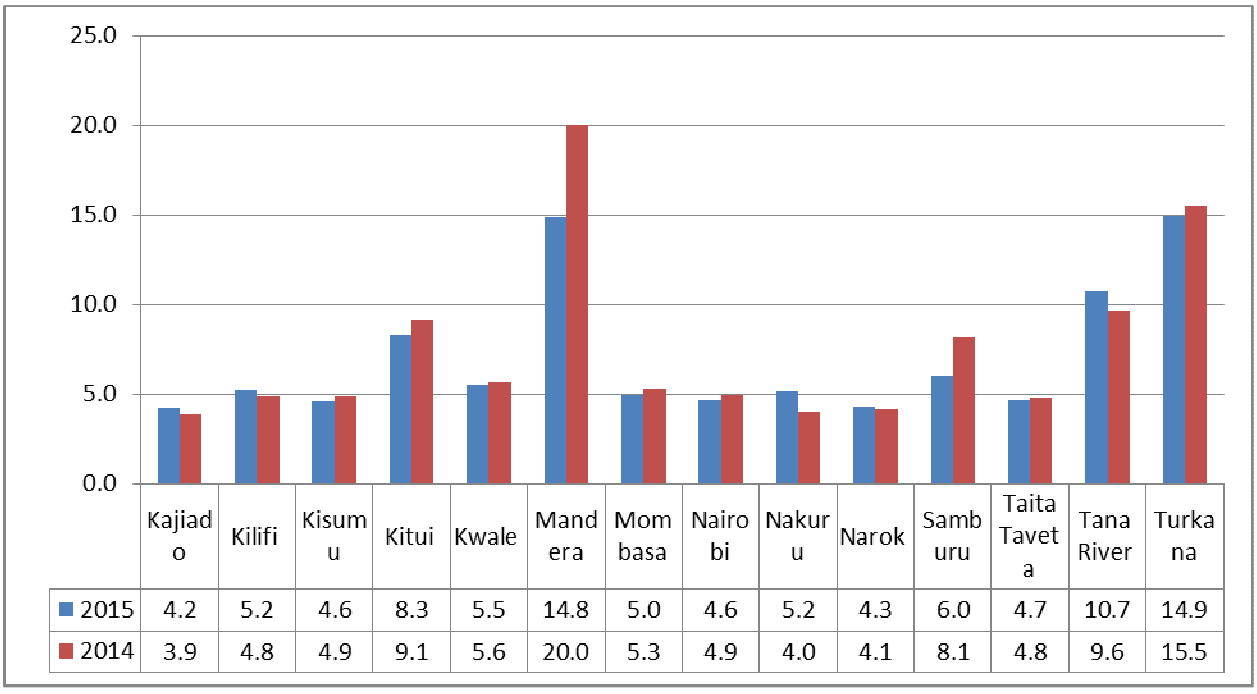
% OF ANC CLIENTS GIVEN IRON&IFAS COMBINED 2015/14



Children 6-59Months Vitamin A Supplementation: Jan-June 2015

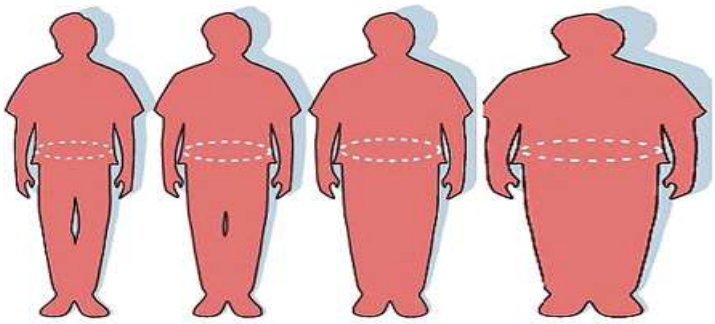


UNDER 5 YEARS UNDERWEIGHT TRENDS 2015/2014(ROUTINE)

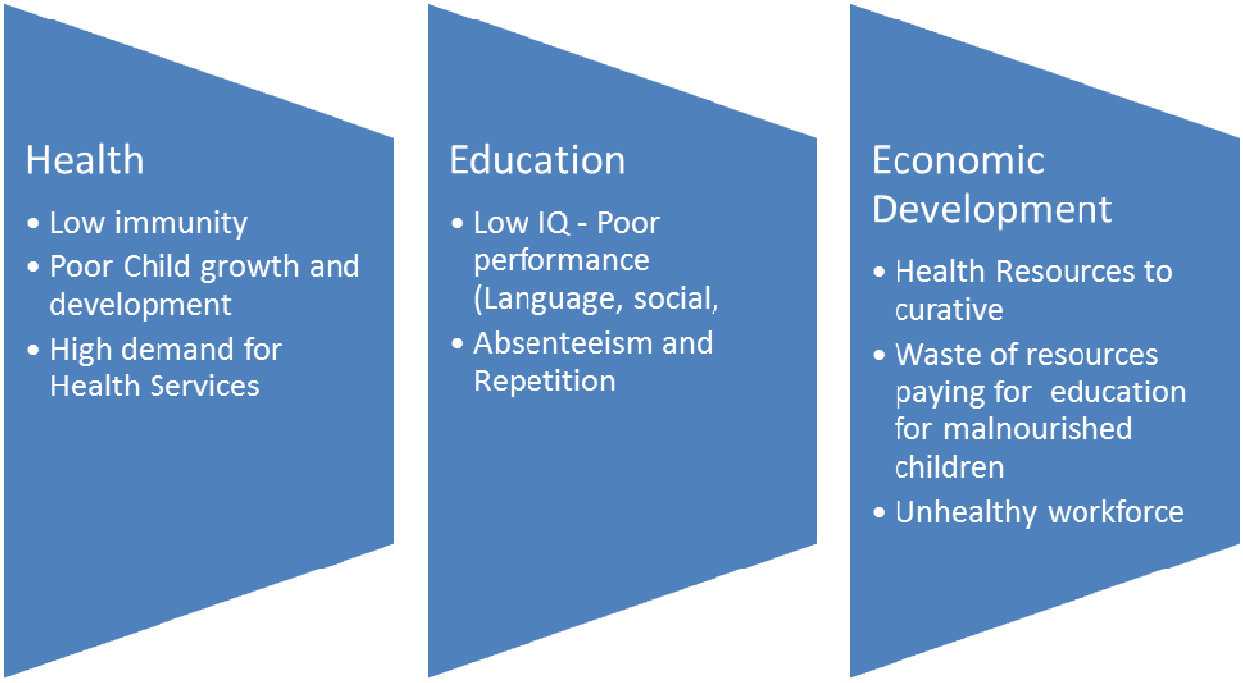


OVERNUTRITION

1. Shift to increased consumption of highly refined foods, Sugars, Salts and Fats
2. Shift to reduced physical activity and sedentary lifestyle



Effects of Malnutrition



Challenges

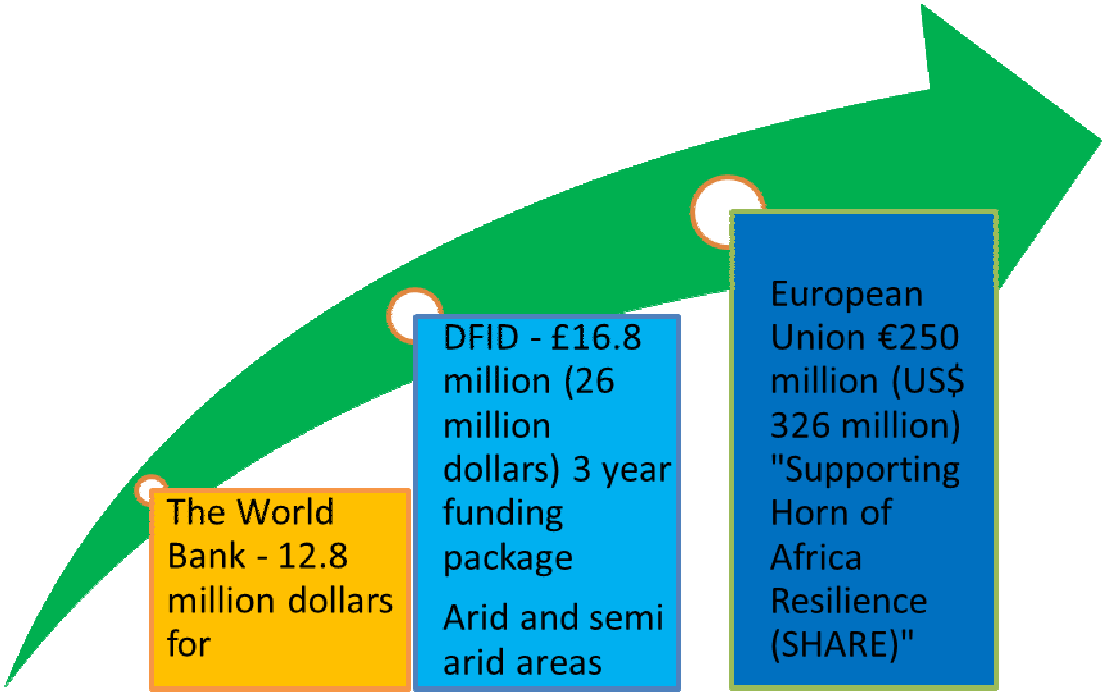
- Low understanding of linkage between national food security, basic education, and water and sanitation strategies on one hand and nutrition on the other.
- Program strategies are vertical and lack nutrition as an outcome indicator.
- Despite the high malnutrition rates and disease burden in the country, the government's budgetary allocation for health sector, still falls below the 15% standard stipulated in the Abuja declaration.
- Human resource gap for nutritionists and dieticians within public health facilities and at community level. According to the Kenya Nutrition and Dieticians Institute, there are 1290

nutritionists, with 600 of them in public health facilities. This translates to 1 nutritionist for every 31,000 people.

Opportunities

- The Food and Nutrition Security Policy is in place.
- National Nutrition Action Plan 2012-2017.
- High Impact Nutrition Interventions. The approach is set out in the National Nutrition Action Plan approved by the government in November 2012
- There is organized coordination and collaboration of the different sectors in relation to nutrition objectives.
- In the light of devolved system of governance, capacity building and advocacy of nutrition in the counties is ongoing in an effort to ensure that nutrition is prioritized in all the 47 counties.
- Donors supporting Kenyan efforts - A number of donors are funding nutrition-related actions in Kenya:

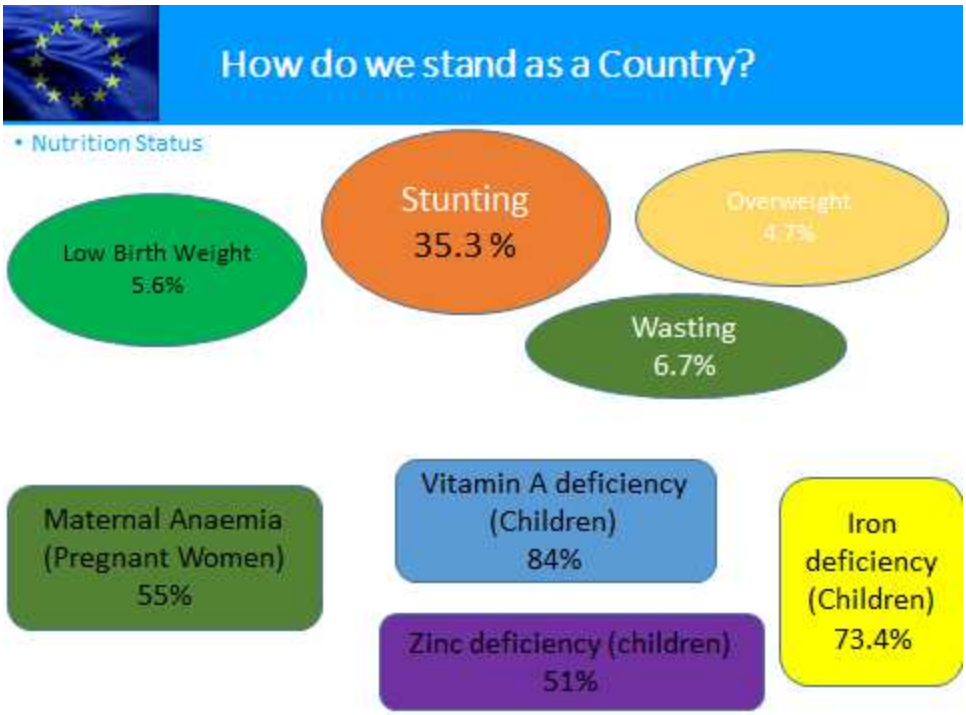
Donor Funding



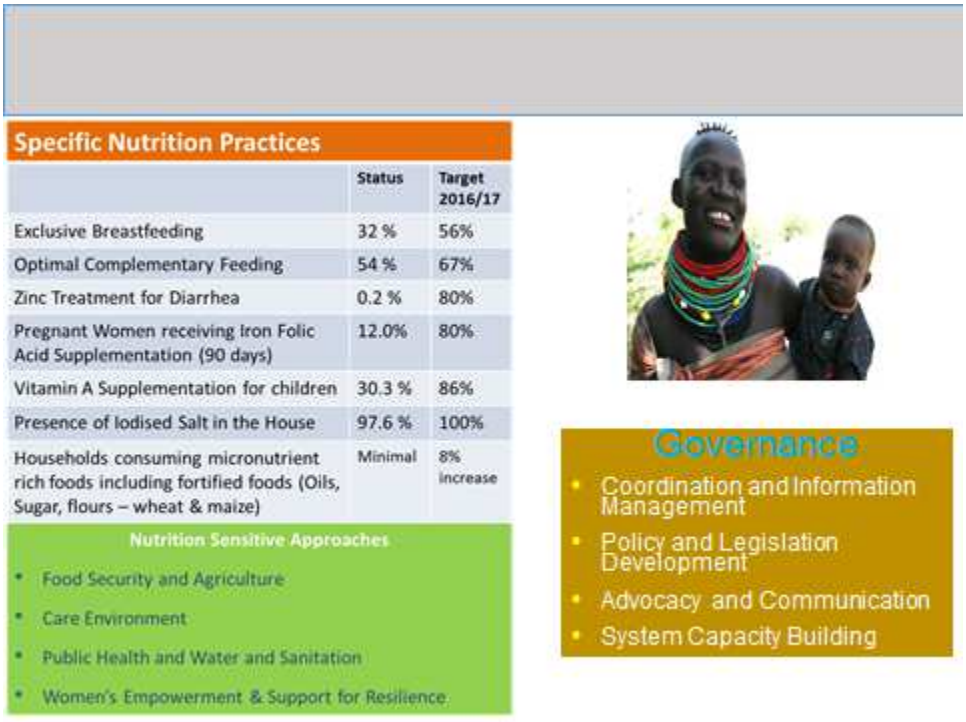
Malnutrition is a National Problem, addressing it is a shared responsibility.
TAKE UP YOUR ROLE, ACT NOW!

Effective Integration of Nutrition in Maternal and Child Health (MCH) by Ms Ann Robins, UNICEF

How do we stand as a Country?



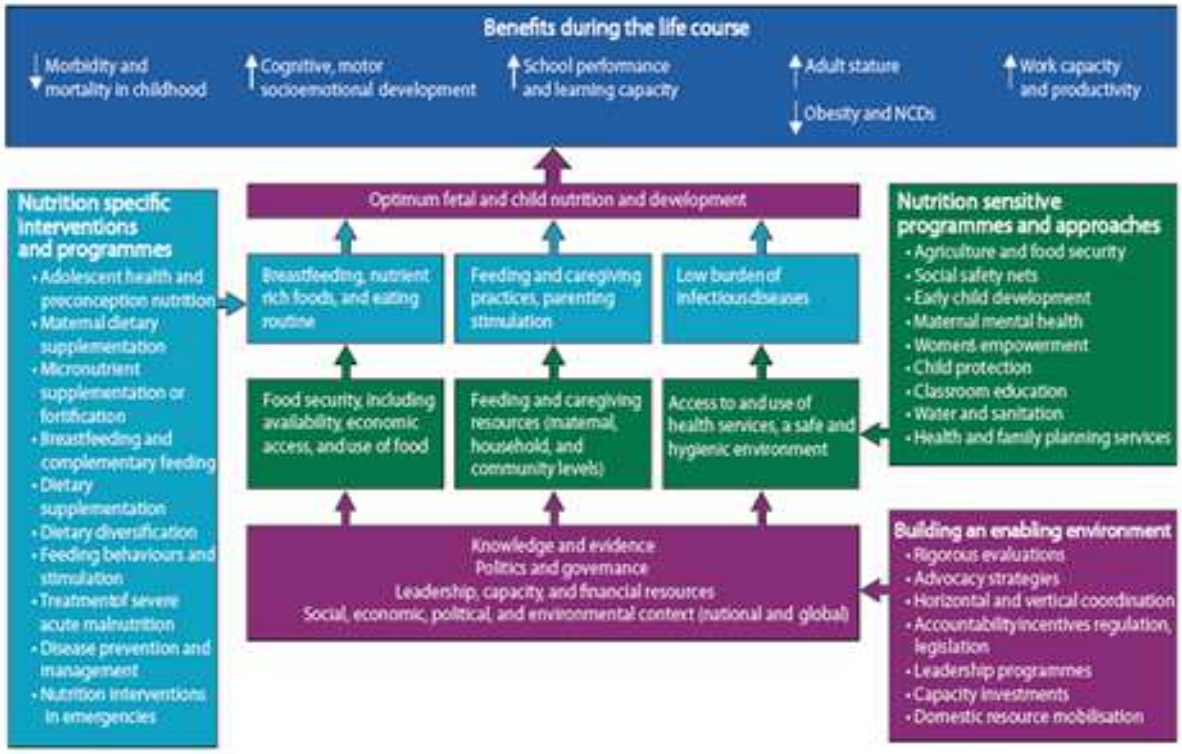
Government Action on Under-Nutrition



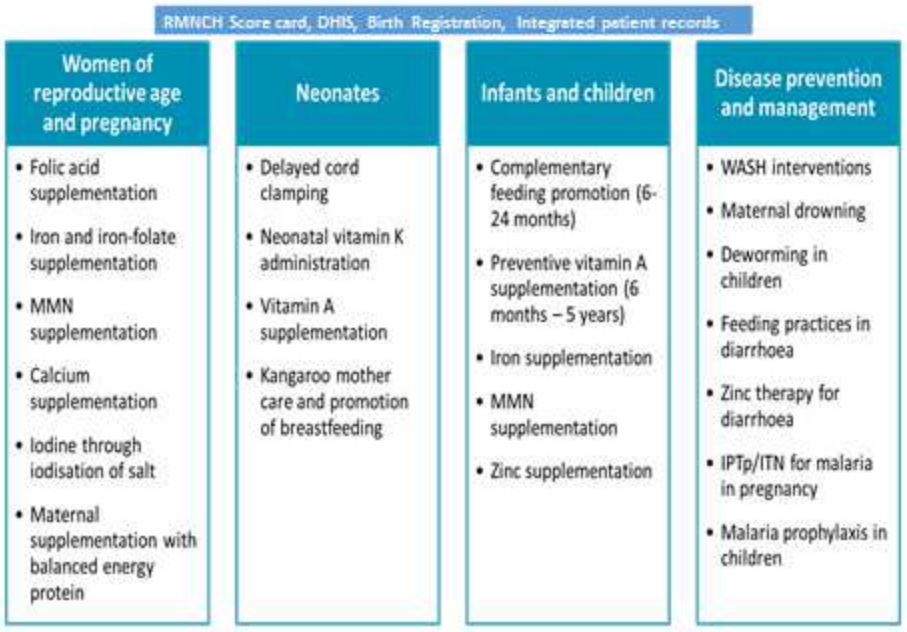
Why do we need integration?

- Kenya's High Impact Nutrition Interventions (HINI) can save at least 15% of child deaths and avert a fifth of all stunting IF DELIVERED AT SCALE (Lancet 2008)
- Undernutrition is a key shared risk factor for morbidity and mortality associated with diarrhea and pneumonia (Bloomberg et al April 2013)
- Delivering at scale requires combination of system resources
- Chronic Emergency context: Ending Drought Emergencies calls for scalability

Framework for Actions to Achieve Optimum Fetal and Child Nutrition and Development (Lancet 2008)



Integration of Nutrition into MCH Services



Health Facility Based Surge Capacity Concept

- A System to provide support to health facilities and the SCHMT when responding to a deteriorating nutrition situation
- Support package is pre-defined at Sub county level
- Support package provided will change according to severity of the situation (scale up and scale down)
- Activation of the support is initiated by health facilities and their case load of new OTP (& SFP) admissions

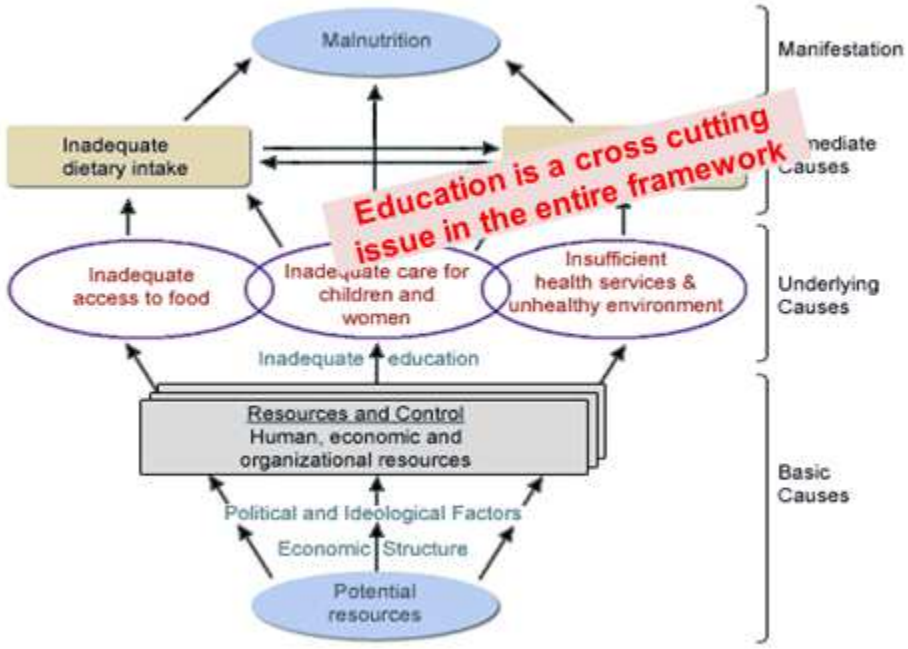
THE BURDEN OF MALNUTRITION AND ITS IMPLICATION TO SCHOOL CHILDREN by Jacob Korir

Why should we <u>integrate nutrition in the school curriculum?</u>

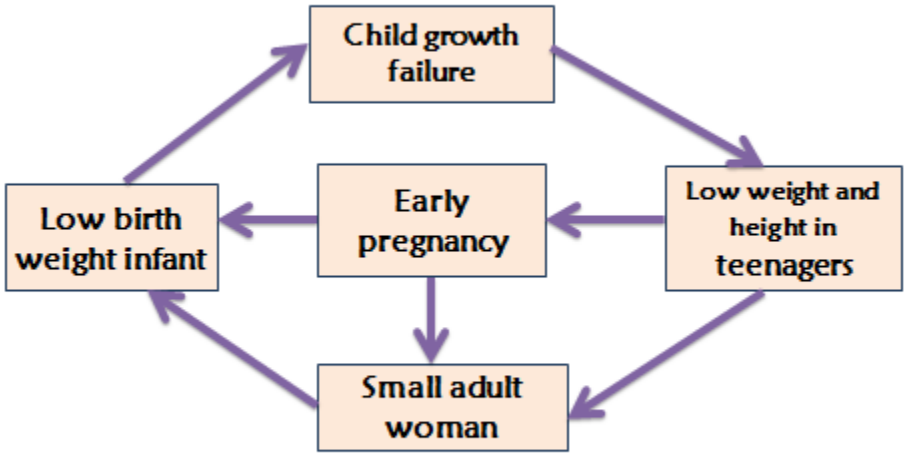
The Bad News

- ✓ Malnutrition is preventable and treatable yet more than a third of deaths in children under-five are attributable to malnutrition every year
- ✓ Malnutrition is the single greatest contributor to child mortality
- ✓ For those children who survive the damage caused by malnutrition is serious and often irreversible
- ✓ Malnutrition in childhood makes them more susceptible to diseases and prevents proper brain development

Nutrition as a key factor in the development agenda



Intergenerational Cycle of Malnutrition



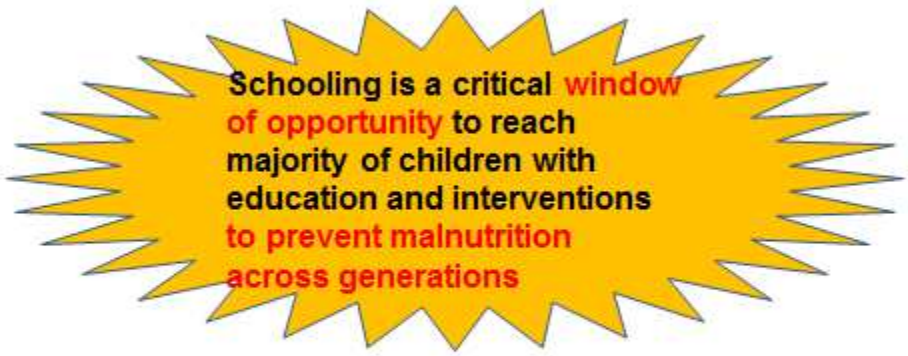
Good nutrition is therefore vital in the entire lifespan

- ✓ Malnourished children in Kenya (too short, too thin or underweight) have;
  - Mothers with no education
  - Mothers who stopped their education at primary school
- ✓ There is therefore a direct link between mothers nutritional status, their education levels, and child nutritional status

Why Focus on School Children?

Nutrition security strategies:

1. Education: Empower populations to make the right decisions and transfer skills as agents of change
2. Law: Constitution of Kenya and sectoral policies
3. Children are the future hope of a society
4. Healthy children will contribute to achieving Vision 2030 of educated, healthy and productive population
5. Over 50% of the population are 3-18 years
6. Children spend more than 75% of time in the school environment
7. Children are excellent change agents



Ongoing strategies to alleviate malnutrition using school platforms

1. Schools health nutrition and meals programme
2. Deworming and supplementation
3. Nutrition education and agriculture in the curriculum (formal and co-curriculum) both in theory and practical- Minimal

We need to scale up especially number 3!

A call to action

- ✓ Malnutrition is predictable, preventable and treatable
- ✓ Malnutrition is the single greatest contributor to child morbidity and mortality
- ✓ Strengthening nutrition in the curriculum is one of the avenues of winning the battle
- ✓ Together, we are shining a spotlight on ending the tragedy of malnutrition

Short term

1. Be Agriculture and Nutrition Champions. Evidence points to the need for holistic education approach,
2. Following extensive review of the current curriculum, support the inclusion of agriculture and nutrition messaging into curriculum.
3. Develop well defined engagement and partnership modalities between MOE, MOH and MOA i.e.
    - Establish a regular coordination mechanism.
    - Develop a modality for information gathering and sharing – e.g. every quarter.

Medium term

1. Consider diverse modalities of passing agriculture and nutrition messaging in schools:
    - School environment (meals and gardens)
    - Drama and music festivals
    - School health clubs etc.
2. Develop a system to roll out, monitor and evaluate nutrition and agriculture in education sector. (the 3 sectors can define indicators to jointly track)

Long term

1. Measure the impact of the cohesive partnership between the 3 ministries and the causal relationship between agriculture, nutrition and education – which impacts the other and to what extent?
2. Focus on pupils and students as future caregivers and potential agents of change.

ANNEX 2: WORKSHOP AGENDA

	8 September 2015	
Time	**Activity**	**Facilitator/Presenter**
7:30 – 8:00	Departure from EU Delegation, Upper Hill and Registration	Mercy Kimani
11:00	➢ Arrival at Lake Naivasha Simba Lodge	Mercy Kimani
11:30 – 12:00	Opening session – Chair: Dr. Hjordis Ogendo	
	➢ Welcome and introductory remarks	European Union Government of Kenya
12:00 – 12:30	Nutrition situation Analysis	Ms Monica Okoth, MOH
12:30 – 14:00	Lunch break	
14:00 – 14:30	Plenary session Topic 1: Effective integration of nutrition in Maternal and Child Health (MCH)	Ms Ann Robins, UNICEF
14:30 – 15:30	➢ Break-out sessions discussion on topic 1	Titus Katembu
15:30 – 16:00	Tea/coffee break	
16:00 – 17:00	➢ Plenary group presentations and discussions on topic 1	Dr. Hjordis Ogendo, EU Rapporteurs
19:00 – 21:00	Dinner	
	9 September 2015	
8:30 – 8:40	Plenary session Summary of discussions for Day 1	Mr. Albert Webale
8:40 – 9:00	The burden of malnutrition and its implication to school children	Mr. Jacob Korir
9:00 – 9:45	Topic 2: Enhancing nutrition sensitive interventions in MCH actions	Mr. Philippe Carette & Mr. Jacob Korir, Action Against Hunger
9:45 – 10:15	Tea/coffee break	
10:15 – 11:15	➢ Break-out session on topic 2	Titus Katembu, EU
11:15 – 12:00	➢ Plenary group presentations and discussions on topic 2	Dr. Hjordis Ogendo, EU Rapporteurs
12:00 – 13:00	Visibility presentation	Mr. Lawrence Gikaru and Ms. Nancy Karanja of Apex Porter Novelli (APN)
13:00 – 14:00	Lunch break	
14:00 – 14:45	Plenary session Topic 3: Developing SMART indicators for effective M&E	Tiia Haapaniemi, Finnish Red Cross
14:45 – 15:30	Beyond Zero Campaign	Ms Angela Githere-Langat
15:30 – 16:00	Tea/coffee break	
16:00 – 17:00	➢ The way forward ➢ Closing remarks	Ms Monica Okoth, Ms Teresia Kadzo, Ms Mary Kanyaman and Dr. Hjordis Ogendo
19:00 – 21:00	Dinner	

ANNEX 3: LIST OF PARTICIPANTS

Contact List for the Naivasha Workshop Participants 8-10 September 2015

	Organization	Title	Name	Surname	Email Address
1	African Development and Emergency Organization	Ms	Veronica	Ochieng	vochieng@adeointl.org
2	Apostles of Jesus AIDS Ministry (AJAM)	Mr.	Estones	Agesa	ajaidsministries@yahoo.com
3	Aga Khan Health Services	Dr	Amyn	Lakhani	Amyn.lakhani@akhskenya.org
4	MOH Kwale County	Ms	Teresia	Kadzo	terrykadzo@yahoo.com
5	Amici Del Mondo	Ms	Stefania	Paracchini	stefania.paracchini@runeemahospital.org
6	Ruaraka Uhai Neema Hospital	Ms	Jane	Githinji	githinjijane906@gmail.com
7	AMREF Health Africa	Ms	Josephine	Lesiamon	Josephine.Lesiamon@Amref.org
8	MOH SCNO -Turkana (AMREF UK)	Ms	Beryl	Ondu	onduberyl@gmail.com
9	AMREF Health Africa	Mr.	Peter	Ofware	Peter.Ofware@Amref.org
10	AMREF Health Africa	Ms	Dorcus	Indalo	Dorcus.Indalo@Amref.org
11	Wikivuvwa Development Actions	Mr.	Kevin	Musau	wikivuvwadevact@gmail.com
12	AMREF Health Africa	Mr.	Jillo	Ali Jillo	jillo.ali@amref.org
13	MOH Samburu County	Ms	Mary	Kanyaman	mkanyaman@gmail.com
14	AMURT	Dr	Edward	Kinyanjui	ekinyanjui@amurtafrica.org
15	National Organization for Peer Educators (NOPE)	Mr.	Peter	Onyancha	ponyancha@nope.or.ke
16	CARE Kenya	Mr.	Emmanuel	Wamalwa	wamalwa@care.or.ke
17	Family Health Kenya	Ms	Esther	Muketo	emuketo@fhok.org
18	Christian Aid	Ms	Jane	Machira	JMachira@christian-aid.org
19	ACK Narok Integrated Development Program	Ms	Mary	Naikumi	mary.naikumi@yahoo.com
20	Danish Red Cross	Mr.	Daudi	Makamba	dauml@rodekors.dk
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