MULTI-SECTORAL NUTRITION STRATEGY
Global Learning and Evidence Exchange
East and Southern Africa Regional Meeting

Kenya Nutrition and Health Program plus
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Introduction – Kenya Demographics

• Of the 43 millions Kenyans, 32% live in urban areas implying that majority of the population is rural

• Majority of households (89%) have acceptable food consumption score

• 54% of married women participate in four common household decisions, a reflection of increasing women empowerment

• 87% women aged 15 – 49 are literate, contributing to decline in fertility rates (3.9 births/ woman)

• 9% of women have BMI < 18.5; 33% BMI> 25 ; 10% BMI > 30 pointing to changing ‘manifestation’ of malnutrition and increasing risk of NCDs among women

• Only 58% of women attend 4 ANC visits, pointing to missed opportunities for improving pregnancy outcomes

• Only 23% of HHs have improved toilet facility, while 34% of HHs have a hand washing facility, increasing risk of hygiene related illnesses

Source: KDHS 2014
Introduction – Kenya Nutrition Profile

• One in every 19 Kenyan children does not survive to age of 5yrs.

• 26% of children under 5 years are stunted; 4% are wasted whereas 11% are underweight

• 61% of children < 6 months are exclusively breastfed

• Only 22 percent of children are fed in accordance with the recommended infant and young child feeding practices

• 72% of children aged 6 – 59 months receive Vitamin A supplementation

• 51% of children aged 12 – 59 months receive deworming

Source: KDHS 2014
## Situational Analysis

### Operational and structural challenges
- Poor access to MNCH health services
- Stock out and poor commodity management practices
- Inadequate knowledge on importance of first visit during pregnancy
- Sub-optimal complementary feeding practices
- Poor access to IMCI services
- Weak workplace support structures for breastfeeding mothers
- Weak integration of nutrition interventions into routine health services

### Consequences
- 58% of women make the recommended four or more ANC visits during their pregnancy
- 8% of women take iron tablets daily for 90 or more days during the pregnancy
- 20% of women make their first visit before the fourth month of pregnancy
- 22% of children 6–23 months receive minimum acceptable diets
- 56% of Infant mortality rates occurs within 1st one month of life
- 42% of infants 4–5 months old are exclusively breastfed
- Low coverage of HiNi

Source: KDHS 2014
Kenya Nutrition and Health Program plus

- Overall objective: To improve the nutrition status of Kenyans
- Intermediate result areas
  1. Improved access and demand for quality nutrition interventions at community and facility levels
  2. Strengthened nutrition commodity management
  3. Improved food and nutrition security
- Scope: National (NACS) and 5 FtF & MNCH counties (Busia, Tharaka Nithi, Samburu, Marsabit and Kitui)
- Funding streams: PEPFAR, Nutrition (MNCH), FtF
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Nutrition and Health Program plus Multisectoral Integration Model

IMPROVED NUTRITION STATUS
LOW DISEASE BURDEN
- Improved Access and demand for quality nutrition interventions at facility and community levels
- Strengthened commodity management

Adequate Dietary Intake
- Improved Food and Nutrition security

Access to effective Health services & MIYCN
- Maternal Nutrition
- IYCF
- Growth Monitoring
- IMAM
- VAS
- NCDs
- WASH

Access to Health & Healthy Environment
- Growth Monitoring
- VAS
- MNPs
- Deworming
- Demo gardens
- Hand washing

Healthy Environment
- Hand washing
- Point of use water treatment
- Sanitation

Sustainable Household food security
- Kitchen gardens (Vit. A & Fe rich crops)
- Cooking demos
- Hunger safety nets
- Food processor value chain linkages
- Nutrition education

HEALTH FACILITY & COMMUNITY
Health workers, Community health volunteers, Front line extension workers, Community strategy coordinator, DICECE
Mother to Mother support groups, farmer groups, ECDs
Children under 5 yrs., adolescents, WRA, Adults, Pregnant, Lactating mothers
Designing the Service Delivery Model

• Strengthening capacity for multisectoral nutrition programming at sub-county levels
  • Joint work planning
  • Capacity building of multidisciplinary teams
  • Support supervision
  • Dissemination and contextualization of guidelines

• Strengthening informed decision making of sub-county multisectoral teams for effective coordination, communication and directing demand driven result oriented activities

• Multisectoral communication strategies for maximum engagement and reach to all target audiences
From Design to Implementation

- Harmonized multisector calendar of events:
  - Malezi bora, World breastfeeding week, Nutrition week, World AIDS day, agriculture shows
- Integrated approach to needs or gap assessment analysis at all levels
- Standardization of multisectoral service delivery and reporting systems
- Support for cross training for multisectoral activities
  - Orientation of HCWs, ECD teachers, CHVs, Agri. Extension
  - Supplementation & set up of school gardens in ECDE centres to address dietary diversity and consumption Vit. A rich foods
Challenges – looking for adaptive design

• Missed opportunities for harmonization of Country, Donor and sector wide priorities

• Parallel reporting systems

• Lack of multi-sectoral M&E framework to track key indicators

• Varying agro-climatic zones in the five focus counties

• Funding for multi-sector nutrition sensitive activities at national and county levels

• Weak decentralization of multi sectoral coordination mechanisms to county level
Lessons Learned

• Multisectoral programs must go *mile deep, inch wide* as opposed to *inch deep, mile wide* and implement in a focused approach, by doing few activities really well rather than many activities inadequately.

• Opportunities for multi-sectoral linkage across different programs exist and are untapped.

• Nutrition sector needs to make more effort to match and translate key nutrition information for specific audiences across sectors.

• An open mind is fertile ground for learning.
Recommendations

• Multi-sectoral nutrition programming requires dedicated efforts towards documentation beyond program reporting

• There is need for alignment of strategies to global WHA targets e.g. for stunting

• Development of indicator monitoring framework for multisectoral nutrition strategy
Key Takeaways

• Kenya is making progress towards multisectoral nutrition programming

• Large-scale impact comes from better multisector coordination rather than from the isolated intervention of individual organizations