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END-TERM QUALITATIVE EVALUATION, KAJIADO NUTRITION PROGRAMME

Final Report

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Executive Summary

Background

This end-term evaluation assesses the performance of Concern Worldwide's Emergency Response Nutrition Programme -*Cross-sectoral +Emergency Response in Kajiado and Loitokitok Districts, Kenya*- in Kajiado and Loitokitok Districts.

In response to the 2009 drought, Concern Worldwide implemented a cross-sectoral emergency response with funding by the Office of the U.S. Foreign Disaster Assistance (OFDA). The programme focused both on responding to emergency needs and in building sustainability and resilience in nutrition service provision. The programme also included a nutrition and health education component designed to address apparent poor levels of understanding of the causes of malnutrition in the community.

The intervention was implemented in partnership with the MoH, local NGOs Neighbours Initiative Alliance (NIA), African Inland Church (AIC), Catholic Diocese of Ngong, and Africa Infectious Disease clinic (Mbirikani Aids Village clinic), as well as UNICEF and WFP.

To assess the relevance of the programme, the evaluation posed the following queries: How relevant was the programme to the initial problems identified by local stakeholders? Were the assumptions used correct? Was the programme compatible and reflective of Concern's policies, approaches and guidelines? Were the targeted recipients the most vulnerable?

Although the programme was intended primarily as an emergency response, it was also prioritised sustainability and what nutrition services would look like following the eventual exit of the programme. This evaluation also looked at the sustainability of the programme initiatives; and the possibility of taking the current programme model at scale, including the cost implications as well as required staff capacities for that.

Evaluation Context

The objective of the programme was to rehabilitate those with acute malnutrition and promote appropriate key nutrition practices for prevention of malnutrition in target areas.

The programme began with an emergency nutrition intervention response component, adopting the Integrated Management of Acute Malnutrition (IMAM) approach between July 2009 and 2010. This approach focused on four sub-sectors;

1) the management of moderate acute malnutrition

2) the management of severe acute malnutrition;

3) nutrition education; and

4) Strengthening of nutrition systems.

Following the initial emergency phase during the 2009-2010 period, the programme shifted its focus in the second (2011-2012) phase to supporting local health systems to implement the Government of Kenya's Nutrition Strategy, focusing on delivering a set of 11 High Impact Nutrition Interventions (HiNi) endorsed by a large group of international partners in the report "Scaling Up Nutrition - A Framework for Action." These HiNi interventions are set out in Box 2.1 below.

Programme Context

Malnutrition has remained high in Kenya amongst children under 5 in the last decade. The proportion of stunted children rose slightly from 33% to 35% in the period 1993 to 2008-09. The proportion of wasted children under 5 has not changed significantly over the same period, while underweight rates among the same cohort have dropped by 6 percentage points within the period. The most recent national micronutrient survey (from 1999) also suggests that micronutrient deficiencies are highly prevalent in Kenya. The most common deficiencies include vitamin A deficiency (84.4% amongst under 5s), iron deficiency anaemia (69% amongst 6-72 month olds), iodine deficiency (36.8%) and zinc deficiency (51%). Results of a micronutrient survey conducted in second half of 2011 are yet to be released.

National surveys also reveal little improvement in some Infant and Young Child Feeding (IYCF) practices, particularly the duration of exclusive breastfeeding and complementary feeding. Data from DHS surveys shows that the median duration of exclusive breastfeeding is less than one month. There has been an increase in prevalence from 11% to 32% of children in 2008-09, but this remains low compared to the WHO recommendation of universal exclusive breast-feeding for the first six months of a child's life. 60% of children in Kenya aged 4-5 months are given complementary food.

Within this context, the Government of Kenya recently adopted the new international standard High Impact Nutrition Interventions (HINI) as official policy.

The Government of Kenya is the lead partner in establishing nutrition policy, and the Concern programme has been designed appropriately to support district level MoH to implement existing government policy on the ground.

Malnutrition indicators deteriorated in 2009 leading to the programme response. Since then, levels have stabilised, but food security in the pastoral areas has remained precarious.

Evaluation Methodology

The evaluation consisted of four principal parts:

1. A desk review of programme documents and design of tools
2. Meetings with Concern programme staff
3. Fieldwork in Kajiado and Loitokitok
4. Analysis, reporting, and a presentation to Concern and partners

Fieldwork was conducted in Kajiado and Loitokitok Districts where the programme operated. Programme participants were selected at random to participate in the groups and interviews based on Concern's beneficiary list. Non-beneficiaries were selected using snowball sampling. Recipient interviewees and FGD participants were selected randomly from the beneficiary lists and where possible phoned in advance to arrange meetings.

The evaluation uses both key informant interviews (KII) and focus group discussions (FGD) to gather information about the programme. Participant and non-participant respondents in groups and interviews were also asked to complete a short questionnaire in Swahili to generate some quantitative opinion data (8 participants in 10 groups so a total of 80 responses).

The quantitative component of the work entailed review and analysis principally of available secondary data, including surveys conducted by Concern and their partners, and the data gathered during the evaluation focus groups.

The causes of malnutrition are complex, and include food intake and dietary diversity, disease, inadequate care (such as not exclusively breastfeeding), and poor hygiene and sanitation. This is set out in the causal framework and serves as a guide in assessing and analysing the causes of the nutrition problem and helps in identifying the most appropriate mixture of actions.

Evaluation

The programme was assessed against seven criteria; Relevance, Fit with Concern Worldwide Policies, Coverage, Coherence, Effectiveness, Efficiency, Sustainability,

Relevance (to the context)

This section considers the relevance of the programme in two senses; the degree to which malnutrition is a specific problem in Kajiado and Loitokitok, and the degree to which the design of the programme was appropriate in addressing the identified malnutrition problems in the district.

The programme was clearly relevant to the context in Kajiado and Loitokitok, where a recent survey[1] found that 91% of households reported difficulty accessing food in the last year. Drought is becoming ever more frequent[2] and pastoralist livelihoods face chronic difficulties[3].

Malnutrition is not only a clear problem, but it is also an area where government and NGO action is clearly effective and cost effective. Nutritional interventions have been assessed by numerous sources to be some of the most cost effective of all proven interventions. A panel of economic experts was convened in 2004 to consider the range of all major global challenges, and which had the most cost-effective solutions. Solutions to malnutrition constituted 5 of the top 10 most cost effective solutions.

The set of 11 High Impact Nutrition Interventions adopted by the Government of Kenya have evolved from a list compiled by the Lancet in 2008, of which the World Bank investigated the programmatic feasibility in 2009, and a larger group of international partners endorsed as priorities for action in report “Scaling Up Nutrition - A Framework for Action.”

There is though a question mark regarding the effectiveness of nutrition interventions alone without some kind of cash transfer, food aid, or livelihoods support. Due to a sheer lack in sufficient quantity of food, many households share therapeutic feeding products prescribed for a single malnourished child between the whole family, leading to relapse back into the program for treatment and extended stay on the program by the affected child. The livelihood interventions with food support that seem to have addressed household food access were implemented briefly for a period of six month in 2010.

[1] NIA Survey, Nov 2011

[2] http://www.fews.net/docs/Publications/Kenya_Special_Report_2011_06_final.pdf

[3] Demombynes and Kiringai (2011),

Fit with Concern Worldwide Policies, Approaches, and Guidelines

The section looks at how well the nutrition programme fits with the Concern Worldwide policies more broadly. Overall the programme is a good fit with Concern strategies, contributing to outcomes for the Global Health Strategy, the global Food, Incomes & Markets programme, and the Kenya Strategic Plan. The main concern is that Kajiado County is possibly not the place with the poorest people in Kenya, and Concern typically aims to focus on the most vulnerable. This calls for an evaluation of Concern's presence in Kajiado as well as further consultative interrogation of the rating of the poverty status of the County.

Coverage

Coverage was in general as good as it could have been within the available budget, with some support provided to all of the government and NGO clinics in the districts. Although coverage of health *facilities* by the programme was good, there was clearly unmet need of *individuals* for health services and food or income support. The focus on providing universal support to facilities in understanding how to implement the HiNi package was well placed. Both service providers and beneficiaries were clear that there was insufficient outreach which seemed to be driven by insufficient funding rather than a misunderstanding of the situation. The programme had 86 outreaches in January 2011 and these were progressively reduced to less than 20 by May 2011. Concern did respond flexibly to the extent possible following a deterioration of the nutrition situation in August 2011, increasing the number of sites to 39, and subsequently reducing them to 14 by January 2012.

The SQUEAC coverage survey conducted in November/December estimated that around half of Severe Acute Malnutrition (SAM) cases were being covered by the programme (48.4%, with a confidence interval between 31.7% and 65.1%). "Period coverage" including those cases which have recovered as well as existing cases is slightly higher at 52.7% (with a confidence interval of 36.9% to 68.5%).

The last quarter report of 2011 showed that 50% of facilities were offering the full HiNi package. Coverage of Vitamin A was at 30% in Kajiado and 38% in Loitokitok, and coverage of Zinc supplements was 32% in Kajiado and 48% in Loitokitok.

Coherence

This section considers how well the programme activities were coordinated with other stakeholders. In general the Concern programme seemed to be well coordinated and well received by both local and national partners.

Concern is effectively the lead provider of technical assistance in the nutrition sector in Kajiado County. Policy direction and leadership comes from the local government, with support from international agencies UNICEF and WFP as the lead agencies in the supply of therapeutic commodities. Concern plays a key role in supporting both the local government at a technical level, at local health facilities, as well as other local NGO health partners.

AIC were very positive about the role of Concern Worldwide in encouraging a coordinating role for MOH. Local NGO health providers such as AIC consult with the MOH on the areas which are underserved before expanding provision in any way.

Concern Worldwide has been coordinating the receipt of food from UNICEF and WFP in conjunction with NIA and the delivery of the food to the beneficiaries through health facilities and outreach sites.

Joint supervision meetings of health care facilities by partners (MoH, Concern, UNICEF and WFP) were effective at monitoring health facilities performance and ensuring that processes were embedded. Local partners (AIC, CDON, and NIA) provide regular monthly and quarterly activity reports to Concern.

Effectiveness

By the end of March 2012, the nutrition program had treated and rehabilitated 28,087 malnourished under five years' children and pregnant and lactating mothers. In addition 27,755 beneficiaries had benefited from the nutrition and health education. The brief livelihood support implemented in 2010 reached 4,118 h/h (close to 50,000 direct beneficiaries through the varied activities on asset protection, economic support to community groups and food security through food vouchers.

The Concern Knowledge and Practice survey seems to suggest that there was only a very small impact of the nutrition education programme. The education group was twice as likely to know that they should eat more rather than less food during pregnancy compared to a control group, but it was still only 23% of people that knew this (see Figure 5.3). The education group was also slightly more likely to know that they should eat food rich in energy and nutrients during pregnancy. However, there seemed to be no difference in knowledge between the two groups about taking folic and iron tablets during pregnancy. Only 60% of the "education" group actually reported being taught anything.

Overall outreaches did seem to be an effective way of reaching remote communities who would otherwise be too far from a health clinic to access any health and nutrition services, but the nutrition education training does not seem to have been very effective. NIA staff did report that many training participants had followed up with them by telephone with some specific questions.

The impact of food treatment on child malnutrition seemed to be limited in some cases due to frequent sharing of food treatments amongst an entire family. This led to some high rates of relapse and extended stay on the program of malnourished children

Training for health facility staff does seem to have had a positive impact on knowledge and practice, with all of the facilities we visited implementing the relatively recently adopted range of high impact nutrition interventions as standard and with malnutrition screening for all children they saw at the clinic.

Efficiency

Given that the package of high impact nutrition interventions is so demonstrably cost effective, any questions around the cost efficiency of the Concern programme are around implementation, and the effectiveness of behaviour change strategy.

Whilst the programme began as a "vertical" programme focused just on providing nutritional supplements and therapeutic food, it quickly moved towards integrating nutritional interventions with broader health services. This was partly driven by cost efficiency as well as sustainability considerations. Once a set of outreaches had been arranged to remote locations it makes sense to deliver as comprehensive a package of services as possible rather than requiring repeated visits to the same locations to deliver different services.

The programme generally seemed to have been delivered at reasonable costs, focusing on essential inputs and leveraging partnerships effectively with other providers of inputs such as WFP and UNICEF. Figure 5.7 shows a breakdown of the project budget between July 2009 and December 2010. The largest single item was a sub-grant to NIA in 2009-2010 of over $600,000, followed by spending on project staff and vehicles. The total budget was $1.6 million in 2009-2010

and $0.5 million in 2011. Given the weak evidence of impact of the nutrition education component, greater spending on support to health service delivery or livelihoods might have been more cost effective.

Sustainability, Phasing out, and exit strategy

Although this programme was primarily an emergency response, it was broadly successful in supporting local government health services to integrate nutritional interventions along with the rest of their services, in line with the new government of Kenya strategy. Local officials felt that, although integration of nutrition interventions is part of the government's strategy, its implementation would not have been as successful without the involvement of Concern Worldwide. Provision of nutritional services at clinics seems likely to continue. Local health workers were positive about the capacity-building components of the programme.

There were lots of worries about what would happen to the outreach programme following the withdrawal of Concern support for logistics. This is clearly a service which should be funded and run by the local Ministry of Health, but for which funding is insufficient.

Concern obligation for the running of outreaches was handed over to MoH from April. It was clear that MoH had no capacity to run the outreaches and it was suggested that the sites be linked to the general food distribution (GFD) so that SFP/OTP beneficiaries are targeted. For ongoing 2012 programming, it will be important that MoH capacity to run the outreaches without Concern support is assessed.

Government ownership was stronger in Loitokitok than Kajiado. This seemed to be due primarily to better leadership in Loitokitok. Capacity building by Concern was enhanced significantly by the physical location of Concern within the district hospital in Loitokitok. This approach should be adopted wherever possible for future projects with significant capacity building components. Conversely, given the same level of need, Concern Worldwide should initially roll out programs in areas with comparatively efficient and motivated government, health and local personnel. This would maximize capacity development returns.

Recommendations

This section considers how the programme could be improved to better support vulnerable households improve their food and nutrition security, in line with Concern policies and strategies.

Integrating Livelihoods with Nutrition

Concern's goal of integrating livelihoods interventions with nutrition programmes in the future is based on a good understanding of the drivers of malnutrition. Kajiado does seem to be a place in which the sheer quantity of access to food is an important determinant of malnutrition. Complementary nutritional interventions will continue to be required, but not sufficient to prevent malnutrition without an increase in incomes and food security. It is not however clear which livelihoods strategies are likely to be the most effective.

Concern's approach to livelihoods for nutrition in Moyale, Northern Kenya[4] seems to have been successful, seeing lower rates of malnutrition than neighbouring areas, but further evaluation would help to strengthen the case for these solutions. Strategies included encouraging pastoralists to switch to drought-resistant livestock (e.g. from cows to camels), improved rangeland management, and increasing water availability through rainwater harvesting.

Livelihoods as Social Protection

Providing cash safety nets allows households to adequately feed their families whilst exploring for themselves what their best livelihoods opportunities are. There is evidence that cash transfers can improve nutritional outcomes, though they are not sufficient without other nutritional interventions.

Cash transfers could address the common issue of "sharing" of supplementary feeding between a whole household by reducing household food insecurity and income poverty, which are underlying causes for malnutrition. Further detailed analysis needs to be done to see if Concern Worldwide should explicitly explore cash transfers. They could be targeted towards families that do not reach a specified income and whose children do not pass some pre-determined anthropometric measurements. The cash transfers would be conditional on the fulfilment of criteria like registered attendance of nutrition education sessions. These cash transfer programmes would have to correspond with or enhance current government livelihood programmes and other donor provision, such as WFP general food distributions.

Market access is a challenge for the provision of cash but markets do exist, and households already rely on markets for food consumption, as they primarily sell livestock in order to purchase grains. "A growing body of evidence shows that safety nets are an important complement to efforts to improve the livelihoods of the poor, particularly in areas that remain vulnerable to shocks such as drought. Reliable access to safety net support allows households to take on more investment risk and thus produce higher returns" (Demombynes and Kiringai, World Bank 2011).

Other Strategic Issues

Male involvement in effective nutrition programing is key: As they are frequently household heads and decision-makers it is crucial to engage men in health and nutrition education and related behaviour change activities .Men can be useful as 'good nutrition' change agents in the communities.

Women's empowerment: Maasai society is patriarchal in nature and some program participants reported having had difficulties getting permission to attend outreach programs and receiving nutrition education. Early motherhood, forced marriages and relatively poor education levels amongst women contributed to the underlying causes of malnutrition. Introduction of measures to improve the social, economic and political levels of Maasai women would increase their potential. The underlying causes of malnutrition, based on the causal framework in figure 5.1, clearly show that the approaches should be systemic. Further analysis needs to be done to see how this can be explored.

Advocacy: Staff annual performance agreements and reviews at district MoH and health centres could be linked to nutrition indicators.

[4] Erasmus, W., Mpoke, L., and Yishak, Y., (2012) Mitigating the impact of drought in Moyale District, Northern Kenya, Humanitarian Exchange, Number 53 February 2012

Operational

The physical presence of Concern Worldwide staff at the district hospital in Loitokitok clearly contributed to positive outcomes, both in terms of effective coordination and capacity building. This is a model which should be pursued as far as possible in other Concern programmes.

Donating current programme vehicles to local partners at the end of the programme may help with the continuation of outreach activities.

A further constraint to sustainability seemed to be the seemingly minor issue of lunch allowances for outreach teams. Future programmes should pay attention to working with local partners to ensure adequate funding can be put in place for essential logistical arrangements for the continuation of service delivery. Each health facility currently receives approximately Ksh 27 000 per quarter through the Health Sector Support Fund kitty of the health centers.

M-Pesa has been used very effectively for cash transfers in urban Kenya, and it could be worth exploring the possibility of using M-Pesa for payments for CHWs and health workers to reduce costs. Limited network coverage is a constraint, but where coverage is available transferring cash via M-Pesa could save significantly on transport costs.

Table of contents

List of tables and figures

Abbreviations

AIC	Africa Inland Church
AOP	Annual Operation Plan
ASALs	Arid and Semi-Arid Lands
AWP	Annual Work Plan
CBS	Central Bureau of Statistics
CCF	Christian Children Fund
CDoN	Catholic Diocese of Ngong
CHEWs	Community Health Extension Workers
CHWs	Community Health Workers
CSB	Corn Soya Blend
CTC	Community Therapeutic Care
DHS	Demographic and Health Survey
DSG	District Steering Group
EBF	Exclusive Breastfeeding
ERS	Economic Recovery Strategy
FEWS-NET	Famine Early Warning System Network
FGD	Focus Group Discussion
FLA	Field Level Agreements
GAM	Global Acute Malnutrition
HH	Household
HiNi	High Impact Nutrition Interventions
IDA	Iron Deficiency Anaemia
IMAM	Integrated Management of Acute Malnutrition
IYCF	Infant and Young Child Feeding
KAP	Knowledge and Practice Survey
KDHS	Kenya Demographic and Health Survey

KII	Key Informant Interview
KNBS	Kenya National Bureau of Statistics
MAM	Moderate Acute Malnutrition
MDGs	Millennium Development Goals
MI	Micronutrient Initiative
MMS	Ministry of Medical Services
MoH	Ministry of Health
MoPHS	Ministry of Public Health and Sanitation
MoU	Memorandum of Understanding
NCHS	National Centre for Health Statistics
NCPD	National Council for Population and Development
NGO	Non-Governmental Organization
NIA	Neighbours Initiative Alliance
NTF	Nutrition Technical Forum
OFDA	Office of the U.S. Foreign Disaster Assistance
OJT	On-the-job Training
OPM	Oxford Policy Management
OTP	Outpatient Therapeutic Programme
PHC	Primary Health Care
PRA	Participatory rural appraisal
RGA	Research Guide Africa
RUSF	Ready-to-use supplementary food
RUTF	Ready-to-use therapeutic food
SAM	Severe Acute Malnutrition
SC	Stabilization Centre
SFP	Supplementary Feeding Programme
SMART	Standardized Monitoring & Assessment of Relief & Transitions Survey

SQUEAC	Semi Quantitative Evaluation of Access and Coverage Survey
ToRs	Terms of Reference
UNICEF	United Nations Children's Fund
VAD	Vitamin A Deficiency
WFP	World Food Programme
WG	Working Group

1 Background

This end-term evaluation assesses the performance of Concern Worldwide's Emergency Response Nutrition Programme in Kajiado and Loitokitok Districts.

In response to a drought in 2009, Concern Worldwide implemented a cross-sectoral emergency response with funding by the Office of the U.S. Foreign Disaster Assistance (OFDA). The programme focused both on responding to the emergency needs and in building sustainability and resilience in nutrition. The programme included a nutrition health education component designed to address apparent poor levels of understanding of the causes of malnutrition in the community.

The intervention was implemented in partnership with the MoH, local NGOs Neighbours Initiative Alliance (NIA), African Inland Church (AIC), Catholic Diocese of Ngong, and Africa Infectious Disease clinic (Mbirikani Aids Village clinic), as well as UNICEF and WFP.

To assess the relevance of the programme, the evaluation posed the following queries: How relevant was the programme to the initial problems identified by local stakeholders? Were the assumptions used correct? Was the programme compatible and reflective of Concern's policies, approaches and guidelines? Were the targeted recipients the most vulnerable?

In regard to implementation, the evaluation assessed whether the various initiatives implemented under the programme met the objective of reducing vulnerability of beneficiary households. Apart from judging whether the programme was implemented in an efficient, effective and timely manner, the evaluation also looked at how appropriate the targeting mechanism was.

To gauge the impact of the programme, the evaluation searched for indications of change as a result of the programme at the household and community level. Key areas of interest included household food security and dietary diversity. This evaluation also highlights the relevance of the programme's interventions to malnutrition prevention and recommends ways of enhancing synergies between livelihoods and nutrition.

Although this programme was intended primarily as an emergency response, it was also concerned with sustainability and what nutrition services would look like following the eventual exit of the programme. This evaluation also looked at the sustainability of the programme initiatives; and the possibility of taking the current programme model at scale, including the cost implications as well as required staff capacities for that.

Finally, this end term evaluation was intended to offer recommendations on how the programme could be aligned with other Concern programmes and Concern's global Food, policies such as the Income and Markets strategy and the Kenya Country Strategy.

2 Evaluation Context

2.1 Outline of the Programme

Concern Worldwide implemented a cross-sectoral emergency response in Kajiado and Loitokitok Districts in response to a drought in 2009. The programme came to an end in March 2012.

The objective of the programme was to rehabilitate those with acute malnutrition and promote appropriate key nutrition practices in target areas. Specifically, the program's aims were to:

1) Manage moderate acute malnutrition, through the following activities:
    - Strengthening existing & new health facilities for delivery of SFP services
    - Training of health workers(both skilled and CHWs)
    - Provision of on-the job mentoring, monitoring and evaluation support to partners
    - Orientation meetings for the engagement of community leaders per facility

2) Manage severe acute malnutrition, through the following activities:
    - Training of the DHMT/HMT on HiNi
    - Inpatient training for existing inpatient therapeutic care sites
    - Training of health workers(both skilled and CHWs
    - Provision of on job mentoring, monitoring and evaluation support to partner staff

3) Nutrition education, through the following activities:
    - Health education conducted at health facilities offering nutrition services.
    - Conducting nutrition education at community (village) level
    - Training community CHW/volunteers on provision of nutrition education

4) Promotion of Infant and Young Child feeding
    - Training of health workers on IYCF
    - Establishment of Mother to Mother support groups

5) Strengthening nutrition systems, through the following activities:
    - Dissemination of OJT national guidelines and reporting tools for HINI components
    - Strengthen functional capacity of nutrition information system for each district
    - Coverage assessments

Full detail of the targets and indicators used to monitor progress are contained in Annex D.

The programme began with an emergency nutrition intervention response component, adopting the Integrated Management of Acute Malnutrition (IMAM) approach between July 2009 and 2010. This approach focused on four sub-sectors that were in line with the program objectives above, focused on mitigating the plight of acutely malnourished children.

Following the initial emergency phase, the programme shifted its focus in the second phase to supporting local health systems to implement the Government of Kenya's Nutrition Strategy, focusing on delivering a set of 11 High Impact Nutrition Interventions (HiNi), endorsed by a large group of international partners in the report "Scaling Up Nutrition - A Framework for Action." These HiNi interventions are set out in Box 2.1 below.

Box 2.1 High Impact Nutrition Interventions (HiNi)

Promotion of Good Practices

1. Exclusive breast-feeding for the first six months of infancy.
2. Complementary feeding after six months of age.
3. Hand washing and basic hygiene

Increasing Intake of Vitamins and Minerals – Provision of micronutrients for Young Children

4. Vitamin A supplements
5. Zinc supplementation in the management of diarrhoea
6. Multiple-micronutrients
7. De-worming for children
8. Iron and folic acid supplements for pregnant mothers
9. Iron fortification of staple foods

Therapeutic feeding for severely malnourished children

10. Prevention or treatment for moderate under nutrition
11. Treatment of severe acute malnutrition

Strengthening nutrition and health education was a key component of the programme. According to a baseline Knowledge and Practice survey carried out in November 2009 in Kajiado, it was apparent that there was a lack of knowledge about correct practices and poor actual behaviours around child and maternal health and nutrition. Among other findings, the results showed that maternal dietary restrictions during pregnancy were different and stricter than those during lactation. Specifically, there is a widespread belief that women should restrict their food intake during pregnancy to limit the growth of the baby in a mistaken belief that this will minimise difficulties and complications during delivery – a harmful practice to the baby right from the neonatal stage. These findings led to implementation of a nutritional education intervention that has reached 102 villages in the 2 districts.

3 Programme Context

3.1 Malnutrition in Kenya

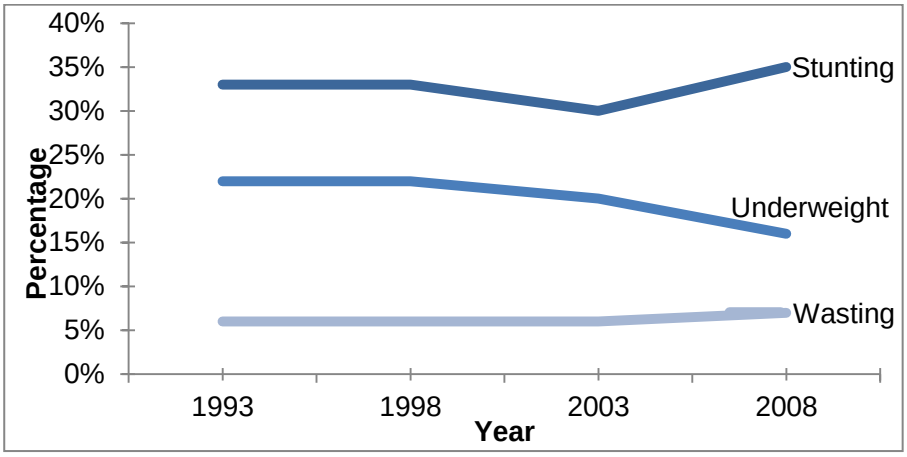
An analysis of the nutritional status of key vulnerable groups in Kenya including children under 5 years and women (especially expectant and lactating women) points at trends and differentials that call for urgent attention. The most recent Kenya Demographic and Health Survey (DHS), carried out in 2008-09, showed that malnutrition has remained high amongst children under five years and women over the previous decade. The proportion of stunted children increased from 33% to 35% in the period 1993 to 2008-09 (see Figure 3.1), with the most affected age-group being 18-23 months (46%). The proportion of wasted children under five years has not changed significantly over the period 1993 to 2008-09, while underweight rates among the same cohort have dropped by 6 percentage points within the period. North Eastern province has the highest proportion of children exhibiting severe wasting (8%) while Eastern province has highest level of stunted children (42%). The proportion of wasted and underweight children is negatively correlated with the level of education, wealth and nutrition status of the mother. Evidence also points at growing prevalence of overweight and obesity in Kenya. Obesity among pre-school children indicates that approximately 18% of them are overweight while 4% are obese. With regards to women, a comparison of the mean BMI of women (15-49 years) indicates no meaningful change over the period 1998 to 2008-09. The proportion of women aged 15-49 that are overweight or obese has increased in the period 2003 to 2008-09 from 23% to 25%.

The most recent national micronutrient survey from 1999[5] suggests that micronutrient deficiencies are highly prevalent in Kenya, especially among children under five years and women. The most common deficiencies include vitamin A deficiency (VAD), iron deficiency anaemia (IDA), iodine deficiency and zinc deficiency. The data on these deficiencies is as follows: VAD among under-fives (84.4%); IDA among 6-72 month olds (69%) and among pregnant women (55.1%); iodine deficiency (36.8%); and zinc deficiency among mothers (52%) and among children under 5 years (51%). Iron deficiency is emerging as an important condition among non-target groups with the prevalence of iron deficiency among adolescents in refugee camps at 46% and 21.1% among school girls in western Kenya. Risk of zinc deficiency was significantly associated with the distribution of hookworm, current fever, and history of perceived malaria.

National surveys reveal stagnation in some Infant and Young Child Feeding (IYCF) practices, particularly the duration of exclusive breastfeeding (EBF) and complementary feeding. Data drawn from KDHS 1998, 2003 and 2008-09 shows that the median duration of any breastfeeding has remained at 21 months. The median duration of EBF is less than one month. There has been an increase in the prevalence of EBF, from 11% of children under six months to 32% in 2008-09, but this remains low compared to the WHO recommendation of universal exclusive breast-feeding for the first six months of a child's life. 60% of children in Kenya aged 4-5 months are given complementary food.

[5] A new survey is underway but does not yet have results.

Figure 3.1 Nutritional status of Kenyan children under 5 (1993 -2008/09)



(Sources: NCPD, CBS and MI, 1999; CBS, MOH and ORC Macro 2004; KNBS & ICF Macro, 2010)

3.2 Government Policy

The Government of Kenya is the lead partner in establishing nutrition policy, and the Concern programme has been designed appropriately to support local officials to implement existing government policy on the ground.

Kenya first developed a Food Policy in 1981 with the main objective of supporting self-sufficiency in major foodstuffs while ensuring equitable distribution of food of good nutritional value to the population. This policy was reviewed in 1994 with the same objective. Since then, major strides have been made in developing strong nutrition-related policies that address the persistently high malnutrition levels and their underlying causes. Important among these policies are the Nutrition and Dieticians Act (2007) and the draft National Food Security and Nutrition Policy.

The Government has also committed to several initiatives such as the Millennium Development Goals (MDGs), Vision 2030 and Economic Recovery Strategy (ERS) that aim to improve the health status and reduce poverty rates in Kenya thus ensuring improved nutritional status. Realization of these targets, like the MDGs, which include eradicating extreme poverty; reducing child mortality rates; fighting disease epidemics; and developing a global partnership for development, will lead to improved nutrition. There is a clear established link between nutrition and the MDGs to which the Concern nutrition program is contributing to.

The Kenyan Constitution establishes the structure of the Kenyan government, and also defines the relationship between the government and the citizens of Kenya. In Cap 54 Article 53c of the current Kenyan constitution that was enacted on 27th August 2010**,** nutrition is strongly recognized as a basic right for children. Unfortunately, key-nutrition policies have not been aligned to the Constitution in order to fulfil the provision within Cap 4 Article 53c.

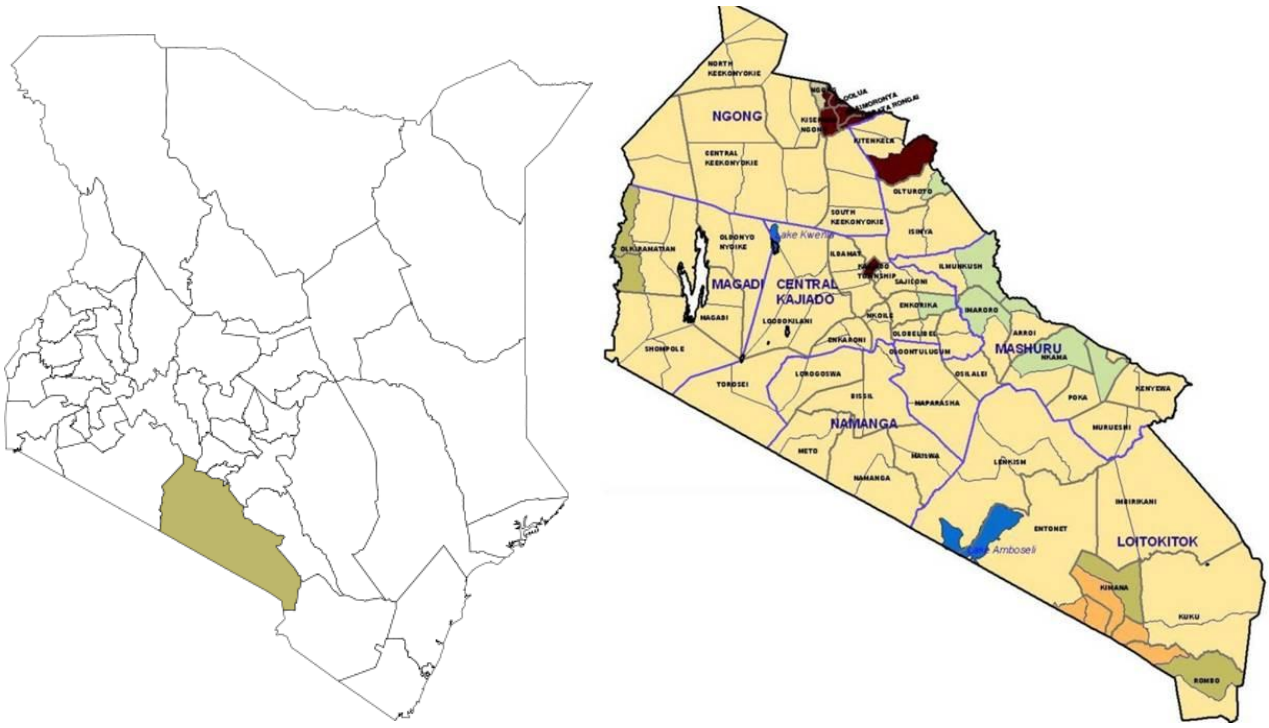
The organisational structure of government institutions with respect to nutrition are laid out in Annex E for the Ministry of Medical Services and Annex F for the Ministry of Public Health and Sanitation.

3.3 Kajiado

The programme was implemented in two districts; Kajiado and Loitokitok. Loitokitok was previously an administrative division of Kajiado district.These districts are both part of Kajiado County which is one of the new 47 counties envisioned by the new Kenyan constitution that was promulgated in August 2010. Counties will replace provinces as second-tier administrative units, after the central government.

Kajiado County is located south of Nairobi on the border with Tanzania (see Figure 3.2). Following years of drought, the region is dry and is officially designated as semiarid, covering an area of over 20,000 km^2. Annual rains are low and uneven. Kajiado Central Districts experiences two rainy seasons, with the short rains between October and December and long rains between March and May while Loitokitok District experiences long rains between October and December and short rains between March and May . In recent years there have been long periods of drought when there have been little or no rains to support a predominantly pastoralist population.

Figure 3.2 Kajiado County Map



In November 2011, Concern's partners, the Neighbourhood Initiative Alliance, conducted a detailed household survey in Kajiado. The survey found that 91% of households reported difficulty accessing food in the previous year. According to the Kenya County Fact Sheets (2011), out of 47 counties, Kajiado ranked 41st in percentage population with a primary school education and was ranked 44th in 15 to 18yr olds attending school. The population of Kajiado Central is estimated at 162 000 and Loitokitok at 137 000 (see Table 3.1).

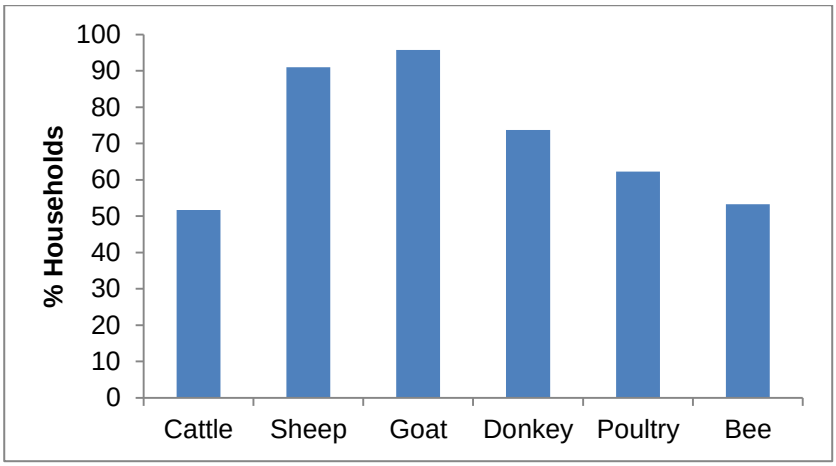
Table 3.1 Population in Kajiado and Loitokitok

District	Male	Female	Under 5s	Total
Kajiado Central	80,354	81,924	29,409	162,278
Loitokitok	68,837	68,659	25,052	137,496

Source: Population Census 2009, quoted in NIA Annual Livelihoods Report, January 2011 – December 2011

The range of livelihoods available in rural Kajiado is extremely limited. Participants in focus groups conducted for this evaluation listed the following common occupations; buying & selling cows, selling milk, making and selling charcoal, working for neighbours (at wages of 100ksh per day), selling land, working at the quarry (breaking rocks by hand), making beads, and working as security. The NIA survey also confirms the predominance of pastoralism, with over 90% of households owning some sheep and goats, and over 50% owning cattle (see Figure 3.3).

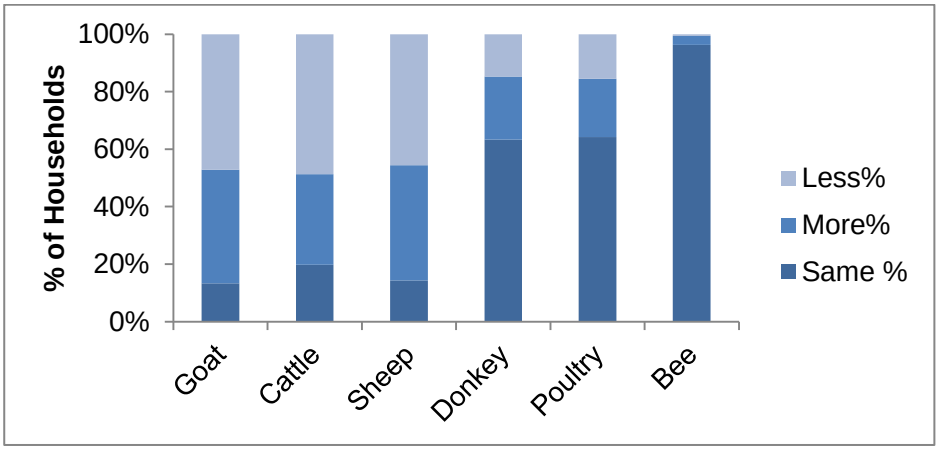
Figure 3.3 Household Livestock Ownership



Source: NIA Survey, Nov 2011

Around half of households reported a reduction of their goat, cattle and sheep holdings in the six months prior to November 2011 (see Figure 3.4). This is reflective of the deterioration of the nutrition situation experienced during the same period and the subsequent increase in the number of outreach sites to provide services to increasing cases of malnutrition.

Figure 3.4 Change in livestock holdings (6 months prior to November 2011)

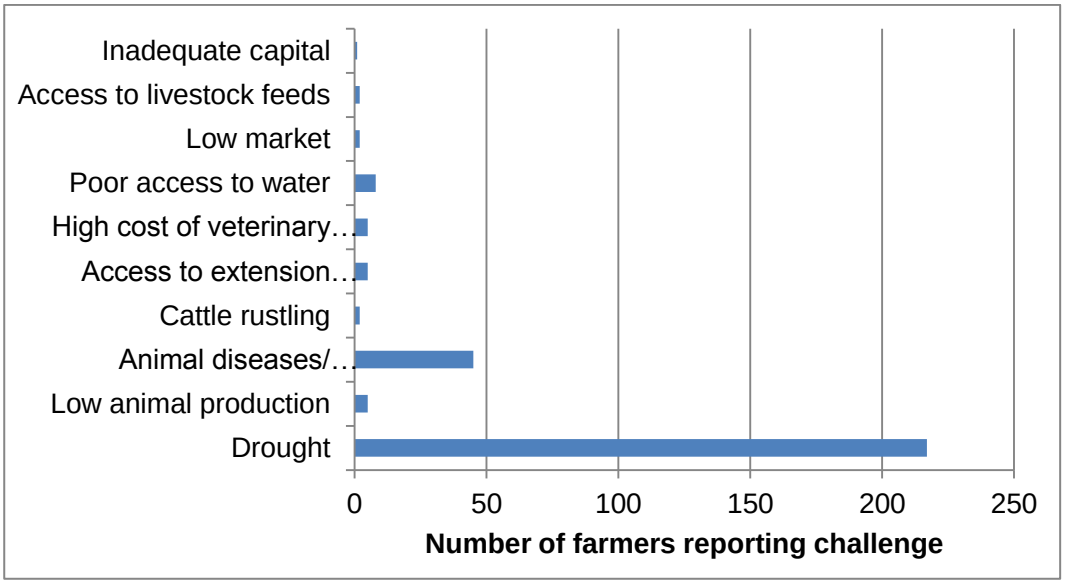


Source: NIA Survey, Nov 2011

The key challenge reported by an overwhelming majority of farmers was drought (see Figure 3.5). This aligns with the FEWS-Net report from June 2011 which read that "The 2011 long rains have ended in the drought-affected pastoral, south eastern, and coastal marginal agricultural areas, culminating in the second or third successive poor or failed season in most parts of the rangelands and cropping lowlands. Many of these areas received 10-50 per cent of normal rains, with most rains occurring late in the season from late April to mid-May." Pastoralists terms of trade (kilograms of maize purchased from the sale of a goat) were in around 30% lower than average in Kajiado in May 2011[6].

Interestingly, in the Kenya County Fact sheet (2011), Kajiado county was ranked 4th in the country as regards access to electricity. It came in 7th out of 47 counties in adequate height for age. These estimates are generated based on the Kenya Integrated Household Budget Survey (KIHBS) 2005/06.

Figure 3.5 Challenges facing farmers in Kajiado

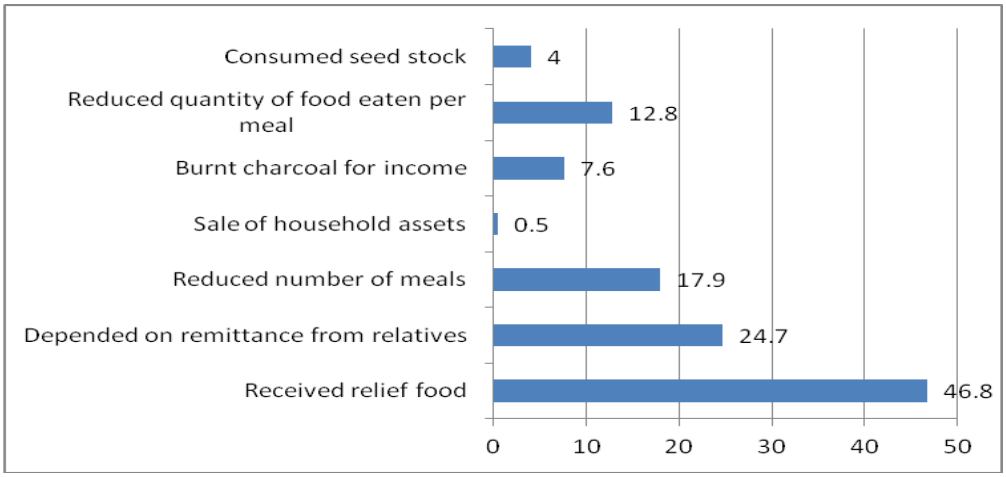


Source: NIA Survey, Nov 2011

The most common reported coping mechanism by households in the NIA survey was food aid, followed by remittances from relatives. Food aid was also mentioned heavily by all of the focus group participants we spoke to. Most importantly, almost everyone we spoke to stated that they sometimes skipped meals.

[6] FEWS-Net (2011), SPECIAL REPORT Kenya Food Security June 2011, Food insecurity for pastoral and marginal agricultural households deepens to precarious levels

Figure 3.6 Coping Mechanisms



Source: NIA Survey, Nov 2011

3.4 Partnerships

The nutrition interventions have been implemented in partnership with Neighbours Initiative Alliance (NIA) for the health and nutrition education and the MoH, African Inland Church (AIC), Catholic Diocese of Ngong, and Africa Infectious Diseases clinic (Mbirikani Aids Village clinic), with the Ministry of Health taking the lead. In addition, collaboration was forged with UNICEF, WFP, the local administration and the community leadership. The partners' roles and responsibilities are laid out in Table 3.2 and Table 3.3 below.

Table 3.2 Local NGO Partners

Partner	Location	Activities
Neighbours Initiative Alliance (NIA)	Kajiado Central & Loitokitok	Run the Nutrition Education (Outreach-Village level) Programme Deliver health and nutrition messages to pre and post natal care service points Support Mother to Mother Support Groups Training of community health workers and volunteers to assist with the health and nutrition education.
African Inland Church (AIC)	Kajiado Central	Operation of two health clinics (Concern funds two staff, fuel, administration) as well delivery of services at outreach sites.
Catholic Diocese of Ngong (CDON)	Loitokitok	Operation of health facilities at Lenkism and Rombo. (Concern provides funds for community mobilizers, CHWs, supervision, drugs) as well delivery of services at outreach sites.

UNICEF, WFP and NGOs work in close collaboration with and under the direction of the Ministry of Health. Roles and responsibilities are defined between MoH and partners through signed

Memorandums of Understanding (MOUs), such as the national MOU between WFP, MoH, and UNICEF. At the sub-national level, WFP has Field Level Agreements (FLA) with NGOs such NIA for the delivery of Food and SFP therapeutic commodities. In Kajiado County, the engagement of these partners is as follows:

Table 3.3 National Partners

Partner	Activities
Ministry of Health	Chair NTF and related Working groups. Ensures NTF and WG follow up of action points in collaboration with partners. Support & ensure ToRs for National, Province & District Nutrition Coordination & Information System respected Address issues raised in District Coordination meetings minutes in collaboration with partners. Facilitate integrated implementation of HINI at subnational level. Ensure and advocate for fortification, micronutrients and systematic essential drugs supplies. Ensure and advocate for availability of adequate human resources at District and Health Facility level. Ensure dissemination of National Guidelines, OJT tools and other relevant documents at subnational level in collaboration with partners.
UNICEF	Support to and participation in coordination mechanisms at nation and sub-national level. Direct support at district level in monitoring and reporting including coverage, standards, progress towards targets and supplies. Emphasis on sustainability and incorporation within existing systems. Support to ensure management of nutrition supplies is well incorporated within the existing government systems. Direct logistic support only in exceptional cases. On the job training and mentoring of health workers (using appropriate tools to monitor progress) to ensure capacities for scaling up essential actions are in place and sustained.
WFP	Nutrition supplies for the treatment of moderate malnutrition Technical support for efficient stock management & support with storage structure where necessary Human resource support, particularly at field level to support efficient running of nutrition programmes Support to joint monitoring initiatives, supporting supervision and programme reviews and evaluations Support to and participation in coordination mechanisms at the sub-national level Support to ensuring timely and accurate nutrition information for sectoral and multi-sectoral use

4 Evaluation Methodology

4.1 Overview

The evaluation consisted of four principal parts:

1. A desk review of programme documents and design of tools
2. Meetings with Concern programme staff
3. Fieldwork in Kajiado and Loitokitok
4. Analysis, reporting, and a presentation to Concern and partners

4.1.1 Review of documents

This short initial phase interrogated the programme documentation to develop an understanding of the programme's theory of change. Potential discrepancies between the design of the programme and its objectives were identified at this stage, which informed the next phase. Hypotheses and programme assumptions to be tested were identified.

Documents reviewed also include other literature on nutrition policy in Kenya, such as Kenya Vision 2030, the Kenya National Food Security and Nutrition Strategy (2008), the Kenya National Nutritional Plan of Action (2011-2017), and the MoPHS/UNICEF Guidelines for the Implementation of the High Impact Nutrition Interventions.

4.1.2 Meeting with Concern staff

Yacob Yishak (National Nutrition Coordinator- Concern Worldwide) and Martin Kumbe (Roving Nutrition Program Manager) discussed and reviewed the proposed evaluation methodology and questions to ensure that they sufficiently reflect Concern Worldwide's needs with regards to this end-term evaluation of their nutrition programme. They talked through:

- The programme's theory of change, assumptions and hypotheses to be tested
- The evaluation requirements
- The proposed methodology to evaluate whether the programme achieved its desired objectives.
- Further issues to be discussed
- Relevant documentation that set out the programme approach and methods more clearly.

This meeting ended with a shared understanding of the aims of the programme, hypotheses to be tested, the evaluation approach, questions and sub-questions, and proposed methodology. This is summarised in Table 6.1.

4.1.3 Fieldwork

Fieldwork was conducted in Kajiado and Loitokitok districts where the programme operated. Research participants were selected at random to participate in the groups and interviews based on Concern's beneficiary list. Non-beneficiaries were selected using snowball sampling. Recipient interviewees and FGD participants were selected randomly from the beneficiary lists and where possible phoned in advance to arrange meetings.

The evaluation uses both key informant interviews (KII) and focus group discussions (FGD) to gather information about the programme. Participant and non-participant respondents in groups and interviews were also asked to complete a short questionnaire in Swahili to generate some quantitative opinion data (8 participants in 10 groups so a total of 80 responses). These English tools are given in Annex B.

Concern and partner help was very important for gaining access to the communities, but the research was conducted without NGO staff present to avoid bias in the findings (participants tailoring their responses in presence of NGO staff).

We conducted 10 FGDs in total in the 2 districts. We also interviewed the relevant partner staff in each location.

4.1.4 Analysis and reporting

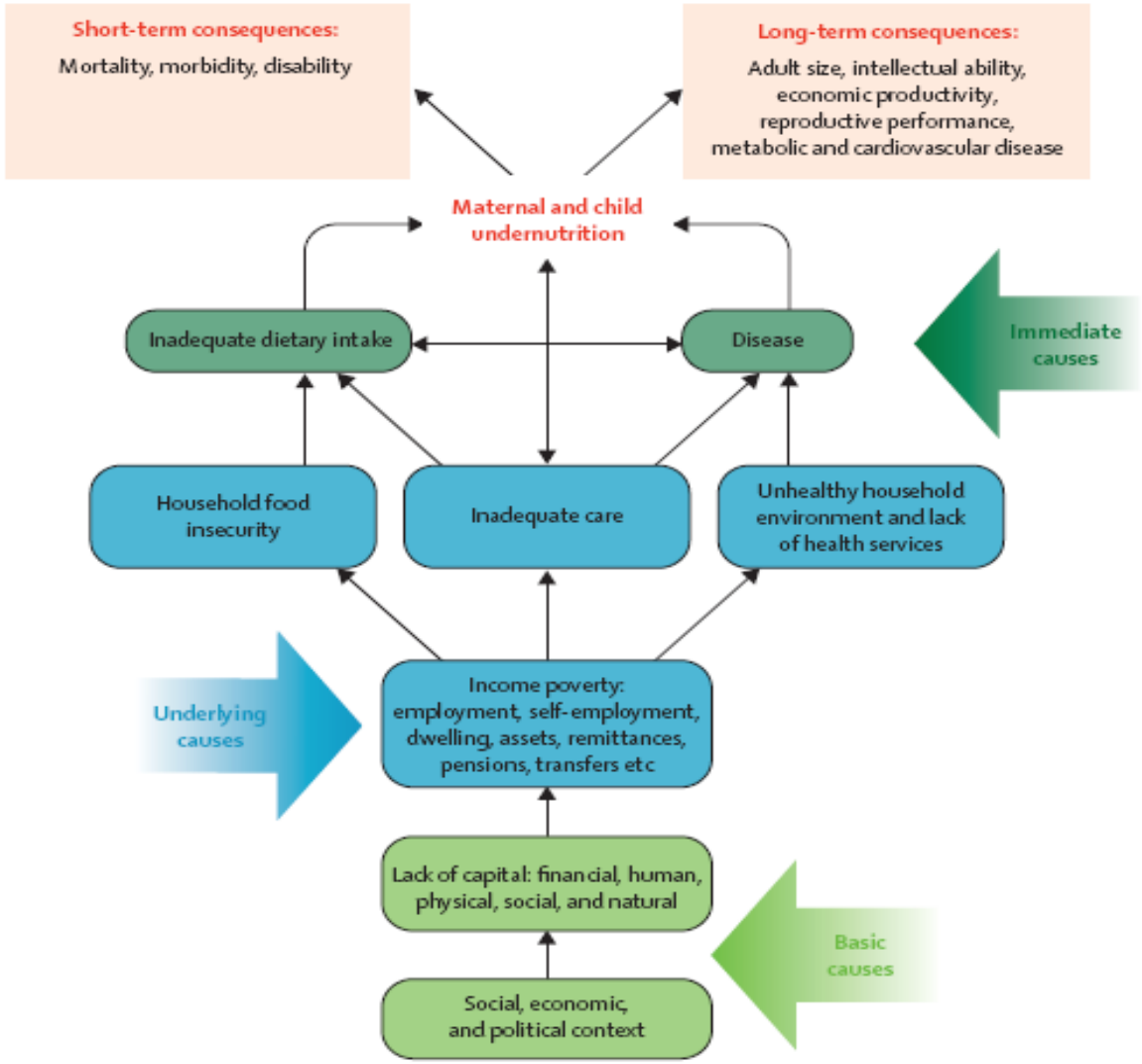
The final phase began with a brief informal presentation of findings to Concern and partner staff to ensure that any mistaken interpretations could be corrected and to ensure that the concept and premise of the programme were fully understood by the evaluators. This presentation was used to direct analysis into particularly important issues.

Transcripts and notes were typed up and used to inform the analysis. Programme documentation was also revisited, and secondary data, including surveys conducted by Concern and their partners, and the data gathered during the evaluation focus groups was reviewed and analysed.

4.2 Conceptual Framework for malnutrition

The causes of malnutrition are complex, and include food intake and dietary diversity, disease, inadequate care (such as not exclusively breastfeeding), and poor hygiene and sanitation. This is set out in the causal framework in the figure below and it serves as a guide in assessing and analysing the causes of the nutrition problem and helps in identifying the most appropriate mixture of actions.

Figure 4.1 Causal framework of malnutrition



Adapted from UNICEF.

5 Evaluation

This section evaluates the performance of the programme against 7 criteria;

1. Relevance (to the context),
2. Fit with Concern Worldwide Policies, Approaches, and Guidelines
3. Coverage
4. Coherence
5. Effectiveness
6. Efficiency
7. Sustainability, Phasing out, and exit strategy

5.1 Relevance

This section considers the relevance of the programme in two senses; the degree to which malnutrition is a specific problem in Kajiado and Loitokitok, and the degree to which the design of the programme was appropriate to address any nutrition problems identified.

5.1.1 Relevance of Nutritional Interventions

The programme was clearly relevant to the context in Kajiado and Loitokitok, where a recent survey[7] found that 91% of households reported difficulty accessing food in the last year. Drought is becoming ever more frequent[8] and pastoralist livelihoods face chronic difficulties[9].

Table 5.1 Nutritional Status of Children aged 6-59 months in Kajiado June 2009

	WHO	NCHS
Global Acute Malnutrition (GAM)	**11.5%** (8.5 – 15.4 95% CI)	**11.1%** (8.4 – 14.5 95% CI)
Severe Acute Malnutrition (SAM)	**1.8%** (1.0 – 3.1 95% CI)	**1.5%** (0.8 – 2.7 95% CI)
Stunting	**33.9%** (28.0 – 40.3 95% CI)	**28.0%** (22.8 – 33.8 95% CI)
Underweight	**25.6%** (20.3 – 31.6 95% CI)	**32.7%** (27.2 – 38.8 95% CI)

Source: Concern Worldwide (2009)

[7] NIA Survey, Nov 2011

[8] http://www.fews.net/docs/Publications/Kenya_Special_Report_2011_06_final.pdf

[9] Demombynes and Kiringai (2011),

By 2011, the Global Acute Malnutrition (GAM) rate in Kajiado had fallen to 8.6%. Severe Acute Malnutrition (SAM) is 0.9%, the under-five mortality rate is 0.3/10,000/day and the crude mortality rate is 0.23. The prevalence of stunting is 19.7% and underweight prevalence is 12.1% (all figures from Mercy/MPHS/MMS/UNICEF 2011). It is important to note that this survey covered the whole County of Kajiado including five districts, of which Kajiado Central and Loitokitok are just 2, and so they also include other districts not covered by the programme.

Malnutrition is not only a clear problem, but it is also an area where government and NGO action is clearly effective and cost effective. Nutritional interventions have been assessed by numerous sources to be some of the most cost effective of all proven interventions. A panel of economic experts was convened in 2004 to consider the range of all major global challenges, and which had the most cost-effective solutions. Solutions to malnutrition constituted 5 of the top 10 most cost effective solutions.

The set of 11 High Impact Nutrition Interventions adopted by the Government of Kenya have evolved from a list compiled by the Lancet in 2008, of which the World Bank investigated the programmatic feasibility in 2009, and a larger group of international partners endorsed as priorities for action in report “Scaling Up Nutrition - A Framework for Action.”

The evidence on the effectiveness of behaviour change interventions is more mixed than that for direct medical interventions. An evaluation of deworming treatment in Western Kenya which found very large impact of the pills themselves, found no impact of additional interventions around behaviour change, such as public health lectures, wall charts, and teacher training on hygiene.[10] A rigorous evaluation in Peru found that providing child and maternal health education had an impact on knowledge but no impact on actual child health outcomes.[11] On the other hand, a recent randomized evaluation by Fitzimmons et al (2012) found a positive and unexpected impact on behaviour simply through the information on child feeding practices – seeing an increase in adult male labour supply and increased feeding.

According to our conceptual framework, referenced above, household hygiene impacts the effect of nutrition programs. The Concern Worldwide nutrition programme did not seem to specifically target this aspect and, as such, number of households did not have, for example, proper toilets or latrines. In addition, the scarcity of water exacerbates the effects of the drought and unhygienic practices and the Concern Worldwide programme left this responsibility to other stakeholders.

Also, to the extent that food security is a key driver of malnutrition in Kajiado, this project was not focused on livelihoods or income generation.

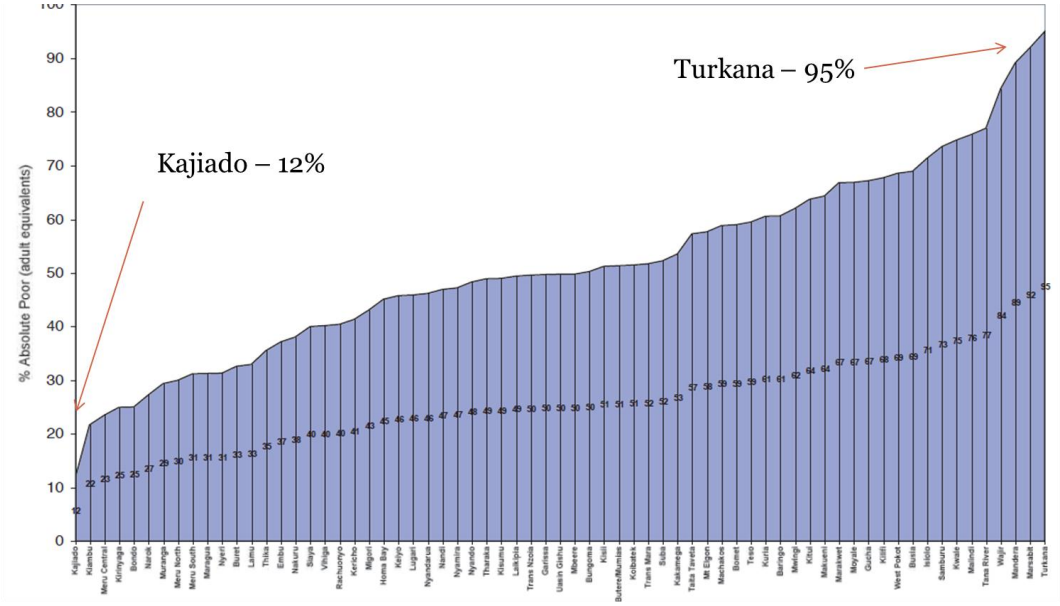
5.1.2 Relevance of Nutritional Interventions to Kajiado County

Kajiado is probably not the poorest county in Kenya, which raises a question about whether Concern should be focusing its work there. The Kenya Integrated Household Budget Survey (2005) actually suggests that Kajiado County has one of the lowest poverty rates in all of Kenya, at just 12%. There is though widespread scepticism about the accuracy of this figure, and it is true that poverty rates for small areas estimated based on relatively small sample sizes may be quite inaccurate for some counties. The 12% rate in Kajiado is based on a sample of just 100 households, and there is a chance that this was just a very unrepresentative sample.

[10] http://www.poverty-action.org/project/0269

[11] http://www.poverty-action.org/project/0023

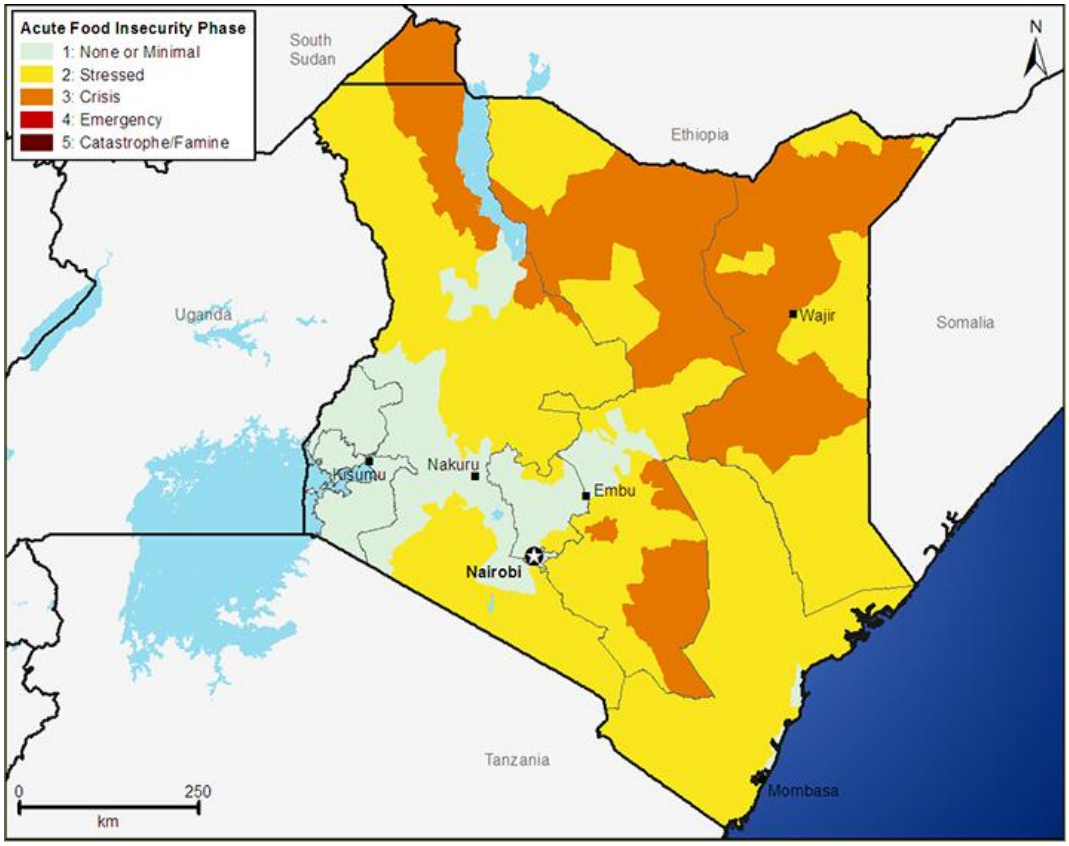
Figure 5.1 Absolute Poverty Rates in Rural Districts (2005/06)



Source: KIHBS (2005)

The Famine Early Warning System (FEWS-NET) puts much of Kenya in the "stressed" food insecurity phase in April-June 2012, including Kajiado County (see Figure 5.2). There are regions with more severe food insecurity conditions, including much of the north of the country, which are classed as in "crisis." Food security has clearly been an issue in Kajiado, with repeated mentions in the FEWS-NET food security alert since 2009 (see summary in Box 5.1).

Figure 5.2 Estimated Food Security Conditions (April-June 2012)



Source: Famine Early Warning System Network (FEWS-NET)

Box 5.1 Summary of FEWS-NET Food Security Outlooks 2009-12

Jul - Dec 2009	Failure of the rains in pastoral areas … have also culminated in rapid deterioration of livestock body conditions and productivity [The worst affected areas include Kajiado]
Oct 2009 - Mar 2010	Livestock mortalities have been reported in many parts of the pastoral livelihood areas, particularly in Kajiado … livestock productivity is unable to support household food needs since milk output is largely absent, while cattle and goat prices are as much as 40 per cent lower than average due to their poor body condition and the unwillingness of traders to purchase livestock at the peak of the drought.
Jan - Jun 2010	Livestock body conditions have improved but more slowly in the areas that began receiving good rains late, in December. Significant livestock mortalities in Kajiado … have slowed the beginning of the recovery process, such that the increase in milk availability at the household level is marginal. While livestock prices had increased by 30-70 in December as compared to November and are up to 25 per cent higher than respective average levels, food prices have remained over 100 per cent higher than December average levels in most of the pastoral districts

Apr - Sep 2010	The food security situation in most of the pastoral areas has improved significantly in many areas, after a good short-rains season …, The main shock experienced in pastoral areas is excessive rains … with many areas already reporting rainfall amounts in excess of seasonal averages. The rains are expected to cause additional but localized flooding in … Kajiado
Oct 2011 - Mar 2012	The onset of the 2011 October-December short rains has brought marked relief in most pastoral areas that had experienced two to three successive failed seasons … distances to water for both livestock and households have also declined and are below average with the exception of Narok and Kajiado, where distances are still 50-60 per cent above normal.
Feb - Jun 2012	The gradual improvement in the pastoral food security situation across … parts of the southern Maasai rangelands, after significantly above-average October-December 2011 short rains, is starting to slow down … Livestock prices have increased significantly … in Kajiado …. By 80-120 per cent … terms of trade are 10-45 per cent below average in … Kajiado … due to significantly above-average cereal prices

There is though a question mark regarding the effectiveness of nutrition interventions alone without some kind of cash transfer, food aid, or livelihoods support. Due to a sheer lack in sufficient quantity of food, many households share therapeutic feeding products prescribed for a single malnourished child between the whole family, leading to relapse of the affected child back into malnutrition treatment as well as extended stay on the program.

Though it is not clear that Kajiado is the neediest county in all of Kenya, there is a case to be made that Concern does have a comparative advantage operating in the area given existing relationships will local stakeholders.

5.1.3 Design of the Programme

The design of the programme seems to be appropriate to the context; beginning initially as a vertical intervention designed to directly address acute malnutrition, and transitioning to a more integrated approach in the second phase designed to assist local government to integrate the set of HiNi interventions into routine service delivery by local health clinics. This approach is key to allowing for the sustainable delivery of essential supplements and treatment.

5.1.4 Involvement of Beneficiaries

Beneficiaries of the programme have been surveyed several times by Concern and its partners, with results feeding into the design of the programme. Concern conducted a SMART survey in 2009, and participated as a stakeholder in the April 2011 SMART survey led by Mercy USA. Concern also conducted 3 Knowledge and Practice surveys (in 2009, 2010, and Nov/Dec 2011) and these were used to assess the needs of the community and include them in the design of the programmes. In all the surveys, the CHWs drawn from the health facilities/Community Units participated as enumerators and guides after undergoing training.

Community leaders such as the chiefs and village elders were consulted and their views and recommendations included in the initial design of the programme. A total of 10 leaders from the catchment of 46 facilities were briefed/given orientation on HiNi at the time of adoption.

Local partner organizations were generally very positive about the level of community engagement of Concern.

Local community members who participated in focus groups felt that there had been some consultation. They would have liked more consultation, but did recognise the logistical difficulties given how far many of them live from a road or town. Overall the programme seems to have consulted sufficiently with beneficiaries of the programme at the beginning and through the implementation period.

5.1.5 Involvement of other local stakeholders (including health workers and specific vulnerable groups)

The MoH has rolled out a Community Strategy approach. In this strategy, each community unit serves 1,000 households with one volunteer CHW assigned to serve 20 households and supervised by a trained health extension worker. The strategy is also supported by a team of volunteers trained on IMAM that is community-based. This is anticipated to improve the health status of Kenyan communities through, initiation and implementation of life cycle-focused health actions at the community level. This is done through the provision of community level services for all cohorts and socioeconomic groups. Each of the 46 functional health facilities in the 2 districts are expected to have at least one community unit, though at the time of the evaluation there were only 27 active units (up from 24 in 2011). Community Strategy Units were involved in the selection of areas where Concern and local health facilities should hold outreach centres.

Since August 2011, Concern has shifted to integrating nutrition service delivery in the community units and this is in line with the MoH's approach of integrating nutrition into existing health care service delivery at levels 1 to 3 of the health care delivery system. Initial activities in this engagement have included training of Community Health Committees (CHC) drawn from 27 units and Community Health Extension Workers (CHEWs). CHC members and CHEWs have received training on identification of malnutrition, referral, defaulter tracing, importance of breast feeding, maternal nutrition, Vitamin A supplementation, deworming, health service utilization motivation and their role in mobilization and utilization of health data collected from the community. This has been an effective method. The trainings conducted were to secure active participation of the units in the delivery of HiNi services.

At the start of the programme, facility-community linkages were established through the engagement of Community Health Workers (CHWs) drawn from the catchment area of the facilities.

By and large, programme staff felt that most of the vulnerable people in the community were catered for. However, there were concerns, especially by health care workers, that the elderly should also have been included in the programme. In fact, to get around this, the health care workers would initially include the elderly and children above five years of age by fixing them in the 'OTHERS' grouping. However, there came a time when these non-targeted beneficiaries were more than the targeted beneficiaries. Concern Kenya staff rightly advised health care workers against including non-targeted beneficiaries in the programme, as targeting of beneficiaries was conducted in accordance with MoH approved protocols and supplies were probably not enough to cover even this group.

In Loitokitok district, health care professionals at Kimana Health Centre reported that non-Maasai beneficiaries were not receiving adequate support from the local administration. When referred to the chief's offices for general food supplies, some of them received little, if any, food supplies.

District administration officials in Kajiado were of the view that children between the ages of five and twelve years should have been included in the nutrition programme, which perhaps reflected a lack of understanding on their part of the urgency of interventions for under 5s, or perhaps just reflecting their role as advocates for increased funding for food distribution and other forms of food

aid to supplement existing targeted nutrition interventions. District level health personnel should be actively involved in any planning meetings for the preparation of district emergency preparedness plans.

The participants in focus group discussions felt that orphans and vulnerable children and widows were catered for by the nutrition programme, although there was no explicit targeting of them as these were essentially covered under the cohort group of children targeted by the program.

Disabled children who met the inclusion criteria also directly benefitted from the programme. Staffs from Rombo Health Centre in Loitokitok district have been providing early child development schools in the area with parts of the HiNi package like de-wormers and food supplements.

5.1.6 Mainstreaming

The Concern Worldwide nutrition programme has prioritized mainstreaming nutritional interventions into routine health care provision. There has been the integration of maternal and child health initiatives into the nutrition programme at both the health facility and outreach sites that Concern Worldwide carries out. For instance, each field outreach team in Loitokitok includes at least one community health nurse, one community health extension worker and one public health officer. A similar arrangement takes place in Kajiado Central with the exception of the extension workers as the district does not have this cadre of staff. During the outreaches, apart from the nutrition education and therapeutic food supplies that the beneficiaries receive, they were also offered immunization services, deworming, family planning education services and sensitization on basic hygiene and hand washing as well as treatment of minor ailments.

Although gender was not an explicit focus of the programme, there was an implicit emphasis on women's issues as a result of the design of the programme including pregnant and lactating women. There was no direct focus on women's social, political and economic empowerment. Equally, IYCF has focussed more on mothers in an effort to improve child feeding practices. By design, there was a 100% exclusion of men in the Mother to Mother support groups.

Failure to enhance the level of involvement of elders and other members of the community significant to improving IYCF may have compromised an improvement in the practices of some IYCF indicators as reflected in the preliminary results of the KAP survey of 2011.

HIV/AIDS, which has a strong component on nutrition, was not addressed in this intervention even though Concern has an HIV/AIDs program that is run in other regions.

5.2 Fit with Concern Worldwide Policies, Approaches, and Guidelines

The section looks at how well the nutrition programme fits with the Concern Worldwide policies more broadly. Overall the programme is a good fit with Concern strategies, contributing to outcomes for the Global Health Strategy, the global Food, Incomes & Markets programme, and the Kenya Strategic Plan. The main concern is that Kajiado County is possibly not the place with the poorest people in Kenya, and Concern typically aims to focus on the most vulnerable.

The goal of the **Concern Global Health Strategy (2011 – 2015)** is to contribute to the achievement of health and nutrition security of the poor within the context of the health related MDGs. Providing support to the mainstreaming of nutritional interventions in arid regions of Kenya clearly contributes to this goal.

Concern's global **Food, Income and Markets Programme (2009-2014)** focuses on improving the livelihoods options of the poorest. The desire to integrate nutrition interventions with livelihoods is clearly driven by a correct analysis of the situation. Malnutrition in Kajiado is evidently driven by a mix of factors including insufficient access to health services, and sheer lack of access to a sufficient quantity and quality of food through markets or livelihoods. It is not however clear what livelihoods interventions would be best suited to enhancing food security in Kajiado County.

The Kajiado Nutrition Programme clearly constitutes two key goals of the **Kenya Strategic Plan 2011 – 2016** in demonstrating pro poor service delivery models, and delivering emergency response.

Table 5.2 Objectives of the Concern Worldwide Kenya Strategic Plan 2011 - 2016

1. Promote a people centred approach	• No of local governments plans informed by community identified priorities from at least one sector • Number of programmes built on CC	7 Counties All (5)	**Sector Programme Strategies**
2. Demonstrate pro poor service delivery models	• No of service delivery models initiated by Concern adopted by at least one other stakeholder	1 per programme	
3. Deliver quality emergency response	• Emergency assistance is in line with SPHERE standards	100%	**Emergency preparedness and response plan**
4. Quality programme management	• % of projects PCMS compliant	100%	**PCMS** **HAP system** and procedures
5. Effective networking and advocacy	• % increase in budgetary allocation by central government for pro-poor social and economic policy implementation	10%	**Programme advocacy plans**

Source: Concern Worldwide Kenya Strategic Plan 2011-2015

The Semi Quantitative Evaluation of Access and Coverage Survey (SQUEAC) is a standard low cost survey methodology for establishing programme coverage. The 2010 SQUEAC survey found that the Concern/MOH IMAM programme met **Sphere standards** for cure rates (75%, compare to a standard minimum of 75%) and death rates (1%, compare to a standard maximum of 10%), but had default rates above the maximum (22%, compared to a standard maximum of 15%). Our discussions with nutrition officials in Kajiado suggested that there are high levels of default, or children returning repeatedly for therapeutic feeding. At least part of this problem was attributed to the practice of sharing therapeutic food rations between the whole household due to very low incomes, which means that severely malnourished children do not receive the full benefits that they require to recover. On the other hand defaulting was majorly attributed to delays in delivery of SFP therapeutic commodities and the migratory nature of the target population. This highlights the need for income or livelihood support to end the practice of sharing therapeutic food by the whole household. Improved livelihoods would also improve other indicators such as cure rates, length of stay on the programme, and admissions outcomes.

Some efforts have been made by Concern to establish linkages to livelihoods programmes, and were successful in linking some mother support groups to a livelihood and income-generating activity project. Three groups of these support groups have received livelihoods grants. The objective of creating these linkages was to provide additional income to improve complementary feeding of children, although there were some concerns about whether additional income generating activities may make it more difficult for caregivers to attend nutrition/health sessions. It is unfortunately not within the scope of this evaluation to comment on the effectiveness of these livelihoods programmes and their impact on nutritional outcomes.

5.3 Coverage

Coverage was in general as good as it could have been within the available budget, with some support provided to all of the government and NGO clinics in the districts. Although coverage of *facilities* by the programme was good, there was clearly unmet need of *individuals* for health services and food or income support. The focus on providing universal support to facilities in understanding how to implement the HiNi package was well placed. Both service providers and beneficiaries were clear that there was insufficient outreach which seemed to be driven by insufficient funding rather than a misunderstanding of the situation. The programme had 85 outreaches in January 2011 and these were progressively reduced to less than 20 by May 2011. Concern did respond flexibly to the extent possible following a deterioration of the nutrition situation in August 2011, increasing the number of sites to 39, and subsequently reducing them to 14 by January 2012.

The SQUEAC coverage survey estimated that around half of Severe Acute Malnutrition (SAM) cases were being covered by the programme (48.4%, with a confidence interval between 31.7% and 65.1%). “Period coverage” including those cases which have recovered as well as existing cases is slightly higher at 52.7% (with a confidence interval of 36.9% to 68.5%).

The programme report of the last quarter of 2011 showed that 50% of facilities were offering the full HiNi package (see **Error! Reference source not found.**). Coverage of Vitamin A was at 30% in Kajiado and 38% in Loitokitok, and coverage of Zinc supplements was 32% in Kajiado and 48% in Loitokitok.

Vitamin A and Zinc coverage has been low due to poor tallying at points of delivery as well as cases of stock outs in some facilities. To improve coverage, health workers were taken through OJT on tallying and reporting which has seen the coverage reported increase from 14% to 30%. Zinc coverage has also been affected by slow uptake of the practice by MOH staff due to it being relatively new. Facilities staff are encouraged by the DHMTs in the 2 districts to procure own Iron folate supplies as the commodity is affordable pending delivery from MOH.

The geographical targeting of support to outreach services was based on simple transparent criteria of those communities furthest from existing health clinics, with also some attempt to target the poorest communities. This selection was done in consultation with health clinics and district health officials. The MoH suggested a number of sites, and mass MUAC screening was conducted to determine which sites had caseloads that would justify siting an outreach. There was some a discontention from MoH which wanted to establish outreaches in areas with low immunisation coverage, but which upon screening did not have levels of malnutrition to warrant support for outreach from this project. It was not possible to assess the effectiveness of the poverty-targeting of the programme.

Individual targeting for nutrition support is conducted through clear objective criteria (malnutrition screening). There was disagreement amongst community members in the focus groups around the best method for finding households in the outreaches – whether to go house to house or to send out a call for the community to come together at a church or school. Both methods risk missing out vulnerable households, who may either be away from their home at the time of a visit, or fail to be informed of the meeting call. The best approach may be a flexible one adapting to local circumstances and where possible combining both approaches, dividing a team between a health workers stationed at a single site and others going door to door to visit households, and put out notice with community leaders.

Box 5.2 Nutrition Programme Coverage

Overall coverage of both OTP and SFP was well below the 50% target for rural areas are 70% for nutrition emergencies. One of the key challenges encountering in planning the coverage assessment and one that likely also impacts on coverage itself is that the coverage areas of individual sites are not well defined. Without clear catchments areas for each OTP/SFP site not only is it very difficult to carry-out a stratified coverage assessment but it also means identifying areas of poor geographic coverage is not possible. If staff connected to a particular OTP site do not know which villages they are responsible for covering then it is not surprising that outreach and community mobilization is inconsistent with some areas receiving no mobilization at all.

Following the introduction of HiNi programme coverage also needs to be assessed in terms of micronutrient supplementation (VAS, zinc and Iron), but monitoring of these has been challenging due to a lack of reporting tools. Efforts are being made to improve on this through planned training of the health workers on health information systems.

Source: Concern Worldwide (2010)

5.4 Coherence

This section considers how well the programme activities were coordinated with other stakeholders. In general the Concern programme seemed to be well coordinated and well received by both local and national partners.

Concern is effectively the lead provider of technical assistance in the nutrition sector in Kajiado County. Policy direction and leadership comes from the local government, with support from international agencies UNICEF and WFP. Concern plays a key role in supporting both the local government at a technical level, at local health facilities, as well as other local NGO health partners.

AIC were very positive about the role of Concern Worldwide in encouraging a coordinating role for MOH. Local NGO health providers such as AIC consult with the MOH on the areas which are underserved before expanding provision in any way.

Health centres had a somewhat more negative view of MOH coordination and participation and there were some worries about the sustainability of the programme when Concern Worldwide pulls out. This was specifically to do with the role that Concern Worldwide has played in as far as providing vehicles, fuel and staff lunch allowances for outreach programmes. Some health centres in Loitokitok, such as Kimana Health Centre, have started to fund their own outreach activities from their Health Sector Support Fund kitty which may ultimately be the best approach to sustaining

these activities, though existing funds are unlikely to be sufficient to provide the level of outreach necessary to provide complete service coverage.

Concern Worldwide has been coordinating the receipt of food from UNICEF and WFP in conjunction with NIA and the delivery of the food to the beneficiaries.

Concern has facilitated the establishment of District Nutrition Coordination Meetings in the two districts (Kajiado and Loitokitok) to harmonize nutrition activities. A monitoring committee to look at quality issues in the management of acute malnutrition, and the integration of IMAM services was established and meets fortnightly. As a result of Concern's active advocacy, IMAM has been included in both district Annual Operation Plans (AOP 7). Concern actively participates in the District Steering Group (DSG) meetings. The DSG is in charge of food security issues at the district level. Concern works closely with the other NGOs on the ground including Mercy USA, Christian Children Fund (CCF) and World Vision. Support to government clinics is well coordinated between Concern and Mercy USA with no overlap.

Joint supervision meetings of health care facilities by partners (MoH, Concern, UNICEF and WFP) were effective at monitoring health centre performance and ensuring that processes were embedded. Local partners (AIC, CDON, and NIA) provide regular monthly and quarterly activity reports to Concern.

Coordination with Mbirikani AIDs Clinic was challenging to begin with, stemming from different management, procurement and reporting and accountability structures. For example, they did not want to use WFP CSB and instead wanted to use their own Unimix. These issues are being resolved with Mbirikani aligning themselves with government systems.

5.5 Effectiveness

5.5.1 Impact of programme activities on objectives and results

Targets were met for number of sites and health care providers supported and trained in managing acute malnutrition while the target for the number of beneficiaries treated was significantly well over the target.

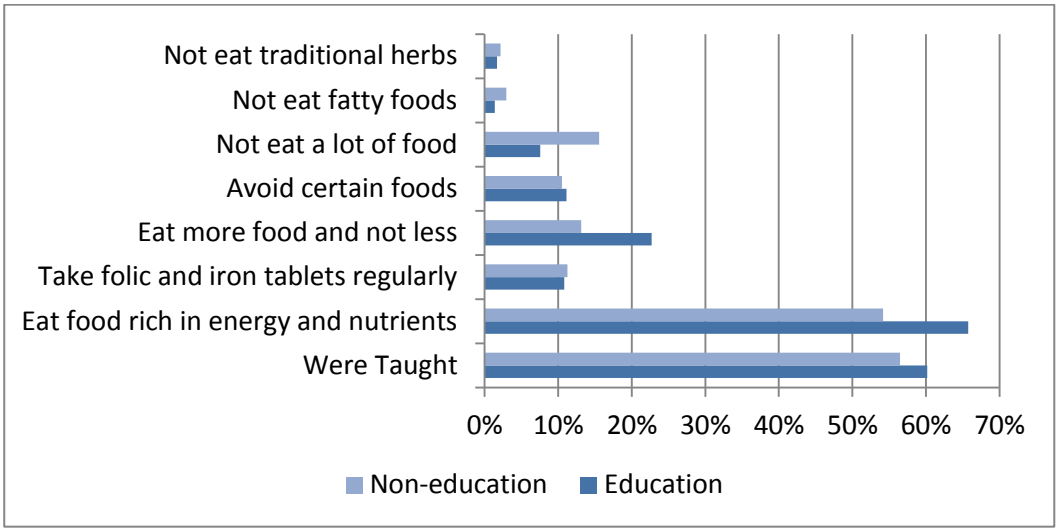
Outcomes for infant and young child feeding actually appear to be worse for education villages than no education villages, despite the substantial training of healthcare staff on IYCF

All of the targets for system strengthening have been met

Targets for the overall number of beneficiaries reached over the life of the programme were just narrowly missed.

The Concern Knowledge and Practice survey seems to suggest that there was only a very small impact of the nutrition education programme. The education group was twice as likely to know that they should eat more rather than less food during pregnancy compared to a control group, but it was still only 23% of people that knew this (see Figure 5.3). The education group was also slightly more likely to know that they should eat food rich in energy and nutrients during pregnancy. However, there seemed to be no difference in knowledge between the two groups about taking folic and iron tablets during pregnancy. Only 60% of the "education" group actually reported being taught anything.

Figure 5.3 Nutrition awareness/knowledge during pregnancy

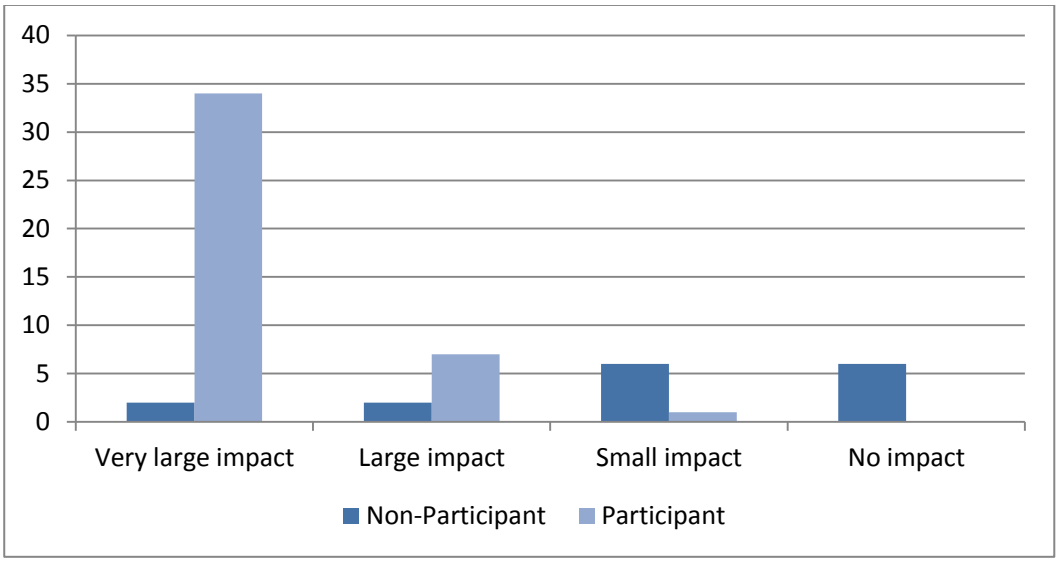


Source: Concern Knowledge and Practice Survey 2009/10

The nutrition education group was slightly more likely to seek out a health facility during illness (31%) than a control group (24%), but this was still only a small proportion of the total population.

Participants in focus groups also reported significant impacts of outreach and training on their knowledge and practices. The most common reported practices were exclusive breastfeeding, basic hygiene (hand washing) and deworming, with some knowledge of other supplements.

Figure 5.4 Reported impact of outreach or training on knowledge or practices

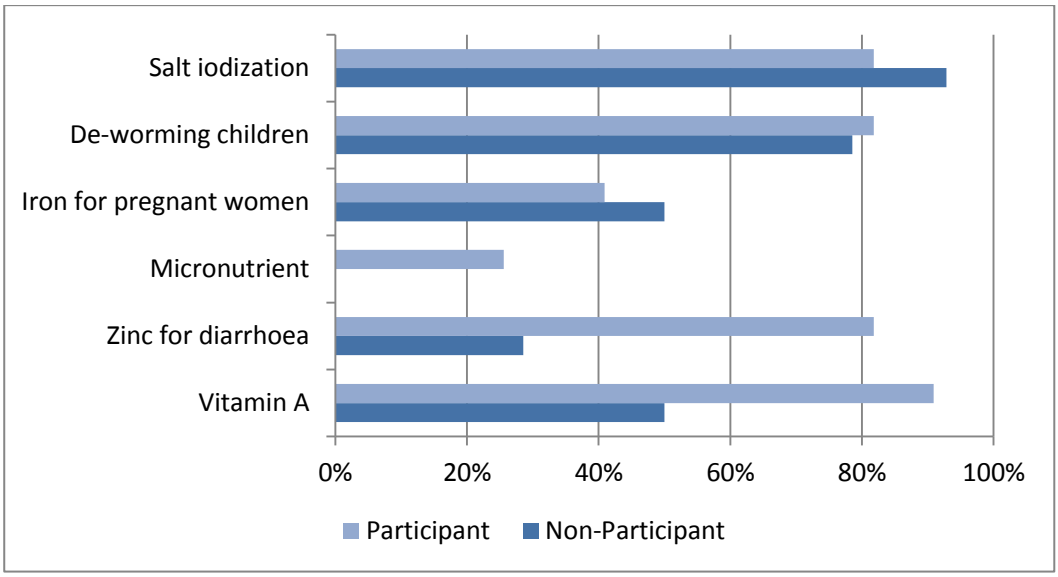


Source: OPM Focus Groups

Awareness of the importance of salt iodization and deworming was high amongst both programme participants and non-participants. Participants were more than twice as likely to use zinc supplements and Vitamin A supplements as non-participants, but non-participants seemed to be

more likely to use iron supplements for pregnant women and iodized salt, which overall does not inspire great confidence about the effectiveness of the nutritional education programme.

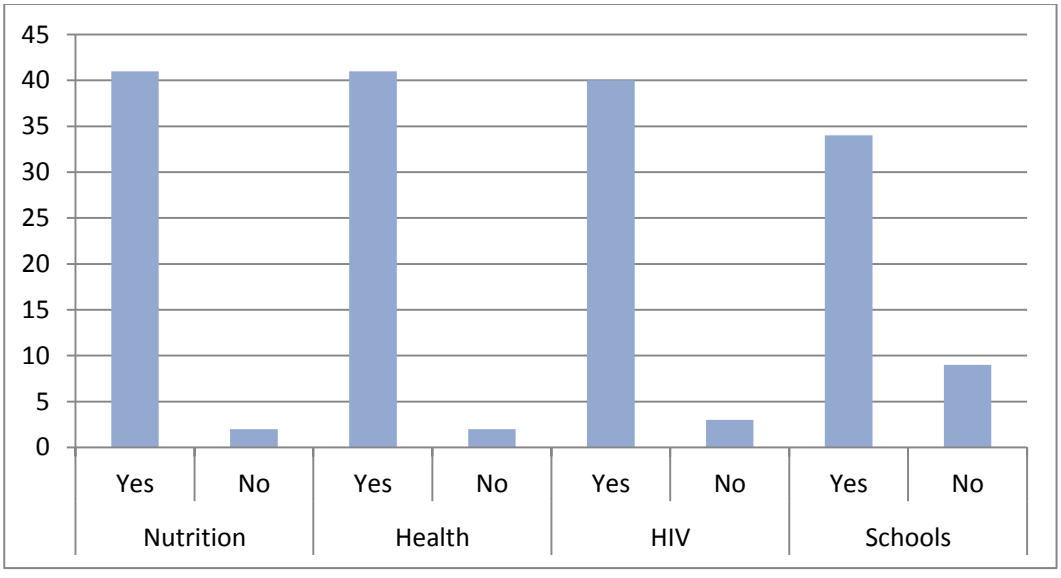
Figure 5.5 Use of nutritional supplements / interventions



Source: OPM Focus Groups

The majority of Concern programme participants did report that they had been informed of other available services by Concern or their partners (nutrition services, health services, HIV services, and schools).

Figure 5.6 Programme participants reporting referrals to services



Source: OPM Focus Groups

Overall outreaches did seem to be an effective way of reaching remote communities who would otherwise be too far from a health clinic to access any health and nutrition services, but the

nutrition education training does not seem to have been very effective. NIA staff did report that many training participants had followed up with them by telephone with some specific questions.

The impact of food treatment on child malnutrition seemed to be limited in some cases due to frequent sharing of food treatments amongst an entire family. This led to some high rates of relapse of malnourished children.

Scarcity of toilets and water is a key constraint to better hygiene practices.

A final challenge is the life span of therapeutic feeding products. One programme coordinator reported situations of receiving feeding products with only a few months validity remaining, which then expired before they could be used, and yet continued to pose a storage challenge as there are strict regulations for the disposal of expired food products. Further interrogation revealed that although the therapeutic feeding products were being distributed in a timely and efficient manner within the districts, the problem lay with the WFP general stores where the therapeutic feeding products lay once they had been produced. Sometimes, there was an apparent disconnect in in the national supply chain, from the main national stores to the district or regional stores. This delay in supplying led to products near their expiry dates being supplied to the district distribution points.

Training for health facility staff does seem to have had a positive impact on knowledge and practice, with all of the facilities we visited implementing the relatively recently adopted range of high impact nutrition interventions as standard and with malnutrition screening for all children they saw at the clinic.

A Knowledge, Attitude and Practice (KAP) survey conducted in March 2009 revealed harmful practices that could compromise the nutrition status of mothers. Sixty per cent of mothers restrict their diets during pregnancy because of fear of having a large baby and consequently a difficult delivery. Exclusive breastfeeding was low with 77.1% of children reported to have been given either fat or sugared water within the first day of delivery. Dietary diversity among children and mothers was also low with only 19% of respondents consuming four or more different food groups.

Concern focused on the scale up of nutrition services to High Impact Nutrition Interventions (HINI) in line with 2010/2011 nutrition sector plan and the Ministry of Health (MoH) strategy to reduce morbidity and mortality associated with acute malnutrition and its underlying causes. The aim was to continue strengthening the capacity of MoH staff enabling them to effectively manage acute malnutrition as part of health facilities' emergency response. Concern's role was also to provide intensive on-the-job training of health workers. It was envisaged that the trained and experienced MoH staff would take the lead in conducting on the job training for the rest of the programme duration and beyond. This was effectively achieved and the MoH staff feels confident about their capabilities.

Another key objective was to build in strong community linkages, in line with the national Integrated Management of Acute Malnutrition (IMAM) guidelines as well the integration of high impact nutrition interventions into the Primary Health Care (PHC) system. Concern achieved this through their coordination with community health workers and community health extension workers that were trained, and through connections with the local administration and community leaders. This was constrained by the limited number of active Community Units, leaving the program to work with CHWs who were normally based at health facilities and who conducted limited community outreach.

5.5.2 Understanding and acceptance of the programme by local communities

There was a high acceptance of Concern Worldwide's nutrition programme across the two districts where the programme was implemented. The district administrations were complimentary about the consultative process that Concern Worldwide and its partners used in assessing the needs of the community and engaging the major stakeholders. There was a high degree of acceptance and ownership of the programme by the MoH in Loitokitok district, but much weaker ownership in Kajiado Central. This partly reflected generally better motivated and more effective staff in Loitokitok than in Kajiado Central. There was no clear consensus on why this might be, but some of the reasons suggested were:

- Kajiado's more urban composition compared to Loitokitok and its proximity to Nairobi provided more distractions for the health care officials in Kajiado Town, and this affected their commitment to the work.

- Loitokitok's work culture that has been a product of its more agrarian environment as opposed to the more pastoral livelihood of Kajiado. This has created a more conducive work environment for all professionals.

- Loitokitok being a newer district curved out of the larger Kajiado district has had to be more competitive and efficient. The government departments in Loitokitok have therefore been more active, inclusive and productive compared to those in Kajiado district.

- Loitokitok has simply been blessed by better leaders who have run more effective systems.

Greater ownership of the Concern programme in Loitokitok was also clearly driven by the physical location of Concern staff within an office in the main district hospital, allowing for the development of much stronger relationships between the project and government staff.

Although there was high acceptance of the programme, there wasn't initially a universal understanding by the community about the inclusion and exclusion criteria. Food hand-outs appeared similar to what communities had received during previous droughts, the difference this time being that there were targeted beneficiaries (pregnant women and young children) rather than a general distribution of food. It was also initially difficult for some members of the community to understand the intricacies of the inclusion criteria. During the Focus Group Discussions, some beneficiaries felt that they had been included because they were 'lucky' and some non-beneficiaries thought their exclusion was politically motivated.

The health workers and the Concern staff have been aware of this misunderstanding and are working hand in hand with the community health workers to resolve this. They have been educating the community on the inclusion and exclusion criteria (a focus on pregnant women and malnourished children, as measured by mid upper arm circumference), and the reasons for focusing on this target group.

5.5.3 Anticipation of constraints

Concern Worldwide, through the various surveys and initial stakeholder surveys, anticipated some of the cultural and social barriers to the successful implementation of their nutrition programme. By working with and through the community with the help of community health workers, there has been an understanding of these social and cultural barriers. Concern Worldwide's nutrition programme has recognized these constraints but the issue has been the speed, efficiency and prioritization of their responses. For example, it has been widely acknowledged by field staff that sharing food, especially in times of need, is a basic tenet of Maasai culture. The guardians of

children beneficiaries have been known to share the food supplies they receive amongst the children in their homesteads. This inevitably reduces the speed and rate of recovery of the intended beneficiaries because they do not receive as much food as they should. In spite of Concern Worldwide's recognition of this, there seems to be a certain ambivalence and resignation to this amongst the community health workers. It must be admitted, nonetheless, that efforts have been there by Concern Worldwide staff to educate the programme beneficiaries about the impact of sharing their food, which is clearly detrimental to vulnerable children suffering from acute malnutrition.

The nutrition programme did not anticipate that an increase in their coverage and the integration of other health components would lead to a high demand for services like family planning and HIV/AIDS education and services. Concern Worldwide responded well and in a timely manner to the logistical and cultural constraints these demands placed on them and went ahead to incorporating other services during field outreach visits as far as feasible.

Concern Worldwide anticipated the geographical and logistical challenges of implementing the nutrition programme in Kajiado and Loitokitok districts, which are primarily related to distance and sparse population. In spite of these challenges, Concern Worldwide has covered a wide geographical area with good coordination and facilitation from the staff and between the various stakeholders.

5.5.4 Response to unforeseen events and impacts on objectives and results

All activities were carried out with the involvement of the community and community-based organizations that know about the area. This increased the credibility, acceptance and appropriateness of the programme.

The beneficiaries and the guardians of the child beneficiaries of the programme were expected to be women. It was not anticipated that men would attend some of the health education sessions or the outreach programmes but, when they did, the programme staff adapted their messages and activities well to accommodate the men.

There was flexibility in the rolling out of outreach services. Within limited budgetary allocation, the number of sites was revised upwards to prevent a deterioration of the nutrition situation during the August-September period 2012.

In responding to the high staff turnover, the programme set aside some funds for training newly deployed staff to ensure consistency in capacity

5.5.5 Monitoring systems

Following the adoption of the HiNi approach, monitoring within the MoH systems was not sufficient to adequately monitor a number of the components due to a lack of appropriate monitoring tools and technical understanding of reporting some of the components. Lobbying at the national level by Concern is ongoing to have the current Health Information System updated to take these indicators into account.

Concern provides technical guidance, transport, and lunch allowance to the DHMT to conduct monthly joint support supervision across all the facilities. Support was also provided to the DNOs in convening the monthly coordination meetings.

Concern received regular monthly reports from local partners laying out their progress against planned activities and results achieved.

Concern has played a crucial role in filling a reporting gap for government health centres. Data on nutrition status indicators and anthropometrics is not currently captured in the national health information system and official forms, although policy is moving in the direction. In the interim Concern has provided clinics with supplementary forms for the collection of information on nutrition, which is collated by the district ministry of health.

Concern supported surveys, such as the Knowledge and Practice Survey and the NIA food security survey, are key sources of information on Kajiado County. The design and analysis of the Knowledge and Practice survey could have been tweaked at relatively low cost to constitute a cutting edge academically rigorous impact evaluation. The follow-up survey included both participants and non-participants. To rigorously demonstrate impact, it would have been preferable to include a statistically matched comparison non participant group in the baseline survey as well. This would have allowed for more robust causal attribution which the current survey does not strictly permit.

5.5.6 Impact on livelihoods

As an emergency nutrition-focused programme, improving livelihoods was not the primary goal of the programme, and we did not find any demonstrated impact on livelihoods. We can though expect there to be positive impacts on the lifetime earnings of children treated for malnutrition. Evidence from a deworming programme evaluation in Western Kenya found an increase in earnings 10 years on for children who were dewormed in school. There is considerable evidence that child malnutrition impairs cognitive development, which can be expected to reduce future productivity.

Concern's ambitions to supplement nutrition programs with livelihoods programs are well placed given the clear problem of low income leading to inadequate quantity of food available to households.

5.5.7 Targeting process

The targeting process seemed to be good. The selection of children to receive therapeutic feeding is based on a simple transparent measure (mid upper arm circumference). The focus group participants that we spoke to generally agreed that the process had been fair. The outreach programmes supported by Concern and partners NIA and AIC, targeted the areas furthest from clinics. Outreaches also attempted to target the poorest communities, but we were not able to come to an assessment of this claim. It did seem that the participants we spoke with were worse nourished than non-participants in focus groups.

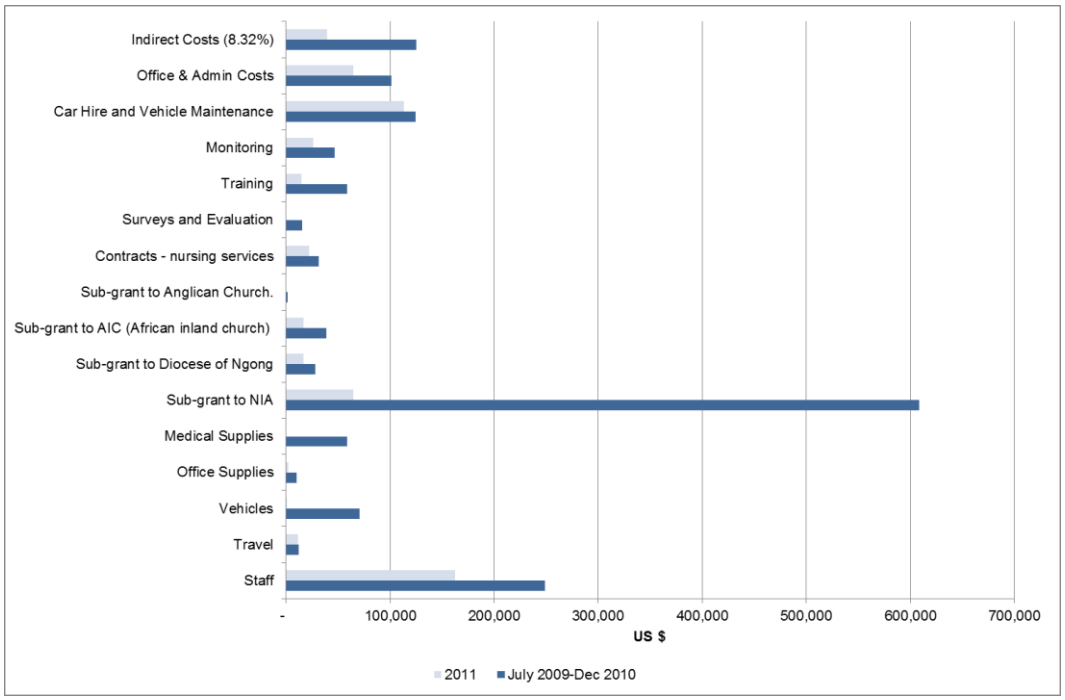
5.6 Efficiency

Given that the package of high impact nutrition interventions is so demonstrably cost effective, any questions around the cost efficiency of the Concern programme are around implementation, and the effectiveness of behaviour change strategy.

Whilst the programme began as a "vertical" programme focused just on providing nutritional supplements and therapeutic food, it quickly moved towards integrating nutritional interventions with broader health services. This was partly driven by cost efficiency considerations. Once a set of outreaches had been arranged to remote locations it makes sense to deliver as comprehensive a package of services as possible rather than requiring repeated visits to the same locations to deliver different services. Same efforts were also directed to the facilities.

The programme generally seemed to have been delivered at reasonable costs, focusing on essential inputs and leveraging partnerships effectively with other providers of inputs such as WFP and UNICEF. Figure 5.7 shows a breakdown of the project budget between July 2009 and December 2010. The largest single item was a sub-grant to NIA in 2009-2010 of over $600,000, followed by spending on project staff and vehicles. The total budget was $1.6 million in 2009-2010 and $0.5 million in 2011. Given the weak evidence of impact of the nutrition education component, greater spending on support to health service delivery or livelihoods might have been more cost effective.

Figure 5.7 Project Budget Breakdown



It may have been more efficient to integrate nutrition education and service provision through a single provider rather than dividing this function between the two local partners NIA and AIC. Though there may be an argument for specialization, the distances between villages and low population densities in Kajiado and Loitokitok imply that it makes more sense to have a single provider with as many services as possible. It did not seem to make much sense to send NIA staff from Kajiado Town all the way to the border with Tanzania to deliver nutrition education in Loitokitok which could conceivably have been implemented by CDoN or AIC.

5.7 Sustainability, Phasing out, and exit strategy

Although this programme was primarily an emergency response, it was broadly successful in supporting local government health services to integrate nutritional interventions along with the rest of their services, in line with the new government of Kenya strategy. Local officials felt that, although integration of nutrition interventions is part of the government's strategy, its implementation would not have been as successful without the involvement of Concern Worldwide. Provision of nutritional services at clinics seems likely to continue. Local health workers were positive about the capacity-building components of the programme.

There were lots of worries about what would happen to the outreach programme following the withdrawal of Concern support for logistics. This is clearly a service which should be funded and run by the local Ministry of Health, but for which funding is insufficient.

Concern obligation for the running of outreaches was handed over to MoH from April. It was clear that MoH had no capacity to run the outreaches and it was suggested that the sites be linked to the general food distribution (GFD) so that SFP/OTP beneficiaries are targeted. For ongoing 2012 programming, it will be important that MoH capacity to run the outreaches without Concern support is assessed.

A Concern assessment in 2011 of local government progress in implementing the Community Strategy was hampered by key challenges including

- Lack of transportation and lunches for the outreaches
- Lack of lunches/logistics for DHMT supervision- there is no proper budget in this line as per the guidelines.
- No CBHIS tools- she requested for retooling of the DHMT, CHEWS (2 days training) and 1 week training for the CHWs. An external facilitator required for this.
- No proper CHWs kit provided
- No bicycles for CHWs- GAVI have just delivered some bicycles.

The following gaps are therefore likely to happen after phasing out of the programme: lack of frequent supervision due to logistical issues, quality and frequency of outreach services is likely to deteriorate, increased work load in the facility as a result of reduced number of outreach, and a reduction in coverage levels.

Government ownership was stronger in Loitokitok than Kajiado. This seemed to be due primarily to better leadership in Loitokitok. Capacity building by Concern was enhanced significantly by the physical location of Concern within the district hospital in Loitokitok. This approach should be adopted wherever possible for future projects with significant capacity building components. Conversely, given the same level of need, Concern Worldwide should initially roll out programs in areas with comparatively efficient and motivated government, health and local personnel. This would maximize capacity development returns.

Government staff turnover is a major problem, particularly in Kajiado. Ministry staff suggested that training may actually exacerbate the problem by making employees better skilled and more able to obtain better paying jobs elsewhere. There does not appear to be an easy solution to this conundrum besides wider civil service reform, which may be outside the scope of Concern to address.

Supplements are cheap and easily affordable from within government budgets. Supplementary feeding supplies are more expensive and more of a challenge.

Additional support to MoH for conducting surveys/research could be useful. Staff in Kajiado raised this specifically as a recommendation for Concern Worldwide, that though they may have been involved in some capacity in undertaking surveys, they would appreciate greater training on data collection.

6 Recommendations

This section considers how the programme could be improved to better support vulnerable households improve their food and nutrition security, in line with Concern policies and strategies.

6.1 Integrating Livelihoods with Nutrition

Concern's goal of integrating livelihoods with nutrition programmes in the future is based on a good understanding of the drivers of malnutrition. Kajiado does seem to be a place in which the sheer quantity of access to food is an important determinant of malnutrition. Complementary nutritional interventions will continue to be required, but not sufficient to prevent malnutrition without an increase in incomes and food security. It is not however clear which livelihoods strategies are likely to be the most effective.

The predominant livelihood in Kajiado are cattle, and this livelihood is being overwhelmed by increasingly frequent drought driven by climate change, and may not be sustainable in the long term. It is furthermore unlikely that significant other livelihoods will emerge in these low-density poor geographic regions. Economists at the World Bank have argued that "The future welfare for people in these communities is likely to be driven largely by migration to areas of economic concentration. The top priority for government investment and migrant remittances should be ensuring basic education and health care for children in arid areas" (Demombynes and Kiringai, World Bank 2011). There also needs to be support for other labour-constrained individuals, such as the disabled and the elderly. The welfare of the elderly was raised repeatedly by focus group participants. Not factoring in the elderly and disabled could lead to the worsening of household food insecurity as evidenced in the causal framework referenced in figure 5.1 above. Social protection systems have been shown to be very effective at supporting incomes and nutrition in Kenya and elsewhere.

A useful way forward would be to assess the evidence-base for livelihoods interventions and consider conducting some formal experiments with livelihoods policy in order to better understand what works. There is a very strong evidence-base underpinning nutritional interventions and social protection, which is not currently matched for livelihoods interventions.

Concern's approach to livelihoods for nutrition in Moyale, Northern Kenya[12] seems to have been successful, seeing lower rates of malnutrition than neighbouring areas, but further evaluation would help to strengthen the case for these solutions. Strategies included encouraging pastoralists to switch to drought-resistant livestock (e.g. from cows to camels), improved rangeland management, and increasing water availability through rainwater harvesting.

6.2 Livelihoods as Social Protection

Providing cash safety nets allows households to adequately feed their families whilst exploring for themselves what their best livelihoods opportunities are. There is evidence that cash transfers can improve nutritional outcomes, though they are not sufficient without other nutritional interventions.

[12] Erasmus, W., Mpoke, L., and Yishak, Y., (2012) Mitigating the impact of drought in Moyale District, Northern Kenya, Humanitarian Exchange, Number 53 February 2012

> "Evidence from humanitarian evaluations makes a strong case that cash transfers often improve dietary intake. There is less evidence that cash transfers improve caring practices and almost no evidence for or against their impact on disease" (Bailey and Hedlund 2012).

Cash transfers could address the common issue of "sharing" of supplementary feeding between a whole household by reducing household food insecurity and income poverty, which are underlying causes for malnutrition. Further detailed analysis needs to be done to see if Concern Worldwide should explicitly explore cash transfers. They could be targeted towards families that do not reach a specified income and whose children do not pass some pre-determined anthropometric measurements. The cash transfers would be conditional on the fulfilment of criteria like registered attendance of nutrition education sessions. These cash transfer programmes would have to correspond with or enhance current government livelihood programmes and other donor provision, such as WFP general food distributions.

Market access is a challenge for the provision of cash but markets do exist, and households already rely on markets for food consumption, as they primarily sell livestock in order to purchase grains. "A growing body of evidence shows that safety nets are an important complement to efforts to improve the livelihoods of the poor, particularly in areas that remain vulnerable to shocks such as drought. Reliable access to safety net support allows households to take on more investment risk and thus produce higher returns" (Demombynes and Kiringai, World Bank 2011).

6.3 Other Strategic Issues

Male involvement in nutrition is key. As they are frequently household heads and decision-makers it is crucial to engage men in health and nutrition education. Men can be useful as 'good nutrition' change agents in the communities.

Women empowerment: Maasai society is patriarchal in nature and some program participants reported having had difficulties getting permission to attend outreach programs and receiving nutrition education. Early motherhood, forced marriages and relatively poor education levels amongst women contributed to the underlying causes of malnutrition. Introduction of measures to improve the social, economic and political levels of Maasai women would increase their potential. The underlying causes of malnutrition, based on the causal framework in figure 5.1, clearly show that the approaches should be systemic. Further analysis needs to be done to see how this can be explored.

Advocacy: Staff annual performance agreements and reviews at district MoH and health centres could be linked to nutrition indicators.

6.4 Operational

The physical presence of Concern Worldwide staff at the district hospital in Loitokitok clearly contributed to positive outcomes, both in terms of effective coordination and capacity building. This is a model which should be pursued as far as possible in other Concern programmes.

Donating current programme vehicles to local partners at the end of the programme may help with the continuation of outreach activities.

A further constraint to sustainability seemed to be the seemingly minor issue of lunch allowances for outreach teams. Future programmes should pay attention to working with local partners to ensure adequate funding can be put in place for essential logistical arrangements for the

continuation of service delivery. Each health facility currently receives approximately Ksh 27 000 per quarter through the Health Sector Support Fund kitty of the health centers.

M-Pesa has been used very effectively for cash transfers in urban Kenya, and it could be worth exploring the possibility of using M-Pesa for payments for CHWs and health workers to reduce costs. Limited network coverage is a constraint, but where coverage is available transferring cash via M-Pesa could save significantly on transport costs.

In the last SMART survey of 2011, there were 2 District Nutrition Officers, 1 District Public Health Officer and 1 officer from the District statistics office who participated as supervisors during data collection. For purposes of capacity building and ownership, government staff should always be closely involved in the conduct of surveys and data analysis where possible.

The sourcing of RUTF (ready to use therapeutic food) should be made from local production wherever possible. Locally produced generic RUTF are likely to be cheaper than the costlier Plumpy Nut (imported from France), have a positive impact on the local Kenyan economy and employment, and also reduce the time taken to get supplies to rural areas (and therefore increasing their shelf-life). Quality control has to be established to ensure no sub-standard products are produced. Recently Nutriset (the French company which produces Plumpy Nut) has allowed permission for local production of Plumpy Nut after an agreement for sharing of profit, which may be worth exploring.

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Annex A Terms of reference

Background

Kajiado County is located at the southern tip of the former rift valley province. It borders Tanzania to the south west, the County of Taita Taveta (to the south East) Machakos County (to the East), Nairobi County (to the North East), Kiambu County (to the North) and Narok County (to the west). The landscape consists of plains and some volcanic hills and valleys. Following years of drought, the region is very dry, with no continually flowing rivers and is officially designated as semiarid and covers an area of 21, 903km2. The annual rain which ranges between 500-1250 mm is poorly distributed in amounts and space. Kajiado experiences a bimodal rainfall pattern; two rain seasons with the short rains between October and December and long rains between March and May. In recent years there have been long periods of drought when there have been little or no rains to support a predominantly pastoralist and marginal agro population.

The population, according to 2009 census, was 687,312 (Kajiado Central and Loitokitok Districts population is 297,774. The indigenous people of the area are Maasai but there is an increasing influx of people from other tribal groups which is, consequently, increasing pressure on land in urban and peri-urban parts of region. This influx has compounded the effects of many years of drought, thereby making life extremely challenging for the Maasai pastoralists who make up the majority of the population.

Dramatic decrease of livestock-main livelihood of the community-following the drought of 2009 where it is estimated that 80 -90% of livestock died, has greatly compromised household food security. This has, over time, significantly contributed to the current high levels of malnutrition among children under 5 years, pregnant & lactating women. Coupled with low purchasing power due to diminished incomes and high food prices, 8.6 % of children under-five years are at risk of dying from malnutrition according to nutrition survey conducted in April 2011 compared to a prevalence of 11.5 % in 2009.

Food security has continued to deteriorate for most households; grazing areas have dried up or are rapidly being depleted following the predicted la Nina phenomena that saw October November and December 2010 rains perform poorly followed by failure of 2011 rains from March to May .The pastoralists have moved their remaining livestock herds in search of pasture over great distances. The Neighbourhood Initiative Alliance, Concern's partner NGO in Kajiado has been involved in the implementation of livelihood and water related interventions in the region.

Located in the Arid and Semi-Arid Lands (ASALs), pastoralism dominates in both areas with some agro-pastoralist areas in Kajiado and some distinct agrarian areas in Loitokitok; agricultural produce from these areas in Loitokitok also supplies markets in Kajiado district. The area is predominantly inhabited by the Maasai but changes in the traditional land tenure system (shift from communal to individual and increase in privatization) has seen most of the locals sale their land, especially in urban and peri-urban areas. This implies a threat to the traditional communal grazing arrangement that enabled livestock to be moved around flexibly to good grazing areas. Due to the loss of communal land and thus grazing opportunities for the livestock, the Maasai are, progressively, compelled to take up other unfamiliar income earning/ livelihoods activities to sustain their families while, reluctantly, giving pastoralism. Major challenges in the districts besides the recurring drought that impacts on livestock levels and thus livestock prices and livelihoods

capacities include the shift in income earning activities, for instance, to charcoal making, which has further contributed to another major challenge, deforestation; deforestation in turn is closely related to the water holding capacity of the area, which yet again aggravates the drought. Changing livelihoods pattern also forces the population to migrate – Nairobi is very near – thus increasing pressure further on urban settlements.
Challenges from a health and nutrition point of view include an insufficiently decentralized health system lacking in capacity with fairly poor coverage due to vast distances for effective delivery of healthcare services; high child morbidity; high prevalence of child malnutrition and poor infant feeding practices.

Current implementation/intervention

In response to the 2009 drought, Concern Worldwide has implemented a *cross-sectoral emergency response* in Kajiado and Loitokitok Districts, with funding by the Office of the U.S. Foreign Disaster Assistance (OFDA). The emergency response that started in 2009 is planned to end in 2011 and in preparation for an intervention that focuses and prioritizes sustainability and resilience in the implementation design while addressing emergency needs. The emergency nutrition intervention of the response component adopted the IMAM approach between 2009 July and 2010 period and followed by the High Impact Nutrition Interventions (HiNi) approach in 2011. The former approach focused on four sub-sectors; treating severe acutely malnourished children for 1) the management of moderate acute malnutrition and 2) the management of severe acute malnutrition; 3) nutrition education; and 4) strengthening of nutrition systems while the later has prioritized MoH recommended interventions;

1. Promotion of Good Practices
    - Breast feeding
    - Complementary feeding
    - Hand washing
2. Increasing Intake of vitamins and minerals – Provision of micronutrients for Young Children
    - VAS
    - Zinc supplementation
    - Multiple-micronutrients
    - De-worming for children
    - Iron-folic for pregnant mothers
    - Iron fortification of staple foods
3. Therapeutic feeding for severely malnourished children
    - Prevention or treatment for moderate under nutrition
    - Treatment of severe acute malnutrition

Nutrition and health education intervention component: According to a baseline KAP survey carried out in November 2009, of which one of its objectives was to establish the levels of knowledge and practices and inform on attitudes towards certain practices and issues with regard to child health and maternal nutrition, it was apparent that there was need for proper health and nutrition education to be offered to the community. Among other findings, the results showed that maternal dietary restrictions during pregnancy were different and stricter than those during lactation as there existed a widespread belief that women should restrict their food intake during pregnancy so that their baby would not grow thereby minimising difficulties and complications during delivery- a harmful practice to the baby right from the neonatal stage. This causal practices to malnutrition led to implementation of a nutritional education intervention that has reached 103 villages in the 2 districts.

The intervention has been implemented in a partnership with Neighbours Initiative Alliance (NIA) for the health and nutrition education and the MoH, African Inland Church (AIC), Catholic Diocese

of Ngong and Africa Infectious Disease clinic (Mbirikani Aids Village clinic) with the Ministry of Health taking lead. In addition, collaboration was forged with UNICEF, WFP and local administration and community leadership.

Programme evaluations/surveys conducted

Since the start of the programme in July 2009 the following evaluations/Surveys have been conducted;

1. SMART survey: 2009 and April 2011
2. Knowledge , Attitude and Practices (KAP): 2009 and 2010
3. Coverage Survey: November, 2010. One planned for October 2011

Reasons and Users of the Evaluation

This end term evaluation is part of a strategy aiming at strengthening Concern's responses to emergencies that prioritizes resilience and sustainability as well as enhancing communication and transparency towards various partners about Concern' s performance and approaches in the programme area since July 2009.

Specific Objectives

- To evaluate the results of the programme in an independent and structured manner, in assessing relevance, coverage, coherence, efficiency, effectiveness and sustainability on how the proposed results were achieved.
- To evaluate the capacity of baseline and other assessments carried out and project design processes in addressing the immediate and underlying causes of malnutrition in the target population. Was the intervention response evidence based?
- Evaluate the performance, relevance and effectiveness of Concern partnership with CDoN, AIC, Mbirikani, MOH and NIA
- Evaluate the evolution of the programme process, strategies/ approaches from the initial start-up in 2009 to end of 2011
- To provide recommendations for the overall strategy that will improve quality of subsequent projects and inform the planned integration of nutrition and Livelihood programme interventions in achieving resilience and sustainability goals.

Scope and Focus of the evaluation

Major Factors to be taken into account

-The project is implemented across 2 districts with differently functioning MoH systems and possibly varying levels of vulnerability of the target population owing to distinct livelihood zones.

-As of January 2011, there were 85 outreach sites which were reduced to only 24 by end of first half of the year.

-Two different approaches have been adopted during the 2009-2011 period; IMAM in 2009-2010 and High Impact Interventions in 2011

Detailing of the Evaluation Criteria

Relevance

The evaluator should assess the appropriateness of the objective and results pursued by the programme in relation to the identified needs.

- Was the analysis of needs adequate (methodology, findings, conclusion and recommendations)?
- Was the involvement of beneficiaries ensured in the design phase?
- Did this analysis lead to the elaboration of adequate objectives in relation to the needs identified?
- Were the correct assumptions made in the original problem analysis?
- How does the intervention relate to problems identifies by local stakeholders?
- Were the views of all stakeholders, and particularly women, elderly, marginalized, and other vulnerable groups, represented in the planning process?
- Is the intervention compatible and reflective of Concern policies, approaches and guidelines e.g. Sphere standards and gender guidelines?
- Were there unexpected outputs from the intervention?
- How effective was the issue of mainstreaming addressed?

Coverage

The evaluator should assess the coverage of the programme in relation to the identified needs.

- Is an adequate percentage of the needs covered?
- Were the worst-affected groups correctly identified?
- Was there appropriate geographical coverage?
- Was there fair targeting of beneficiaries?

Coherence

The evaluator should assess the adequacy of the activities that were implemented in relation to the objectives and results pursued by the programme.

- Did the activities have a direct relationship with the objective and results pursued? Were the activities adequately coordinated with other humanitarian actors/stakeholders?

Monitoring

- Did the communities understand, accept and welcome Concern's/MOH programme?

Effectiveness

- The evaluator should assess the adequacy of the results that were reached in relation to the objective and results that were pursued by the program as set out in the original project/programme document.

- Has the programme reached the intended results and specific objective? If not, what are the justifications provided for the risk of non-achievement? What hampered the achievement of the target? Does the organization anticipate the constraints that are met? Does the organization react adequately to unforeseen events in order to re-adjust/ adapt

the programme and ensure the achievement or the readjustment of the objective and results pursued by the programme?

- Were the monitoring systems adequate? If no, how can the systems be strengthened in order to measure impact more effectively in the coming years?

- Is there a demonstrated impact of the intervention on the livelihoods of the targeted beneficiaries and other stakeholders?

Efficiency

The evaluator should assess the cost-efficiency of the program, per se and through a comparison with similar programmes in the area.

- Was the programme cost-effective? Were the inputs, costs and budgets adequate?
- Were the costs reasonable in relation to the achievements or could this have been realized more cost effectively?
- Did the intervention receive sufficient support from the Programme Support Unit at Nairobi and field levels?
- Is the internal coordination and communication efficient?

Sustainability, Phasing Out and Exit Strategy:

Though this was an emergency response, the evaluator should assess whether or not the intervention could "durably" improve reduction of malnutrition risk within the targeted population.

- Was there a reasonable focus on the preventive component of malnutrition?
- With reference to Ministry of Health as the lead partner, the evaluator should look at the programme's capacity-building components, local ownership aspects, and financial sustainability aspects.
- In engaging the partners, did the intervention adequately build local capacity
- Are there any capacity gaps that require further support?

Concern worldwide policies and guidelines:

To understand how the following cross-cutting issues have been taken into account at all stages of programme implementation so far:

- Disaster risk reduction and Preparedness;
- HIV/AIDs mainstreaming
- Gender and other aspects of equality;
- Participation of the beneficiaries.

Methodology

The evaluation will be integrated through three main activities:

<u>Briefings/ preparation</u>

- Reviewing of the project documents (proposal, reports, monitoring reports, surveys, assessments, national policy documents, etc.)

- Meeting (physical if possible or by teleconference) with staff and partners

Field activities

For data collection, 3 levels shall be used:

Direct information:

- Visit to project sites
- Interviews with beneficiaries
- Interviews with project staff(both Concern and partners)

Indirect information:

- Interviews with local representatives; Interviews with project staff, meeting with local authorities (local administration), groups of beneficiaries, Other stakeholders/agencies, donor representatives, or any other relevant stakeholder

- For data collection, standard and participatory evaluation methods are expected to be used (PRA / HH interviews and FGDs with beneficiaries, non-beneficiaries, key informants – health workers).

- Secondary information analysis: e.g. information about the organization of the project – general coordination, communication, how capitalization is being organized, etc…

To have a clear picture of the context and past intervention in the area the consultants should devote the beginning of the mission to discuss with select members of the District Steering Group and stakeholders on different activities occurring in the region.

Elaboration of the final report and recommendations

The report shall follow a format as agreed up between the consultant and Concern

The date for submission of the final draft report by the evaluator to Concern is no later than 3 weeks on completion of field activities are completed.

When the first draft of the report is completed, a presentation of the findings followed by discussion will be made at the field and Nairobi level or as shall be advised

Rights

The ownership of the draft and final document belong to Concern and the funding donor exclusively. The document, or any publication related to it will not be shared with anybody except Concern.

Concern is to be the main addressee of the evaluation, and its results might impact both operational and technical strategies. This being said, Concern is likely to share the results of the evaluation with the following groups:

- Donor(s)

- MOH and other partners
- Various co-ordination bodies and other stakeholders/agencies

Sources and Documentation

The following documentation will be available from Concern:

- Project proposal
- Budget
- Contract
- Interim report(s): Monthly and quarterly for Concern and partners
- Reports of all surveys conducted
- Data base holding various programme data
- Other relevant MOH and Concern technical/operational

Reporting and Feedback

Responsibilities and lines of communication

The National Nutrition Coordinator, Concern Kenya, who is responsible for the nutrition programme, is accountable for the coordination of the delivery of quality evaluation of the Kajiado nutrition project. The coordinator shall be supported by Project Manager and entire nutrition team in the field responsible for day to day management. MoH and other implementing partners will provide assistance where needed in this evaluation.

The consultant will be responsible for the overall co-ordination of the evaluation and the report in terms of content and presentation. Concern will be responsible for the coordination of the financial and logistics aspects of the evaluation.

Annex B Research Tools

B.1 Focus Group Discussion guides

Focus group questions

Introduce yourselves with your name and where you are from

My name is _____ from RGA. *Show the letter of introduction if this seems appropriate.*

Explain why we are doing these discussions

I work for a research organisation (RGA/Oxford Policy Management) and we are not part of the NGOs or the programme in any way. We are working with Concern Worldwide to ask some questions about the functioning of nutrition outreach and education programmes in Kajiado County. We are totally separate from Concern. Are you all aware of this programme? We are trying to find out the views of those who have benefited from nutrition and health services on the operation and the impact of the programme. We are doing this to understand what was good and what was bad about the programme. I would like to emphasise again that although we are working with Concern, we are independent of them. So please feel free to be totally honest.

Please understand that you will not benefit from talking to us – we will not provide any benefit and are not registering people for a programme. You will suffer no penalty from not talking to us. If you would like to leave, please feel free. Are you happy to stay on this basis?

Explain what we would like to do

We would like to ask your views on a range of subjects and would like to hear all of your opinions. Sometimes we will ask you to discuss amongst yourselves and agree on some things, but you should feel free to say if you disagree with someone else.

I will ask the questions and what we would like you to explain to us, and my colleague will write down the discussion and your opinions.

We would also like to record our discussion if you give us permission and are all happy for us to do so. This will help us accurately remember what you said, but we can stop recording at any time if anyone wants us to.

Explain about confidentiality

Your personal contributions and views will not be shared with anyone outside this group. We will explain to Concern what people in this and other groups think in a report but we will not mention any names.

Ask if there are any questions before starting

Do you have any questions you would like to ask us before we start? Feel free to ask anything later in the discussion too.

Introductory questions

1. Can I check that you all received the health or nutrition services, education, or training through either the Ministry of Health, Catholic Diocese of Ngong, Africa Inland Church, Neighourhood Initiative Alliance, or Concern Worldwide? Has anyone been referred to a service through the community health worker? Have you received any other associated services from Concern or their partners?
2. What did you learn from the training?
3. Have you changed your behaviour as a result of the training programme?

Prompt for Knowledge of the 11 Elements of the High-Impact Nutrition Interventions Package

The HINI package will particularly target children below five years old as well as pregnant and lactating mothers, and will include the following:

Behaviour Change

1) Support and promote exclusive breast feeding until the age of 6 months
2) Support and promote adequate complementary feeding from the age of six months
3) Improved hygiene practices, including hand washing

Preventative

4) Twice yearly Vitamin A Supplementation
5) Therapeutic zinc supplementation for diarrhoea management
6) Multiple micronutrient fortification
7) Iron-folate supplements for pregnant women
8) De-worming for children
9) Salt iodization

Treatment

10) Prevention of acute malnutrition
11) Management of acute malnutrition (moderate and severe)

Involvement in programme design

4. Were you consulted by the government or any NGO about what kind of training you thought you needed?
5. Were you consulted about the kind of nutrition services to be provided?
6. Do you think there is sufficient consultation with the community about the kind of services to be delivered? How could government and NGOs do a better job of listening to the community?

Food security

I'd like to discuss household food consumption:

7. In a normal healthy daily diet here, how many meals would this be? What would be the content of each meal? Why is this healthy?
8. Why do people not eat this healthy diet normally?
9. Do people in this community ever miss these meals? Sometimes, often, or never? Who? Why?

Malnutrition

I'd like to discuss malnutrition, its causes and responses to it in this area.

10. Are there many children suffering from malnutrition here?
11. Why is this?
12. What causes malnutrition in this area?
13. What is the most effective way to address malnutrition?
14. Why?
15. Why haven't organisations or people done this?

Access to services

16. What are the main government and non-government services in 1) nutrition for severely malnourished children, 2) health, 3) care and support for people living with HIV and AIDS including children, and 4) existing schools with subsidized programmes for poor and vulnerable children that people around here use? Please list all.
17. Are there any services that you have heard of and want to use but do not use? What are these? Why do you want to use them?
18. What are the main barriers to accessing these services here? Please give all reasons.
19. How can these barriers be overcome?
20. *If there are no mentions of services in those categories above, please ask:* if you knew about services available in these categories, would you use them? If not, why not?
21. How does the referral service by the community health workers help?
22. How could it be improved?
23. Is this the best way to improve access to services? If not, what is?

Targeting

I'd like to ask about the process by which people are selected for outreach services and health education programmes.

24. What do you know about the process of selection?
25. Do you think going house-to-house is an effective way to select people?
26. Why? Why not?
27. Do you think the staff implemented the targeting effectively? Did they visit each house? Were any areas missed out? Were any houses missed out? Why was this?

28. Who are the 'poorest of the poor' in this village? What are their characteristics? *Prompt for: low income, being on programmes, family size, child-headed, having AIDS or terminal illness, elderly, single mothers, orphans.*
29. Where do the poorest in this village live? Do they all live in the same place? Why?
30. Is there a particular tribe that is particularly badly off? Which? Why?
31. Is there any particular religious group that is particularly badly off? What? Why?
32. Are people who have recently arrived particularly badly off? Why?
33. Would you consider yourself amongst the poorest in this village? Why?
34. Do you think there are poorer individuals or households in this village than yourselves?

Livelihoods

35. In this community, please list all the types of jobs that people do. I'd like to know all the things people do to make money. *Keep asking for more types of jobs – shop keeping, road stalls, services (e.g. washing, bar work), salaried job, trading, earning money from rent, scavenging, begging, stealing, prostitution. Write these up on a flip chart clearly.*
36. Are these jobs done by men, women and children? Who does what?
37. Can we rank these businesses from best to worst? *If impossible, select best 3 and worst 3.*
38. Are there any jobs that are better than these?
39. Are there any jobs that are worse than these?
40. Why are the best businesses the best? Are they the highest earning? Are they the most reliable?
41. Do most people do the job they want to do? Why or why not? *This is about moving up the list of priority.*
42. If people have one of these jobs but it fails or they can't do it any more, what do they do then? *Leave to answer then prompt: other less preferred livelihoods eat less or less often, send children to work, take children out of school. This is about moving down the list of priorities.*

Coping strategies

43. When times are difficult, what do people do here to get by? Please discuss all.
44. Are any of these strategies harmful to people (themselves, their children or others?)?
45. Why do they do this?

Conclusion

46. How could health and nutrition services be improved? What could be added, what could be changed, etc.?
47. Are there are negative effects of health provision?

Thank you for your time. Are there any other questions I should have asked? Do you have any questions for me?

Questionnaire

1	Are you male or female? Wewe ni mme au mke?	Gender: Male Jinsia: Mme		Female Mke	
2	How many children do you have? Uko na watoto wangapi?			Number/Nambari	
3	Have you participated in outreach or education programme run by CDON/AIC /NIA? Je, umewahi kushiriki katika uhamasishaji au mpango wa elimu unaoendeshwa na CDON / AIC / NIA?	Yes/Ndiyo		No/La	
4	Has everyone in this community participated? Je, kila mtu katika jamii hii walishiriki?	Yes/Ndiyo		No/La	
5	Do you know why some people have participated and some have not? Je, unajua nisababu ipi baadhi ya watu walishiriki na wengine hawakushiriki?	Yes/Ndiyo		No/La	
6	Did the outreach or training have an impact on your knowledge or practices? Je, haya mafunzo au uhamasishwa imechangia kuimarisha maarifa au mienendo yenu?	Very large impact/ Imeimarika sana	Large impact/Imeimarika	Small impact/ Imeimarika kidogo	No Impact/Haijaimarisha
7	Did the outreach or training have an impact on the community as a whole? Kwa ujumla, uhamasisho au mafunzo imeimarisha jamii?	Very large impact/ Imeimarika sana	Large impact/Imeimarika	Small impact/ Imeimarika kidogo	No Impact/Haijaimarisha

8	Do the services run by CDON/AIC/NIA have an impact on the community as a whole? Je, huduma ambazo zinazoletwa na wafadhili zimeimarishaje jamii?	Very large impact/ Imeimarika sana	Large impact/Imeimarika	Small impact/ Imeimarika kidogo	No Impact/Haijaimarisha
9	Have you been referred to any services by Concern? Circle all Je, umeelekezwa kwa huduma zozote na Concern?	Nutrition/Lishe bora	Health/ Afya	HIV care/ Huduma kwa wanaoishi na virusi vya ukimwi	Schools/Shule
10	Why did you not use these services before? Circle all Mbona hukutumia huduma hizi hapo awali?	Didn't realise they were available Sikujua zapatikana.		Didn't think we needed them Sikudhania nazihitaji	
		Too expensive Bei ghali		Too far away Mbali sana	
		Other: specify Ingine: Elezea			
11	Will you continue to use these services? Utaendelea kutumia huduma hizi?	Yes/Ndiyo		No/La	
12	If not, why? Kama la, kwanini?	Too expensive Bei ghali		Too far away Mbali	
		Other: specify Ingine: Elezea			
13	What are the main causes of malnutrition in young children?		Poor care practices/Utunzi duni		

	Please order these 1, 2, 3, 4 with 1 the main cause and 4 the least important Ni sababu gani watoto wadogo wana afya duni? Orodhesha, sababu kuu ikiwa nambari mmoja, ya mwisho ikiwa nne, sababu duni.		Low income/ mapato duni/kidogo
			Irresponsible children/ Watoto wasiojali
			Poor sanitation and hygiene/ Mazingira duni na ukosefu wa usafi
14	Have you used any of these supplements for yourself or your child? Please tick each one Wewe au watoto wako mmetumia virutubisho au madini haya?		Vitamin A Supplements
			Zinc supplements for Diarrhoea
			Micronutrient fortification
			Iron supplements for pregnant women
			De-worming children
			Salt iodization

Annex C Evaluation Work Plan

Table C.1 Activities and timeframe

	March				April			
Activity	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Preparation of work plan and methodology								
Field visit								
Report writing								
Presentation								
Final Report								
Total								
Outputs								
Presentation initial findings to concern staff								
Draft report								
Presentation of final report to concern staff								
Final report and recommendations								

Table C.2 Field visit workplan

Day	Date	District	Focus Group Team (RGA)	KII (Lee)	KII (Serufusa Sekidde)
Tue	13	Flight to Nairobi			
Wed	14	Nairobi			
Thu	15	Nairobi Training			
Fri	16	Kajiado	1 Group - Beneficiaries	Neighbours Initiative Alliance (NIA) staff	1 or 2 Health Facilities
Sat	17	Kajiado	2 Groups - non-Beneficiaries		AIC Coordinator and Facility in-charges
Sun	18				
Mon	19	Kajiado	2 Groups - Beneficiaries	DC & DMO + Kajiado District Health Mgmt Team	CHEWS
Tue	20	Loitokitok	2 Groups - Beneficiaries	Loitokitok District Health Mgmt Team	1 or 2 Health Facilities
Wed	21	Loitokitok	2 Groups - Beneficiaries	Neighbours Initiative Alliance (NIA) staff	CDON Facility in-charges, DC & DMO
Thu	22	Loitokitok	1 Groups - non-Beneficiaries	CHEWS	CDON Coordinator
Fri	23	Debrief in Nairobi			

Table 6.1 List of Key Informants

Given Name	Surname	Affiliation/Organization	Rank/Position
Nuria	Mohammed	Ministry of Health	District Nutrition Officer
Janet	Ntwiga	UNICEF	Nutrition Support Officer
Samuel	Onyango	Emotoroki Dispensary	Facility in charge (Nursing Officer)
Moses	Olepurkei	Neighbourhood Initiative Alliance	Community Health Worker
Rebecca	Karinga	Bissil Dispensary	Facility in charge (Community Nurse)
John	Lekishon	Neighbourhood Initiative Alliance	Community Health worker
Martin	Kumbe	CONCERN	Roving Nutrition Programme Manager
Yishak	Yacob	CONCERN	National Nutrition Coordinator
Muthoni	Maina	Kimana Health Centre	Public Health officer
Geoffrey	Ampuria	Kimana Health Centre	Facility in charge (Nursing Officer)
James	Kamotho	Loitokitok District MoH	District Nutrition Officer
William	Ole Kakimoni	Kajiado District Commissioner's Office, District HQ	District Officer I
William	Macharia	CONCERN	Finance and Logistics Officer
Ketsia	Mwangi	Rombo Health Centre	i/c of IMAM programme (Nurse)
Judah	Kiminza	CONCERN	Assistant Project Manager
Ezekiel (Dr)	Kapkoni	MoH (Loitokitok District Hospital, Member of DHMT)	District Medical Officer of Health- Loitoki
Wilson	Chesum	MoH (Loitokitok District Hospital, Member of DHMT)	District Public Health Nurse- Loitokitok
Justus	Kioko	MoH (Loitokitok District Hospital, Member of DHMT)	District AIDS/STD Coordinator- Loitokito
Daniel	Siaka Pashile	Neighbourhood Initiative Alliance	Community Health Worker
		Africa Inland Church	Facility in charge (Nursing Officer)
		Catholic Diocese of Ngong	Programme Coordinator
		Kajiado County District Health Management Team	Nutrition Officer, Information Officer

Table 6.2 Evaluation Approach

	Evaluation Questions	Information Sources
RELEVANCE *The evaluator should assess the appropriateness of the objective and results pursued by the programme in relation to the identified needs.*	Was the analysis of needs adequate (methodology, findings, conclusion and recommendations)? Did this analysis lead to the elaboration of adequate objectives in relation to the needs identified? Were the correct assumptions made in the original problem analysis?	Programme documents and other surveys and secondary data sources
	Was the involvement of beneficiaries ensured in the design phase? How does the intervention relate to problems identifies by local stakeholders? Were the views of all stakeholders, and particularly women, elderly, marginalized, and other vulnerable groups, represented in the planning process?	Interviews and focus groups with beneficiaries, interviews with programme staff
	Is the intervention compatible and reflective of Concern policies, approaches and guidelines e.g. Sphere standards and gender guidelines?	Concern Policies & Programme Documents
	Were there unexpected outputs from the intervention?	Interviews & focus groups with beneficiaries & programme staff, programme documents
	How effectively was the issue of mainstreaming addressed?	Interviews with programme staff, programme documents

COVERAGE *The evaluator should assess the coverage of the programme in relation to the identified needs.*	Are an adequate percentage of the needs covered? Were the worst-affected groups correctly identified? Was there appropriate geographical coverage? Was there fair targeting of beneficiaries?	Programme documentation and secondary data source analysis
COHERENCE *The evaluator should assess the adequacy of the activities that were implemented in relation to the objectives and results pursued by the programme.*	Did the activities have a direct relationship with the objective and results pursued?	Program documentation, interviews with programme staff
	Were the activities adequately coordinated with other humanitarian actors/stakeholders?	Interviews with programme staff & other humanitarian actors/stakeholders
MONITORING	Did the communities understand, accept and welcome Concern's/MOH programme?	Interviews & focus groups with beneficiaries and non beneficiaries
EFFECTIVENESS *The evaluator should assess the adequacy of the results that were reached in relation to the objective and results that were pursued by the programme as set out in the original project/programme document.*	Has the programme reached the intended results and specific objective? If not, what are the justifications provided for the risk of non-achievement? What hampered the achievement of the target? Does the organization anticipate the constraints that are met? Does the organization react adequately to unforeseen events in order to re-adjust/ adapt the programme and ensure the achievement or the readjustment of the objective and results pursued by the programme?	Interim reports
	Were the monitoring systems adequate? If no, how can the systems be strengthened in order to measure impact more effectively in the coming years?	Interim reports
	Is there a demonstrated impact of the intervention on the livelihoods of the targeted	Interim reports

	beneficiaries and other stakeholders?	
EFFICIENCY *The evaluator should assess the cost-efficiency of the programme, per se and through a comparison with similar programmes in the area.*	Was the program cost-effective? Were the inputs, costs and budgets adequate? Were the costs reasonable in relation to the achievements or could this have been realized more cost effectively?	Budget, program database, data from similar programs
	Did the intervention receive sufficient support from the Program Support Unit at Nairobi and field levels? Is the internal coordination and communication efficient?	Budget, program database
SUSTAINABILITY, PHASING OUT, AND EXIT STRATEGY *Though this was an emergency response, the evaluator should assess whether or not the intervention could "durably" improve reduction of malnutrition risk within the targeted population.*	Was there a reasonable focus on the preventive component of malnutrition?	Programme documents
With reference to Ministry of Health as the lead partner, the evaluator should look at the programme's capacity-building components, local ownership aspects, and financial sustainability aspects.	In engaging the partners, did the intervention adequately build local capacity? Are there any capacity gaps that require further support?	Interviews with government partners

CONCERN WORLDWIDE POLICIES AND GUIDELINES *To understand how the following cross-cutting issues have been taken into account at all stages of programme implementation so far*	Disaster risk reduction and Preparedness; HIV/AIDs mainstreaming Gender and other aspects of equality; Participation of the beneficiaries.	Interim Reports

Annex D Progress Update to OFDA (Program Update # 11)

Period: 3rd January-30th March, 2012

Objective: To rehabilitate those with acute malnutrition and promote appropriate key nutrition practices in target areas.

Table 6.3 Sub-sector 1: Management of Moderate Acute Malnutrition

Activities				
	Planned / 2011 Targets	**Achieved Q1 2012**	**Cumulative**	**Comments**
Strengthening existing & new health facilities for delivery of SFP services	46	0	46	Achieved in Q3 2011
Training of health workers	30	81	110	Orientation of health workers on use of new RUSF
Provision of on-the job mentoring, monitoring and evaluation support to partners	Weekly	Weekly	Weekly	Achieved
Orientation meetings for the engagement of community leaders per facility	46	0	46	Achieved in Q3 2011
Indicators / Ouputs				
# of sites managing acute malnutrition	46	0	46	Achieved Q3 2011
# of beneficiaries admitted to Moderate Acute Malnutrition (MAM) services by beneficiary type (< 5s; adults)	14,159	Total: 1034 (>5s:782 P&L: 252)	7,913	Beneficiaries admitted are below target due to the improving GAM rates and progressive scale down of outreach services
# of health care providers and volunteers trained in prevention and management of MAM	490	22	883	22 CHC members trained during review meetings

Table 6.4 Sub-sector 2: Management of Severe Acute Malnutrition

Activities				
	Planned / 2011 Targets	**Achieved Q1 2012**	**Cumulative**	**Comments**
Training of the DHMT/HMT on HiNi	2	-	2	Achieved in Q1 2011
Inpatient training for existing inpatient therapeutic care sites	2	-	2	Achieved in Q3 2011
Provision of on job mentoring, monitoring and evaluation support to partner staff	Weekly	Weekly	Weekly	OJT on-going based on capacity gaps identified in 46 facilities.
Indicators / Ouputs				
# of health care providers and volunteers trained in the prevention and management of SAM	530	22	883	22 CHC members trained this quarter
# of sites established or rehabilitated for outpatient care	4	0	4	Achieved in Q3 2011
# of beneficiaries treated for SAM by type (<5s; adults; inpatient care with complications; outpatient care without complications)	2608	248 (213 OTP & 35 IP)	1,535	Beneficiaries admitted are below target due to the improving GAM rates and progressive scale down of outreach services

Table 6.5 Sub-Sector 3: Nutrition Education

Activities				
	Planned / 2011 Targets	**Achieved Q1 2012**	**Cumulative**	**Comments**
Health education conducted at health facilities offering nutrition services.	46	46	46	This is a routine activity conducted regularly
Conducting nutrition education at community (village) level	36	-	54	
Training community CHW/volunteers on provision of nutrition education	400	22	1385	22 CHC members trained this quarter
Indicators / Ouputs				
Number of beneficiaries receiving nutrition education	22,662	101	12,920	From three mother support groups
Number of providers (health care and/or community volunteers) trained in provision of health and nutrition education	430	0	1,335	Activity not targeted this quarter.
Percentage change in practice and/or knowledge pertaining to nutrition education topics	10% increase			

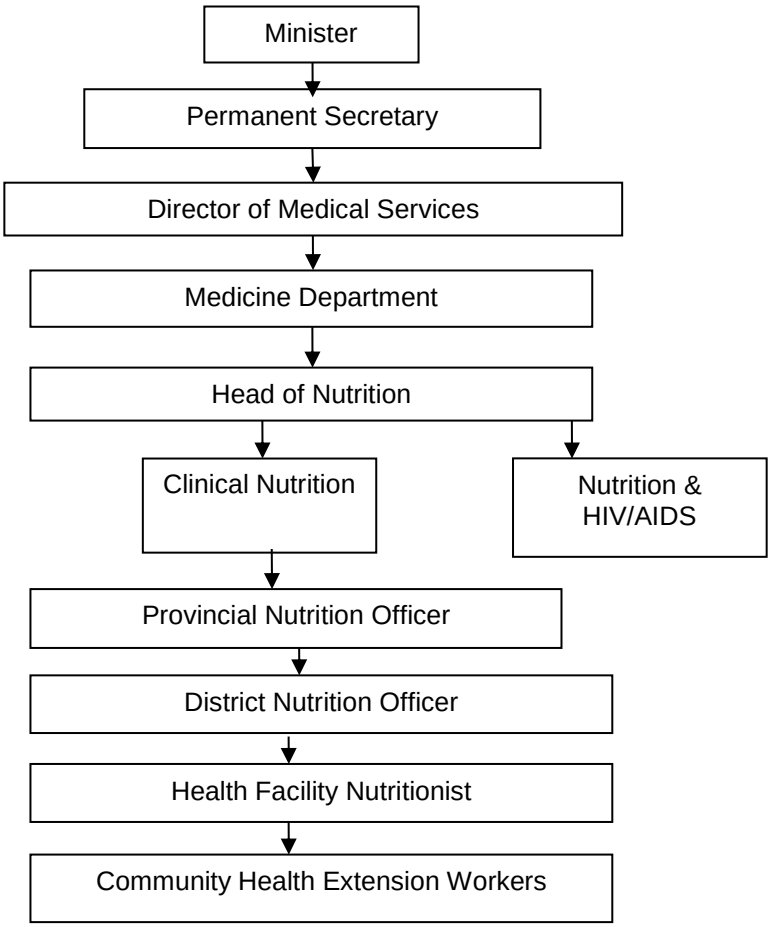
Table 6.6 Sub-Sector 4: Infant and young child feeding

Activities				
	Planned / 2011 Targets	**Achieved Q1 2012**	**Cumulative**	**Comments**
IYCF training in the two districts	2	0	2	Achieved Q3,2011
Establishment of Mother to Mother support Groups	10	0	19	No new groups were formed this quarter.
Indicators / Ouputs				
Percentage of infants 0-6months exclusively breastfed	10% increase	Baseline: 46.5% Education villages: 33.9% No education villages: 35.2% Overall: 34.5%		Refers to comments above
Percentage of children 6-24 months who receive food from 4 or more food groups	10% increase	Baseline:32.5% Education villages: 23.3% No education villages: 27.2 Overall: 25.3%		Refers to comments above
Number of health care providers, CHWs,CHC, DHMT and volunteers trained on IYCF	500	0	1335	Activity not conducted this quarter.
Is an IYCF in Emergencies policy in place (Y/N)	Y	Y	46	Achieved in 3rd quarter

Table 6.7 Sub-Sector 5: Nutrition Systems

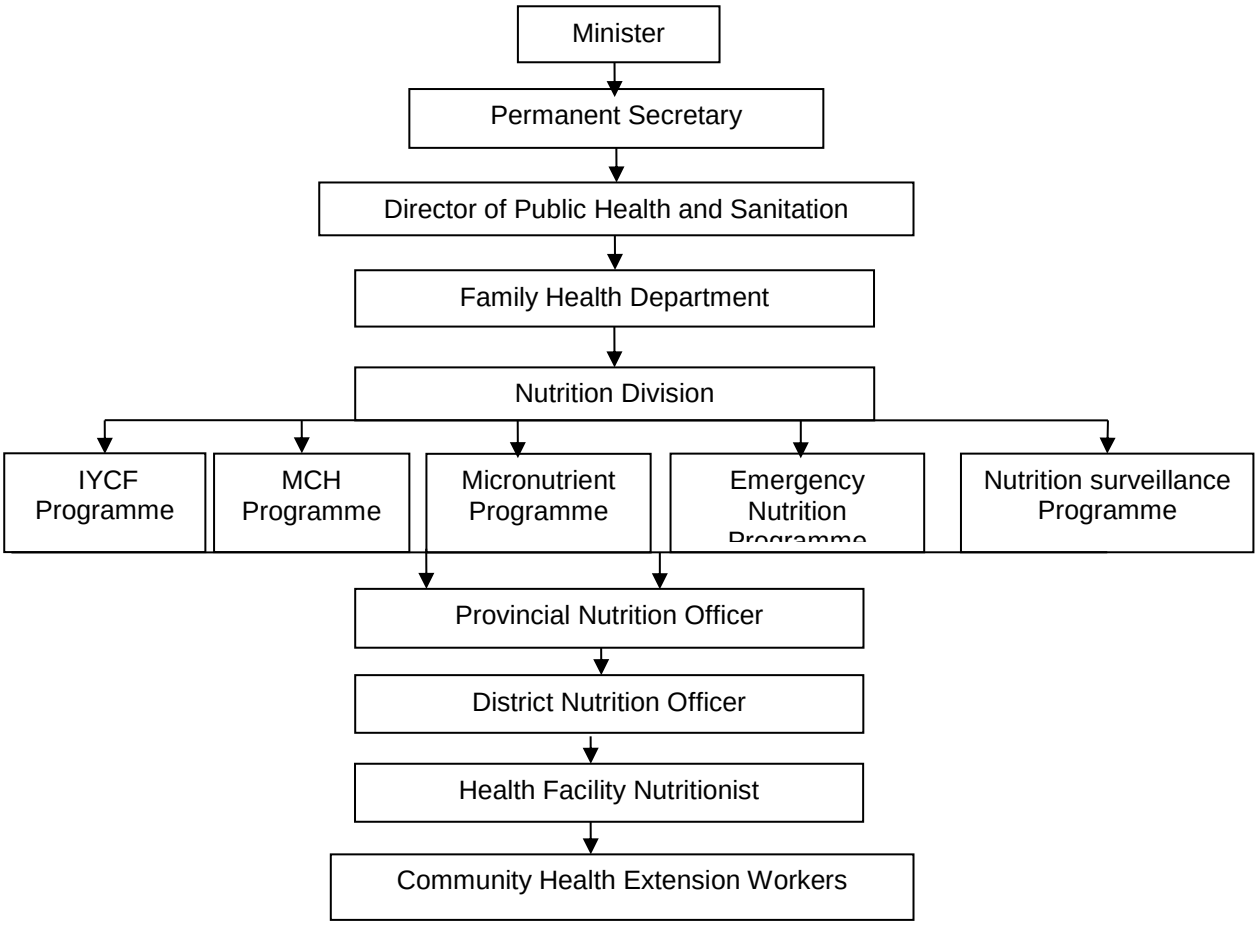
Activities				
	Planned / 2011 Targets	**Achieved Q1 2012**	**Cumulative**	**Comments**
Dissemination of OJT national guidelines and reporting tools for HINI components	46	0	46	Achieved Q3
Strengthen functional capacity of nutrition information system for each district	2	0	2	Training 2 MOH staff on data management has been ongoing since Jan. 2011 continued.
Coverage assessment	1	1	1	Program evaluation conducted in March. Coverage survey not conducted.
Indicators / Ouputs				
Number and percentage of health providers /officials trained in established/strengthened nutrition guidelines/policies/systems for the prevention and treatment of acute malnutrition	20	4	23	4 staff received training on management of commodities used for the management of moderate acute malnutrition.
Number of nutrition information systems established and functioning	2	0	2	
Is a nutrition supply system established (Y/N)	Y	Y	Y	
Number of coverage assessment and KAP survey conducted	2	0	1	No assessment conducted this quarter.

Annex E The structure of MMS in relation to nutrition



Source: Situation Analysis of Nutrition in Kenya, May 2011

Annex F The structure of MoPHS in relation to nutrition



Source: Situation Analysis of Nutrition in Kenya, May 2011