COUNTY GOVERNMENT OF ELGEYO MARAKWET

COUNTY NUTRITION ACTION PLAN (CNAP)

2018/19-2022/23

COUNTY NUTRITION ACTION PLAN (CNAP) 2018/19-2022/23

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LIST OF ABBREVIATIONS AND ACRONYNMS

ANC	Antenatal Care
CIDP	County Integrated Development Plan
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
BMS	Breast Milk Substitute
BOM	Board of Management
CDOH	County Department of Health
CHV	Community Health Volunteer
CLTS	Community-Led Total Sanitation
CNAP	County Nutrition Action Plan
CNTF	County Nutrition Technical Forum
CRAF	Common Results and Accountability Framework
CSB	Corn Soya Blend
CSG	County Steering Group
CU	Community Unit
DHIS	District Health Information System
DRNCD	Diet-Related Non-Communicable Diseases
EBF	Exclusive Breastfeeding
ECD	Early Childhood Development
ENRICH	Enhancing Nutrition Services to Improve Maternal and Child Health
EPI	Expanded Programme on Immunization
FBO	Faith-Based Organization
FGD	Focus Group Discussion
GBD	Global Burden of Disease
GOK	Government of Kenya
HCW	Health Care Worker
HFI	Health Facility In-charge
ICT	Information Communication and Technology
IFAS	Iron Folic Acid Supplementation
IGA	Income Generating Activity
IHRIS	Integrated Human Resource Information System
IMAM	Integrated Management of Malnutrition
KDHS	Kenya Demographic Health Survey
KHIS	Kenya Health Information System

KMC	Kangaroo Mother Care
KNBS	Kenya National Bureau of Statistics
LMIS	Logistic Management Information System
MAD	Minimum Acceptable Diet
M&E TWG	Monitoring and Evaluation Technical Working Group
MEAL	Monitoring Evaluation Accountability and Learning
MNP	Micronutrient Powder
MOH	Ministry of Health
NACS	Nutrition Assessment Counselling and Support
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NI	Nutrition International
OJT	On-the-Job Training
PLW	Pregnant and Lactating Woman
SDG	Sustainable Development Goal
SMART	Standardized Monitoring Assessment for Relief and Transition
SOP	Standard Operating Procedure
ToC	Theory of Change
TBA	Traditional Birth Attendant
UHC	Universal Health Care
URTI	Upper Respiratory Tract Infection
VAS	Vitamin A Supplementation
WIFAS	Weekly Iron Folic Acid Supplementation

FOREWORD

The Constitution of Kenya article 43 (1) gives every person the right to the highest attainable standard of health, freedom from hunger and access to adequate food of acceptable quality.
The national and county governments are committed to creating an enabling environment for citizens to realize these rights as evidenced in the Vision 2030, Kenya Health Policy (2014–2030), Kenya Health Sector Strategic and Investment Plan (2018 – 2022) and the National Food and Nutrition Security Policy, 2012.

The Kenya Health Policy (KHP) and the National Food and Nutrition Security Policy (NFNSP) outline some of the key measures the government will put in place to realize the Vision 2030. This is to be achieved through supporting the provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans. The government's commitment to providing a high quality of life to all its citizens was further affirmed by the declaration of His Excellency President Uhuru Kenyatta's Big Four Agenda in 2017, which prioritizes Universal Health Coverage (UHC) by the year 2022.

The Elgeyo Marakwet County Nutrition Action Plan (CNAP) 2018/19-2022/23 is aligned with the Kenya Nutrition Action Plan (KNAP 2018-2022), the Elgeyo Marakwet County Health Sector Strategic & Implementation Plan (CHSSIP) 2018-2022 and the County Integrated Development Plan (CIDP) 2018–2022. The plan recognizes the role of nutrition as a fundamental human right and a driver to accelerating economic development as envisioned in Vision 2030.

The Elgeyo Marakwet County Department of Health has led the development of the CNAP 2018/19–2022/23 to coordinate nutrition and dietetics interventions by county government and nutrition stakeholders.

The CNAP reflects lessons learnt in the implementation of nutrition activities, as well as global, national and regional nutrition targets.
The main objective of the CNAP is to contribute to acceleration and scale-up of efforts to eliminate malnutrition as a problem of public health significance in Kenya by 2030, with specific targets to achieve by 2022. The CNAP focuses on three areas of intervention, namely nutrition specific; nutrition sensitive and enabling environment; these emphasize the need to strengthen multi-sectoral collaboration in addressing malnutrition. We believe this five-year plan will contribute to achieving the Kenyan Development Agenda.

The alignment of CNAP to CHSSIP 2018-2022 facilitates the mainstreaming of the nutrition budgeting process into the county budget, and hence, the allocation of resources to nutrition programmes. CNAP also provides guidance on nutrition resource mobilization within and outside the county borders. The document also emphasizes a collaborative multi-sectoral approach to planning, fostering improvement from past trends in addressing the nutrition agenda within the county.

Isaack Kamar
County Executive Committee Member

PREFACE

Nutrition is a vital building block in the foundation of human health and development. It has a direct relationship with child survival, physical and mental growth, learning capacity, adult productivity and overall social and economic development.

Unacceptably high levels of malnutrition remain a public health concern and a hindrance to achieving the country's developmental agenda.

Kenya is experiencing an emerging triple burden of malnutrition, where under-nutrition (underweight, stunting and wasting), overweight and obesity, and micronutrient deficiencies are increasing along with the burden of Non-Communicable Diseases (NCDs) (Kenya Demographic and Health Survey (KDHS), 2014).

The Elgeyo Marakwet County Nutrition Action Plan (CNAP) 2018/19-2022/23 is a comprehensive and overarching framework for coordination, implementation and mobilization of resources for nutrition interventions in health and other county departments. The plan has incorporated priorities in the CIDP 2018-2022 and the CHSSIP 2018-2022 that will inform subsequent nutrition annual work plans.

The CNAP 2018/19–2022/23 applies a multi-sectoral approach and promotes cross-sectoral collaboration to address the social determinants of malnutrition in a sustainable manner with an overall aim to secure optimal nutrition for the entire population by ensuring that the roles and responsibilities of different sectors are clear.

The CNAP outlines high impact nutrition specific interventions and nutrition sensitive interventions to be undertaken at all levels in the health sector and other county line departments.

CNAP has integrated other cross-cutting nutrition sensitive sector-based legislations, policy, plans and guidelines in support of an enabling environment for optimal food and nutrition security in the county.

These address poverty alleviation, gender equality and empowerment of women and girls, child and maternal health, reducing HIV/AIDS and communicable diseases, and environmental sustainability. Specifically, in line with the Constitution of Kenya, the CIDP 2018-2022 and the Sustainable Development Goals (SDG) several SDGs are integrated into the CNAP. There are interventions focused on improved climate-smart agri-nutrition productivity, (SDGs 13, 14 and 15), promoting gender empowerment (SDGs 5 and 10) and reducing poverty levels (SDG 1). This is hoped to increasingly contribute to elimination of hunger under SDG 2, where all men and women across different ages and backgrounds have equitable access to quality and sustainable food and nutrition security, for improved nutrition and related health outcomes.

The County Department of Health will provide the required stewardship and oversight to ensure full implementation of CNAP and to review the plan periodically as new ideas, innovations, programmes and policies are developed. We urge all partners, line departments and stakeholders to familiarize themselves with the content to achieve the overall CNAP objective.

Mary Kipchumba
Chief Officer

ACKNOWLEDGEMENTS

Elgeyo Marakwet County (EMC) takes this opportunity to thank everyone who participated in the drafting and development of the EMC County Nutrition Action Plan (CNAP) 2018/19-2022/23. The EMC CNAP could not have been finalized without the contributions and commitment of the members from different working groups drawn from both the government and development partners. The support from the County Government of Elgeyo Marakwet through the Ministry of Health is highly appreciated.

This CNAP was developed with support from Nutrition International (NI) under the Technical Assistance for Nutrition (TAN) project, funded by UK Aid from the United Kingdom government and the ENRICH project, funded by Global Affairs Canada. Special thanks go to NI staff led by Joy Kiruntimi, Sarah Kihianyu, Kirorei Kiprotich and Daisy Mundia for the immense technical leadership support in the entire process of developing the CNAP 2018/19 – 2022/23.

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Lastly, the County Department of Health greatly recognizes Betty Samburu and the consulting team who provided the technical support and inputs throughout the whole development process:

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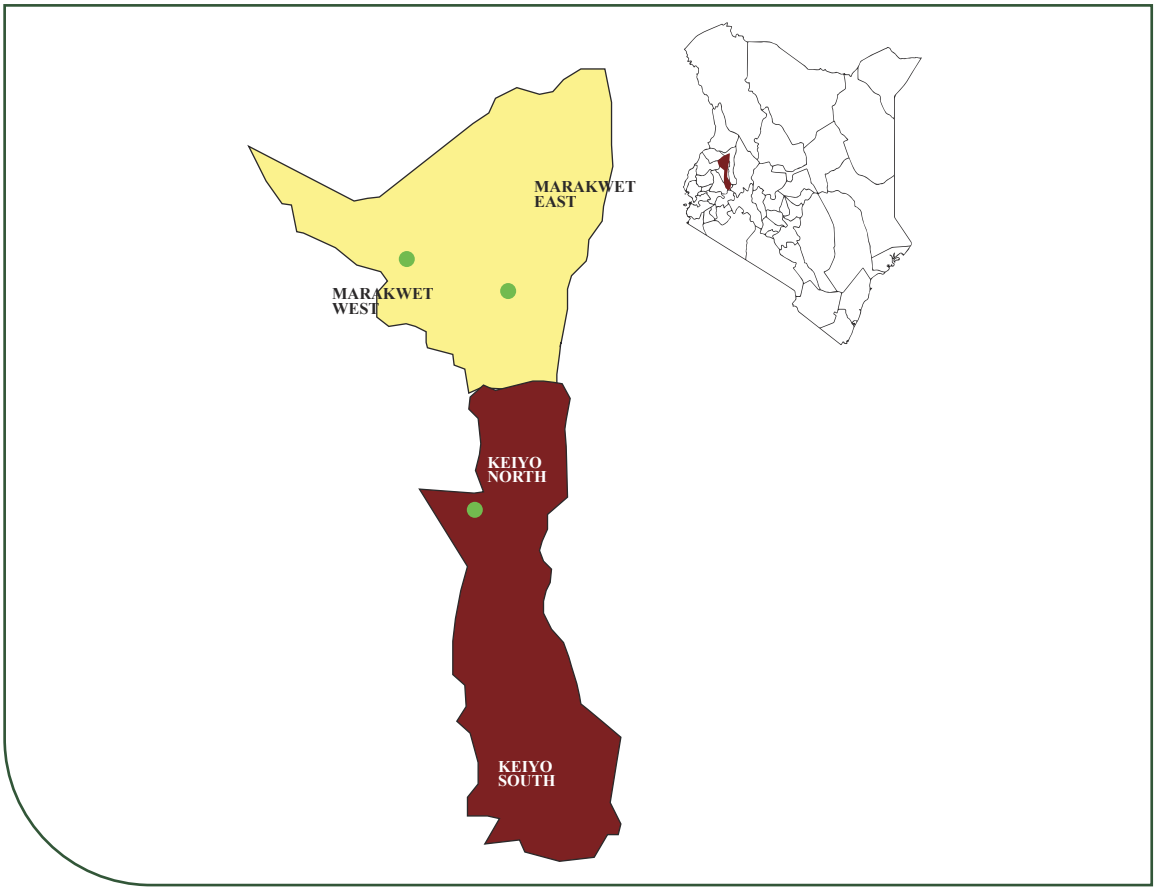
1 INTRODUCTION

1.1. Background information

1.1.1 Location and size

Elgeyo Marakwet County (EMC) covers a total area of 3,029.6 km2, which constitutes 0.4 percent of Kenya's total area. It borders West Pokot County to the north, Baringo County to the east, Trans Nzoia County to the northwest and Uasin Gishu County to the west. The county is divided into three topographic zones: Highlands, Escarpment and Kerio Valley. Figure 1.1 shows the location of EMC in Kenya and the administrative divisions.

Figure 1.1: Location of Elgeyo Marakwet County and Administrative Divisions



1.2 Demographic profile

The population for 2019 was 454,465, of which 227,317 were male and 227,138 were female; a male to female ratio of about 1:1. Table 1.1 shows the population breakdown for Elgeyo Marakwet County.

Table 1.1: Population Breakdown and Description

	Description	Population proportion	County population 2019
1	Total population in the county		454,465
2	Number of households		187,230
3	Children under one year (12 months)	3.70%	16,815
4	Children under five years (60 months)	16.90%	76,805
5	Children under 15 years	42.30%	192,239
6	Women of child-bearing age (15-49 years)	24%	109,072
7	Estimated number of pregnant women	3.84%	17,451
8	Estimated number of deliveries	3.84%	17,451
9	Estimated live births	3.79%	17,224
10	Adolescents (15-24)	19.80%	89,984
11	Adults (25-59)	28.80%	130,886
12	Elderly (60+)	5.4%	27,860

Source: (KNBS, November 2019)

1.2.1 Population description of sub-counties

The county is divided into four sub-counties: Keiyo North, Keiyo South, Marakwet West and Marakwet East. Table 1.2 shows the population distribution trends from 2009 to 2019 as per the Kenya National Bureau of Statistics.

Table 1.2: Population Distribution per Sub-County

Constituency / Sub-county	Area (Km²)	2009 (Census)		2018 (Projections)		2019 population	
		Population	Density (Km²)	Population	Density (Km²)	Male	Female
Marakwet East	784	78,749	100	106,908	136	47,849	49,190
Marakwet West	805	108,374	135	147,126	183	68,948	68,560
Keiyo North	541	73,715	136	100,074	185	49,601	49,574
Keiyo South	900	109,160	121	148,193	165	60,919	59,824
Total	3,030	369,998	492	502,301	669	227,317	227,148

Source: (KNBS, November 2019) (KNBS, August 2010)

1.3 Health facility distribution within the county

The county has only one referral hospital, the Iten County Referral Hospital. There are also six sub-county hospitals, one mission hospital, 28 health centres, 92 dispensaries and 22 private clinics in the county. The average distance to a health facility is 3.7 km as compared to the national average of 5 km, which can be attributed to the construction of new facilities. There is a wide range of health facilities distributed all over the county, which are operated by the government, Faith-based Organizations (FBO) and private institutions (see Table 1.3).

Table 1.3: Health Facility Distribution within the County

Facility Type	GOK	FBO	Private	Totals
Hospitals	7	2	0	9
Health Centres	22	5	1	28
Dispensaries	89	3	0	92
Clinics	0	0	22	22
Chemists	0	0	24	24
Community Units (Gazetted)	85	0	0	85
TOTAL	**203**	**10**	**47**	**260**

Source: CIDP, 2018

1.4 Trends in nutrition and health in Kenya

Kenya has made tremendous progress in addressing major health challenges over the last few decades resulting in decreased morbidity and mortality among the population's most vulnerable groups. For example, the Kenya Demographic Health Survey (KDHS) findings indicate that maternal mortality rate decreased from 520 deaths per 100,000 live births in 2008 to 362 deaths per 100,000 live births in 2014. Similarly, the infant mortality rate fell from 52 deaths per 1,000 live births in 2008 to 39 deaths per 1,000 live births in 2014. The mortality rate for children under five dropped from 74 deaths per 1,000 live births in 2008 to 52 deaths per 1,000 live births in 2014. Additionally, the neonatal mortality rate also declined from 31 deaths per 1,000 live births in 2008 to 22 deaths per 1,000 live births in 2014.

There has also been an improvement in the nutritional status of children. Stunting declined from 35 percent in 2008 to 26 percent in 2014, wasting decreased from 7 percent to 4 percent and underweight from 16 percent to 11 percent (KDHS, 2014). Nationally, the prevalence of exclusive breastfeeding for the first six months has increased from 32 percent in 2008 to 61 percent in 2014.

Malnutrition puts children at increased risk of morbidity and mortality and is also shown to be related to impaired cognitive development. About one-quarter (26 percent) of Kenyan children are stunted, while 8 percent are severely stunted (KDHS 2014). This is well above the World Health Organization (WHO)'s critical threshold of 15 percent. Analysis of stunting by age group shows that stunting is highest in children between the ages of 18-23 months (36 percent), and lowest among children under the age of six months (10 percent). The high rate of stunting is attributed to food insecurity and poor infant and young child feeding practices (World Vision Kenya 2015).

1.5 Trends in nutrition and health in Elgeyo Marakwet County

1.5.1 Under-nutrition

Various forms of malnutrition can coexist in an individual. A child can be stunted as well as wasted, underweight, and suffer from one or more micronutrient deficiencies. On the other hand, a person may be overweight or obese and at the same time suffer from multiple micronutrient deficiencies.

According to the KDHS 2014, the stunting, wasting and underweight rates in EMC were higher than the national rates. The Enhancing Nutrition Services to Improve Maternal and Child Health (ENRICH) project baseline assessment conducted in 2017 shows the stunting rates in the escarpment and the Kerio valley areas are higher, at 40 percent. Table 1.4 shows the wasting, underweight and stunting rates for EMC compared to national rates as per KDHS, 2014.

Table 1.4: Wasting, Underweight and Stunting Rates in EMC

Indicator	National	EMC
Wasting: % of children aged 6-59.9 months whose weight for height score is below the NHCS/CDC/WHO recommended scores	**4.%**	**4.3%**
Underweight: % of children aged 6-59.9 months whose weight for age score is below the NHCS/CDC/WHO recommended scores	**11%**	**12.6%**
Stunting	**26%**	**29.9%**

Source: KDHS, 2014

ENRICH project is a five-year project, funded by the Government of Canada through Global Affairs Canada. It is implemented by World Vision Canada, Nutrition International, Harvest Plus, the Canadian Society for International Health, and the University of Toronto's Dalla Lana School of Public Health, covering selected areas in Kenya, Tanzania, Bangladesh and Myanmar. In Kenya, the project covers the escarpment and Kerio valley regions of Elgeyo Marakwet County.

1.5.2 Micronutrient supplementation coverage

According to the Kenya National Micronutrient Survey in 2011, significant progress is being made in reducing the prevalence of micronutrient deficiencies, except in the area of zinc deficiency.

Anaemia is a major public health challenge and is associated with impaired cognitive and motor development in children especially those under the age of five years. According to the KNMS 2011, the prevalence of anaemia was highest in pregnant women (41.6 percent), followed by children 6–59 months (26.3 percent), school–age children (5–14 years) at 16.5 percent. The prevalence of iron deficiency in the same groups was 21.8 percent, 9.4 percent and 36.1 percent (KNMS, 2011).

The county is undertaking several micronutrient supplementation initiatives which include Vitamin A Supplementation (VAS) among children between the ages of 6-59 months, Iron Folic Acid Supplementation (IFAS) among pregnant women and Micronutrient Powder (MNP) supplementation among children aged 6-23 months.

According to the DHIS 2019, VAS coverage for children between the ages of 6-11 months was high at 56 percent compared to children between the ages of 12-59 months, which was low at 25 percent. This gap is attributable to caregivers not bringing children to the child welfare clinics for growth monitoring after completing the Expanded Programme on Immunization (EPI) schedule.

IFAS coverage was notably low due to late Ante-Natal Care (ANC) attendance by pregnant women. Another reason for low coverage of VAS was poor data recording and reporting rates. The MNP coverage is low as 30 percent, which is attributed to gaps in reporting, low demand for MNP in targeted communities and sub-optimal functionality of the community health strategy. Table 1.5 shows the micronutrient supplementation coverage as per the ENRICH project results.

Table 1.5: IFAS and MNP Supplementation in Elgeyo Marakwet County

Indicator	Baseline 2017	Midterm 2019
Iron Folic Acid (IFA) consumption for ≥ 90 days among mothers of children aged 0-23.9 months during last pregnancy	**4.3%**	**17.3%**
Coverage of MNP: % of children 0-23.9 months who received recommended dosage of MNP in the last one year	**0%**	**19.8% (Boys)** **26.7% (Girls)**

Source: ENRICH Midterm Evaluation Report 2019

1.5.3 Diet-related non-communicable diseases

According to the KDHS 2014, the proportion of women who were overweight or obese increased from 25 percent to 33 percent and those who were obese increased from 7 percent to 10 percent.

The prevalence of overweight or obesity is higher in urban areas (43 percent) than in rural areas (26 percent); in women with higher education (38 percent) than with low education (18 percent); and higher in women in the highest wealth quintile (50 percent) compared with those in the lowest wealth quintile (12 percent).

The Kenya 2015 STEPwise survey also confirmed an increasing rate of overweight/obesity and diet-related non-communicable diseases (DRNCDs) in adults. A total of 28 percent of adults between the ages of 18–69 years were either overweight or obese, with the prevalence in women being 38.5 percent and men 17.5 percent.

EMC recognizes the need for an accelerated response in control, prevention and management of DRNCDs. There has been a steady increase in morbidity and mortality resulting from DRNCDs, mainly diabetes, hypertension, cancers, as well as cardiovascular and chronic respiratory diseases. The Kenya Health Information System (KHIS) reported an increase in cases of hypertension from 1,000 to 4,441 cases between 2017 and 2019, as well as an increase in the cases of diabetes from 1,111 to 1,900 between 2017 and 2019.

1.5.4 Feeding practices for children younger than five years and women of reproductive age

WHO recommends Exclusive Breast Feeding (EBF) during the first six months of life because breast milk contains all the nutrients required for development, growth and child survival. According to KDHS 2014, EBF rates in Kenya have markedly improved from 32 percent in 2008 to 61 percent in 2014. WHO recommends infants be initiated to breastfeeding within one hour after delivery.

According to the Lancet 2016, this can prevent 22 percent of neonatal deaths within the first hour of birth and 16 percent of neonatal deaths within the first 48 hours. In Kenya, trends in early initiation of breastfeeding show an increase from 58 percent in 2008–9 to 62 percent in 2014 (KDHS 2014).

Timely, adequate and safe introduction of complementary foods is critical at six months when breast milk alone is no longer sufficient to meet the nutritional requirements of infants and young children. The KDHS 2014 found that 81 percent of breastfed children aged 6–9 months received complementary foods in addition to breastfeeding, indicating timely complementary feeding.

However, only 22 percent of children between the ages of 6–23 months consume a minimal acceptable diet (MAD), indicating a dire nutritional situation in this age group. Furthermore, 49 percent of children aged 6–23 months do not consume the minimum required number of meals per day, while 59 percent do not consume an adequately diversified diet, indicating restriction in access to quality diets for this age group.

The EMC is rolling out the Baby Friendly Hospital Initiative (BFHI) in level 4 and 5 facilities which will contribute to the improvement of maternal, infant and young child indicators. The county is also rolling out the implementation of the Baby Friendly Community Initiative (BFCI) and care groups by building the capacity of the County Health Management Team, health facility staff and Community Health Volunteers (CHV) in breastfeeding counseling and lactation support.

Additionally, through the health department, the county is implementing its mandate in enforcing the Breast Milk Substitutes (Regulation and Control) Act, 2012 as well as workplace support for breastfeeding mothers as stipulated in Chapter 3 of this CNAP.

The EMC data on feeding practices among children under the age of five years and women of reproductive age is available for the ENRICH project areas and can be used as proxy indicators to reflect the county situation.

According to the ENRICH project midterm evaluation, there was significant improvement in the prevalence of EBF from 42.5 percent in 2017 to 62.9 percent in 2019. However, the prevalence of early initiation to breastfeeding within one hour showed a decline from 34 percent in 2017 to 31 percent in 2019. The prevalence of minimum dietary diversity, minimum meal frequency and MAD among children aged 6-23.9 months showed no significant difference at baseline and midterm. Table 1.6 shows the prevalence of Maternal Infant and Young Child Feeding (MIYCF) practices as per the ENRICH project results.

Table 1.6: Maternal Infant and Young Child Feeding Practices in Elgeyo Marakwet County

Indicator	Baseline 2017	Midterm 2019
Exclusive Breastfeeding (EBF) among children aged 0-5.9 months	**42.5%**	**62.9%**
Minimum Acceptable Diet (MAD) among children aged 6-23.9 months	**23.0%**	**23.4%**
Minimum Dietary Diversity (MDD) among children aged 6-23.9 months	**27.2%**	**25.5%**
Minimum Meal Frequency (MMF) among children aged 6-23.9 months	**79.4%**	**88.0%**
Mother/caregiver knowledge of EBF: % of caregivers of children aged 0-59.9 months who knew about ≥3 benefits of exclusive breastfeeding up to 6 months	**19.8%**	**29.8%**
Mother/caregiver knowledge of infant, youth and young child nutrition (IYCN) recommendations: % of caregivers who knew about ≥ 3 recommendations for appropriate feeding of children aged 6-23.9 months	**14.1%**	**17.0%**
Pregnant women knowledge of nutrition recommendations: % of mothers who knew about ≥3 good nutrition practices for pregnant women to follow during pregnancy	**12.1%**	**13.9%**
Dietary diversity among mothers (MDD-W) of children aged 0-23.9 months in the 24 hours preceding the survey	**27.8%**	**24.6%**
Hand washing: % of women/caregivers of children 0-23.9 months who recall washing hands using an effective product (ash/soap) at least 3 out of 5 critical times in the last 24 hours	**57.6%**	**70.1%**

Source: ENRICH Midterm Evaluation Report 2019

1.5.5 Healthcare services access

The government has introduced initiatives to accelerate the provision of health care. These include free maternity services (over one million mothers get free services when delivering) and removal of user fees for approximately 45 million outpatient services provide annually. The national government has also put in place a health insurance subsidy programme and medical support for the elderly and people with severe disabilities, which the county is implementing fully.

According to the ENRICH project midterm evaluation in 2019, there was an improvement in provision of basic nutrition services and coverage for ANC and home visits by CHVs. Table 1.7 shows the access of healthcare services as per the ENRICH project results.

Table 1.7: Access of Healthcare Services in Elgeyo Marakwet County

Health Services	Baseline 2017	Midterm 2019
Child monitoring (anthropometric): % of mothers of children aged 0-5.9 months reported their child was weighed at least once in the past 3 months	**66.5 %**	**79.0 %**
Basic nutrition services availability: % of health facilities providing basic child nutrition services		
o Weight	**88.9%**	**100%**
o Mid-upper arm circumference (MUAC)	**74.1%**	**88%**
o Management of malnutrition	**51.8%**	**84%**
o Nutrition education	**100%**	**100%**
Coverage of ANC: Percentage of mothers who attended at least four (≥4) ANC visits	**37.9%**	**41.6%**
Coverage of home visit by CHVs: Percentage of mothers of children aged 0-5.9 months reported receiving at least one home visit by CHV in the past 3 months	**15.4%**	**38.6%**

Source: ENRICH Midterm Evaluation Report 2019

1.5.6 Food access

Agriculture is the leading source of livelihood for more than three-quarters of the households in EMC. Since 2017, the county has been implementing the Kenya Climate Smart Agriculture Project (KCSAP), supported by the World Bank. The KCSAP seeks to increase agricultural productivity and build resilience to climate change risks in targeted smallholder farming and pastoral communities in Kenya. The project focuses primarily on:

- Improving water/soil management
- Promoting sustainable, community-driven rangeland management and improved access to quality livestock services
- Supporting the generation and dissemination of improved agricultural technologies, innovations and management practices to build resilience and adaption to climate change

In addition to the KCSAP project, the county—through the Department of Agriculture— has established interventions to train and engage men and women equally across different ages and diversities on agri-nutrition with the aim of increasing food security.

These interventions include:

- Promoting the farming of agro-ecologically appropriate, micronutrient-dense food such as fruits and indigenous vegetables.
- Enhancing knowledge on the nutritional value of under-utilized traditional foods and recipes.
- Training communities on sustainable income generating activities such as solar drying of vegetables.

These interventions will also lead to improved dietary diversity as well as increased purchasing power of households, enhanced asset building mechanisms, access to market and other social infrastructures.

Additionally, there are ongoing efforts to build individual household capacity on proper food preparation, post-harvest handling and storage, as well as fuel-saving technologies. The EMC government is making efforts to develop and enhance the efficiency of various agricultural value chains including those for fruits, potato, dairy and indigenous poultry. For the dairy value chain, the county government is supporting milk production, processing and marketing through cooperative societies.

Similarly, efforts towards value addition of local farm produce such as mangoes are ongoing, and the county has included establishment of processing factories among the flagship projects under the CIDP. Stakeholders are working together closely to advance agricultural productivity and nutrition outcomes.

Through the support of the ENRICH project, there is an ongoing collaboration between the County Departments of Agriculture, Water and Health, as well as the Kenya Agricultural and Livestock Research Organization (KALRO) and Harvest Plus to enhance bio-fortification of crops.

The OFSP is a good source of energy, as well as vitamins (A, B, C and K) and minerals (phosphorus and potassium). The ENRICH project partners are working together to promote uptake of the bio-fortified crop varieties by establishing demonstration farms and distributing bean seeds and OFSP vines to farmers.

The initiative has supported the distribution, farming and local consumption of beans high in iron and Orange-Fleshed Sweet Potato (OFSP) in addition to promoting other drought tolerant crops such as cassava, sorghum and green grams. The bio-fortified bean varieties are rich in iron and zinc; they are early maturing and high yielding.

1.6 Human resources for nutrition

Currently, there are inadequate numbers of nutrition staff at all levels of the health system in the county. Additionally, there is need to train nutrition staff to offer specialized services including (1) Clinical nutrition (e.g. Management of patients with reduced renal function and other medical conditions), and (2) Public health and community nutrition services (e.g. seeking active cases of children with acute malnutrition within the communities).

The Ministry of Health developed the Human Resources for Health Norms and Standards Guidelines for Health Sector in 2014 to provide guidance on the nutrition staffing requirements at each level of the health system to ensure that specific needs of different demographics are met. Table 1.8 shows the current nutrition staffing and the gaps that exist in EMC.

Table 1.8: Current Nutrition Staffing and Gaps in Required Staff in EMC

Category of Health Facility	Number of facilities (A)	Nutrition and dietetic officers required (B)	Nutrition and dietetic technologists required (C)	Nutrition technicians required (D)	Total nutrition staff required A*(B+C+D)	Total nutrition staff in-post	Nutrition staffing gaps
County referral hospital (Level 5)	1	10	8	4	**22**	4	18
Sub-county hospital (Level 4)	5	2	4	1	**35**	8	27
Health centres (Level 3)	22	-	2	1	**66**	6	60
Dispensaries (Level 2)	89	-	1	1	**178**	0	178
Community Units (Level 1)	85	-	-	1	**85**	0	85
Total	**202**	**12**	**15**	**8**	**376**	**18**	**358**

Source: (KNBS, November 2019) (KNBS, August 2010)

1.7 Constraints to uptake of health and nutrition practices in EMC

The following factors collectively contribute to the low uptake of health and nutrition services within the county:

Constraints to delivery of nutrition services

- Inadequate resource allocation for nutrition
- Poor dissemination of policies
- Lack of policy, guidelines and standards (e.g. for nutrition in sports)
- Inadequate nutrition staff
- Low capacity for provision of specialized nutrition services (e.g. clinical nutrition, sports nutrition, IMAM)
- Inadequate data collection and reporting tools and dashboards at county, sub-county and facility level to track nutrition indicators
- Limited quality data to support prioritization and appropriate decision-making by the relevant actors
- Inadequate Information Communication and Technology (ICT) infrastructure
- Inadequate anthropometric and medical diagnostic equipment at health facilities
- Lack of youth friendly centres to address knowledge gap and poor feeding practices among pregnant teens
- Frequent stock-outs of nutrition commodities (therapeutic and supplementary) due to parallel uncoordinated supply chains and poor data on consumption.
- No local production for therapeutic milk products (F100 and F75) leading to erratic supplies
- Inadequate storage facilities for nutrition commodities at the facility and county levels
- Steady increase in morbidity and mortality resulting from DRNCD, especially diabetes, hypertension, cancers, cardiovascular and chronic respiratory diseases

- Lack of coordinated approach to nutrition across sectors
- Poor linkages between health facilities and CHVs for community–based nutrition services
- Low community awareness of the available nutrition services

Constraints to adoption of optimal health and nutrition practices

- High levels of poverty
- Dependency on rain fed agriculture
- Inadequate production of diversified food
- Poor post-harvest handling and storage leading to wastage and destruction of farm produce by rodents and pests
- Knowledge gap on maternal, infant and young child nutrition among health workers and care-givers
- Poor dietary practices among children and women of reproductive age
- Long distance to health facilities resulting in home deliveries by Traditional Birth Attendants (TBA)
- Lack of male involvement on Infant and Young Child Feeding (IYCF)
- Prevalent alcoholism among the population (both men and women)
- Lifestyle changes especially among urbanized communities
- Insecurity due to inter-clan conflicts in some parts of the county
- Poor hygiene practices with low coverage of hand washing at critical times, low latrine coverage and few households consuming treated waterPoor health seeking behaviours (e.g. low uptake of growth monitoring after 18 months)
- Inadequate technical personnel
- Lack of coordinated approach across sectors

2 COUNTY NUTRITION ACTION PLAN FRAMEWORK

2.1 Introduction

Malnutrition is caused by factors which are broadly categorized as immediate, underlying and basic.

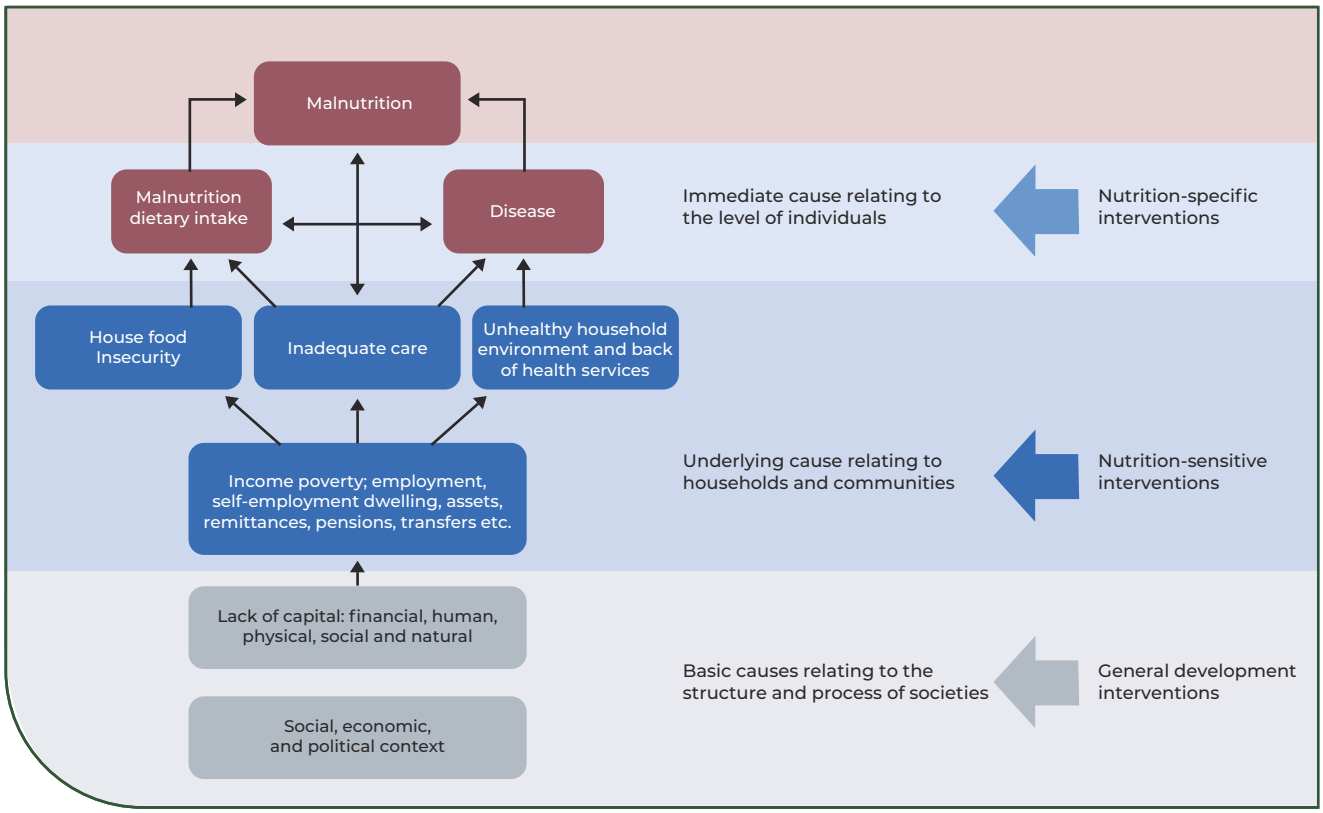
The **immediate** causes of malnutrition include disease and inadequate food intake. This means that disease can affect nutrient intake and absorption, leading to malnutrition; not taking sufficient quantities and the right quality of food can also lead to malnutrition.

The **underlying** causes of malnutrition are food insecurity (including availability, economic access and use of food), feeding and care practices (at the maternal, household and community levels), environment and access to—and use of—health services (WHO and The World Bank, 2012). Household food insecurity implies that there is lack of access to sufficient, safe and nutritious food to support a healthy and active life. The level of nutrition awareness among mothers or caregivers and other influencers affects the child feeding and care practices, consequently impacting their nutrition status. Similarly, poor access to, and utilization of, health services as well as environmental contaminants brought about by inadequate water and poor sanitation and hygiene practices, influence the nutrition status at the household level.

Lastly, the **basic** causes of malnutrition appear at the macro level and include issues such as knowledge gap, politics and governance, leadership, infrastructure, and socio-cultural and financial resources. In general, nutrition specific interventions address the manifestation and immediate causes of malnutrition, whereas nutrition sensitive interventions address the underlying causes and enabling environment interventions for the basic causes of malnutrition. Further, food and nutrition security is characteristic of people's physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences. This refers to effective empowerment of all citizens and provision of an equitable enabling environment to become change agents and address the key long-term drivers of food and nutrition security. To achieve this, it is essential to understand the specific needs and vulnerabilities of women, men, girls and boys across all diversities in the county. This will help design tailor-made nutrition programming while equitably building on citizens' capacities, knowledge and experiences, and directing capacity, human and material resources as best needed.

Nutrition is neither a sector nor a domain of one ministry or discipline. It is a multi-sectoral and multi-disciplinary issue with ramifications at the individual, household, community, national and global levels. Addressing all forms of malnutrition at all three levels of causation (immediate, underlying and basic) requires triple-duty actions that have the potential to improve nutrition outcomes across the spectrum of malnutrition through integrated initiatives, policies and programmes. The potential for triple-duty actions emerges from the shared drivers behind different forms of malnutrition, and from shared platforms that can be used to address these various forms. Examples of shared platforms for delivering triple-duty actions include health systems, agriculture and food security systems, education systems, social protection systems, water, sanitation and hygiene (WASH) systems, as well as nutrition sensitive policies, strategies and programmes. Strategies to integrate nutrition specific interventions and nutrition sensitive interventions have been tested and proved effective according to case studies of successful multi-sectoral efforts to integrate actions on nutrition in Senegal and Colombia. (James L. Garrett, Marcela Natalicchio, 2010)

Figure 2.1: Conceptual Framework for Malnutrition



Source: UNICEF, June 2015

2.2 National policy and legal framework for CNAP

The Constitution of Kenya states that every person has the right to be free from hunger and the right to adequate food of acceptable quality (Article 43c), and that every child has the right to basic nutrition (Article 53). The country has the significant responsibility of ensuring communities have access to good quality health care and individuals can live healthy lives. To achieve the goals set out in the Constitution and Vision 2030, Kenya has given legislative force to some key aspects of nutrition interventions.

Legislation includes:

1. Mandatory salt iodization for the prevention and control of iodine deficiency disorders
2. Food Drugs and Chemical Substances Act for mandatory fortification of cooking fats and oils, and cereal flours
3. The Breast Milk Substitutes (Regulation and Control Act) 2012 protects the benefits of breast-feeding
4. Mandatory establishment of lactation stations at workplaces (Health Act Art 71 & 72)
5. The Food, Drugs and Chemical Substances Act (food labelling, additives, and standard (amendment) regulation 2015 on trans fats) provides key legislation central to the control of DRNCD
6. The Nutritionists and Dieticians Act 2007 (Cap 253b) determines and establishes a framework for the professional practice of nutritionists and dieticians

Monitoring compliance is even more critical in the light of devolution. The county's ability to implement and monitor the regulations is crucial and hence is considered within the scope of the CNAP. The county will have a key role in implementing, monitoring and enforcing legislation.

In September 2019, the County Government of Elgeyo Marakwet, in collaboration with Nutrition International, commisioned a nutrition policy and programme review. The purpose of the review was to analyse the status of existing policies and programmes and identify the gaps in order to improve implementation of nutrition specific and nutrition sensitive actions and programmes.

The key findings of the nutrition policy and programmes review are as follows:

- Visibility and prioritization of nutrition and food security in county planning and budgeting have improved in recent years due to concerted stakeholder efforts.
- CIDP 2018-2022 has a considerable emphasis on investments in nutrition and food security interventions across multiple sectors.
- Notable existing gaps in interpretation and implementation of some national policies can be attributed to inadequate dissemination of policy documents, lack of supporting county legislation, inadequate financing and technical capacity to execute policies, among other reasons.
- Dissemination and implementation of some nutrition policies depend heavily on support from NGO partners, thus presenting a sustainability challenge.
- There are numerous ongoing nutrition specific and nutrition sensitive interventions in EMC, which are implemented by both the county government and partners.
- There are efforts to strengthen the enabling environment to enhance effectiveness of multi-sectoral nutrition and food security investment.

Key nutrition actions and interventions being implemented in EMC include:

1. Maternal, Infant and Young Child Nutrition (MIYCN)
2. Promotion of nutrition in older children, adolescents, adults and older persons
3. Prevention, control and management of micronutrient deficiencies
4. Prevention, control and management of Diet-Related Non-Communicable Diseases (DRNCD)
5. Integrated Management of Acute Malnutrition (IMAM)
6. Clinical nutrition and dietetics in disease management including HIV and tuberculosis (TB)
7. Integration of nutrition in agriculture
8. Integration of nutrition in education and early childhood development
9. Integration of nutrition in water, sanitation and hygiene (WASH)
10. Integration of nutrition in social protection programmes
11. Promotion of nutrition in sports

EMC is committed to the vision articulated in the National Food and Nutrition Security Policy that "all Kenyans, throughout their life-cycle, enjoy at all times safe food in sufficient quantity and quality to satisfy their nutritional needs for optimal health." The CIDP 2018-2022 articulates considerable emphasis on investments in nutrition and food security interventions across multiple sectors. All the key recommendations from the review of nutrition policy and programmes have been incorporated within the key results areas in Chapter 3 of this CNAP.

2.3 Vision, mission, and guiding principles

2.3.1 Vision

A county free from all forms of malnutrition.

2.3.2 Mission

To reduce all forms of malnutrition in EMC using a well-coordinated, multi-sectoral and community-centred approach for optimal healthy population and to grow the county's economy.

2.3.3 Core values and guiding principles

- Professionalism
- Integrity
- Accountability
- Partnership
- Teamwork and collaboration
- Innovation
- Ethics
- Equity
- Efficiency and effectiveness
- Quality
- Risk management
- Sustainability and ownership

2.4 Rationale

The CNAP has been developed to further accelerate and scale up efforts towards eliminating malnutrition as a significant public health problem in Kenya by 2030, focusing on specific achievements by 2022.
The three basic rationales for the action plan are:

1. The impact on health: improved nutrition status leads to a healthier population and enhanced quality of life;
2. The economic impact: improved nutrition and health make up the foundation for rapid economic growth; and
3. The ethical argument: optimal nutrition is a human right.

There is existing evidence that improving nutrition contributes to economic productivity, development and poverty reduction by improving physical work capacity, mental capacity and school performance. Improving nutrition is tremendous value for money as it reduces the costs related to lost productivity and health care expenditures. Every dollar spent on nutrition in the first 1,000 days of a child's life can give a saving of an average $45 and in some cases as much as $166. "The returns to investments in nutrition have high benefit cost ratios, and that this should be a top development priority." (Horton and Hoddinott 2013). Investing in early nutrition is one of the best value for money development actions. Additionally, improved nutrition outcomes can have ripple effects across an individual's livelihood and productivity (World Bank.Org)

2.5 Objectives

The objective is to contribute to the national agenda outlined in the KNAP, which is to accelerate and scale up efforts towards the elimination of malnutrition in Kenya, in line with Kenya's Vision 2030 and SDGs, focusing on specific achievements by 2022.
The overall expected result or desired change is that "The entire population of Elgeyo Marakwet County achieves optimal nutrition for a healthier and better quality of life and improved productivity for the county's accelerated social and economic growth." The key strategies that will be adopted in the implementation of CNAP include:

- Life course approach to nutrition programming, which is a holistic approach to nutrition issues for all population groups across different ages, genders and diversity in EMC.

- Gender mainstreaming to ensure consistent application of gender transformative approaches across all interventions in all sectors.

- Coordination and partnerships targeting sectoral and multi-sectoral approaches to enhance programming across various levels and sectors.

- Integration, which will consider the various platforms in place to deliver gender transformative nutrition services (e.g. health centres and schools, and at the community level).

- Strengthening capacity to implement nutrition services that respond to the specific needs of men and women across different ages and diversities. This strategy will target service providers and related systems for Advocacy, Communication and Social Mobilization (ACSM). It acknowledges that improved food and nutrition security for all requires political goodwill for increased investments, advocacy for population-level awareness and increased public support and adoption of good nutrition practices.

- Promoting equity and human rights, especially among vulnerable and marginalized populations, to ensure that every person is free from hunger and has adequate food of acceptable quality.

- Promoting resilience and risk-informed programming that focuses on anticipating, planning and reducing disaster risks to effectively protect people, communities, livelihoods and health.

- Enhancing Monitoring, Evaluation, Accountability and Learning (MEAL)—in other words, promoting the use of the Triple A (assessment, analysis & action) cycle to provide feedback, learn lessons and adjust strategy as appropriate.

- Promoting sustainability of results—recognizing the need to ensure predictable flow of resources, develop technical and managerial capacity of implementers, motivate implementers, ensure vertical and horizontal linkages, and facilitate a gradual exit upon completing an intervention.

2.6 Nutrition through the life-cycle approach

Nutritional requirements vary during different stages of the life-cycle and can be classified into the following groups, which correspond to different stages: pregnancy and lactation, infancy, childhood, adolescence, adulthood, and old age.

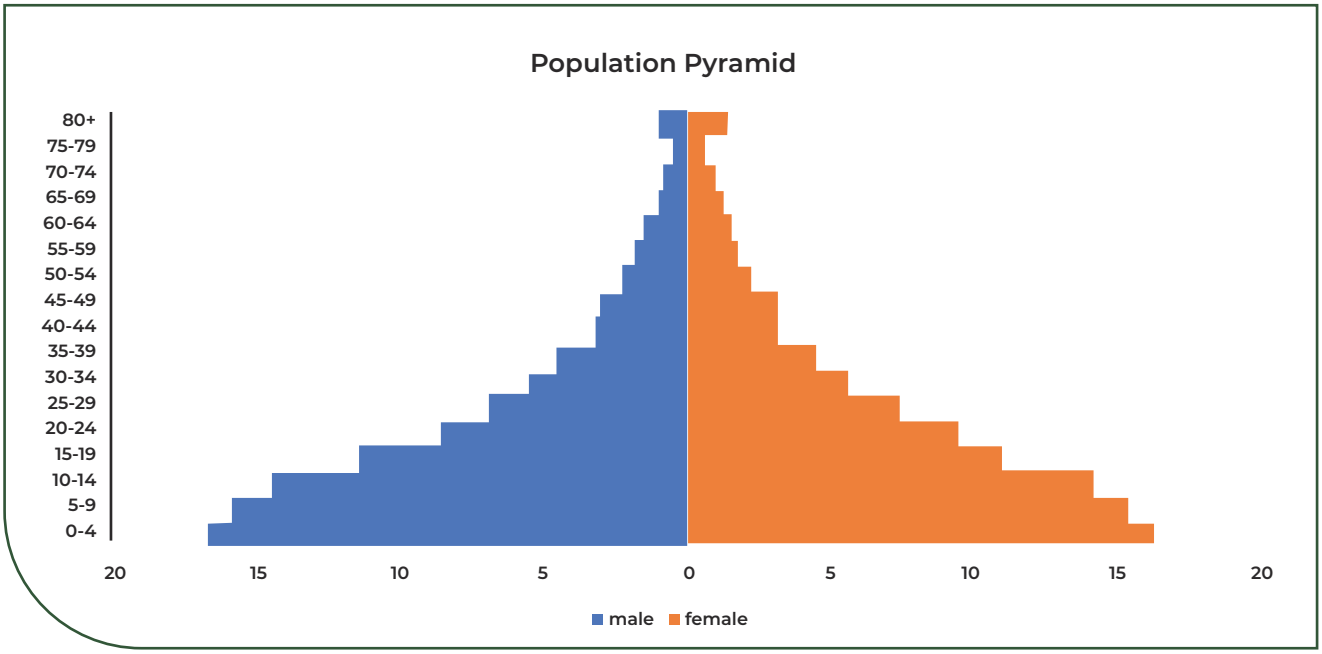
The CNAP takes into consideration the specific nutritional requirements of individuals and groups of all genders and ages, and across social, economic, cultural, and physiological determinan ts and dimensions.

2.6.1 Population pyramid

EMC is currently experiencing the second stage of a demographic transition with a high birth rate and low death rate as indicated in Figure 2.2. In this stage, the population increases at a rapid rate, while life expectancy and the ratio of dependent population also increases.

It should be noted that EMC has the second highest life expectancy among Kenya's 47 counties. This calls for prioritization of interventions that are geared towards addressing the needs of an aging population in the county development plans.

Figure 2.2: EMC Population



Source: CIDP 2018-2022

2.7 Gender mainstreaming

Gender and nutrition are inextricable parts of poverty's vicious cycle, and they are important cross-cutting issues. Gender inequality is a cause, as well as an effect, of malnutrition and hunger. Higher levels of gender inequality are associated with higher levels of acute and chronic under-nutrition. Conversely, gender equality is firmly linked to enhanced productivity, better and more sustainable development outcomes for future generations, and improvements in the functioning of institutions.

Deep-rooted gender inequalities exist within EMC, including unequal access to, and control over, resources and limited decision-making power for women and girls. This inequality denies women and girls equal opportunities to leverage their potential and improve food and nutrition security for themselves, their families and their communities (CIDP, 2018).

Recent drought vulnerabilities have aggravated biased social systems, cultural norms, beliefs and practices that greatly influence the socio-economic vulnerability and human development.

The youth who form the majority of the productive population have been equally left out, and so miss realizing their potential and contributing to the county's socio-economic development. Although men are considered decision-makers and custodians of household and community resources, they are not adequately involved in issues related to nutrition; this role is largely perceived to belong to women.

This can result in a lack of support by men, which can have a significant negative impact on the efforts to improve nutrition and health related outcomes. Other factors that disproportionately affect women and girls and have a negative impact on food and nutrition security include:

- Overburdened mothers
- Socio-cultural beliefs and practices around food sharing and uptake
- Negative cultural practices such as child marriage and forced marriage
- Water scarcity
- Unequal or limited access to information
- Literacy levels

These factors underscore the need to apply a rights-based approach to gender programming, with opportunities to leverage complementary rights-based and gender responsive nutrition principles, all of which have been factored into this CNAP.

Notwithstanding, the roles, priorities, needs and use of resources may differ between men and women. The way women and men are affected by nutrition actions may also differ as demonstrated within the CNAP. Weak inter-sectoral linkages, inadequate gender integration in nutrition assessments, surveys/research, inconsistent collection and use of sex-age disaggregated nutrition data results in a lack of evidence-based decision-making.

To achieve effective and sustainable nutrition and health outcomes, the CNAP integrates a gender transformative approach through effective gender mainstreaming at all levels of nutrition and health interventions. This nutrition action plan uses a variety of approaches to integrate gender into the development process, including:

- Using the life-cycle approach to empower "all residents of Elgeyo Marakwet County, throughout their life-cycle, to enjoy safe food in sufficient quantity and quality to satisfy their nutritional needs for optimal health at all times." The action plan identifies key nutrition interventions for each age cohort and provides the linkages of nutrition to food production and other relevant sectors that impact nutrition.

- Ensuring nutrition programming at all levels in EMC is consistently informed by context-based gender analysis defining the gender issues and relations concerning the specific nutrition needs and priorities of men and women of different ages and diversities across the county.

- Prioritizing specific strategies, interventions and activities to address nutrition needs specific to women, men and adolescents (boys and girls). These help identify and address the socio-cultural, economic, technological and political barriers to achieving gender equality in areas of human rights and equal participation of men and women in key decision processes pertaining to their nutrition and wellbeing.

- Developing and implementing a Social and Behaviour Change Communication (SBCC) strategy to address underlying socio-economic barriers, cultural norms, beliefs, knowledge and practices affecting improved and sustainable food, nutrition and health-related outcomes in EMC.

- Launching support interventions that promote increased male involvement and community engagement on the role men play in supporting improved uptake of optimal nutrition and health practices at the household, community and county levels.

- Strengthening health systems to improve delivery of gender responsive health services by health care workers as well as increased demand and equitable uptake of optimal nutrition and health services and practices by men and women of all ages and diversities in EMC.

- Mainstreaming gender in the CNAP development process by ensuring both females and males are invited and make meaningful contributions to at all stages. This includes active participation in the inception meeting and in intervention prioritization meetings (including validation).

- Including indicators in the result and accountability framework that monitor and evaluate gender transformative nutrition interventions for improved and sustainable nutrition and health related outcomes.

- Enhancing accountability for results to improve transparency, leadership and the quality of statistics and information made available to the various stakeholders and the public through collection, analysis and use of sex- and age-disaggregated data at all levels.

2.8 Development process

The CNAP development process was widely consultative with stakeholders from all units of the Department of Health, representatives from other county departments in (i.e. Health, Agriculture, Education, Water, Gender and Social Services), as well as development partners and Civil Society Organizations (CSO).

The County Nutrition Coordinator gathered evidence through desk reviews of relevant documents and information from key sectors. They also provided guidance and monitored progress throughout the entire development process.

This process ensured that the plan is evidence-informed and recognizes successes, challenges and lessons learnt from the implementation of nutrition activities within the county. The process also ensured that the CNAP is results-based and provides a common results and accountability framework for performance-based Monitoring and Evaluation (M&E).

2.9 Target audience

The CNAP's target audience includes health care planners and policymakers at the national and county levels, global and national decision-makers, nutrition sensitive sectors, nutrition officers and managers at all levels, donors, development partners, NGOs, CSOs, FBOs, the private sector, academia, research institutions, the media and the Kenyan public at large. This will enable stakeholders to understand what the county government is doing to ensure optimal nutrition for all Kenyans and what they can do individually to contribute to the effort.

3 KEY RESULT AREAS, OUTCOMES, OUTPUTS AND ACTIVITIES

3.1 Introduction

The overall expected result or desired change for the CNAP is to contribute to the goal of KNAP 2018-2022 of achieving optimal nutrition for a healthier population that has a better quality of life, as well as improved productivity that supports Kenya's accelerated social and economic growth. To achieve the expected result, a total of 11 key result areas (KRA) have been defined for EMC.

The KRAs are categorized into three focus areas:
1. Nutrition specific
2. Nutrition sensitive
3. Enabling environment

The KRAs have been matched with a corresponding set of expected outcomes and outputs, as well priority activities. For more details, please see Section 3.3.

Table 3.1: Prioritized KRAs per Focus Area

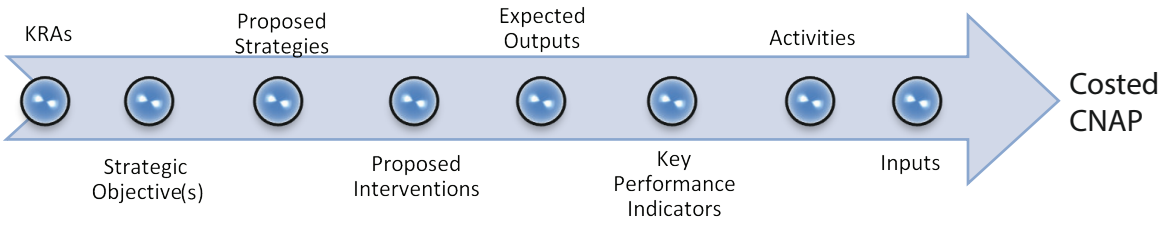
CATEGORY OF KRA BY FOCUS AREA	KEY RESULT AREAS (KRAs)
Nutrition specific	1. Scale up Maternal, Infant and Young Child Nutrition (MIYCN)
	2. Promote nutrition of older children, adolescents, adults, and older persons
	3. Scale up prevention, control and management of micronutrient deficiencies
	4. Scale up prevention, control and management of diet-related risk factors for NCDs
	5. Strengthen IMAM
	6. Strengthen clinical nutrition and dietetics in disease management, including HIV&TB
Nutrition sensitive	7. Strengthen nutrition in sports
	8. Promote and strengthen nutrition in agriculture, education, WASH and social protection
Enabling environment	9. Strengthen sectoral and multi-sectoral nutrition governance (MNG), including coordination and legal/regulatory framework
	10. Strengthen sectoral and multi-sectoral nutrition information systems, learning and research
	11. Strengthen supply chain management for nutrition commodities and equipment

3.2 Theory of change and CNAP logic framework

The Theory of Change (ToC) is a specific type of methodology for planning, participation, and evaluation that is used to promote social change—in this case nutrition improvement.
The ToC defines long-term goals and then maps backward to identify necessary pre-conditions. It describes how and why a desired change is expected to happen in a particular context. The pathway of change for the CNAP is therefore best defined through the ToC.
The ToC was used to develop a set of results that would be realized if certain strategies were deployed to implement prioritized activities. If scaled up, these strategies and activities would contribute to improved nutritional status of EMC residents.

Figure 3.1 shows the logic framework outlining the elements and process used to integrate ToC in the CNAP development. Please refer to Section 3.3 for the expected outcome, expected output and priority activities that align with the logic process.

Figure 3.1: CNAP Logic Process



3.3 Key result areas, expected outcome, outputs and activities

KRA 01: Scale up Maternal, Infant and Young Child Nutrition (MIYCN)

Expected outcome

Improved nutrition status of women of reproductive age and children between the ages of 0-59 months.

Output 1

Enhanced capacity and advocacy, communication & social mobilization for implementation of MIYCN activities at the county level

Interventions/Activities

1. Conduct high level advocacy meeting for policymakers and county leaders on MIYCN
2. Mark world/national nutrition days/weeks (world prematurity day, World Breastfeeding Week, Malezi bora, Nutrition day)
3. Disseminate MIYCN documents (e.g. international code of marketing breast milk substitutes, policy guidelines, implementation strategies etc.) to decision-makers, health care workers and the community
4. Develop policy briefs on various existing national and international MIYCN policies and disseminate to decision-makers and health care workers
5. Pilot and adapt the use of mobile phones to disseminate MIYCN messages and to send reminders to mothers
6. Train HCW on MIYCN
7. Sensitize CHVs on MIYCN

Output 2

Scale-up implementation of baby friendly community initiative (BFCI) and care group approach at community unit level

Interventions/Activities

1. Sensitize county level health care managers on BFCI
2. Train health care workers (HCWs) on BFCI
3. Train community health volunteers (CHVs) on C-BFCI
4. Establish community mother support groups(CMSGs) in cooperating both genders
5. Sensitize Community Health Committee, Primary Health Care Facility Committee, and other community leaders on BFCI targeting both gender

6. Establish BFCI committees at community unit level
7. Establish Mother-to-Mother (MTMSG) support groups at community unit level
8. Conduct monthly MTMSG and FTFSG meetings
9. conduct monthly CHVs meeting
10. conduct quarterly CHVs review meetings on BFCI
11. Conduct self-assessment and continuous self –assessments at community unit level
12. Conduct external assessment for BFCI at community unit level
13. Train/sensitize HCWs and promoters on care group model
14. C nduct monthly meetings for care group volunteers (GV)
15. Conduct support supervision for care groups (CG)
16. Conduct quarterly promoters review meetings for care group review meetings

Output 3
Strengthened baby friendly hospital initiative (BFHI) implementation in level 5, 4 and 3 health facilities

Interventions/Activities
1. Train HCWs on BFHI and kangaroo mother care (KMC)
2. Sensitize HCWs and support staff on BFHI
3. Sensitize HCWs on the importance of early initiation to breastfeeding
4. Establish BFHI committee at health facility level
5. Conduct self-assessment and continuous assessments at health facility level
6. Conduct continuous medical education (CMEs) on BFHI
7. Conduct BFHI external assessment at facility level

Output 4
Strengthened growth monitoring and promotion (GMP) in health facilities

Interventions/Activities
1. Train HCWs on WHO growth monitoring and promotion standards
2. Sensitize CHMT on importance of Growth Monitoring and Promotion (GMP)
3. Conduct On-the-Job Training (OJT), Continuous Medical Education (CME) and mentorship to HCWs in health facilities on GMP
4. Train HCWs to effectively mainstream gender in nutrition programming for improved provision and implementation of gender responsive nutrition and health services and interventions

Output 5
Enhanced adherence to policies and legislations protecting, promoting and supporting breastfeeding at the workplace and among the general population

Interventions/Activities
1. Procure MIYCN legislation documents from government printers (e.g. Health Act 2017, Breast Milk Substitute (regulations and control) Act,2012 and Public Health Act)
2. Advocate for establishment of breastfeeding space/lactation stations at the workplaces
3. Hold advocacy meeting with key stakeholders (e.g. employers within the county)
4. Train HCWs, employers, manufacturers and retailers on the Breast Milk Substitute (BMS) Act, 2012, mandatory law on food fortification and implementation framework for securing a friendly breastfeeding environment at work place
5. Sensitize HCWs on importance of having breastfeeding spaces/lactation stations at the workplace

Output 6
Improved MIYCN knowledge among caregivers, influencers and community members

Interventions/Activities
1. Develop and disseminate a county specific complementary feeding recipe book and materials, such as brochures, posters, etc.
2. Conduct food demonstrations on dietary diversity at the community level
3. Conduct nutrition education for mothers of children 0-23 months at the community level
4. Establish social support groups at the community level
5. Sensitize mothers on importance of EBF using barazas, market activation, radio spots, events and ceremonies
6. Conduct community health and nutrition education targeting men to encourage increased engagement and support for MIYCN
7. Train community peer-to-peer support groups on agri-nutrition livelihood activities and Income Generating Activities (IGAs) and link the peer groups to productive livelihood-based sectors and financial institutions for support
8. Advocate for enforcement of the school re-entry policy for teenage mothers at least one year after delivery to allow uptake of EBF and optimal complementary feeding at the community level
9. Train mother-to-mother support groups on IGAs, household based agri-nutrition technologies and linkages to other productive livelihood-based sectors and financial institutions for support
10. Sensitize the community on dietary diversification including production, storage, preparation and uptake of nutritious, locally available traditional foods

KRA 02: Promote nutrition of older children, adolescents, adults, and older persons

Expected outcome
Increased nutrition awareness and uptake of nutrition services for improved nutritional Status of older children (5-9 years) adolescents (10-19 years), adults and older persons

Output 1
Improved policy environment at county, sub-county and community level for older children (5-9 years), adolescents (10-19 years), adults and older persons

Interventions/Activities
1. Disseminate policies and guidelines (e.g. food-based dietary guidelines, school meal guidelines, healthy diet and lifestyle guidelines, comprehensive school health guidelines) to CHMT, SCHMT, HCWs and other key stakeholders
2. Conduct dissemination meetings for CHMT, SCHMT and HCWs on healthy diets and lifestyle guidelines
3. Sensitize the community on healthy diets and lifestyles and physical activity by equally targeting men and women across different ages and diversities through organized community forums, churches, etc.

Output 2
Increased awareness among board of school management (BOM) members and teachers on optimal nutrition for older children and adolescents.

Activities
1. Carry out high level advocacy meeting targeting key decision-makers on school meal/feeding programs
2. Train/sensitize school board of management (BOM) and teachers on nutrition for older children and adolescents
3. Train/sensitize school BOM and teachers on school meal guidelines and comprehensive school health policy & guidelines
4. Conduct gender sensitive assessment on Body Mass Index (BMI) for older children and adolescents between the ages of 5-19 years

Output 3
Increased Weekly Iron Folic Acid Supplementation (WIFAS) intake among adolescent girls in schools.

Activities
1. Train/sensitize school BOM, head teachers, teachers and HCWs on WIFAS for adolescent girls
2. Conduct school health education targeting adolescent girls on the importance of WIFAS
3. Procure and distribute WIFAS in selected schools
4. Conduct WIFA Supplementation to adolescent girls in selected schools
5. Conduct joint monitoring of the WIFAS programme and the school meal programme
6. Prepare and submit WIFAS plans

Output 4
Improved knowledge and skills among HCWs and CHVs on optimal nutrition for adults and older persons.

Activities
1. Train/sensitize HCWs on optimal nutrition for adults and older persons (geriatric nutrition)
2. Carry out CMEs in health facilities on optimal nutrition for adults and older persons
3. Sensitize health care providers on nutrition for the elderly
4. Sensitize CHVs on optimal nutrition for adults and older persons (geriatric nutrition)
5. Link and refer older persons to social protection support systems at community level

KRA 03: Scale up prevention, control and management of micronutrient deficiencies

Expected outcome
Improved micronutrient status for children, adolescents, women of reproductive age, men and older persons

Output 1
Increased knowledge of HCWs and CHVs on the importance of micronutrient intake.

Activities
1. Develop and disseminate educational materials (brochures, factsheets) on importance of micronutrients among the population
2. Train health care workers on micronutrient powders (MNPs)
3. Train health care workers on Vitamin A supplementation (VAS)
4. Train health care workers on iron folic acid supplementation (IFAS)
5. Conduct OJT and CME on prevention, control and management of micronutrient deficiencies
6. Conduct support supervision for micronutrient program by CHMT and SCHMT

7. Procure and distribute VAS,IFAS,MNPS, dewormers ,ZINC and ORS to health facilities within the county

Output 2
Increased dietary diversity and Bio-fortification of food

Activities
1. Conduct community mobilization to promote micronutrient intake at household level
2. Disseminate Behaviour Change Intervention (BCI) strategy on micronutrients to health care workers and CHVs to increase uptake among the population
3. Promote increased production, preservation and consumption of micronutrient-rich foods at household level
4. Sensitize community members on growing and utilization of diversified and bio-fortified crops
5. Sensitize the nutritionists, extension workers, CHVs, on food diversification and bio-fortification

Output 3
Promote compliance, production and consumption of fortified foods

Activities
1. Train public health officers on monitoring of fortified foods in the market and enforcement of policies and regulations around food fortification
2. Conduct annual monitoring of salt iodization at community level
3. Sensitize CHMT,SCHMT and health care workers on mandatory law on food fortification including fortified foods in the market and fortification logo
4. Sensitize CHVs on mandatory law on food fortification including fortified foods in the market and fortification logo
5. Sensitize community members on food fortification including fortified foods in the market and fortification logo through community forums

KRA 04: Scale up prevention, control and management of diet-related risk factors for NCDs

Expected Outcome
Improved detection and management of diet related NCDs.

Output 1
Increased capacity of HCWs and the communities to handle diet related NCDs.

Activities
1. Establish NCD taskforce at the county level
2. Conduct gender integrated survey on nutrition-related risk factors for diet related NCDs
3. Disseminate the national strategy for the prevention and control of NCDs to CHMT,SCHMT and health care workers
4. Train HCWs and CHVs on prevention, control and management of diabetes, hypertension and cancer
5. Conduct quarterly performance review meeting on nutrition status of adults between the ages of 18-69 years

Output 2
Increased awareness on DRNCD prevention, control and management at the community level.

Activities
1. Conduct nutrition screening/assessment for adults at community and facility levels
2. Conduct social mobilization and advocacy on DRNCDs at the community level, equally targeting men and women across different ages and diversities using different forums

Output 3
Quality and timely provision of nutrition therapy in management of DRNCDs

Activities
1. Conduct individual nutrition assessment and counselling to all clients with diet related NCDs at health facility level
2. Establish/reactivate NCD support groups in the health facilities in collaboration with other departments
3. Carry out nutrition education to DRNCD support groups
4. Advocate for procurement of nutrition supplies and equipment for NCDs screening

KRA 05: Integrated management of acute malnutrition (IMAM) strengthened

Expected outcome:
Increased coverage of integrated management of acute malnutrition (IMAM) services

Output 1
Strengthened capacity of HCWs and CHVs to provide gender transformative IMAM services

Activities
1. Disseminate policies and guidelines on IMAM to CHMT,SCHMT and health care workers
2. Train HCWs and CHVs on IMAM, and how to effectively identify, document and address underlying social, cultural and economic factors that contribute to malnutrition and that affect optimal adherence to IMAM services and relapse by MAM/SAM patients

Output 2
Enhanced early detection and treatment of malnourished children.

Activities
1. Conduct nutrition screening for children at community level and refer appropriately to the link health facilities
2. Increase the number of health facilities implementing IMAM programme
3. Sensitize the community through the local media on prevention of acute malnutrition
4. Conduct nutrition assessment, counselling and support to IMAM clients at health facility level
5. Carry out defaulter tracing, follow-up and referrals for IMAM across all levels
6. Link and refer IMAM clients to other relevant programs using the available mechanisms

Output 3
Improved IMAM data generation.

Activities
1. Promote appropriate documentation of related research, best practices and learning
2. Conduct quarterly performance review meetings on IMAM program
3. Conduct quarterly data quality audit on IMAM in all health facilities offering IMAM services
4. Conduct targeted support supervision in all facilities offering IMAM services

Output 4
Strengthened supply chain management for IMAM commodities

Activities
1. Procure and distribute nutrition commodities for management of acute malnutrition
2. Sensitize HCWs on logistic management and information system ,forecasting and quantification of IMAM commodities

KRA 06: Strengthen clinical nutrition and dietetics in disease management, including HIV&TB

Expected outcome 1
Improved access to quality clinical nutrition and dietetics services.

Output 1
Policies and guidelines on clinical nutrition and dietetics disseminated to CHMT, SCHMT and HCWs

Activities
1. Disseminate clinical nutrition and dietetics policy guidelines to the CHMT, SCHMT ,health facility in-charges (HFI/C) and health care workers
2. Disseminate nutrition therapy guidelines for infant and young child nutrition and HIV care
3. Disseminate nutrition therapy guidelines for HIV, TB and related co-morbidities to the CHMT, SCHMT ,(HFI/C) and health care workers
4. Adopt and disseminate county Nutrition Assessment and Counselling Services (NACS) guidelines to CHMT, SCHMT , (HFI/C) and health care workers
5. Disseminate enteral and parenteral nutrition therapy guidelines to CHMT,SCHMT,HFI/C and health care workers

Output 2
Improved competencies, skills and knowledge of nutritionists and dieticians.

Activities
1. Train HCWs on nutrition care process in disease management
2. Train HCWs on Logistics Management Information Systems (LMIS) for commodities used for in-patient management
3. Train nutrition officers on specialized clinical nutrition courses for management of diseases (e.g. oncology, renal, diabetes etc…)
4. Adopt and utilize clinical nutrition, monitoring and reporting tools in all the health facilities
5. Train HCWs on pre-term and low birth weight management
6. Carry out nutrition assessment, counselling and support to clients in both outpatient and in-patients services delivery points

Output 3
Enhanced standards for quality nutrition and dietetics services for in-patients and general hospital services.

Activities
1. Adopt gender sensitive scorecards for nutrition indicators including NACS
2. Conduct annual gender sensitive quality assurance assessment for clinical nutrition
3. Develop and disseminate simplified protocols or standard operating procedures for nutrition management in diseases and conditions for in-patient care
4. Hold stakeholder consensus meetings
5. Advocate for integration of nutrition screening, assessment and triage areas in all health facilities
6. Conduct quarterly data review meetings for clinical nutrition and dietetics
7. Develop and disseminate in-patient feeding protocols to CHMT, SCHMT and HCWs
8. Establish/strengthen in-patient feeding committees in health facilities offering in-patient care
9. Develop inter-facility nutrition referral protocol

Output 4
Improved supply chain for clinical nutrition and dietetics

Activities
1. Procure parenteral and enteral commodities for disease management
2. Procure clinical nutrition assessment tools, feeding pumps, giving sets, anthropometric equipment's
3. Procure and install special equipment for dietary modification in health facilities offering in-patient care

Expected Outcome 2: HIV /TB
Reduced impact of HIV-related co-morbidities among people living with HIV through targeted nutrition therapy

Output 1
Improved routine screening for nutrition related problems and referral for all PLHIV and TB patients

Activities
1. Train health workers through in-person continuous professional development on integrated nutrition therapy for TB/HIV nutrition
2. Disseminate and make available new training guidelines and policies for HIV/TB to the county, sub-county, facility, and community-level workforce
3. Adopt and disseminate context-specific job aids for patient-focused nutrition therapy and interpersonal counselling t health care workers
4. Scale up nutrition screening at HIV/TB service points while simultaneously strengthening facility referral linkages for HIV/TB patients

Output 2
Increased coverage for nutrition screening and referral of PLHIV and TB patients

Activities

1. Offer comprehensive nutrition assessments, counselling and support in all HIV, TB, MNCH service points to reduce missed opportunities and improve service uptake and retention into care
2. Invest in adaptive and innovative mechanisms that enhance delivery nutrition interventions for children and adolescents exposed or living with HIV/TB
3. Implement county-level forecasting, quantification, and supply planning exercises through integrated operationalized county-level commodity security committees
4. Utilize routine supply chain monitoring, including electronic Logistic Management Information System (LMIS) systems, to minimize stock outs, avoid expiries, and over/under-stocking of HIV/TB nutrition commodities

Output 3

Strengthened integration of nutrition interventions for home-based care at community level for PLHIVs towards the 90.90.90

Activities

1. Develop/adopt and disseminate a series of small doable actions that enhance dietary diversity and physical exercises at household level for HIV and TB patients
2. Train CHVs and other community resource persons to promote healthy and sustainable lifestyles at household level
3. Adopt and disseminate key context-specific nutrition messages that promote positive lifestyles and behaviour for HIV /TB patients
4. Conduct outreaches, referrals, and linkage systems to involve all community actors and optimize identification and linkage of PLHIV and TB patients with nutrition care and management

KRA 07: Strengthen nutrition in sports

Expected outcome

Improved nutrition status of athletes.

Output 1

Quality data on sports nutrition generated for evidence-based programming.

Activities

1. Conduct gender integrated baseline survey and situational analysis of nutrition and health status for athletes
2. Conduct benchmarking/learning visits for policymakers and implementers in countries with best practices on sports nutrition

Output 2

Improved performance of athletes and quality programming on sports nutrition.

Activities

1. Develop and review gender sensitive strategies, guidelines, standard operating procedures (SOP) on sports nutrition
2. Develop sports nutrition training package for athletes
3. Develop a sports nutrition advocacy package at county level
4. Train HCWs on sports nutrition
5. Sponsor HCWs to specialize in sports nutrition

Output 3
Increased priority accorded to sports nutrition at the county.

Activities
1. Advocate for a budget line for sports nutrition to address procurement and distribution of sports nutrition commodities
2. Hold high level sensitization meetings for policymakers on sports nutrition
3. Promote collaboration with other health sector interventions to promote sports nutrition Ministry of Agriculture, Livestock, Fisheries and Irrigation (MOALF&I), MOH, Industry, Finance, Gender, Sports) and the private sector.

Output 4
Increased performance of athletes and other men and women in sport.

Activities
1. Conduct gender sensitive nutritional screening and assessment for athletes
2. Establish separate gender responsive nutrition counselling and recovery centre for athletes
3. Hold nutrition counselling sessions for athletes in training centres, camps and clubs
4. Promote food safety and proper sanitation practices in training centres, camps and clubs
5. Sensitize athletes and community members on sports nutrition using effective communication strategies

KRA 08: Promote and strengthen nutrition in agriculture, education, WASH and social protection

Expected outcome 1: Agriculture
Linkages between nutrition, agriculture and food security strengthened

Output 1
Strengthened agri-nutrition capacities and coordination at county levels

Activities
1. Train health workers and agriculture extension workers on agri-nutrition
2. Participate in agri-nutrition coordination mechanisms at county level and between private and public sectors

Output 2
Improved access to nutritious and safe foods along the food value chain

Activities
1. Establish five kitchen gardens and hold cooking demonstration in 60 community units
2. Promote uptake of food processing, preservation and storage technologies

Output 3
Consumption of safe, diverse, and nutritious foods promoted

Expected outcome 2: Education
Nutrition mainstreamed in education sector policies, strategies and action plans

Output 1
Policies, strategies, standards and guidelines on nutrition and physical activity in schools and other learning institutions adopted and promoted

Activities
1. Sensitize school stake holders on existing school health policies ,guidelines and strategies (school health policy, school meals guidelines)
2. Advocate for inclusion of nutrition and physical activity themes in co-curricular school activities (drama, music, talent shows, contests, symposia)
3. Sensitize stakeholders including, curriculum support officers, food service providers and handlers, Parent–Teacher Associations (PTA) on healthy and safe food environment

Output 2
Nutrition assessments in schools and other learning institutions conducted

Activities
1. Sensitize school stakeholders on nutrition assessments , Vitamin A and deworming in schools
2. Procure nutrition assessment equipment for schools
3. Conduct bi-annual nutritional status assessments, Vitamin A supplementation and deworming in schools
4. Establish a referral system for health and nutrition interventions for those assessed to link health facilities

Expected outcome 3: WASH
Nutrition integrated into WASH policies, strategies, plans and programmes

Output 1
Collaboration with relevant stakeholders on WASH strengthened

Activities
1. Participate in high level advocacy meetings for adoption of WASH activities in institutions
2. Participate in development of IEC materials for WASH and nutrition activities
3. Advocate for the provision of adequate potable water and safe storage within households, health facilities and schools
4. Advocate for protection of water sources and regular water treatment quality checks

Output 2
Optimal WASH practices promoted

Activities
1. Sensitize CHVs and community members across different ages and diversities on WASH practices
2. Conduct sensitization meeting to community members on safe and hygienic practices during food preparation and storage
3. Integrate WASH messages (hand washing, safe water storage ,water treatment latrine use and hygiene) during nutrition sessions
4. Promote environmental hygiene at household level

Expected outcome 4: Social Protection
Integration of nutrition in social protection programmes strengthened

Output 1
Nutrition promoted and linkages enhanced in social protection programmes including in crisis

Activities
1. Adopt and disseminate targeting criteria for nutrition in social protection programmes; cash transfers, hunger safety nets, and others
2. Advocate for inclusion of nutrition indicators in the M&E of social protection interventions
3. Scale up social safety nets in times of crises
4. Conduct stakeholder mapping of various players in social protection
5. Enhance participation of nutrition stakeholders in social protection coordination mechanisms
6. Train stakeholders in social protection programmes on good nutrition practices
7. Conduct a baseline survey/situation analysis on status of nutrition and health for the vulnerable groups
8. Prioritize vulnerable groups on IGAs towards nutrition interventions
9. Sensitize the community members on health and nutrition of vulnerable groups

Output 2
Strengthened advocacy, communication and social mobilization for social protection

Activities
1. Advocate for governance and accountability for nutrition and social protection for vulnerable groups
2. Collaborate with Department of Children Services, Gender and Social Services to hold advocacy forums for improved nutrition for vulnerable groups
3. Advocate for harmonization of nutrition and social protection services for vulnerable groups
4. Advocate for the linkage of nutrition services and social protection for all vulnerable groups to National Hospital Insurance Fund (NHIF)
5. Advocate for high-level consultations for promotion of health and nutrition for vulnerable groups at County levels
6. Sensitize (a) the public and b) management of institutions of vulnerable persons and correction facilities on health and nutrition

KRA 09: Strengthen sectoral and multi-sectoral nutrition governance (MNG) including coordination and legal/regulatory framework

Expected outcome
Efficient and effective nutrition governance and coordination, with legal and M&E frameworks in place

Output 1
Increased advocacy activities for nutrition.

Activities
1. Hold high level advocacy meetings on equitable hiring of additional male and female nutritionists with the county health executive members and members of the county assembly.
2. Hold advocacy forums for increased resource allocation for clinical nutrition and dietetics.

Output 2
Enhanced existing nutrition coordination and collaborating mechanisms and linkages between national and county governments

Activities

1. Map nutrition partners and stakeholders in the county
2. Hold county and sub –county nutrition technical forums at county level as per TORs
3. Support the establishment and functionality of the Food and Nutrition Security Council and all other structures as approved in the NFNSP-IF at county levels
4. Enhance representation of nutrition at other sectoral forums at county and sub-county level
5. Conduct performance assessment reviews on coordination
6. Support annual County , national ,regional and international learning forums.
7. Hold quarterly governance and accountability meetings

Output 3

Nutrition resource mobilization and accountability tracked

Activities

1. Create a coordinated mechanism for resource mobilization at county level
2. Develop nutrition stakeholder's framework
3. Disseminate a costed CNAP to the county government and stakeholders
4. Develop and disseminate second generation costed CNAP
5. Develop and disseminate nutrition annual work plans
6. Conduct nutrition resource tracking at county and sub-county level
7. Hold nutrition stakeholder review forums
8. Hold public engagements on nutrition services
9. Support participation and representation of nutrition sector in citizen-participation forums at all levels.

KRA 10: Strengthen sectoral and multi-sectoral nutrition information systems, learning and research

Expected outcome

Sectoral and multisectoral nutrition information systems, learning and research strengthened

Output 1

Enhanced evidence-based data for planning and programming.

Activities

1. Conduct gender integrated formative research for MIYCN
2. Conduct gender integrated SMART nutrition survey
3. Conduct MIYCN KAP survey
4. Conduct nutrition capacity assessment for the county
5. Disseminate nutrition survey and assessment findings to stakeholders within the county
6. Develop and use a nutrition multisectoral nutrition scored card to monitor key CNAP indicators bi-annually
7. Upload gender sensitive nutrition reports and bulletins to the county website

Output 2

Ensured data quality for nutrition

Activities
1. Avail airtime for data entry of nutrition reports
2. Carry out nutrition support supervision
3. Conduct gender sensitive and integrated nutrition data quality audits.
4. Support health facilities with gender sensitive nutrition reporting tools
5. Conduct quarterly data review meetings for nutrition activities

Output 3
Improved decision making through research evidence

Activities
1. Develop strategic partnerships and networks in addressing county research agenda (county departments, partners, private sector, etc.)
2. Advocate for research prioritization both at county levels
3. Participate in research coordination committees in the county
4. Advocate for financial support to train nutritionist in research methodologies, knowledge translation and systematic review processes
5. Hold forums for dissemination of research findings and information sharing
6. Participate in knowledge sharing forums such as nutrition symposiums and conferences, workshops, meetings
7. Establish an effective mechanism for knowledge management and learning
8. Promote knowledge sharing through publication
9. Establish research repository for nutrition and dietetics within the county

KRA 11: Strengthen supply chain management for nutrition commodities and equipment

Expected outcome
Strengthened integrated supply chain management system for nutrition commodities, equipment and allied tools.

Output 1
Increased capacity of health care providers to manage nutrition commodities.

Activities
1. Adopt and disseminate guidelines, SOPs and tools for nutrition commodities
2. Conduct training on LMIS including inventory management for health workers
3. Conduct nutrition commodity data audits and review meetings

Output 2
Ensured quality of all nutrition commodities and equipment.

Activities
1. Conduct annual forecasting and quantification exercises for nutrition department
2. Conduct joint support supervision and end user monitoring
3. Monitor end-user of nutrition commodities on a regular basis
4. Conduct redistribution of nutrition commodities
5. Hold joint meetings with food and safety division to ensure nutrition commodities are of good quality

6. Hold quarterly commodity security meetings
7. Conduct Data Quality Assurances (DQA) on commodity management
8. Sensitize staff on commodity management informed by data based on gender, age and diversity
9. Conduct monthly forecasting and quantification for nutrition commodities
10. Advocate for a standing budget line for nutrition commodities and equipment and increased allocation for procurement and distribution of nutrition commodities at county level

Output 3

Ensured availability of nutrition commodities, equipment, resources and management of supply chain.

Activities

1. Adopt guidelines and SOPs for nutrition commodities and tools
2. Procure and distribute nutrition equipment
3. Procure and distribute nutrition supplies and commodities
4. Print BFHI and BFCI assessment and reporting tools
5. Print IMAM data collection and reporting tools
6.Procure Digisomo and customize key messages
7. Renovate existing commodity stores to enhance capacity
8. Review Equitable Development Act 2014 to ring-fence budget line for nutrition commodities and equipment

4 MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING FRAMEWORK

4.1 Introduction

This chapter provides guidance on the monitoring, evaluation, accountability, and learning process, and how the monitoring process will inform the CNAP. The CNAP will evolve as the county assesses data gathered through monitoring.

Monitoring and evaluation (M&E) systematically tracks the progress of suggested interventions and assesses their effectiveness, efficiency, relevance and sustainability. Information generated from routine monitoring will measure progress towards intended results. The information will indicate whether there was an actual change (e.g. the situation got better or worse) which helps inform decision-making. Regular monitoring helps detect obstacles and enables data-driven decisions to address them. A programme may remain on course or change significantly based on the data obtained through monitoring. M&E therefore form the basis for modification of interventions and assessment of the quality of activities being conducted.

It is critical to have a transparent system of joint periodic data and performance reviews that involves key health stakeholders who use the information it generates. /To ensure ownership and accountability, the nutrition programme will maintain an implementation tracking plan, which will keep track of review and evaluation recommendations and feedback. Stakeholders may include donors, departments, staff, national government and the community. Stakeholder involvement contributes to better data quality because it reinforces their understanding of indicators, the data they expect to collect, and how those data will be collected. In addition, it helps to ensure that their user needs will be satisfied.

It is crucial to assess the technical M&E capacity of the programme within the county. This includes the data collection systems that may already exist and the level of skill of the staff in conducting M&E. Approximately 10 percent of a programme's total resources should be slated for M&E, which may include the creation of data collection systems, data analysis software, information dissemination and M&E coordination.

4.2 Background and context

The CNAP outlines expected results, which if achieved, will move the county and country towards attaining the nutrition goals described in the global commitment (e.g. the World Health Assembly, SDGs, NCDs) and national priorities outlined in the KNAP and the Food and Nutrition Security Policy. It also describes the priority strategies and interventions necessary to achieve the outcomes, the strategy to finance them, and the organizational frameworks (including governance structure) required to implement the plan.

4.3 Purpose of the MEAL plan

The CNAP Monitoring Evaluation Accountability and Learning (MEAL) plan aims to provide strategic information needed to make evidence-based decisions at the county level by developing a Common Results and Accountability Framework (CRAF). The CRAF will form the basis of one common results framework that integrates the information from the various sectors related to nutrition, as well as information coming from other non-state actors (e.g. private sector, CSOs, NGOs) and external actors (e.g. development partners, technical partners) resulting in overall improved efficiency, transparency and accountability.

While the CNAP describes the current situation (situation analysis), and strategic interventions, the MEAL plan outlines what indicators to track when, as well as how and by whom data will be collected. It suggests the frequency and the timeline for collective programme performance reviews with stakeholders.
Elements to be monitored will be disaggregated by sex and age, and will include:

- Service statistics and utilization
- Service coverage/outcomes
- Client/patient outcomes (behaviour change, morbidity)
- Client access to services
- Quality of health services
- Impact of interventions
- Client experience/satisfaction

The evaluation plan will elaborate on the periodic performance reviews/surveys and special research that complement the knowledge base of routine monitoring data. It contains evaluation questions, sample and sampling methods, research ethics, data collection and analysis methods, timing/schedule, data sources, variables and indicators.
In effort to ensure gender integration at all levels of the CNAP, all data collected, analyzed, and reported on will be broken down (disaggregated) by sex and age to provide information and address the impact of any gender issues and relations, including benefits from the nutrition programming for men and women. Sex disaggregated data and monitoring can help detect any negative impact of nutrition programming or issues with targeting in relation to gender. Similarly, positive influences and outcomes from the interventions supporting gender equality for improved nutrition and health outcomes shall be documented and learnt from to improve and optimize interventions. Other measures that will be in place to mainstream gender in the MEAL plan will include:

- Developing/reviewing M&E tools and methods to ensure they document gender differences.
- Ensuring that terms of reference for reviews and evaluations include gender-related results.
- Ensuring that M&E teams (e.g. data collectors, evaluators) include men and women, as diversity can help in accessing different groups within a community.
- Reviewing existing data to identify gender roles, relations and issues to help set a baseline prior to the design of nutrition programming.
- Holding separate interviews and Focus Group Discussions (FGD) with women and men across different ages and diversities, including other socio-economic variations.
- Including verifiable indicators focused on the benefits of the nutrition programming for women and men.
- Integrating gender-sensitive indicators to identify gender-related changes leading to improved nutrition and related health outcomes over time.

4.4 MEAL team

The county M&E units or equivalent will be responsible for overall oversight of M&E activities. The functional linkage of the nutrition programme to the Department of Health and the overall county inter-sectoral government M&E will be conducted through the county Monitoring and Evaluation Technical Working Group (M&E TWG). Health department M&E units will be responsible for the day-to-day implementation and coordination of the M&E activities to monitor this action plan.

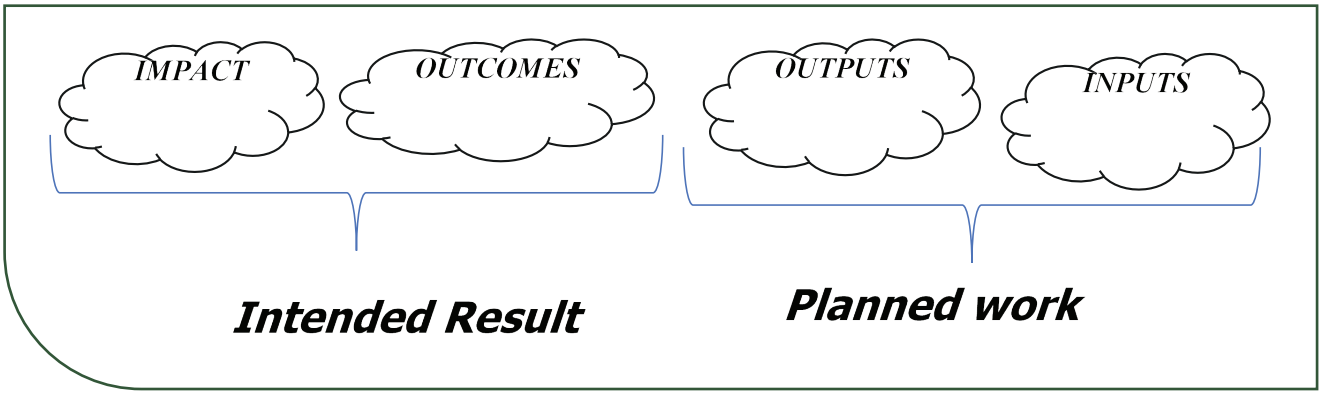
The nutrition programme will share their quarterly progress reports with the County Department of Health (CDOH) M&E unit, which will take the lead in the joint performance reviews at the sub-national level. The county management teams will prepare the quarterly reports in collaboration with county stakeholders and will organize the quarterly county performance review forums. These reports will be shared with the national M&E unit during the annual health forum, which brings together all stakeholders in health to assess the performance of the health sector for the year under review.

For successful monitoring of this action plan, the county will have to strengthen its M&E function by investing in the infrastructure and the human resources for M&E. Technical capacity building for data analysis could be promoted through collaboration with research institutions or training that targets the county M&E staff. Low reporting from other sectors on nutrition sensitive indicators is still a challenge because the different reporting systems used are not inter-operational.

Therefore, investment in Health Information System (HIS) infrastructure to facilitate e-reporting is key. Timely collection and quality assurance of health data will improve with a dedicated team.

4.5 Logic model

The logic model looks at what it takes to achieve intended results. It links the expected results with the strategies, inputs and outputs to provide a shared understanding of the relationships between expected results, activities conducted, and resources required.



The results framework in Table 4.1 is expressed in a logical model from inputs to outputs and outcomes.

Table 4.1: Results Framework

<table>
<tr><td>OUTCOME</td><td colspan="6">IMPACT: IMPROVED NUTRITION STATUS OF THE PEOPLE OF ELGEYO MARAKWET COUNTY

1. Reduction in under-nutrition: (i) Reduced prevalence of stunting among children <5years by 40%; (ii) Reduce and maintain childhood wasting to less than 5%.
2. Reduction in over-nutrition: (i) Number decrease in childhood overweight/obesity.
3. Reduction of micronutrient deficiencies: (i) Reduce folic acid deficiency among non-pregnant women by 50%; (ii) Reduce vitamin A deficiency in children by 50%; (iii) Reduce iodine deficiency among children <5 years by over 50%.</td></tr>
<tr><td>OUTPUTS</td><td>Output 1
Increased priority accorded to nutrition at county level</td><td>Output 2
Strengthened capacity of managers, health care providers and CHVs to deliver quality nutrition services</td><td>Output 3
Improved knowledge of healthy diets and practices among the community</td><td>Output 4
Sufficient health services and a healthy environment</td><td>Output 5
Increased intake of micronutrient rich foods</td><td>Output 6
Improved financing for nutrition</td></tr>
<tr><td rowspan="7">INPUTS</td><td colspan="3">1. Organization of service delivery for nutrition</td><td colspan="3">7. Nutrition research</td></tr>
<tr><td colspan="3">2. Human resources for nutrition</td><td colspan="3">8. Nutrition leadership</td></tr>
<tr><td colspan="3">3. Nutrition infrastructure</td><td colspan="3">9. Household access to better quality and quantity of resources</td></tr>
<tr><td colspan="3">4. Nutrition products and technology</td><td colspan="3">10. Financial, human, physical and social capital</td></tr>
<tr><td colspan="3">5. Nutrition information</td><td colspan="3" rowspan="2">11. Socio-cultural, economic and political context</td></tr>
<tr><td colspan="3">6. Nutrition financing</td></tr>
</table>

4.6 Implementation plan

The county will spearhead implementation of the MEAL framework in collaboration with development partners and stakeholders to support the successful implementation of the CNAP.

To ensure coordinated, structured and effective implementation of the CNAP, the county government will work with partners and the private sector to ensure implementation by:

a) Developing SOPs for data management, monitoring, evaluation and learning among all stakeholders
b) Improving performance monitoring and review process
c) Enhancing sharing of data and use of information for evidence-based decision-making

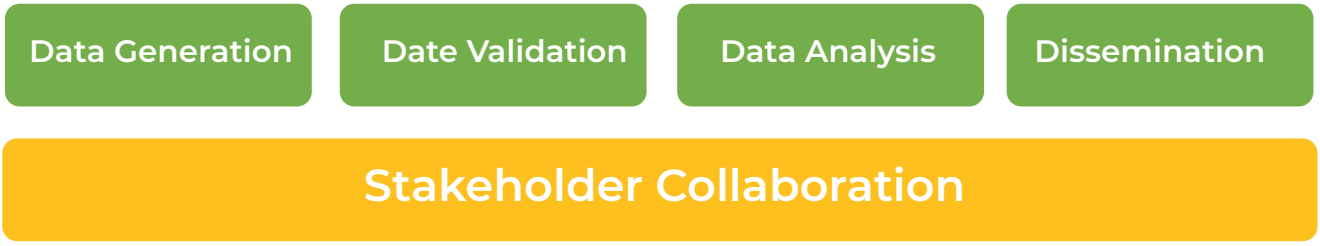
4.7 Monitoring process

To achieve a robust monitoring system, effective policies, tools, processes and systems should be in place and adequately disseminated. The collection, tracking and analysing of data ensures effective implementation and informs decision-making. The critical elements to be monitored are:

- Resources (inputs)
- Service statistics
- Service coverage/outcomes
- Client/Patient outcomes (behaviour change, morbidity)
- Investment outputs
- Access to services
- Impact assessment

The key monitoring processes will incorporate inputs from various stakeholders as outlined, and will involve data generation, data validation, data analysis and dissemination (see Figure 4.1).

Figure 4.1: Monitoring Process



Data generation

- Various types of data will be collected from different sources to monitor the implementation progress. These data will be collected through routine methods, surveys, sentinel surveillance and periodic assessments among others.
- Routine data will be generated using the existing mechanisms and uploaded to the KHIS monthly.
- Strong multi-sectoral collaboration will occur with nutrition sensitive sectors.
- Data flow from the primary source through the levels of aggregation to the national level will be guided by reporting guidelines and SOPs.
- Data from all reporting entities is expected to reach MOH by agreed timelines for all levels.

Data validation

- Data validation involves checking or verifying whether the reported progress is of the highest quality and ensures that data elements are clear and captured in various tools and management information systems through regular data quality assessments.
- Annual and quarterly verification processes will be carried out to review the data across all the indicators.

Data analysis

- This step ensures data is transformed into information that can be used for decision-making at all levels.
- Data analysis will be conducted during continuous monitoring and during evaluations. Products of the analysis will be user specific, targeting a variety of audiences.

Information dissemination

- Information products developed will be routinely disseminated to key sector stakeholders and the public as part of the quarterly and annual reviews to get feedback on the progress and plan for corrective measures

Stakeholder Stakeholder collaboration

- It is necessary to effectively engage other relevant departments and agencies and the wider private sector in the health sector M&E process.
- Each of these stakeholders generates and requires specific information related to their functions and responsibilities.
- The information generated by all stakeholders is collectively required for the overall assessment of sector performance.

4.8 Monitoring reports

Table 4.2 shows the monitoring reports and their frequency.

Table 4.2: Monitoring Reports

Process/Report	Frequency	Responsible	Timeline
Annual work plans	Yearly	All departments	End of June
Surveillance reports	Weekly	Sub-County Disease Surveillance Officer (SC-DSCO) and health facility in-charges	Close of Business (COB) every Friday
Health data reviews	Quarterly	All departments	End of each quarter
Monthly facility reports submissions	Monthly	Facilities, Community Units (CU)	The 5th of every month
Quarterly reports	Quarterly	All departments	After the 21st of the preceding month
Bi-annual performance reviews	Every six months	All departments	End of January and end of July
Annual performance reports and reviews	Yearly	All departments	Begins July and ends November
Expenditure returns	Monthly	All levels	The 5th of every month
Surveys and assessments	As needed	Nutrition programme	Periodic surveys

4.9 Calendar of key M&E activities

The county will adhere to the health sector accountability cycle. This will ensure the alignment of resources and activities to meet the needs of different actors in the health sector.

Updates to the framework

The M&E team will adjust the framework to accommodate new interventions to achieve any of the programme specific objectives. They will conduct a mid-term review of the framework in 2020-21 to measure progress of its implementation and facilitate necessary amendments

Indicators and information sources

The indicators that will guide monitoring of the implementation of the CNAP are captured and outlined in the CRAF, as shown in Table 4.3.

4.10 Evaluation of the CNAP

Evaluation is intended to assess if the results achieved can be attributed to the implementation of CNAP by all stakeholders.

Evaluation ensures stakeholder accountability and facilitates learning with a view to improving the relevance and performance of the health sector over time.

A midterm review and an end term evaluation will be undertaken to determine the extent to which the objectives of this CNAP are met.

4.11 Evaluation criteria

To carry out an effective evaluation of the CNAP, it is necessary to have clear evaluation questions. Evaluators will analyze relevance, efficiency, effectiveness, and sustainability of the CNAP. The proposed evaluation criteria are elaborated on below:

- **Relevance:** The extent to which the objectives of the CNAP correspond to population needs, including vulnerable groups. It also includes an assessment of the responsiveness to changes and shifts caused by external factors.

- **Efficiency:** The extent to which the CNAP objectives have been achieved with the appropriate amount of resources.

- **Effectiveness:** The extent to which CNAP objectives have been achieved, and the extent to which these objectives have contributed to the achievement of the intended results. Assessing effectiveness will require a comparison of the intended goals, outcomes and outputs with the actual achievements in terms of results.

- **Sustainability:** The continuation of benefits from outlined interventions after its termination.

Table 4.3: Common Results and Accountability Framework

ELGEYO MARAKWET CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018/19-2022/23							
KEY RESULT AREA 1: Scale up Maternal, Infant and Young Child Nutrition (MIYCN)							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term target(2020)**	**End-term target(2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Improved nutrition status of women of reproductive age and children between the ages of 0-59 months	Prevalence of stunting in children 0-59 months (%)	34% (2015)	30%	24%	GBD/ KDHS	Annually/ Every 5 years	Nutrition programme
	Prevalence of wasting (W/H >2SD) in children 0-59 months (%)	10% (2015)	8%	6%	GBD/ KDHS	Annually/ Every 5 years	Nutrition programme
	Prevalence of underweight (W/A <2SD) in children 0-59 months	23% (2015)	18%	15%	GBD/ KDHS	Annually/ Every 5 years	Nutrition programme
	Proportion of pregnant women with MUAC < 21cm	No data	5%	2%	KHIS	Quarterly	Nutrition programme
	Proportion of lactating women with MUAC< 21cm	No data	5%	2%	KHIS	Quarterly	Nutrition programme
	Proportion of new-borns with low birthweight (2.5 kg) and below (%)	8%	7%	6%	KHIS	Annually	Nutrition programme
Output	**Indicator**	**Baseline (2018)**	**Mid-term target(2020)**	**End-term target(2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Enhanced capacity and advocacy, communication and social mobilization for implementation of MIYCN activities at the county level	Number of advocacy meetings held for key influencers	0	2	4	Programme reports	Annually	Nutrition programme
	Proportion of children <5 years who are stunted attending Child Welfare Clinic (CWC)	1.2%	<1%	<1%	KHIS	Quarterly	Nutrition programme
Strengthened capacity of managers, health care providers and CHVs to deliver gender transformative and quality MIYCN services	Number of community units trained on BFCI	26	53	89	EMC database	Quarterly	Nutrition programme
	Number of HCWs trained on BFHI (disaggregated by gender)	No data	104	210	Programme Training Report	Annually	Nutrition programme
	Percentage of children aged 0-59 month attending CWC who receive growth monitoring services for the first visit	No data	50%	80%	EMC database	Annually	Nutrition programme
Enhanced adherence to policies and legislations protecting, promoting and supporting breastfeeding in the workplace and among the general population	Proportion of children put to breast within 1 hour of birth	31%	50%	65%	EMC/ ENRICH midline survey	Bi-annual	Nutrition programme
	Number of hospitals in the county with breastfeeding stations	0	2	4	Programme reports	Annually	Nutrition programme

ELGEYO MARAKWET CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018/19-2022/23							
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Improved MIYCN knowledge among caregivers, influencers and community members	Proportion of children younger than 6 months who are EBF (disaggregated by gender)	58.4%	63%	75%	KHIS	Quarterly	Nutrition Programme
	Proportion of children 6-23 months consuming at least 4 food groups (minimum acceptable diets) in the last 24 hours (disaggregated by sex)	24%	32%	40%	Midline survey	Bi-annually	Nutrition Programme
	Number of care groups established	80	240	400	Care group Database	Quarterly	Nutrition Programme
	Number of care groups established for fathers and grandfathers	No data	16%	40%	Depart-mental database	Quarterly	Nutrition Programme
	Number of HCWs trained on MIYCN	30	260	400	Programme reports	Annually	Nutrition programme
	Number of food demonstrations sessions conducted in the community units	16	25	40	EMC database	Quarterly	Nutrition Programme
KEY RESULT AREA 2: Promote nutrition of older children, adolescents, adults, and older persons							
Outcome	**Indicator**	**Baseline (2018**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Increased nutrition awareness and uptake of nutrition services for improved nutritional Status of older children (5-9 years) adolescents (10-19 years), adults and older persons	Mortality due to child and maternal malnutrition among children 5-14 years (prevalence of overweight/ underweight WFH >2 SD, Underweight <-2SD)	2.03 deaths/100,000 population	<2	<2	GBD 2017	Annually	Nutrition Programme
	Mortality attributable to dietary risk factors (between the ages of 15-49)	11.26 deaths/100,000 population	9	7	GBD 2017	Annually	Nutrition Programme
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Improved policy environment at county, sub-county and community level for older children (5-9 years), adolescents (10-19 years), adults and older persons	Number of HCWs trained on healthy diets.	0	100	240	Department Activity reports	Bi-annually	Nutrition Programme
	Number of CHVs trained on healthy diets	0	200	400	Department Activity reports	Bi-annually	Nutrition Programme CHS
Increased awareness among board of school management (BOM) members and teachers on optimal nutrition for older children and adolescents.	Number of male and female head schoolteachers trained on nutrition in older children and adolescents	0	50	100	Department activity reports	Annually	Nutrition Programme/ Department of Education
	Number of male and female ECD teachers sensitized on VAS, growth monitoring and dietary diversity	No data	150	300	Department activity reports	Annually	Nutrition Programme
Increased WIFAS intake among adolescent girls in schools	Proportion of adolescent girls in primary schools supplemented with WIFAS	0	10%	25%	Department activity reports	Monthly	Nutrition Programme/

ELGEYO MARAKWET CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018/19-2022/23							
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Improved knowledge and skills among HCWs and CHVs on optimal nutrition for adults and older persons.	Number of community sensitization sessions conducted on nutrition for older persons	0	30 CU	60 CU	Department activity reports	Monthly	Nutrition Programme/ Department of Education
	Proportion of older male and female persons visiting the outpatient, referred for nutrition support	No data	20%	20%	KHIS	Monthly	Nutrition Programme
	Reporting rates of nutrition for adults and older persons	35%	90%	100%	KHIS	Monthly	Nutrition Programme
KEY RESULT AREA 3: Scale up prevention, control and management of micronutrient deficiencies							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Improved micronutrient status for children, adolescents, women of reproductive age, men and older persons	Proportion of non-pregnant women with folic acid deficiency (%)	39%	28%	20%	KDHS	Every 5 years	Nutrition Programme/ KDHS
	Prevalence of anaemia among non-pregnant WRA (15-49)	21.9%	18%	15%	KDHS	Every 5 years	Nutrition Programme/ KDHS
	Prevalence of anaemia among pregnant women-	41.9%	35%	40%	KDHS	Every 5 years	Nutrition Programme/ KDHS
	Prevalence of VAD in children 0-59 months (%)	9%	6%	4%	KMNS (2011)	Every 5 years	Nutrition Programme/ KDHS
	Prevalence of iodine deficiency in children <5 years (%)	22%	15%	<10%	KMNS (2011)	Every 5 years	Nutrition Programme/ KDHS
	Prevalence of iodine deficiency in non-pregnant women (%)	26%	15%	<10%	KMNS (2011)	Every 5 years	Nutrition Programme/ KDHS
	Prevalence of zinc deficiency in children <5 years (%)	83%	65%	50%	KMNS (2011)	Every 5 years	Nutrition Programme/ KDHS
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Increased knowledge of HCWs and CHVs on importance of micronutrient intake	Number of male and female HCWs trained on micronutrients (VAS, IFAS, MNP)	100	360	680	Programme reports	Annually	Nutrition Programme Community strategy
	Number of male and female CHVs trained on micronutrients (VAS, IFAS, MNP)	400	600	800	Programme reports	Annually	Nutrition Programme
	Number of community sensitizations conducted on micronutrients	26 CU	50 CU	90 CU	Programme reports	Annually	Nutrition Programme

ELGEYO MARAKWET CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018/19-2022/23							
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Increased dietary diversity and Bio-fortification of food	Number of sensitization meetings held on bio-fortification and fortification	0	10	18	Programme reports	Annually	Nutrition Programme
	Proportion of. children 6-59 months receiving recommended doses of vitamin A supplementation	33.4%	50%	70%	KHIS	Quarterly	Nutrition Programme
	Proportion of pregnant women attending ANC receiving IFAS monthly	56%	67%	80%	KHIS	Quarterly	Nutrition Programme
	Proportion of children 6-23 months receiving recommended no. of sachets of MNP on monthly basis	27%	40%	60%	KHIS	Quarterly	Nutrition Programme
	Number of health facilities with working rehydration corner	20	50	100	Super-vision reports	Quarterly	Nutrition programme
	Proportion of the population aware of dietary diverse foods (disaggregated by sex, age and diversities)	No data	60%	75%	KAP Survey	Every 2 years	Nutrition Programme
	Proportions of households consuming iodized salt	99%	99.8%	100%	Iodine salt monitoring	Every 3 years	Nutrition programme
KEY RESULT AREA 4: Scale up prevention, control and management of diet-related risk factors for NCDs							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Improved detection and management of diet-related NCDs	Proportion of adults 18-69 years with raised fasting blood sugar (%)	No data	1.9%	1.5%	STEPwise Survey 2015	Every 5 years	Nutrition Programme/ NCD Programme
	Proportion of men with normal waist: hip ratio (%)	No data	73%	78%	STEPwise Survey 2015	Every 5 years	Nutrition Programme/ NCD Programme
	Proportion of women with normal waist: hip ratio (%)	No data	64%	75%	STEPwise Survey 2015	Every 5 years	Nutrition Programme/ NCD Programme
	Prevalence of overweight/obesity in adults (18-69 years)	No data	28%	20%	STEPwise Survey 2015	Every 5 years	Nutrition Programme/ NCD Programme

ELGEYO MARAKWET CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018/19-2022/23							
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Increased capacity of HCWs and the communities to manage diet-related NCDs	Number of male and female HCWs trained on the national strategy for NCDs, healthy diets and physical activity	30	200	400	Health department	Annually	Nutrition Programme/ NCD Programme
	Number of nutrition clinics set up for NCDs in the county (to include all hospitals and health centres)	6	10	14	Health department	Annually	Nutrition Programme/ NCD Programme
	Number of CHVs trained on NCDs, and on the national strategy for NCDs, healthy diets and physical activity	0	100	300	Health department	Annually	Nutrition Programme/ NCD Programme
Increased awareness on DRNCD prevention, control and management at the community level.	Number of health facilities with active NCD support groups	6	10	14	Health department	Annually	Nutrition/NCD Programme
	Number of mass screening sessions conducted on diet-related risk factors	0	5	10	Programme reports	Annually	Nutrition/ NCD Programme
KEY RESULT AREA 5: Integrated management of acute malnutrition (IMAM) strengthened							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Increased coverage of integrated management of acute malnutrition (IMAM) services	Proportion of deaths among acutely malnourished children (%)	0.2% for MAM 1.7% for SAM	0.2% for MAM 1.7% for SAM	0.2% for MAM 1.7% for SAM	KDHS	Every 5 years	Nutrition Programme
	Prevalence of stunting in children 0-59 months (%)	34% (GBD 2015)	30%	24%	GBD	Annually/ Every 5 years	Nutrition Programme
	Prevalence of wasting (W/H >2SD) in children 0-59 months (%)	10% (2015)	8%	6%	GBD	Annually/ Every 5 years	Nutrition Programme
	Prevalence of underweight (W/A <2SD) in children 0-59 months	23% (2015)	18%	15%	GBD/ KDHS	Annually/ Every 5 years	Nutrition Programme
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Strengthened capacity of HCWs/CHVs to provide gender transformative integrated management of acute malnutrition (IMAM)	Number of male and female HCWs trained on IMAM	0	200	400	Health department	Annually	Nutrition Programme
	Number of male and female CHVs trained on IMAM	0	300	600	Health department	Annually	Nutrition Programme
	Average length of stay in patient, children with SAM.	No data	14 days	10 days	Health department	Annually	Nutrition Programme

ELGEYO MARAKWET CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018/19-2022/23							
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
	Average Length of stay for children 6-59.months on Supplementary Feeding Programme(SFP)	No data	90 days	Less than 90 days	Health department	Annually	Nutrition Programme
	Average length of stay for children 6-59 months on Outpatient Therapeutic Programme (OTP	No data	60 days	Less than 60 days	Health department	Annually	Nutrition Programme
Enhanced early detection and treatment of malnourished children	Proportion of children <5 years visiting the outpatient, screened/assessed for nutrition status	50%	65%	75%	KHIS	Monthly	Nutrition programme
Improved IMAM data generation	Number of SMART surveys conducted	0	1	2	Survey report	Annually	Nutrition Programme
	Proportion of children <5 years seen at the community level, and screened for nutrition status by CHVs (disaggregated by sex)	10%	30%	50%	KHIS - MoH 514	Monthly	Nutrition Programme
KEY RESULT AREA 6: Strengthen clinical nutrition and dietetics in disease management, including HIV&TB							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Improved access to quality clinical nutrition and dietetics services	Average length of stay for patients requiring nutritional management.	3	3	3	DHIS	Monthly	Nutrition Programme
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Policies and guidelines on clinical nutrition and dietetics disseminated to CHMT, SCHMT and HCWs	Number of policies, guidelines for clinical nutrition, HIV and TB disseminated	2	5	5	Departmental Reports	Annually	Nutrition Programme
Improved competencies, skills and knowledge of nutritionists and dieticians	Number of HCWs trained on in-patient nutrition care process	18	80	80	Departmental reports	Annually	Nutrition Programme
	Number of patients requiring nutrition care followed up after discharge	No data	200	500	Departmental reports	Annually	Nutrition Programme
	Number of community nutrition referrals done	0	2,000	2,000	KHIS	Monthly	Nutrition Programme
Enhanced standards for quality nutrition and dietetics services for in-patients and general hospital services	Number of hospitals that offer enteral and parenteral feeds	No data	4	7	Programme reports	Annually	Nutrition Programme
	Proportion of health facilities adhering to hospital menus.	4	7	30	Programme reports	Annually	Nutrition Programme
	Number of DQAs on commodity management conducted	4	12	20	Departmental reports	Quarterly	Nutrition/TB Programme

ELGEYO MARAKWET CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018/19-2022/23							
KEY RESULT AREA 7: Strengthen nutrition in sports							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Improved nutrition status of athletes	Proportion of female athletes with 12-22% body fat	No data	25%	50%	Programme report	Every 5 years	Nutrition Programme Sports programme
	Proportion of male athletes with 5-13% body fat	No data	25%	50%	Programme report	Every 5 years	Nutrition Programme Sports programme
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Quality data on sports nutrition generated for evidence-based programming	Baseline survey on status of nutrition and health for athletes	No	Yes	Yes	Programme report	Every 5 years	Nutrition Programme Sports programme
Improved performance of athletes and quality programming on sports nutrition	Number of policies, strategies, standards and guidelines on sports nutrition developed and reviewed	0	1	2	Depart-mental reports	Annually	Nutrition Programme/ Sports Department
	Number of health workers trained on sports nutrition	0	0	80	Depart-mental data	Quarterly	Nutrition Programme/ Sports Department
Increased priority accorded to sports nutrition at the county	Number of nutrition counselling rooms established for athletes at health facilities and hospitals	0	2	4	Depart-mental reports	Annually	Nutrition Programme/ Sports Department
	Number of nutrition counselling sessions provided at the training centres, camps and clubs	0	20	60	Depart-mental data	Quarterly	Nutrition Programme/Sports Department
Increased performance of athletes and other sportsmen and women	Proportion of athletes, (disaggregated by age, gender and diversity) supported who require additional food and nutrition supplementation	No data	70%	80%	Depart-mental data	Quarterly	Nutrition Programme/ Department of Sports
	Proportion of registered athletes (disaggregated by age, gender and diversity) screened/assessed on nutrition status	0	30%	70%	Depart-mental and Camp/ Centre reports	Quarterly	Nutrition Programme/ Department of Sports
KEY RESULT AREA 8: Promote and strengthen nutrition in agriculture, education, WASH and social protection							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Strengthened linkages with other nutrition sensitive sectors	Number of linkages held for nutrition sensitive sectors.	0	10	20	Programme data	Annually	Nutrition programme

ELGEYO MARAKWET CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018/19-2022/23							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Strengthened agri-nutrition capacities and coordination at county levels	Number of male and female health service providers trained on agri-nutrition	50	70	90	ENRICH	Quarterly	Nutrition Prog./ Department of agriculture
	Proportion of WRA consuming at least 5 recommended food groups in past 24 hours	23%	32%	40%	EMC/WVK midline survey	Every 2 Years	Nutrition Programme
	Number of households with kitchen gardens established	5,000	5,000	5,000	ENRICH	Bi-annually	Nutrition Prog./ Department of Agriculture
	Number of cooking demonstrations on food diversification conducted	50	110	170	ENRICH	Bi-annually	Nutrition Prog./ Department of Agriculture
	Number of agri-nutrition sensitization forums held on nutritious and diversified food	78	330	590	ENRICH	Quarterly	Nutrition Prog./ Department of Agriculture
Policies, strategies, standards and guidelines on nutrition and physical activity in schools and other learning institutions adopted and promoted	Number of ECD and primary schools sensitized on nutrition policies	0	2,000	4,000	Programme reports	Bi-annually	Nutrition programme/ Department of Education
	Number of nutrition outreach sessions conducted in ECDs, primary schools, high schools and colleges	0	2,000	4,000	Outreach reports	Quarterly	Nutrition programme/ Department of Education
Collaboration with relevant stakeholders on WASH strengthened	Number of households sensitized on WASH	5,000	10,000	15,000	ENRICH	Quarterly	Nutrition programme/WASH
	Latrine coverage	76.6%	82%	96.60%	ENRICH survey	Annually	Nutrition Programme/ WASH
	Proportion of households using treated water	30%	50%	70%	Community Led Total Sanitation (CLTS) reports	Monthly	Nutrition programme/WASH
	Proportion of households with hand washing facilities	40%	60%	80%	ENRICH SURVEY	Annually	Nutrition programme/WASH

ELGEYO MARAKWET CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018/19-2022/23							
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Nutrition promoted and linkages enhanced in social protection programmes including in crisis	Number of health service providers (disaggregated by sex) trained on nutrition in social protection	0	74	148	Social Protection Department	Annually	Nutrition Programme/ Social Protection
	Number of gender integrated surveys done on vulnerable groups	0	1	2	Programme report	Every 2 Years	Nutrition Programme/ Social Protection
	Number of sensitization sessions on health and nutrition of vulnerable groups	0	8	16	ENRICH	Quarterly	Nutrition Programme/ Social Protection
	Number of advocacy forums on social protection	2	8	16	ENRICH	Quarterly	Nutrition Programme/ Social Protection
	Proportion of vulnerable beneficiaries (disaggregated by age, gender and diversity) enrolled in social protection services/benefits	0	30	50	Department of Social Services	Quarterly	Nutrition Programme/ Social Protection
KEY RESULT AREA 9: Strengthen sectoral and multi-sectoral nutrition governance (MNG) including coordination and legal/regulatory framework							
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Increased advocacy activities for nutrition	Number of public engagements on nutrition services	80	520	1040	ENRICH	Monthly	Nutrition Programme
	Number of nutrition stakeholders' forums	2	8	16	Programme report	Quarterly	Nutrition Programme
Enhanced existing nutrition coordination and collaborating mechanisms and linkages between national and county governments	Number of nutrition stakeholders' summits	0	2	4	Programme report	Annually	Nutrition Programme
	Developed nutrition stakeholder's framework	0	Yes	Yes	Programme report	Annually	Nutrition Programme
KEY RESULT AREA 10: Strengthen sectoral and multi-sectoral nutrition information systems, learning and research							
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Enhanced evidence-based data for planning and programming	Proportion of public facilities reporting on nutrition	63%	80%	98%	KHIS	Monthly	Nutrition Programme
Ensured data quality for nutrition	Nutrition DQAs conducted	2	10	18	Programme reports	Monthly	Nutrition Programme
	Number of gender sensitive nutrition data review meetings	2	10	18	County report	Quarterly	Nutrition Programme
	Number of nutrition dashboards developed	0	1	1	County website	Quarterly	Nutrition Programme

ELGEYO MARAKWET CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018/19-2022/23							
KEY RESULT AREA 11: Strengthen supply chain management for nutrition commodities and equipment							
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Increased capacity of health care providers to manage nutrition commodities	Number of county/sub-county stores expanded	0	2	1	Depart-mental data	Annually	Nutrition Programme
Output	**Indicator**	**Baseline (2018)**	**Mid-term target (2020)**	**End-term target (2022)**	**Data source**	**Frequency of data collection**	**Responsible person**
Ensured quality of nutrition commodities and equipment	Number of quarterly commodity security meetings held	0	8	16	Depart-mental data	Quarterly	Nutrition Programme
	Number of forecasting and quantification exercises conducted	0	2	4	Depart-mental data	Annually	Nutrition Programme
	Number of male and female health workers trained on LMIS	32	40	40	Depart-mental data	Quarterly	Nutrition Programme
Ensured availability of nutrition commodities, equipment, resources and management of supply chain	Number of nutrition commodity data quality audits and review meetings held	0	8	16	Depart-mental data	Quarterly	Nutrition Programme
	Number of end-user support supervision conducted	0	8	16	Depart-mental data	Quarterly	Nutrition Programme
	Number of redistribution exercises of nutrition commodities done	0	8	16	Depart-mental data	Quarterly	Nutrition Programme

5 RESOURCE REQUIREMENTS

5.1 Introduction

A good health system raises adequate revenue for health service delivery, enhances the efficiencies of management of health resources and provides the financial protection to the poor against catastrophic situations. By understanding how the health systems and services are financed, programmes and resources can be better directed to strategically complement the health financing already in place, advocate for financing of needed health priorities, and aid populations to access available health services.

Costing is the process of determining in monetary terms the value of inputs that are required to generate a particular output. It involves estimating the quantity of inputs required by an activity/programme. Costing may also be described as a quantitative process, which involves estimating both operational (recurrent) costs and capital costs of a programme. The process ensures that the value of resources required to deliver services are cost-effective and affordable.
The chapter describes in detail the level of resource requirements for the strategic plan period, the available resources and the gap between what is anticipated and what is required.

5.2 Costing approach

The financial resources needed for the CNAP were estimated by costing all the activities necessary to achieve each of the expected outputs in each of the KRAs. The CNAP costing process used result-based costing to estimate the total resources needed to implement the action plan for the next five years.

The action plans were put to cost using the Activity-Based Costing (ABC) approach. The ABC approach uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve strategic plan targets. It allocates costs of inputs based on each activity and attempts to identify what causes the cost to change (cost drivers). All costs of activities are traced to the product or service for which the activities are performed. The premise of the ABC methodology is as follows:

1. The activities require inputs, such as labour, a conference hall etc.
2. These inputs are required in certain quantities, and with certain frequencies.
3. Adding the unit cost, the quantity, and the frequency of the input gives the total input cost.
4. The sum of all the input costs is the activity cost. These are added up to arrive at the output cost, the objective cost, and eventually the budget.

The cost over time for all the thematic areas provides important details that will initiate debate and allow CDOH and development partners to discuss priorities and decide on effective resource allocation for nutrition.

5.3 Total resource requirements (2018/19 – 2022/23)

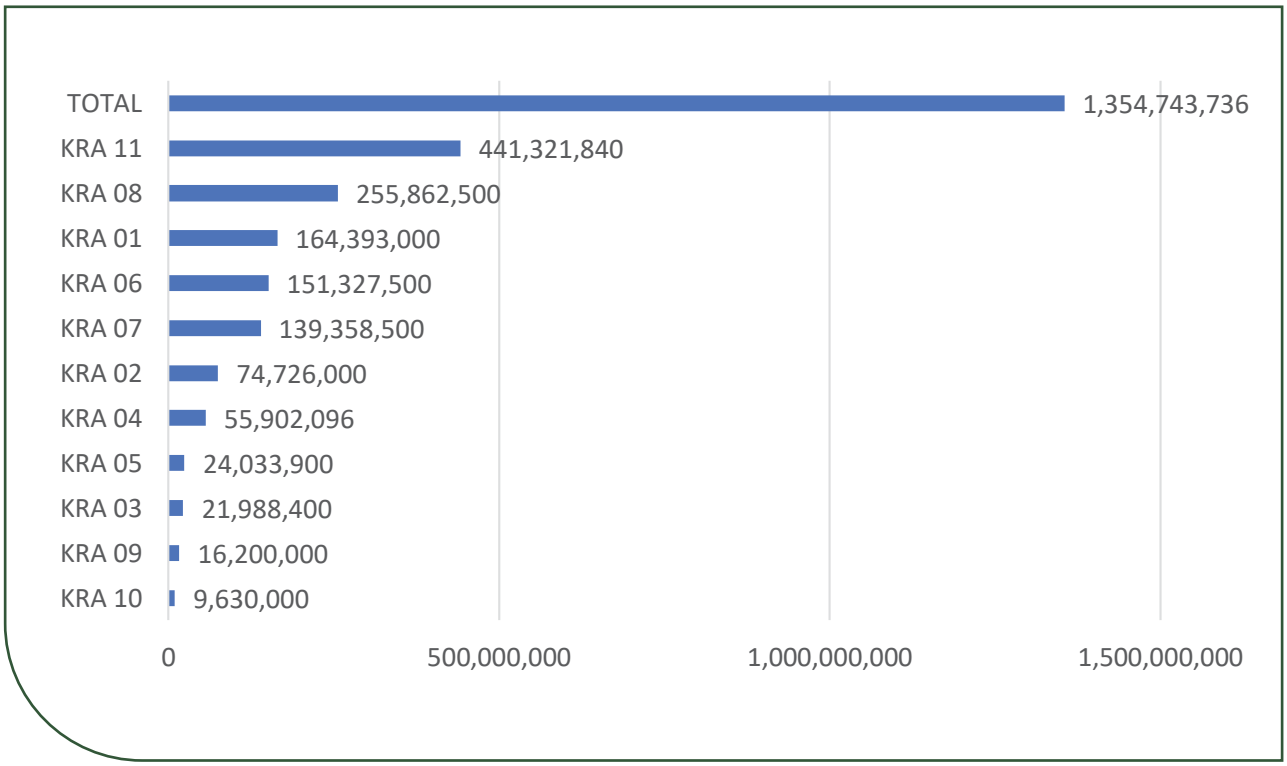
The KRAs provide targets to be achieved within the plan period and the corresponding inputs to support attainment of the targets. Based on the targets and unit costs for the inputs, the costs for the strategic plan were calculated. According to the ABC approach, it will cost KSh 1.4 billion to fully actualize the strategic plan, as shown in Table 5.1. The table also presents further annual breakdown of cost requirements per KRA.

Table 5.1: Annual Summary Cost Requirements per KRA

FOCUS AREA	KEY RESULT AREAS	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Nutrition Specific	KRA 01: Maternal, Infant and Young Child Nutrition (MIYCN) scaled up	2,299,500	92,803,100	34,229,350	18,260,750	16,800,300	164,393,000
	KRA 2: Nutrition of Older Children, Adolescents, Adults and older persons promoted	-	22,760,000	15,654,000	20,658,000	15,654,000	74,726,000
	KRA 3: Prevention, control and management of Micronutrient deficiencies scaled up	-	1,619,300	17,130,500	1,619,300	1,619,300	21,988,400
	KRA 4: Prevention, control and management of Diet related risk factors for NCDs scaled up	-	19,854,024	11,301,024	13,446,024	11,301,024	55,902,096
	KRA 5: IMAM strengthened	-	11,145,200	11,967,700	48,000	873,000	24,033,900
	KRA 6: Clinical Nutrition and Dietetics in Disease management including HIV&TB strengthened	-	49,382,500	38,225,000	34,480,000	29,240,000	151,327,500
Nutrition Sensitive	KRA 7: Nutrition in sports strengthened	-	288,000	68,381,200	38,933,700	31,755,600	139,358,500
	KRA 8: Nutrition in Agriculture, Education, WASH and social protection promoted and strengthened	51,147,300	51,511,300	50,909,300	51,147,300	51,147,300	255,862,500
Enabling Environment	KRA 9: Sectoral and Multi-sectoral Nutrition Governance (MNG) including coordination and legal/regulatory framework strengthened	3,210,000	3,210,000	3,285,000	3,210,000	3,285,000	16,200,000
	KRA 10: Sectoral and Multi-sectoral nutrition information systems, Learning and Research Strengthened	1,806,000	2,406,000	1,806,000	1,806,000	1,806,000	9,630,000
	KRA 11: Supply chain management for Nutrition Commodities and Equipment strengthened	77,631,968	86,507,968	102,593,968	88,113,968	86,473,968	441,321,840
Grand Total		**136,094,768**	**341,487,392**	**355,483,042**	**271,723,042**	**249,955,492**	**1,354,743,736**

Analysis of the cost requirements shows that KRA 11 (Strengthen supply chain management for nutrition commodities and equipment) takes the highest (32.6 percent of the budget) while KRA 10 takes the least (0.7 percent). Summary cost requirements by KRA (s) is illustrated in Figure 5.1.

Figure 5.1: Total Cost Requirements (2018/19 – 2022/23)



5.4 Strategies to ensure available resources are sustained

5.4.1 Strategies to mobilize resources from new sources

- Lobbying for a legislative framework in the county assembly for resource mobilization and allocation
- Identifying potential donors (both bilateral and multi-lateral)
- Conducting stakeholder mapping
- Calling partners to a resource mobilization meeting
- Identifying, appointing and accrediting eminent community members as good will ambassadors for resource mobilization

5.4.2 Strategies to ensure efficiency in resource utilization

- Planning for utilization of the allocated resources (SWOT analysis)
- Developing implementation plans with timelines
- Continuous monitoring of impact process indicators
- Periodic evaluation to assess whether objectives have been achieved as planned

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7 APPENDIX

Appendix A: Summary table of resource needs for KRA outputs and activities

	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL IN KSH.
KRA 01: Maternal, Infant and Young Child Nutrition (MIYCN) scaled up	**2,299,500**	**92,803,100**	**34,229,350**	**18,260,750**	**16,800,300**	**164,393,000**
Conduct training on BMS Act, compliance to food fortification.	-	42,000	167,000	42,000	42,000	293,000
Mark World/National Nutrition days/ weeks.	-	1,730,100	1,730,100	1,730,100	1,730,100	6,920,400
Procure anthropometric and IEC material.	-	121,700	-	2,979,200	-	3,100,900
Advocate for establishment of breastfeeding space at workplaces.	-	365,000	365,000	365,000	365,000	1,460,000
Sensitize mothers on importance of EBF using barazas.	-	892,000	892,000	892,000	892,000	3,568,000
Sensitize workers on importance of breastfeeding spaces in workplaces.	-	125,000	125,000	125,000	125,000	500,000
Capacity building HCW and CHV on growth monitoring.	-	1,472,000	1,472,000	-	-	2,944,000
Train HCWs on MIYCN	-	-	-	-	-	-
Sensitize CHVs on MIYCN	-	-	-	-	-	-
Train community peer to peer support groups on Agri-nutrition livelihoods activities and IGAs and link them to productive livelihood-based sectors and financial institutions for support.	390,000	390,000	390,000	390,000	390,000	1,950,000
Conduct external assessment for BFCI.	-	126,000	48,000	48,000	-	222,000
Establish community mother support groups(CMSGs) in cooperating both genders						
Sensitize Community Health Committee, Primary Health Care Facility Committee, and other community leaders on BFCI targeting both gender	-	-	-	-	-	-
Establish BFCI committees at community unit level	-	-	-	-	-	-
Establish Mother-to-Mother (MTMSG) support groups at community unit level	-	-	-	-	-	-
Conduct monthly MTMSG and FTFSG meetings	-	-	-	-	-	-
Conduct monthly CHVs meeting	-	-	-	-	-	-
Conduct quarterly promoters review meetings for care group review meetings	-	-	-	-	-	-
Conduct quarterly CHVs review meetings on BFCI	-	-	-	-	-	-
Conduct self-assessment for BFCI.	-	1,562,500	781,250	781,250	-	3,125,000
Establish social support groups.	-	-	-	-	-	-
Print reporting tools for BFCI.	-	45,000	-	-	-	45,000
Train CHV of BFCI in all community units.	-	5,600,000	-	-	-	5,600,000
Train HCW of BFCI in all community units.	-	16,460,400	-	-	-	16,460,400
Conduct training for HCW/CHVs on MIYCN.	-	14,126,000	14,126,000	-	-	28,252,000
Develop and disseminate County specific complementary recipe book, and complementary feeding materials like brochures, posters, etc.	-	360,000	819,600	-	-	1,179,600
Advocate for enforcement of school re-entry policy for teenage mothers at least 1 year after delivery to allow uptake of EF and optimal complementary feeding at the community level.	-	365,000	365,000	365,000	365,000	1,460,000
Conduct high level advocacy meeting for policy makers and county leaders on MIYCN.	-	351,000	-	-	351,000	702,000
Policy brief various existing national and international policies on MIYCN.	-	108,000	108,000	144,000	-	360,000
Procure various MIYCN legislations from government printers e.g. Health Act 2017, BMS ACT 2012 and folders.	-	40,000	40,000	-	-	80,000
Conduct food demonstration on dietary diversity.	-	946,000	946,000	946,000	946,000	3,784,000
Conduct trainings on WHO growth monitoring and promotion standards.	-	6,745,600	-	-	-	6,745,600
OJT and mentorship training.	-	-	-	-	-	-
Sensitization to the CHMT importance of GMP.	-	160,000	-	-	-	160,000
Pilot the use of mobile phone to pass MIYCN messages and sending reminders.	-	1,500,000	1,500,000	1,500,000	1,500,000	6,000,000
Sensitize health care managers at the county on BFCI.	-	76,200	-	-	-	76,200
Train HCW on skin to skin contact and Kangaroo mother care.	-	3,629,600	-	-	-	3,629,600
Train health care workers to effectively mainstream gender in nutrition programming for improved provision and implementation of gender responsive nutrition and health services and interventions.	637,000	637,000	637,000	637,000	637,000	3,185,000

KRA 01: Maternal, Infant and Young Child Nutrition (MIYCN) scaled up	**2,299,500**	**92,803,100**	**34,229,350**	**18,260,750**	**16,800,300**	**164,393,000**
Conduct external assessment for BFHI.	-	-	1,452,000	-	1,452,000	2,904,000
Conduct self-assessment and continuous assessments at health facility level for BFHI.	-	44,200	-	-	-	44,200
Conduct training for health care workers on BFHI.	-	11,561,500	-	-	-	11,561,500
Print BFHI reporting tools.	-	-	120,000	-	120,000	240,000
Sensitize support staff on BFHI.	-	-	-	-	-	-
Hold monthly meetings for the CHVs.	-	-	-	-	-	-
Hold advocacy meeting with key stakeholders (Employers within the county)	-	-	290,000	-	-	290,000
Conduct community health and nutrition education targeting men for their increased engagement on their role and support on MIYCN.	-	-	284,200	284,200	284,200	852,600
Conduct continuous medical education (CMEs) on BFHI	-	-	-	-	-	-
Sensitize the community on dietary diversification including production, storage, preparation and uptake of locally available nutritious traditional foods.	-	-	892,000	-	892,000	1,784,000
Train mother to mother support group on IGAs, household based agri-nutrition technologies and linkages to other productive livelihood-based sectors and financial institutions for support.	-	637,000	-	637,000	637,000	1,911,000
Monthly meetings for CGVs.	-	2,800,000	2,800,000	2,800,000	2,800,000	11,200,000
Support supervision for CG.	-	330,000	330,000	330,000	330,000	1,320,000
Train HCW and promoters on care group model.	637,000	7,009,600	-	-	-	7,646,600
Conduct nutrition education for mothers of children 0 to 23 months.	-	-	284,200	-	-	284,200
Conduct OJT and CME in health facilities.	635,500	3,802,500	2,865,000	2,865,000	2,542,000	12,710,000
Sensitize HCW on importance of early initiation to breast feeding.	-	-	-	-	-	-
Develop and disseminate MIYCN documents.	-	8,642,200	400,000	400,000	400,000	9,842,200
KRA 2: Nutrition of Older Children, Adolescents, Adults and older persons promoted	**-**	**22,760,000**	**15,654,000**	**20,658,000**	**15,654,000**	**74,726,000**
Train/sensitize/CME health care workers on nutrition for adults and older persons (geriatric nutrition).	-	452,000	452,000	452,000	452,000	1,808,000
Conduct gender sensitive assessment on Body Mass Index (BMI) for older children and adolescents between the ages of 5-19 years	-	1,489,000	1,489,000	1,489,000	1,489,000	5,956,000
Train /sensitize BOM & teachers on nutrition for older children and adolescents (Boys & Girls).	-	2,500,000	2,500,000	2,500,000	2,500,000	10,000,000
Train/ sensitize BOM & teachers on school meals guidelines; Comprehensive school health guidelines).	-	3,500,000	3,500,000	3,500,000	3,500,000	14,000,000
Train /sensitize BOM teachers & HCW on weekly iron folic supplementation (WIFS) for adolescent girls.	-	2,500,000	2,500,000	2,500,000	2,500,000	10,000,000
Sensitize community health volunteers on nutrition for adults and older persons (geriatric nutrition).	-	4,504,000	-	4,504,000	-	9,008,000
Conduct school health education targeting adolescent girls on the importance of WIFS.	-	570,000	570,000	570,000	570,000	2,280,000
Conduct dissemination meetings to CHMT, SCHMT and health care workers on healthy diets and lifestyle guidelines.	-	752,000	-	-	-	752,000
Procure and distribute WIFAS in selected schools	-	-	-	-	-	-
Conduct WIFA Supplementation to adolescent girls in selected schools	-	-	-	-	-	-
Carry out high level advocacy meeting targeting key decision makers on school meal/feeding program.	-	590,000	590,000	590,000	590,000	2,360,000
Carry out CMEs in health facilities on optimal nutrition for adults and older persons	-	-	-	-	-	-
Prepare and submit weekly iron folic supplementation WIFS plans.	-	90,000	90,000	90,000	90,000	360,000
Conduct joint monitoring of the weekly iron folic supplementation WIFS program & schools meals program.	-	3,438,000	3,438,000	3,438,000	3,438,000	13,752,000
Link and refer older persons to social protection support systems.	-	525,000	525,000	525,000	525,000	2,100,000
sensitize the community through organized community forums, churches on healthy diets and lifestyles and physical activity.	-	500,000	-	500,000	-	1,000,000
Disseminate policies & guidelines (food-based dietary guidelines; school meals guidelines; healthy diet and lifestyle guidelines, Comprehensive school health guidelines) to CHMT, SCHMT, health care workers and other key stakeholders	-	1,350,000	-	-	-	1,350,000

KRA 3: Prevention, control and management of Micronutrient deficiencies scaled up	**-**	**1,619,300**	**17,130,500**	**1,619,300**	**1,619,300**	**21,988,400**
Conduct community mobilization to promote micronutrient intake at household level	-	-	-	-	-	-
Develop and disseminate educational materials (brochures, factsheets) on importance of micronutrients among the population	-	-	50,000	-	-	50,000
Disseminate BCI Strategy on micronutrients to health care workers and CHVs to increase uptake among the population	-	100,000	1,388,400	100,000	100,000	1,688,400
Conduct OJT and CME on prevention, control and management of micronutrient deficiencies	-	1,519,300	1,519,300	1,519,300	1,519,300	6,077,200
Sensitize the nutritionists, extension workers, CHVs, on food diversification and bio-fortification	-	-	-	-	-	-
Conduct annual monitoring of salt iodization at community level	-	-	-	-	-	-
Train on micronutrients MNP.	-	-	1,006,000	-	-	1,006,000
Sensitize CHMT,SCHMT and health care workers on mandatory law on food fortification including fortified foods in the market and fortification logo	-	-	-	-	-	-
Sensitize community members on growing and utilization of diversified and bio-fortified crops	-	-	-	-	-	-
Procure and distribute VAS,IFAS,MNPS, dewormers ,ZINC and ORS to health facilities within the county	-	-	-	-	-	-
Sensitize CHVs on mandatory law on food fortification including fortified foods in the market and fortification logo	-	-	-	-	-	-
Sensitize community members on food fortification including fortified foods in the market and fortification logo through community forums	-	-	-	-	-	-
Train on micronutrients VAS.	-	-	4,530,600	-	-	4,530,600
Training of public health officers on regulatory monitoring of fortified foods.	-	-	1,749,000	-	-	1,749,000
Training on micronutrient IFAS.	-	-	4,194,600	-	-	4,194,600
Training on micronutrient MNPS.	-	-	2,692,600	-	-	2,692,600
KRA 4: Prevention, control and management of Diet related risk factors for NCDs scaled up	**-**	**19,854,024**	**11,301,024**	**13,446,024**	**11,301,024**	**55,902,096**
Develop behavior change communication strategy on nutrition and NCDs.	-	-	-	-	-	-
Conduct survey on nutrition related risk factors for NCDs.	-	628,000	-	-	-	628,000
Do social mobilization and advocacy on diet related NCDs.	-	3,341,024	3,341,024	3,341,024	3,341,024	13,364,096
Procure DigiSomo and customise key messages.	-	600,000	-	-	-	600,000
Establish a taskforce.	-	-	-	-	-	-
Train HCWs and CHVs on prevention, control and management of diabetes, hypertension and cancer	-	5,020,000	-	-	-	5,020,000
Quarterly performance review meeting on nutrition status of adults 18-69 years.	-	-	-	-	-	-
Incentivise ministry of health to integrate nutrition therapy into policy on NCDs prevention and control.	-	-	-	-	-	-
Conduct nutrition Screening/assessment for all adults aged 18-69 years at community and facility levels.	-	7,800,000	7,800,000	7,800,000	7,800,000	31,200,000
Conduct quarterly performance review meeting on nutrition status of adults 18-69 years.	-	160,000	160,000	160,000	160,000	640,000
Establish/reactivate NCD support groups in the health facilities in collaboration with other departments	-	-	-	-	-	-
Advocate for procurement of nutrition supplies and equipment for NCDs screening	-	-	-	-	-	-
Conduct individual nutrition assessment and counselling to all clients with diet related NCDs at health facility level	-	-	-	-	-	-
Disseminate the national strategy for the prevention and control of NCDs to CHMT,SCHMT all health workers.	-	2,145,000	-	2,145,000	-	4,290,000
Establish integrated centres for NCDs management in the county.	-	160,000	-	-	-	160,000
Procure and distribute nutrition supplies and equipment for NCDs screening.	-	-	-	-	-	-
KRA 5: IMAM strengthened	**-**	**11,145,200**	**11,967,700**	**48,000**	**873,000**	**24,033,900**
Conduct nutrition screening/assessment for children under 5 years at community and facility level.	-	-	-	-	-	-
Follow up and referral systems for IMAM across all levels improved.	-	-	-	-	-	-
Data quality audit.	-	-	-	-	-	-
Quarterly performance review meetings on IMAM.	-	-	-	-	-	-
Targeted support supervision to all facilities offering IMAM services.	-	-	-	-	-	-
Procurement of IMAM data collection and reporting tools.	-	-	-	-	-	-
Promote appropriate documentation of related research, best practices and learning.	-	-	-	-	-	-

KRA 5: IMAM strengthened	**-**	**11,145,200**	**11,967,700**	**48,000**	**873,000**	**24,033,900**
Hold high level advocacy meetings on hiring of nutritionists with the county health executive members and members of the county assembly.	-	-	-	-	-	-
Disseminate policies and guidelines on IMAM to CHMT,SCHMT all health workers.	-	-	825,000	-	825,000	1,650,000
Disseminate policies and guidelines on IMAM to all health workers.	-	-	-	-	-	-
Increase the number of health facilities implementing IMAM programme	-	-	-	-	-	-
Sensitize the community through the local media on prevention of acute malnutrition	-	-	-	-	-	-
Conduct nutrition assessment, counselling and support to IMAM clients at health facility level	-	-	-	-	-	-
Carry out defaulter tracing, follow-up and referrals for IMAM across all levels	-	-	-	-	-	-
Link and refer IMAM clients to other relevant programs using the available mechanisms	-	-	-	-	-	-
Procure and distribute nutrition commodities for management of acute malnutrition	-	-	-	-	-	-
Sensitize HCWs on logistic management and information system ,forecasting and quantification of IMAM commodities	-	-	-	-	-	-
Conduct nutrition screening for children at community level and refer appropriately to the link health facilities	-	-	-	-	-	-
Link IMAM to nutrition sensitive programmes.	-	-	-	-	-	-
Training of health care workers and CHVs on IMAM.	-	11,145,200	11,142,700	48,000	48,000	22,383,900
KRA 6: Clinical Nutrition and Dietetics in Disease management including HIV&TB strengthened	**-**	**49,382,500**	**38,225,000**	**34,480,000**	**29,240,000**	**151,327,500**
Disseminate of nutrition therapy guidelines for infant and young child nutrition and HIV care.	-	-	925,000	-	-	925,000
Disseminate policy guidelines of clinical nutrition and dietetics to the CHMT and the SCHMT & Health facility in charges.	-	597,500	-	-	-	597,500
Train nutrition officers on specialized clinical nutrition courses for management of diseases (e.g. oncology, renal, diabetes etc…)	-	11,200,000	11,200,000	11,200,000	11,200,000	44,800,000
Conduct routine data review meetings.	-	3,700,000	3,700,000	3,700,000	3,700,000	14,800,000
Carry out nutrition assessment, counselling and support to clients in both outpatient and in-patients services delivery points	-	-	-	-	-	-
Disseminate enteral and parenteral nutrition therapy guidelines to CHMT,SCHMT,HFI/C and health care workers	-	1,072,500	-	-	-	1,072,500
Train HCWs on nutrition care process.	-	6,160,000	-	-	-	6,160,000
Train health care workers on preterm and low birth weight management.	-	6,160,000	-	-	-	6,160,000
Conduct DQAs on commodity management.	-	1,840,000	1,840,000	1,840,000	1,840,000	7,360,000
Adopt gender sensitive scorecards for nutrition indicators including NACS	-	-	-	-	-	-
Train health workers through in-person continuous professional development on integrated nutrition therapy for TB/HIV nutrition	-	-	-	-	-	-
Disseminate and make available new training guidelines and policies for HIV/TB to the county, sub-county, facility, and community-level workforce	-	-	-	-	-	-
Adopt and disseminate context-specific job aids for patient-focused nutrition therapy and interpersonal counselling t health care workers	-	-	-	-	-	-
Scale up nutrition screening at HIV/TB service points while simultaneously strengthening facility referral linkages for HIV/TB patients	-	-	-	-	-	-
Offer comprehensive nutrition assessments, counselling and support in all HIV, TB, MNCH service points to reduce missed opportunities and improve service uptake and retention into care	-	-	-	-	-	-
Invest in adaptive and innovative mechanisms that enhance delivery nutrition interventions for children and adolescents exposed or living with HIV/TB	-	-	-	-	-	-
Implement county-level forecasting, quantification, and supply planning exercises through integrated operationalized county-level commodity security committees	-	-	-	-	-	-

KRA 6: Clinical Nutrition and Dietetics in Disease management including HIV&TB strengthened	**-**	**49,382,500**	**38,225,000**	**34,480,000**	**29,240,000**	**151,327,500**
Utilize routine supply chain monitoring, including electronic Logistic Management Information System (LMIS) systems, to minimize stock outs, avoid expiries, and over/under-stocking of HIV/TB nutrition commodities	-	-	-	-	-	-
Develop/adopt and disseminate a series of small doable actions that enhance dietary diversity and physical exercises at household level for HIV and TB patients	-	-	-	-	-	-
Train CHVs and other community resource persons to promote healthy and sustainable lifestyles at household level	-	-	-	-	-	-
Conduct outreaches, referrals, and linkage systems to involve all community actors and optimize identification and linkage of PLHIV and TB patients with nutrition care and management	-	-	-	-	-	-
Adopt and disseminate key context-specific nutrition messages that promote positive lifestyles and behaviour for HIV /TB patients	-	-	-	-	-	-
Procure and install special equipment for dietary modification in health facilities offering in-patient care	-	2,100,000	2,600,000	4,960,000	2,100,000	11,760,000
Adopt and utilize clinical nutrition, monitoring and reporting tools.	-	3,965,000	3,660,000	3,965,000	3,660,000	15,250,000
Develop and disseminate inpatient feeding protocols to CHMT, SCHMT & HCWs	-	1,182,500	-	-	-	1,182,500
Conduct facility data review meetings.	-	500,000	-	500,000	-	1,000,000
Hold advocacy forums for increased resource allocation for clinical nutrition and dietetics.	-	250,000	-	-	-	250,000
Adopt and disseminate County NACS validation guidelines to CHMT, SCHMT and HFI/Cs health care workers	-	925,000	-	-	-	925,000
Disseminate clinical nutrition and dietetics policy guidelines to the CHMT and the SCHMT & Health facility in charges (HFI/C) and health care workers	-	825,000	-	825,000	-	1,650,000
Advocate for integration of nutrition screening, assessment and triage areas in all health facilities	-	690,000	-	-	-	690,000
Disseminate nutrition therapy guidelines for HIV, TB and related co-morbidities to the CHMT and the SCHMT and Health Facility in-charges health care workers	-	995,000	-	-	-	995,000
Procure parenteral and enteral commodities for disease management	-	-	-	-	-	-
Procure clinical nutrition assessment tools, feeding pumps, giving sets, anthropometric equipment's	-	-	-	-	-	-
Hold stakeholder consensus meetings.	-	-	250,000	-	-	250,000
Conduct forecasting and quantification.	-	-	1,610,000	-	-	1,610,000
Conduct annual gender sensitive quality assurance assessment for clinical nutrition	-	4,040,000	4,040,000	4,040,000	4,040,000	16,160,000
Train health care workers on LMIS.	-	-	1,100,000	-	-	1,100,000
Conduct quarterly data review meetings for clinical nutrition and dietetics.	-	2,100,000	2,100,000	2,100,000	2,100,000	8,400,000
Establish/strengthen in-patient feeding committees in health facilities offering in-patient care	-	-	-	-	-	-
Develop and disseminate simplified protocols or standard operating procedures for nutrition management in diseases and conditions for in-patient care	-	480,000	-	-	-	480,000
Develop inter-facility nutrition referral protocol						
Sensitize staff on commodity management.	-	-	-	750,000	-	750,000
Adopt use of county level scorecards for nutrition indicators including NACS.	-	600,000	5,200,000	600,000	600,000	7,000,000
KRA 7: Nutrition in sports strengthened	**-**	**288,000**	**68,381,200**	**38,933,700**	**31,755,600**	**139,358,500**
Advocate for a budget line for sports nutrition to address procurement and distribution of sports nutrition commodities.	-	-	-	-	-	-
Advocate for a budget line for sports nutrition to address procurement and distribution of sports nutrition commodities.	-	288,000	288,000	288,000	288,000	1,152,000
Supporting athletes with additional food and nutrition supplements.	-	-	-	-	-	-
Conducting baseline Survey and Situational analysis on Status of Nutrition and health for the athletes.	-	-	911,500	45,500	-	957,000
Conducting Benchmarking/ learning visits for policy makers and implementers in countries with best practices on Sports Nutrition.	-	-	51,677,500	-	-	51,677,500
Document and disseminate best practices, case studies, research findings and success stories.	-	-	-	-	-	-
Promote collaboration with other health sector interventions to promote sports nutrition (MOALF&I, MOH, Industry, Finance, Gender, Sports) and the private sector.	-	-	288,000	216,000	216,000	720,000
Promote food safety and proper sanitation practices in training centers, camps and clubs.	-	-	510,000	510,000	-	1,020,000
Training of Health Care Workers on Sports Nutrition.	-	-	-	4,224,000	4,224,000	8,448,000

KRA 7: Nutrition in sports strengthened	**-**	**288,000**	**68,381,200**	**38,933,700**	**31,755,600**	**139,358,500**
Sponsoring Health Care Workers to Specialize in Sports nutrition.	-	-	1,069,200	1,069,200	1,101,600	3,240,000
Holding high level Sensitization meetings for policy makers on sports nutrition	-	-	1,152,000	864,000	864,000	2,880,000
Develop IEC materials for micronutrient supplements and nutritional ergogenic aids.	-	-	-	-	-	-
Procure micronutrient supplements and nutritional ergogenic aids.	-	-	-	-	-	-
Conducting nutritional screening and assessment for athletes.	-	-	1,020,000	1,020,000	-	2,040,000
Setup a nutritional supplementation centre for athletes.	-	-	-	-	-	-
Developing and reviewing Strategies, guidelines, standards, SOPs on Sports nutrition.	-	-	-	8,704,500	8,704,500	17,409,000
Developing Sports Nutrition Training Package for athlete.	-	-	480,000	14,737,500	14,737,500	29,955,000
Sensitize athletes and community members on sports nutrition using effective communication strategies	-	-	-	1,620,000	1,620,000	3,240,000
Holding Nutrition Counselling Sessions to athletes in training centres, camps and clubs.	-	-	510,000	510,000	-	1,020,000
Separate nutrition counselling room for athletes established.	-	-	10,475,000	5,125,000	-	15,600,000
Establishing separate Nutrition Counselling and recovery centre for athletes.	-	-	10,475,000	5,125,000	-	15,600,000
Develop a sports nutrition advocacy package at county level.	-	-	-	-	-	-
Develop sports nutrition training package for athletes.	-	-	-	-	-	-
Develop a supplementation package for athletes.	-	-	-	-	-	-
KRA 8: Nutrition in Agriculture, Education, WASH and social protection promoted and strengthened	**51,147,300**	**51,511,300**	**50,909,300**	**51,147,300**	**51,147,300**	**255,862,500**
Dissemination on ECD and primary school teachers on nutrition polices.	3,940,400	3,940,400	3,940,400	3,940,400	3,940,400	19,702,000
Conduct outreaches to ECD and primary schools (GM, Vitamin A and Deworming).	7,500,000	7,500,000	7,500,000	7,500,000	7,500,000	37,500,000
Promote uptake of food processing, preservation and storage technologies	-	-	-	-	-	-
Sensitize school stake holders on existing school health policies ,guidelines and strategies (school health policy, school meals guidelines)	-	-	-	-	-	-
Advocate for inclusion of nutrition and physical activity themes in co-curricular school activities (drama, music, talent shows, contests, symposia)	-	-	-	-	-	-
Sensitize stakeholders including, curriculum support officers, food service providers and handlers, Parent–Teacher Associations (PTA) on healthy and safe food environment	-	-	-	-	-	-
Sensitize school stakeholders on nutrition assessments , Vitamin A and deworming in schools	-	-	-	-	-	-
Procure nutrition assessment equipment for schools	-	-	-	-	-	
Conduct bi-annual nutritional status assessments, Vitamin A supplementation and deworming in schools	-	-	-	-	-	-
Establish a referral system for health and nutrition interventions for those assessed to link health facilities	-	-	-	-	-	-
Advocate for the provision of adequate potable water and safe storage within households, health facilities and schools	-	-	-	-	-	-
Advocate for protection of water sources and regular water treatment quality checks	-	-	-	-	-	-
Sensitize CHVs and community members across different ages and diversities on WASH practices	-	-	-	-	-	-
Conduct sensitization meeting to community members on safe and hygienic practices during food preparation and storage	-	-	-	-	-	
Integrate WASH messages (hand washing, safe water storage ,water treatment latrine use and hygiene) during nutrition sessions	-	-	-	-	-	-
Promote environmental hygiene at household level	-	-	-	-	-	-
Adopt and disseminate targeting criteria for nutrition in social protection programmes; cash transfers, hunger safety nets, and others	-	-	-	-	-	-
Scale up social safety nets in times of crises	-	-	-	-	-	-
Conduct stakeholder mapping of various players in social protection	-	-	-	-	-	-
Enhance participation of nutrition stakeholders in social protection coordination mechanisms	-	-	-	-	-	-
Train stakeholders in social protection programmes on good nutrition practices	-	-	-	-	-	-
Conduct a baseline survey /situation analysis on status of nutrition and health for the vulnerable groups	-	-	-	-	-	-
Sensitize the community members on health and nutrition of vulnerable groups	-	-	-	-	-	-

KRA 8: Nutrition in Agriculture, Education, WASH and social protection promoted and strengthened	**51,147,300**	**51,511,300**	**50,909,300**	**51,147,300**	**51,147,300**	**255,862,500**
Advocate for governance and accountability for nutrition and social protection for vulnerable groups	-	-	-	-	-	
Collaborate with Department of Children Services, Gender and Social Services to hold advocacy forums for improved nutrition for vulnerable groups	-	-	-	-	-	-
Advocate for harmonization of nutrition and social protection services for vulnerable groups	-	-	-	-	-	-
Advocate for the linkage of nutrition services and social protection for all vulnerable groups to National Hospital Insurance Fund (NHIF)	-	-	-	-	-	-
Advocate for high-level consultations for promotion of health and nutrition for vulnerable groups at County levels	-	-	-	-	-	-
Sensitize (a) the public and b) management of institutions of vulnerable persons and correction facilities on health and nutrition	-	-	-	-	-	-
Sensitize CHVs and community member of meal planning and energy fuel saving technologies using effective communication strategies	-	-	-	-	-	-
Participate in high level advocacy meetings for adoption of WASH activities in institutions	-	-	150,000	-	-	150,000
Participate in development of IEC materials for WASH and nutrition activities	3,855,000	3,855,000	3,855,000	3,855,000	3,855,000	19,275,000
Sensitize the CHVs and community on WASH practices.	10,320,000	10,320,000	10,320,000	10,320,000	10,320,000	51,600,000
Sensitization of caregivers of vulnerable groups on good nutrition practices.	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	9,000,000
Prioritize vulnerable groups on IGAs towards nutrition interventions.	-	-	-	-	-	-
Improve nutrition status among the risk and vulnerable groups.	388,000	388,000	-	388,000	388,000	1,552,000
Establish 5 kitchen gardens and hold cooking demonstration in 60 units.	3,360,000	3,360,000	3,360,000	3,360,000	3,360,000	16,800,000
Sensitizing the community on identification and consumption of fortified food products.	2,400,000	2,400,000	2,400,000	2,400,000	2,400,000	12,000,000
Sensitize health care providers on nutrition for the elderly.	570,000	570,000	570,000	570,000	570,000	2,850,000
Collaborate with departments to hold advocacy forums.	390,000	390,000	390,000	390,000	390,000	1,950,000
Sensitization of the community on health and nutrition of vulnerable groups.	2,400,000	2,400,000	2,400,000	2,400,000	2,400,000	12,000,000
Advocate for governance and accountability for nutrition and social protection for vulnerable groups.	502,000	502,000	502,000	502,000	502,000	2,510,000
Train health workers and agriculture extension workers on agri-nutrition.	13,697,900	13,697,900	13,697,900	13,697,900	13,697,900	68,489,500
Conduct survey on vulnerable groups.	24,000	388,000	24,000	24,000	24,000	484,000
KRA 9: Sectoral and Multisectoral Nutrition Governance (MNG) including coordination and legal/regulatory framework strengthened	**3,210,000**	**3,210,000**	**3,285,000**	**3,210,000**	**3,285,000**	**16,200,000**
Map nutrition partners and stakeholders in the county	-	-	-	-	-	-
Hold county and sub –county nutrition technical forums at county level as per TORs	-	-	-	-	-	-
Support the establishment and functionality of the Food and Nutrition Security Council and all other structures as approved in the NFNSP-IF at county levels	-	-	-	-	-	-
Enhance representation of nutrition at other sectoral forums at county and sub-county level	-	-	-	-	-	-
Conduct performance assessment reviews on coordination	-	-	-	-	-	-
Support annual County , national ,regional and international learning forums	-	-	-	-	-	-
Hold quarterly governance and accountability meetings	-	-	-	-	-	-
Develop and disseminate second generation costed CNAP	-	-	-	-	-	-
Develop and disseminate nutrition annual work plans	-	-	-	-	-	-
Conduct nutrition resource tracking at county and sub-county level	-	-	-	-	-	-
Support participation and representation of nutrition sector in citizen-participation forums at all levels	-	-	-	-	-	-
Disseminate a costed CNAP to the County Government and Stakeholders.	-	-	75,000	-	75,000	150,000
Hold public engagements on nutrition services.	390,000	390,000	390,000	390,000	390,000	1,950,000
Dissemination of a costed CNAP to the county Government and Stakeholders.	-	-	-	-	-	-
Create a coordinated mechanism for resource mobilisation at County level.	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	9,000,000
Hold nutrition stakeholder review forums.	240,000	240,000	240,000	240,000	240,000	1,200,000

KRA 9: Sectoral and Multisectoral Nutrition Governance (MNG) including coordination and legal/regulatory framework strengthened	**3,210,000**	**3,210,000**	**3,285,000**	**3,210,000**	**3,285,000**	**16,200,000**
Holding nutrition stakeholder summit.	390,000	390,000	390,000	390,000	390,000	1,950,000
Developing nutrition stakeholders' framework.	390,000	390,000	390,000	390,000	390,000	1,950,000
KRA 10: Sectoral and Multi-sectoral nutrition information systems, Learning and Research Strengthened	**1,806,000**	**2,406,000**	**1,806,000**	**1,806,000**	**1,806,000**	**9,630,000**
Develop strategic partnerships and networks in addressing county research agenda (county departments, partners, private sector, etc.)	-	-	-	-	-	-
Advocate for research prioritization both at county levels	-	-	-	-	-	-
Participate in research coordination committees in the county	-	-	-	-	-	-
Advocate for financial support to train nutritionist in research methodologies, knowledge translation and systematic review processes	-	-	-	-	-	-
Hold forums for dissemination of research findings and information sharing	-	-	-	-	-	-
Participate in knowledge sharing forums such as nutrition symposiums and conferences, workshops, meetings	-	-	-	-	-	-
Establish an effective mechanism for knowledge management and learning	-	-	-	-	-	-
Promote knowledge sharing through publication	-	-	-	-	-	-
Establish research repository for nutrition and dietetics within the county	-	-	-	-	-	-
Conduct MIYCN KAP survey	-	-	-	-	-	-
Conduct nutrition capacity assessment for the county	-	-	-	-	-	-
Disseminate nutrition survey and assessment findings to stakeholders within the county	-	-	-	-	-	-
Develop and use a nutrition multisectoral nutrition scored card to monitor key CNAP indicators bi-annually	-	-	-	-	-	-
Avail airtime for data entry of nutrition reports.	60,000	60,000	60,000	60,000	60,000	300,000
Upload nutrition reports and bulletins in the county website.	-	600,000	-	-	-	600,000
Conduct integrated nutrition data quality audit.	216,000	216,000	216,000	216,000	216,000	1,080,000
Carry out nutrition support supervisions.	216,000	216,000	216,000	216,000	216,000	1,080,000
Conduct quarterly data review meetings for nutrition activities	690,000	690,000	690,000	690,000	690,000	3,450,000
Conduct gender integrated formative research for MIYCN	150,000	150,000	150,000	150,000	150,000	750,000
Conduct gender integrated SMART nutrition survey	-	-	-	-	-	-
Support health facilities with gender sensitive nutrition reporting tools	474,000	474,000	474,000	474,000	474,000	2,370,000
KRA 11: Supply chain management for Nutrition Commodities and Equipment strengthened	**77,631,968**	**86,507,968**	**102,593,968**	**88,113,968**	**86,473,968**	**441,321,840**
Holding joint meetings with food and safety division to ensure nutrition commodities are of good quality.	-	-	-	-	-	-
Adopt guidelines and SOPs for nutrition commodities and tools	-	-	-	-	-	-
Reviewing of EDA Act 2014 to ring-fence budget line for nutrition commodities and equipment.	-	-	-	-	-	-
Advocate for a standing budget line for nutrition commodities and equipment and increased allocation for procurement and distribution of nutrition commodities at county level	-	-	-	-	-	-
Conducting monthly annual forecasting and quantification exercises for nutrition department	-	720,000	-	720,000	-	1,440,000
Conduct joint support supervision and end user monitoring	-	-	-	-	-	-
Monitor end-user of nutrition commodities on a regular basis	-	-	-	-	-	-
Renovation of existing commodity stores to enhance capacity.	7,500,000	7,500,000	7,500,000	7,500,000	7,500,000	37,500,000
Monitor end user of nutrition commodities.	-	-	-	-	-	-
Adopt and disseminate guidelines, SOPs and Tools for nutrition commodities.	-	-	7,140,000	-	-	7,140,000
Conducting end user support Supervision.	-	2,448,000	2,448,000	2,448,000	2,448,000	9,792,000
Procure nutrition commodities.	63,181,080	63,181,080	66,247,080	66,247,080	66,247,080	325,103,400
Procure nutrition equipment.	6,950,888	6,950,888	6,950,888	6,950,888	6,950,888	34,754,440
Conducting nutrition commodity data audits and review meetings.	-	2,304,000	2,304,000	2,304,000	2,304,000	9,216,000
Reporting on pharmacovigilance on nutrition commodities.	-	-	-	-	-	-

KRA 11: Supply chain management for Nutrition Commodities and Equipment strengthened	**77,631,968**	**86,507,968**	**102,593,968**	**88,113,968**	**86,473,968**	**441,321,840**
Conducting redistribution of nutrition commodities.	-	1,024,000	1,024,000	1,024,000	1,024,000	4,096,000
Conducting stakeholder sensitization on standing budget line and increased allocation for procurement and redistribution of nutrition commodities and equipment at County level.	-	-	-	-	-	-
Provide quality assurance tools for nutrition commodities.	-	-	-	-	-	-
Conduct training on LMIS including inventory management for health workers	-	2,380,000	7,140,000	-	-	9,520,000
Reviewing of EDA Act 2014 to ring-fence budget line for nutrition commodities and equipment.	-	-	1,840,000	920,000	-	2,760,000
Grand Total	136,094,768	341,487,392	355,483,042	271,723,042	249,955,492	1,354,743,736

8 LIST OF KEY CONTRIBUTORS

	NAME	DESIGNATION	ORGANIZATION
1.	Isaac Kamar	County Executive Committee Member	Elgeyo Marakwet County
2.	Mary Kipchumba	Chief Officer Health	Elgeyo Marakwet County
3.	Dr. Patrick Kosgei	Director – Medical Services	Elgeyo Marakwet County
4.	William Kendagor	Director – Public Health & Sanitation	Elgeyo Marakwet County
5.	Priscilla Ng'etich	County Nutrition Coordinator	Elgeyo Marakwet County
6.	George Obumba	County Sports Officer	Elgeyo Marakwet County
7.	Emily Kiptoo	County Health Records and Information Officer	Elgeyo Marakwet County
8.	Florence Yegon	Sub-County Nutrition Coordinator	Elgeyo Marakwet County
9.	Ben Kibor	Programme Officer, Agriculture and Irrigation	Elgeyo Marakwet County
10.	Duncan Kiplagat	Economist	Elgeyo Marakwet County
11.	Walter Bartai	County Monitoring & Evaluation Officer	Elgeyo Marakwet County
12.	Alex Kiplagat	Sub-County Nutrition Coordinator	Elgeyo Marakwet County
13.	Jacob Ayienda	Chief Public Health Officer	Elgeyo Marakwet County
14.	Sandra Sirma	Sub-County Nutrition Coordinator	Elgeyo Marakwet County
15.	Caleb Otichilo	Sub-County Public Health Nurse	Elgeyo Marakwet County
16.	Matthew Kore	County Public Health Officer	Elgeyo Marakwet County
17.	Felix Rotich	Director – Water Services	Elgeyo Marakwet County
18.	John Kiprono	County Nursing Officer	Elgeyo Marakwet County
19.	Dr. Stella Chepkwony	Sub-County Medical Officer of Health	Elgeyo Marakwet County
20.	Franscisca Maemba	Director ECD and Technical Training	Elgeyo Marakwet County
21.	Susan Barsulai	Sub-County Nutrition Coordinator	Elgeyo Marakwet County
22.	Daisy Mundia	Project Officer	Nutrition International
23.	Elizabeth Herman	Monitoring & Evaluation Officer	World Vision Kenya
24.	Linda Mdune Rotich	Program Manager	ENRICH
25.	Sarah Ayodi	Elgeyo Marakwet County MNP Coordinator	Nutrition International


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