COUNTY GOVERNMENT OF KAJIADO

DEPARTMENT OF HEALTH SERVICES

KAJIADO 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
ASDSP	Agricultural Sector Development Support Programme
BCC	Behavior Change Communication
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
CHMT	County Health Management Team
CHV	Community Health Volunteer
CLTS	Community Led Total Sanitation
CNAP	County Nutrition Action Plan
DRNCDs	Diet Related Non-Communicable Diseases
EBF	Exclusive Breast Feeding
FEED	Feed The Children
GOK	Government of Kenya
HINI	High Impact Nutrition Interventions
HH	Household
HIV	Human Immunodeficiency Virus
IFAS	Iron Folic Acid Supplementation
IMAM	Integrated Management of Acute Malnutrition
KCNAP	Kajiado County Nutrition Action Plan
KDHS	Kenya Demographic Health Survey
KNAP	Kenya National Action Plan
KRCS	Kenya Red Cross Society
MAD	Minimum Acceptable Diets
MEAL	Monitoring Evaluation Accountability and Learning
MIYCN	Maternal Infant and Young Child Nutrition
NASCOP	National AIDS and STI Control Programme
NCDs	Non Communicable Diseases
NI	Nutrition International
NIA	Neighbors Initiative Alliance
PHASE	Personal Hygiene and Sanitation Education
SCHMT	Sub County Health Management Teams
SDGs	Sustainable Development Goals
UNICEF	United Nations Children's Fund
WBW	World Breastfeeding Week
WVI	World Vision International

FOREWORD

Proper nutrition is one of the critical foundations for the development of a healthy and productive workforce, with the first 1000 days of an individuals' life being the most critical period.

Investing in proper nutrition for all population groups across different ages and diversities and especially for women and children, will be essential in achieving the overall developmental goals for Kajiado County.

Kajiado County Government recognizes that the high rate of malnutrition is a threat to achieving Sustainable Development Goals and Vision 2030 and goes against our constitution, which emphasizes the right to the highest standard of health. Reducing the rates of malnutrition in Kajiado is not just a health issue but calls for a multi-sectoral approach where different sectors join hands with a common goal.

Men and women across all ages and diversities must be empowered to claim their right to proper nutrition and provided with equal opportunities and enabling the environment to meaningfully contribute to an equally benefit from the development agenda towards realizing this right.

Kajiado County Nutrition Action Plan (KCNAP) has been aligned to Key County strategic documents such as the County Integrated Development Plan, County Health Strategy and Investment Plan, and County Medium Term Expenditure Plans. The solutions to solving nutrition issues are practical and basic; the CNAP has outlined a road map for reaching the goal.

It provides practical guidance to implementation and a framework for coordinated implementation of proven and cost-effective High Impact Nutrition Interventions (HINI).

This CNAP will facilitate mainstreaming of the nutrition budgeting process into County development plans, and subsequently, allocation of resources to nutrition programs.

The County Health Management Team (CHMT) shall be directly in charge of coordinating and the implementation of the plan at the county level. On the other hand, the Sub-County Health Management teams (SCHMTs) shall oversee the devolved coordination system at the sub-county level, which will feed into the county level coordination unit.

"Let us join hands in taking up our roles to scale up nutrition in our county".

Esther Somoire

CECM Health Services and Public Health

Kajiado County

PREFACE

Good health has been identified as a crucial driver to improved development in the country. Kenya set up the development blueprint in Vision 2030 under the economic, social, and political pillars aiming to provide an efficient and high quality health care system with the best standards.

Nutrition is fundamental to the achievement of good health among the population. Proper nutrition lays a strong foundation for future productive lives, as evidenced by research.

The first 1000 days offer a window of opportunity for healthy brain development and adequate growth and development. It has far-reaching effects in the cognitive development of children, academic performance, and work performance in adulthood. Investing in proper nutrition for women, adolescents, and children host benefits that are carried on to the next generation.

Existing challenges and constraints are beyond an individual, a unit, or a department. Beyond early exposure to adverse conditions such as illness or inappropriate diets and feeding practices, poor diets as the immediate causes of malnutrition underlie the socio-cultural, political, and economic factors contributing to malnutrition.

With this realization, the Kajiado Department of Health brought together other government line ministries, agencies, and development partners to enrich the County Nutrition Action Plan to ensure a shared multisectoral approach to ending malnutrition.

The process involved revising the 1st CNAP (2016-2018) and considered the lessons learned best practices and challenges in the implementation towards achieving proper nutrition for all and has come up with the 2nd generation CNAP 2018/19-2022/23. KCNAP, therefore, focuses on three main areas of intervention; nutrition-sensitive, nutrition-specific, and an enabling environment.

A lot has been done by the County Government to implement existing nutrition policies and guidelines through integration into the county government policy documents and to set up necessary structures. Despite all this, the county still faces immense challenges to the achievement of the laid targets like perennial droughts affecting the community's livelihood. In an effort to ensure effective and sustainable nutrition outcomes and health-related outcomes, the action plan has integrated gender-responsive interventions to address the underlying and deep-rooted gender inequalities, socio-cultural and economic differences.

This in turn closely affects the improved food and nutrition security and wellbeing of men and women across different ages and diversities in the county. This is in line with the several conventions targeted to achieve gender equality, women empowerment, and sustainable elimination of hunger and malnutrition.

These include but not limited to Sustainable Development Goal 2, on the elimination of Hunger, SDG 5 on promoting gender equality including SDGs 1,3,4,6 and 10. The Convention of the Rights of the Child, Convention on Elimination of all forms of Discrimination Against Women and the declaration of Human Rights, which are vital in creating an enabling environment for improved and sustainable food and nutrition security. Inaction is costly, and as a county, we are convinced that this county nutrition action plan will propel our county towards achieving nutrition for all.

Jacob Sampeke

Chief Officer, Medical Services

Eddah Wakapa

Chief Officer, Public Health

ACKNOWLEDGEMENT

The Kajiado Department of Health takes this opportunity to appreciate everyone who participated in the development of the County Nutrition Action Plan (CNAP) 2018/19–2022/23. The CNAP could not have been finalized without the valuable contributions and full commitment of the technical committee members of different working groups drawn from both the government and partner organizations. The support from the Ministry of Health, Division of Nutrition & Dietetics is highly appreciated.

This CNAP was developed with support from Nutrition International under the Technical Assistance for Nutrition (TAN) project, funded with UK aid from the UK government. Special thanks go to Nutrition International (NI) staff lead by Joy Kiruntimi, Sarah Kihianyu, and Martin Koome, for the immense technical leadership support in the entire process of developing the CNAP 2018/19 to 2022/2023. Further, we express our sincere gratitude and indebtedness to the United Nations Children's Fund (UNICEF) Kenya, Feed the Children (FEED), World Vision International (WVI), Kenya Red Cross Society (KRCS) and Neighbors Initiative Alliance (NIA) for technical and support in developing this County Nutrition Action Plan.

The contributions of the following ministries in providing overall leadership and technical inputs to the CNAP are also highly appreciated: This mainly goes to Ministries of but not limited to Health; Education; Water and Sanitation; Gender, Youth, Culture, sports, Social and Children Services, Agriculture and Livestock. The contribution of the County Executive Committee Member (CECM), Chief Officers Medical and Public Health, the County Health Management Teams (CHMTs), other Health Program Officers, Sub-County Nutrition Coordinators (SCNCs) and Nutrition Officers during the development and validation of the CNAP is gratefully acknowledged.

Special appreciation goes to Ruth Nasinkoi County Nutrition Coordinator, for the overall leadership during the entire process.

Lastly, County Department of Health greatly appreciates the technical support of Betty Samburu and the consulting team; Dr. Daniel Mwai, lead consultant (Health Financing and Universal Health Coverage Expert, Strategic planning, Resource mobilization, Costing, and Resource Tracking); Njuguna David (Health systems strengthening expert, Health policy, Costing, Resource Tracking, Strategy Development); Dr. Elizabeth Wangia (Clinical Nutrition, Accountability plan, Monitoring and Evaluation of health programs) Clementine Ngina (Nutrition technical specialist); Agatha Muthoni (Gender specialist); and Ednah Muthoni (Programme Assistant) for providing the technical support throughout the whole development process.

Dr. Ezekiel Kapkoni

County Director Medical Services and Public Health

1 CHAPTER 1: INTRODUCTION

1.1 Background information

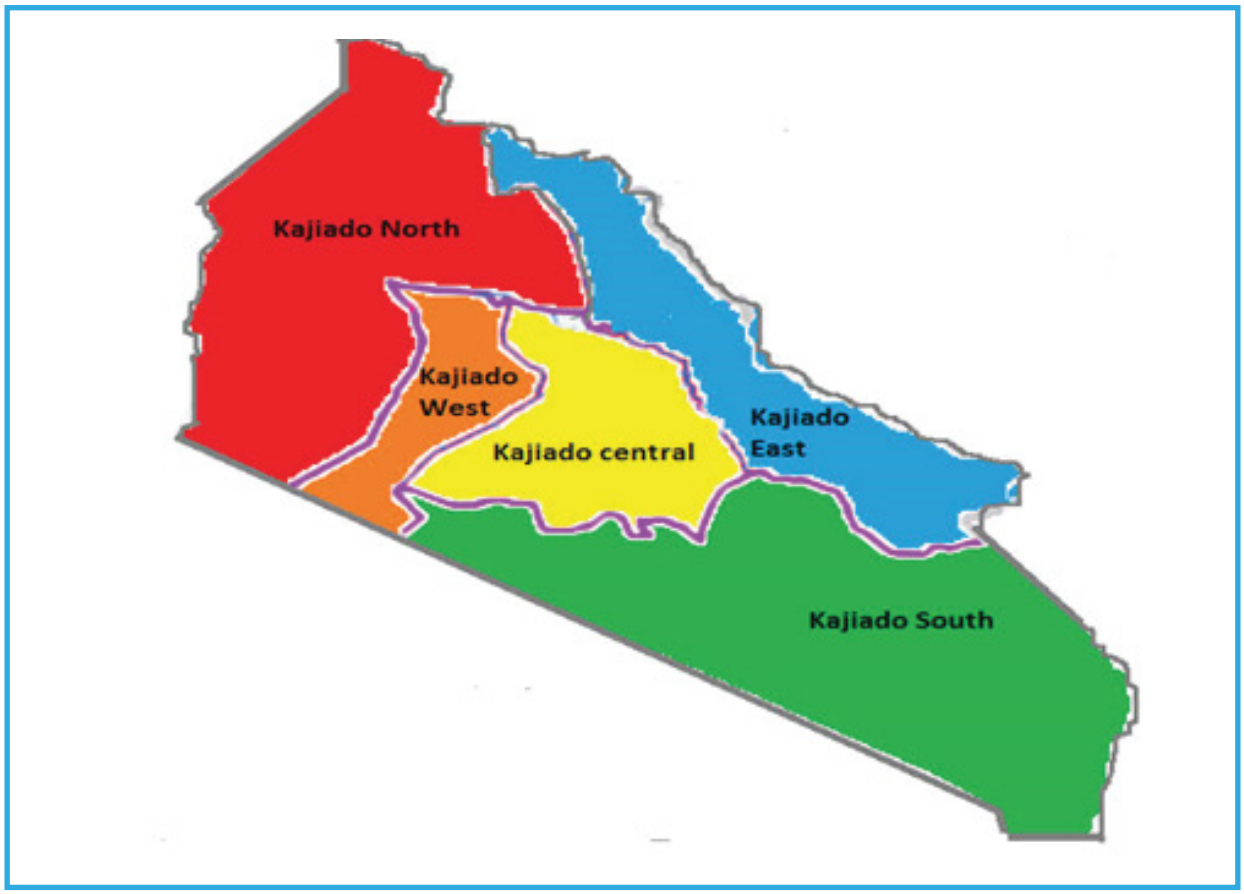
1.1.1 Location and size

Kajiado County is located in the southern part of Kenya. It borders Nairobi County to the North East, Narok County to the West, Nakuru and Kiambu Counties to the North, Taita Taveta County to the South East, Machakos and Makueni Counties to the North East and East respectively, and the Republic of Tanzania to the South. The county covers an area of 21,900.9 square kilometers (Km2).

1.1.2 Administrative Map

Administratively; Kajiado County is subdivided in to 5 sub counties namely; Kajiado North, Kajiado West, Kajiado Central, Kajiado East and Kajiado South. Kajiado County has three main livelihood zones. These include; pastoral (all species) which account for 52%, agro pastoral (31%) and mixed farming (12%).

Figure 1.1: Kajiado County Sub - Counties Distribution



1.1.3 Population size and composition

The population for 2019 stands at 1,117,840 with male constituting of 49.8 percent and female constituting 50.2 percent of the total population.

Kajiado Population distribution per Sub County

Sub county	Male	Female	Intersex	Total
Isinya	105,607	104,860	6	**210,473**
Kajiado Central	81,514	80,343	5	**161,862**
Kajiado North	150,675	155,908	13	**306,596**
Kajiado West	91,607	91,237	5	**182,849**
Loitokitok	94,613	97,225	8	**191,846**
Mashuuru	33,082	31,131	1	**64,214**
Total	**557,098**	**560,704**	**38**	**1,117,840**

Source: KNBS census, 2019

Table 1.1: Population Distribution Disaggregated by Gender

Age Groups	2009 census			2018 projections			2020 projections			2022 projections		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Under 5	66,992	64,996	131,988	108,466	105,235	213,701	120,726	117,129	237,855	134,371	130,367	264,738
Grade 1-Grade6 Pop (Age 7-12)	70,732	69,417	140,149	114,522	112,393	226,914	127,466	125,096	252,561	141,872	139,235	281,107
Junior and Senior High School Pop (Age 13-18)	26,950	26,793	53,743	43,635	43,380	87,015	48,566	48,283	96,850	54,056	53,741	107,796
Youth Pop (Age 15-29)	101,969	113,738	215,707	165,097	184,153	349,250	183,758	204,966	388,724	204,527	228,133	432,659
Female Reproductive Pop (Age 15-49)	-	178,547	178,547		289,084	289,084		321,758	321,758		358,125	358,125
Labour Force Pop (15-64)	192,998	192,516	385,514	312,482	311,702	624,184	347,800	346,932	694,732	387,110	386,144	773,254
Aged Population 65+	7,212	8,135	15,347	11,677	13,171	24,848	12,997	14,660	27,657	14,466	16,317	30,783

Source: (KNBS, 2018)

1.2 Health Access (Health Facilities, Human Resource for Health)

There are five (5) sub-county hospitals, twenty-two (22) health Centre's and seventy-nine (79) dispensaries run by the county government. There are also six (6) hospitals, thirteen (13) nursing homes, seven (7) health Centre's, twenty-seven (27) dispensaries and one hundred and one (101) clinics which are either run by private, faith-based, community-based and other non-government organizations. Together with these, the county has a total of ninety-two (92) community health units established, out of which only seventy-three (73) are active and functional.

The health facilities in the county are poorly equipped. The average distance to a health facility is 14.3 km, with only 9.9% of the population accessing health facilities within a range of less than a Kilometer. The majority of people cannot access primary health care, and this affects their productivity.

The Inability to access health care can be firmly attributed to high levels of poverty in the county, with more than 47 percent of the population living below the poverty line, the high levels of illiteracy, frequent droughts, poor infrastructure, inadequate water resources, and socio-economic vulnerabilities. This disproportionately affects women and girls, resulting from their unequal access, control, and benefit from productive resources like land and livestock, which is a preserve for men. Most people in rural areas also rely on traditional methods of treatment as they are cheap and readily available.

There are also high occurrences of nutrition-related ailments in children due to lack of food variety and adequate quantity as a result of frequent droughts.

Human Resource for Health allocation accounts for the highest proportion of budgets assigned to the health sector. In Kenya, the doctor to patient ratio is 1 to 17,000 against the World Health Organization's recommended ratio of 1 to 1,000. The nurse-patient ratio is 83:10,000, way below the 25:10,000 ratios recommended by the World Health Organization.

In Kajiado County, there are 55 doctors serving a population of over a million giving a doctor-patient ratio of 1 to 17,575, almost at par with the national ratio. Nurses are 537 in the county giving a ratio of 1:1,800 against a ratio of 1:400. The distribution of health care workers is dependent upon a number of health facilities and levels of service delivery. Kajiado County has over 1,000 Human Resource for Health, with only 32 being nutrition staff. The table below depicts the human resource for nutrition within the county as well as the gaps.

Table1.2: Kajiado County Human Resource for Nutrition

Sub Category	Available number	Gap
Nutrition and Dietetics Officers	9	85
Nutrition and Dietetics Technologists	22	337
Nutrition and Dietetics Technicians	1	217
TOTAL	**32**	**639**

1.3 Nutrition Situation

1.3.1 National Nutrition Situation

There has been an improvement in the nutritional status of children: stunting declined from 35% in 2008-2009 to 26% in 2014, wasting from 7% to 4% and underweight from 16% to 11% (KDHS 2014). About, 8% are severely stunted in Kenya, according to (KDHS, 2014). Analysis of stunting by age group shows that stunting is highest in children age 18-23 months at 36%, and lowest among children age less than 6 months at 10%.

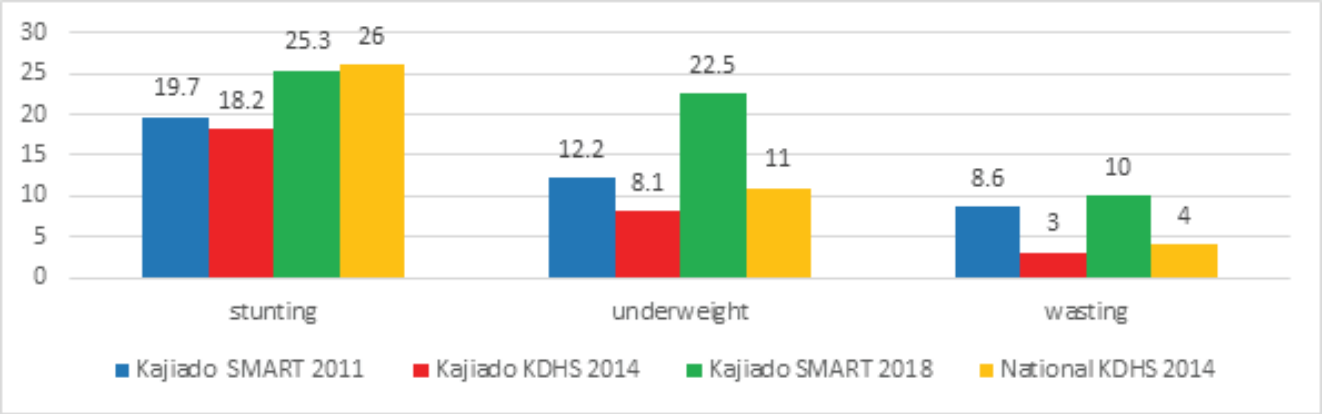
The high rate of stunting is attributed to food insecurity and poor infant and young child feeding practices (World Vision Kenya, 2015). Nationally, 61% of mothers are exclusively breastfeeding for the first six months and only 22% of children aged 6-23 months are fed according to the Minimum Acceptable Diet (MAD). These are some of the factors that have contributed to the decline in maternal and infant mortality in the country. In Kenya, malnutrition places children at increased risk of morbidity and mortality and is also shown to be related to impaired cognitive development.

1.3.2 Kajiado County Nutrition Situation

Hunger and inadequate food supply are still affecting large parts of the County's population with serious consequences for health and well-being, especially in children. Malnutrition in childhood interferes with physical and mental development, thus compromising whole lives. So far, efforts are ongoing to combat malnutrition and make progress towards the achievement of Sustainable Development Goals to end hunger, achieve food security and improved nutrition and promote sustainable agriculture (SDG 2).

Prevalence of stunting (low height-for-age) in children under 5 years of age stands at 25.3% while Prevalence of wasting (low weight-for-height) in children under 5 years of age is at 10% and underweight(low weight-for-age) is 22.5% based on SMART survey results (2018) as shown in the graph below.

Figure 1.2: Trends of under nutrition (stunting, wasting and underweight)



Source: (KDHS, 2014), (SMART SURVEY, May 2011) and (SMART SURVEY, February 2018)

Kajiado's recent SMART survey shows an increased level of malnutrition as compared to the KDHS 2014. A SMART survey conducted in 2018 shows wasting levels of 10% higher than the national of 4%. Stunting has increased from 18.2% to 25.3%. Poor access to clean water, inadequate health services, poor health seeking behavior, poor hygiene and sanitation practices care practices among men and women across all ages and diversities, low community and male support in relieving women of overburdening maternal workload, inadequate and inequitable access to nutrition and health education and information, unequal access.

The use and control of benefits from productive assets disproportionately affecting women and girls leading to economic vulnerability including their discrimination in decision making on issues pertaining their nutrition and wellbeing, make up part of the myriad of issues leading to malnutrition, which must be addressed as part of effective and sustainable ways in addressing malnutrition.

1.3.3 Overweight, Obesity and Diet Related Non-Communicable Diseases

Non-Communicable Diseases (NCDs), mainly cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes, are the world's biggest killers. Most of these premature deaths from NCDs are largely preventable by enabling health systems to respond more effectively and equitably to the health-care needs of people with NCDs and influencing public policies in sectors outside health that tackle shared risk factors—namely tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol. Diet and physical exercise are a powerful tool for the prevention of NCDs.

There is a gap in NCD population-based data for Kajiado. Given its proximity to the city, it's likely that the prevalence of NCD is on the rise. The patients seeking services for NCD related diseases like hypertension, diabetes, and cancer are on the rise. Hospital data shows the increase from 8,449 (2017/18) newly diagnosed cases of diabetes to 9,904 (2018/19) and hypertension from 19,859(2017/18) to 24,183 (2018/19), which accounts for 1.7% of cases seen at the outpatient department.

1.3.4 Micronutrient deficiency situation

Micronutrient deficiency is a critical challenge affecting mostly the children under five, women of reproductive age, and ANC mothers. There are four primary micronutrient deficiencies of public health concern; vitamin A deficiencies, Iron deficiency anemia, Zinc deficiency, and Iodine deficiency. Public health measures have been put in place to address the micronutrient deficiencies, thus dietary diversity, supplementation, and fortification. However, coverage is still low.

Percentage of children 6-59 months receiving routine vitamin A supplementation twice a year is at 50.5% for children aged 6-11 months and 57.1 for children aged12-59 months. Overall Vitamin A supplementation 6-59 months at least twice is very low at 18.1 % (SMART SURVEY, February 2018)

Iron Folic Acid Supplementation is very critical for pregnant women. However, in Kajiado, the coverage for supplementation among pregnant women is still very low despite national and county initiatives to promote IFAS supplementation.

The national government developed IFAS policy where all pregnant women are to be supplemented daily. From the SMART survey data for 2018, only 37.9% of pregnant women were consuming IFAS for 90 days and above, while none consumed for 270 days. Consumption of iodized salt among households was high. A total of 95% of households surveyed in 2018 were using iodized salt.

In addition to ensuring improved health service provision, there is dire need to incorporate nutrition-sensitive interventions to address the underlying non-medical issues affecting increased uptake of diversified diets as well as micronutrients supplements by women, children under 5 and adolescent girls.

In Kajiado County, socio-economic vulnerabilities, cultural norms, beliefs and practices disproportionately affect women's and girls' utilization of skilled health services and antenatal health care services; long distances to the health facilities; age and literacy levels; low knowledge, inadequate counseling and clarity on the importance of different micronutrient supplements before, during and after pregnancy; beliefs against consuming medications during pregnancy; little/lack of male and community support on maternal and child health, including lack of support for teenage mothers to seek health services on time, form some of the detrimental factors affecting optimal uptake of nutrition and health-related services.

Further, collection and use of context-based gender analysis on the underlying socio-cultural, economic and rights related issues affecting affordability and optimal uptake of nutrition and related health services and practices to inform gender-transformative nutrition interventions is paramount.

1.3.5 Maternal Infant and Young Child Feeding Practices

Proper maternal nutrition is very critical for pregnancy outcomes. Women of reproductive age consuming more than five food groups out of 10 are 51.8%. The percentage of children under 6 months exclusively breastfed is at 44.7%. This is below the national level of 61%. Breast milk continues to be an important meal in a child diet up to two years of age. The % of children under two years who continue breastfeeding and receive optimal complementary food up to 2 years is at 72% against the set value of 82% for 2018.

The minimum meal frequency for 6-23 months is at 68.8%. This means that a higher proportion of children 6-23 months do not have an adequate diet. Poor dietary intake for children 6-23 months is related to increased morbidity, and up to 45% mortality for children fewer than five is attributed to malnutrition.

This study shows a strong linkage between social-cultural and economic factors and improved nutrition, especially for women and young children, which must be addressed for effective and sustainable optimal Maternal, Infant, and Young Children's Nutrition and wellbeing (Action against Hunger, April 2017).

Biased gender roles and responsibilities between men and women resulting in overburdening maternal workload for women and girls, with the limited community and male support, lead to insufficient time for women and girls of reproductive age, especially PLWs to practice optimal care and feeding practices for themselves and their young children. Water scarcity leads to long-distance trekking in search of water, food insecurity.

This is normally aggravated by unequal social systems and deep-rooted gender inequalities that have a wide range influence to unequal access to, ownership of and control over benefits from productive resources and decision making disproportionately affecting women and girls in the county, has a great impact on maternal and infant and young children care and feeding practices.

Further cultural norms, beliefs and practices around breastfeeding, food sharing, and uptake related stereotypes, perceptions, and practices. This in turn affects maternal, infant and young children optimal dietary diversity through locally available and affordable nutritious foods.

Levels of knowledge on nutrition among men and women across different ages and diversities further greatly determines the level of support, especially by men and other key influencers within communities, which is crucial in promoting increased uptake of optimal nutrition and health care and practices by women and children in the county.

Thus, in addition to improved health and nutrition service provision, renewed focus to integrate interventions in nutrition programming to identify and address the underlying gender inequalities, socio-economic, and cultural issues across communities in Kajiado county is a prerequisite towards realizing improved MIYCF outcomes.

1.4 Mortality and morbidity

Childhood mortality continues to decline in Kenya infant mortality in Kenya is at 39 deaths per 1,000 live births slightly higher compared to Rift Valley mortality, which stands at 34 deaths per 1,000 live births. In Kenya, under-five mortality stands at 52 deaths per 1,000 live births compared to 45 deaths per 1,000 live births in the Rift Valley (KDHS, 2014)

The burden of communicable diseases in the County, especially HIV/AIDS, STIs, and Tuberculosis is high. According to the National AIDS and STI Control Programme (NASCOP), the county HIV prevalence rate is 3.9 percent compared to the National prevalence of 6 percent. According to routine data, in the financial year 2018/19, the top five most common causes of morbidity in order of prevalence are: Disease of Respiratory System (36%), Diarrhea (7%), Skin Disease (6 %), Urinary Tract Infection (5 %) and Pneumonia (4%). The major risk factors include houses that are congested and poorly ventilated, as well as poor environmental sanitation.

1.5 Agriculture and access to food

The agriculture sector in Kajiado employs 75% of the total population and provides nearly 40% of the county's food requirements, with the main economic activities being livestock rearing and crop growing. According to GoK (2014), at least 78% of households were self-employed and derived their income from on-farm activities (crop, livestock sales, and fishing).

Average annual on-farm income earned the households KSH 193,533 with crop sources contributing 48% of all on-farm income, livestock 28% and 14% from fishing. About 79% of adult male-headed households, 60% of adult female-headed and 79% of youth-headed households derived their income from on-farm activities, but these sources of livelihoods are hampered by climate change effects.

The current situation where prolonged droughts are increasing, production is generally affected hence increasing food insecurity within households. According to the ASDSP household survey report (2014), 79% of households were food insecure with at least four months without enough food for their families.

This eventually flows over to affect the nutrition status of family members due to inadequacy as well as limited diversification of foods. Gender equality and women empowerment is an essential and long-overdue stimulus to a more inclusive human development and accelerated economic growth.

In Kajiado County, the existence of social systems, cultural norms, and beliefs that are discriminative against women and girls form part of the significant detrimental factors to improved social-economic development in the county.

Women, girls, and the youth have limited autonomy and unequal participation in major decision-making processes as strong agents for improved food and nutrition security.

In as much as women contribute to close to 80% labor in crop production, they have unequal access to, use and control over benefits from productive assets such as land and livestock, low access and inclusion in use of new food production systems and technologies as well as inadequate access to affordable credit and farm inputs.

Limited involvement of youth in gainful employment and economic participation, as well as their exclusion and marginalization from decision-making process and policies, is a threat to the stability not only to the county but the entire nation.

Strategies to equally train and engage men and women across different ages and diversities on climate-smart sustainable gardening technologies, enhancing their knowledge on the nutritional value of under-utilized traditional foods, recipes, and preparation methods and sustainable income-generating activities will go a long way in realizing increased food security and improved dietary diversity.

The current efforts are geared towards intensifying farming through promotion of irrigation technologies for farming, management of rangelands and pasture lands for animal production, disease management in crop and livestock, natural resource management and conservation. This also includes diversification of crops through introduction of a variety of food crops which include drought-resistant varieties and traditional high-value crops and capacity building in food handling, utilization, value addition, preservation, and storage.

1.6 Overview of Kajiado County Nutrition Action Plan (KCNAP) 2016-2018 implementation findings

The KCNAP was aligned to key county strategic documents such as the County Health Strategic and Investment Plan and the County Medium Term Expenditure Plans and acted as a road map for reaching nutrition goals to date.

KCNAP 2016-2018 provided a practical guide to a coordinated implementation of proven and cost effective High Impact Nutrition Interventions which focused on nutrition specific and sensitive interventions targeted at women of reproductive age, children aged less than five years, school going children, population groups challenged with overweight & obesity and activities that addressed non-communicable diseases. It also aimed at mainstreaming of nutrition budgeting process into County development plans, and subsequently, allocation of resources to nutrition programs.

The County Health Management team was directly in charge of coordinating the implementation of the plan at the county level, while the Sub-County Health Management teams (SCHMTs) were in charge of coordination at the sub-county level. The KCNAP was rolled out at all levels of service delivery through a collaborative effort by all stakeholders and coordinated by the County Nutrition Technical Forum (CNTF).

Achievements of KCNAP 2016-2018 (During the Implementation period)

- Implementation of > 50% of proposed Interventions
- Improvement of indicators i.e. VAS, IFAS coverage and supplementation
- Strengthened routine monitoring and reporting
- Improved support supervision
- Increased prioritization to Nutrition
- Improved collaborations and coordination
- Increased Human resource for Nutrition.
- Procurement of Nutrition commodities.
- Strengthened national level support through Malezi Bora, Household level monitoring of salt Iodization.
- Improved county and Sub-county Coordination structures such as CNTFs for course correc tion.

Challenges during the implementation period of KCNAP 2016-2018

- Insufficient monitoring of the Process Indicators
- Output indicators were vague, hence measuring success achievement was difficult
- Lack of clarification of the denominators
- Inadequacy of funds to implement interventions such as Micronutrient powders, mass media etc.
- Inadequate capacity on Advocacy, Communication and Social Mobilization (ACSM) by health care workers.
- Inadequate periodic assessment of knowledge practice and coverage (KPC) and knowledge attitude and practice (KAP) surveys
- Inadequate operational research to further ascertain the KAP/KPC findings
- Un-harmonized IEC materials in the county.
- Uncoordinated ACSM activities in the county by partners.
- Low utilization of mass media/local stations for wider coverage of key nutrition messages

Proposed Recommendations during the implementation period of KCNAP 2016-2018

- There is need for continuous advocacy for prioritization of nutrition activities as well as increased nutrition budget
- Recruitment of more nutritionists at least 1 per ward
- Capacity building of nutritionist on key nutrition packages as part of system strengthening.
- Training of CHVs on key nutrition packages.
- Need for clarification on nutrition indicators being monitored
- Increased targeted supportive supervision by the county and sub county teams
- Leverage on existing opportunities to document and share best practices/lessons learnt at the county level i.e. county media etc.
- The county should invest on surveys e.g. knowledge attitude and practices to ensure behavioral indicators are periodically evaluated.
- Strengthen data quality through data quality audits (DQAs) and data review meetings.

1.7 Constraints

The challenges facing the county in terms elimination and reduction of malnutrition, improving of MIYCN, management of NCDs and community nutrition empowerment are as follows:

- In accessibility to safe and quality water
- Inadequate capacity among the Agri-nutritionists
- Inadequate nutrient intake due to poverty, poor nutritional and lifestyle practices, low physical activity
- Inadequate Operation research to inform evidence-based actions
- Inadequate resources to respond to nutrition emergencies
- Inadequate safe and clean water in HH and at schools.
- Inadequate staffing for nutrition and Low knowledge levels on nutrition among non-nutrition staff
- Inadequate support supervision
- Increased defaulter rate due to lack of food
- Increased incidences of opportunistic infections due to malnutrition
- Insufficient funds and resources to conduct community dialogues
- Lack of awareness on food diversification
- Lack of awareness on some of the existing regulatory acts
- Lack of capacity to enforce the regulations
- Lack of clinical nutrition specialists
- Lack of financial support for the sectoral coordination
- Lack of knowledge on NCD
- Lack of nutrition programmes for the elderly persons
- Lack of prioritization of nutrition reports due to inadequate nutrition staff. Most the of the work is done by nurses
- Lack of sewer system and Low of latrine coverage
- Long distances to health facilities
- Low community engagement, participation and feedback mechanism
- Low coverage IMAM services
- Low demand for nutrition services
- Low health and nutrition education amongst vulnerable groups
- Low levels of awareness on nutrition needs for older children
- Low linkages of facility and community linkages.
- Low male and other key influencers engagement and support on MIYCN.

- Low uptake of IFAS
- Multisectoral and sectoral coordination structure not well coordinated
- Negative cultural practices including food uptake related stereotypes e.g. avoidance of iron rich foods
- No linkage between nutrition and social protection
- No ownership of nutrition activities by nutrition sensitive sectors
- No one to guide the sectoral and multisectoral coordination structures
- Over dependence on livestock keeping
- Poor data quality from community to the DHIS
- Poor dietary diversification
- Poor dissemination of guidelines of clinical nutrition and dietetics guidelines
- Poor health seeking behavior
- Poor knowledge of nutrition among health workers and community
- Poor linkage of the elderly persons into nutrition programmes

2 CHAPTER 2: COUNTY NUTRITION ACTION PLAN (CNAP) FRAMEWORK

2.1 Introduction

Malnutrition is caused by factors that are broadly categorized as immediate, underlying, and basic. Immediate causes of malnutrition include disease and inadequate food intake; this means that disease can affect nutrient intake and absorption, leading to malnutrition, while not taking sufficient quantities and the right quality of food can also lead to malnutrition.

The underlying causes are food insecurity-including availability, economic access and use of food; feeding and care practices-at maternal, household and community level; and environment and access to and use of health services (World Health Organization and The World Bank, 2012). Household food insecurity implies that there is a lack of access to sufficient, safe, nutritious food to support a healthy and active life.

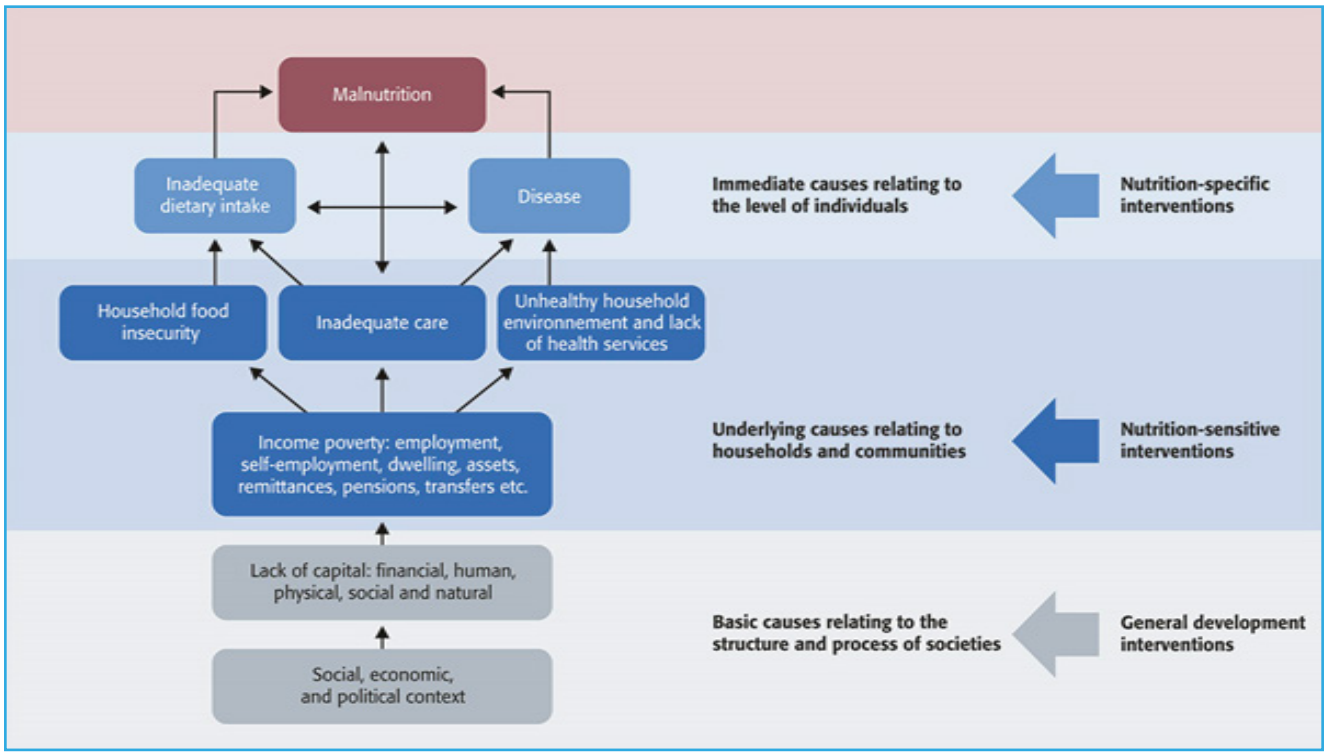
The level of nutrition awareness among mothers or caregivers and other influencers affects the child feeding and care practices, consequently impacting on their nutrition. Similarly, poor access to and utilization of health services as well as environmental contaminants brought about by inadequate water, poor sanitation, and hygiene practices, influence the nutrition of households.

Lastly, the underlying causes of malnutrition which act as the enabling environment on macro-level include issues such as knowledge and evidence, politics and governance, leadership, infrastructure and financial resources In general nutrition-specific interventions address the manifestation and immediate causes; nutrition-sensitive interventions the underlying causes and enabling environment interventions the primary or root causes of malnutrition.

Nutrition is neither a sector nor a domain of one ministry or discipline but a multi-sectoral and multi-disciplinary issue that has many ramifications from the individual, household, community national to global levels. Addressing all forms of malnutrition at all three levels of causation (immediate, underlying, and essential) 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, WASH systems, and nutrition-sensitive policies, strategies, and programs. Strategies for integration of nutrition-specific interventions and sensitive interventions have been tested and proven to work.

Figure 2.1: Conceptual framework for malnutrition



Source: (UNICEF, June 2015)

2.2 Vision

A county free from malnutrition

2.3 Mission

To provide effective and efficient preventive, promotive and curative nutrition intervention within the county

2.4 National policy and legal framework for CNAP

The constitution of Kenya gives every child the right to basic nutrition (Article 43 c) and all individuals the right to free from hunger and food of acceptable quality (Art 53c). The country has a huge responsibility of ensuring the communities have access to good quality health care and live a healthy life. To achieve the aspirations of the Constitution and Vision 2030, Kenya has given legislative force to some key aspects of nutrition interventions.

These include legislation on the following:

1. Prevention and control of Iodine deficiency disorders through mandatory salt iodization,
2. Mandatory food fortification of cooking fats and oils and cereal flours, through the Food Drugs and Chemical Substances Act.
3. The benefits of breastfeeding are protected through the Breast Milk Substitutes (Regulation and Control Act) 2012.
4. Mandatory establishment of lactation stations at workplaces (Health Act Art 71 & 72)
5. The Food, Drugs and Chemical Substances Act (food labeling, additives, and standard (amendment) regulation 2015 on transfats) is also key legislation central to the control of Diet Related Non-Communicable Diseases (DRNCDs).
6. The Nutritionists and Dieticians Act 2007 (Cap 253b) which determine and set up a framework for the professional practice of nutritionists and dieticians;

Monitoring compliance is even more critical in the light of devolution. Counties' ability to implement and monitor the regulations is crucial, and hence is considered within the KNAP. The counties will have a key role in implementing, monitoring and enforcement.

2.5 Rationale

County Nutrition Action Plan has been developed to accelerate and scale up efforts towards the elimination of malnutrition as a problem of public health significance .The three basic rationales for the action plan are: (a) The health consequences – improved nutrition status leads to a healthier population and enhanced quality of life; (b) Economic consequences – improved nutrition and health is the foundation for rapid economic growth; and (c) The ethical argument – optimal nutrition is a human right.

2.6 Nutrition through the life course approach

Nutritional needs and concerns vary during different stages of life from childhood to elderly years. Nutritional requirements in the different segments of the population can be classified into the following groups which correspond to different parts of the lifespan, namely; pregnancy and lactation, infancy, childhood, adolescence, adulthood, and old age

The development of this CNAP had been through intensive consultation in order to capture the nutritional requirements of individuals or groups across different ages and diversities living in the county. The KCNAP has considered the following factors: Physical activity — whether a person is engaged in heavy physical activity; age and sex of the individual or group; body size and composition, Geography; and Physiological states, such as pregnancy and lactation.

From infancy to late life, nutritional needs change. Children must grow and develop, while older adults must counter the effects of aging. The importance of gender, age, and diversity-appropriate nutrition during all stages of the life cycle cannot be overlooked. It is against this background that this action plan has been developed, taking into consideration nutrition needs as per specific appropriate stages of life as well as to capture and optimize the heterogeneity of nutrition needs regardless of gender, age, and other socio-economic, cultural and physiological determinants and dimensions.

2.7 Gender mainstreaming

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

Across Kenyan communities, which are patriarchal, women continue to face discrimination and often have less access to power and resources, including those related to nutrition. It is, therefore, imperative to provide equal opportunity for all genders to participate in economic development for optimal resource generation.

The adoption of a gender-responsive approach to the identification, planning, and implementation of development activities is eminent for improved, transformative, and sustainable food and nutrition security.

Household food insecurity aggravated biased social systems, cultural norms, beliefs, and practices that greatly influence the socio-economic vulnerability and human development form part of the major factors leading to malnutrition in Kajiado County.

Deep-rooted gender inequalities within the county including unequal access to, use and control over benefits from productive resources especially by women and girls and their limited autonomy in decision making which is culturally a preserve for men deny women and girls equal opportunities to exploit their potential as strong agents for increased food and nutrition security (CIDP, 2018).

The youth who form the majority of the productive population have equally been left out, thus the possibility of missing out on the existing potentials and their essential role towards contributing socio-economic development in the county. On the other hand, the above 64 years' category is mainly composed of the aged, with a large proportion being dependent on the working population.

This places a heavy burden on the economically active population that contributes to economic development and, at the same time, provides basic needs to the households. This calls for the need to direct more resources to provide adequate youth polytechnics and invest special programmers in creating employment opportunities. Poverty alleviation programmes should aim at providing subsidies and healthcare programmes for the aged population and their dependents.

Despite their social status as custodians of household and community based productive resources and decision making, men are inadequately involved in issues related to nutrition largely perceived as women's role. This is likely to result in an inadequate lack of support by men, which can have a major negative impact on the efforts being made towards achieving improved nutrition and health-related outcomes.

Other factors such as overburdening maternal roles, socio-cultural beliefs and practices around food sharing and uptake, negative cultural practices such as child and forced marriages, unequal or limited access to information, and literacy levels disproportionately women and girls further represent part of the factors negatively impacting on food and nutrition security. This underscores the need to apply a rights-based approach to gender programming, with opportunities to leverage complementary rights-based and gender-responsive nutrition principles which have been factored in the county CNAP.

Notwithstanding, the roles, priorities, norms, needs, and use of resources may differ between men and women. The way women and men are affected by nutrition actions may also vary, as demonstrated within the CNAP. Weak inter-sectoral linkages, inadequate gender integration in nutrition assessments, surveys/research leads to lack of evidence-based decision making and the design of tailor-made nutrition and health interventions responsive to the specific nutrition needs, priorities, challenges while building on the existing capacities, experience, and knowledge among men and women of different age and diversities. Additionally, disaggregation of data by sex, age groups and diversities at all levels is important to inform the necessary response interventions to address different population group's specific nutrition and health-related needs in the county.

In order to achieve effective and sustainable nutrition and health outcomes, the CNAP seeks to integrate a gender transformative approach through effective gender mainstreaming at all levels of nutrition and health interventions. Specifically, this nutrition action plan has used mix approaches to a larger extent; integrate gender in the development process and the final action plan. These include:

- The use of the life cycle approach "all residents of Kajiado County, throughout their life-cycle enjoy safe food in sufficient quantity and quality to satisfy their nutritional needs for optimal health at all times." By using the life-course approach, the action identifies key nutrition interventions for each age cohort and provides the linkages of nutrition to food production and other relevant sectors that impact on nutrition.
- Ensuring nutrition programming at all levels in Kajiado County is consistently informed by context-based gender analysis defining the gender issues and relations relating to the specific nutrition needs and priorities of men and women of different ages and diversities across the county
- Specific strategies, interventions, and activities are prioritized within the CNAPs addressing nutrition needs specific to women, men, adolescents (boys and girls) giving weight in identification and addressing the socio-cultural, economic, technology and political barriers to achieving gender equality in areas of human rights, equal participation of men and women in key decision processes about their nutrition and wellbeing, equal access, use and control over and benefit from resource development resources adequately respond to the specific nutrition and health-related needs of women and men across all ages and diversities.
- Development and implementation of a SBCC strategy to address underlying socio-economic barriers, cultural norms, beliefs, knowledge and practices are affecting improved and sustainable food, nutrition, and health-related outcomes in Kajiado County.
- Development and implementation of a SBCC strategy to address underlying socio-economic and cultural barriers and practices affecting improved and sustainable food security, nutrition, and health-related outcomes in Kajiado County.
- Support interventions promoting increased male and community engagement on their role in supporting improved uptake of optimal nutrition and health practices at the household level, community, and across the county at large.
- 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 Kajiado County.
- The CNAP development process has mainstreamed gender in its development process by making sure both females and males are invited and make meaningful participation all the stages of CNAP development, this include active participation in the inception meeting, writing and interventions prioritization meetings including validation, making the process inclusive and participatory with women and men having equal opportunity to in setting Nutrition agenda for Kajiado County.
- The Common Result and Accountability Framework for Kajiado CNAP has intentionally included an indicator that is meant to monitor and evaluate gender-transformative nutrition interventions for improved and sustainable nutrition and health-related outcomes.
- Accountability for results is enhanced to improve transparency, leadership, and the quality of statistics and information made available to the various stakeholders and the public by collecting sex age disaggregated data at all levels.

2.8 Target audience for CNAP

The target audience for the Kajiado County Nutrition Action Plan (KCNAP) cuts across policy makers and decision makers both at national and county governments, donors and implementing partners of both nutrition specific and sensitive interventions, county health management team, sub county health management teams, nutrition workforce in health and other departments that influence and provide enabling environment for nutrition to be achieved and the communities at the grassroots level.

3 CHAPTER 3: KEY RESULT AREAS (KRAs), STRATEGIES AND INTERVENTIONS

3.1 Introduction

The overall expected result or desired change for the CNAP is to contribute to the goal of KNAP 2018-2022 in achieving optimal nutrition for a healthier and better-quality life and improved productivity for the country's accelerated social and economic growth. To achieve the expected result, a total of 13 key result areas (KRAs) have been defined for Kajiado County. The KRAs are categorized into three focus areas: (a) Nutrition-specific (b) Nutrition-sensitive and (c) Enabling environment, See, Table 3.1. The KRAs have been matched with corresponding set of expected outcomes and outputs, as well priorities activities per each of the KRA presented in see, section 3.3).

Table 3.1: Prioritized KRAs per Focus Area

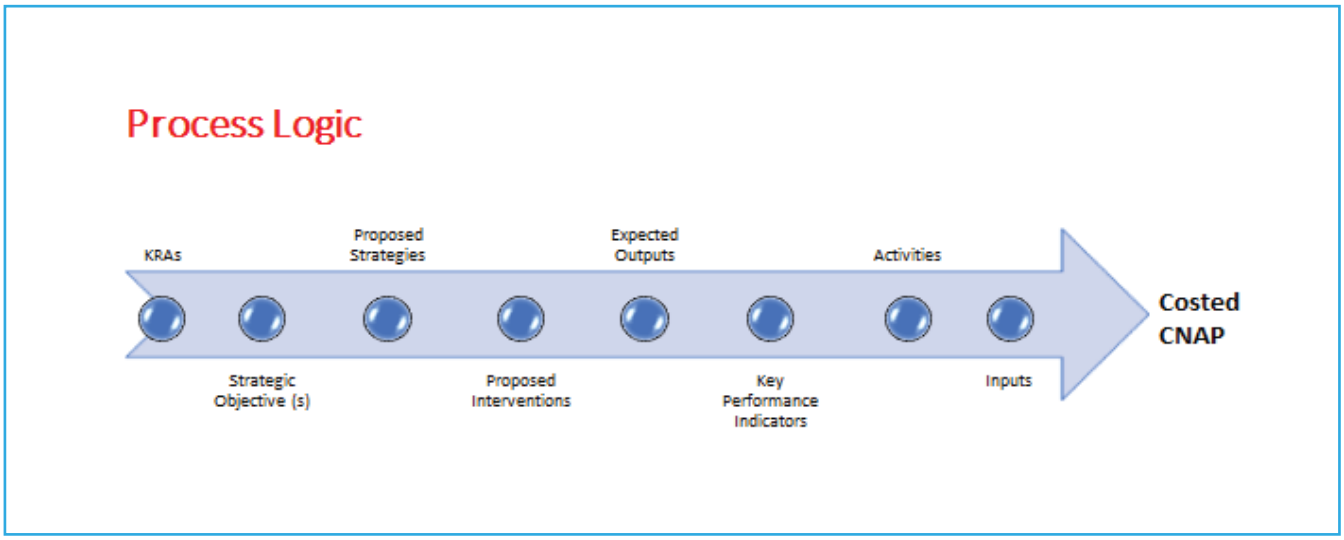
CATEGORY OF KRAs BY FOCUS AREAS	KEY RESULT AREAS (KRAs)
Nutrition specific	1. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up
	2. Nutrition of older children, adolescent, adults and elderly promoted.
	3.Prevention, control and management of Micronutrient Deficiencies Scaled up
	4.Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled up
	5. Integrated Management of Acute Malnutrition and nutrition emergencies Strengthened
	6. Clinical Nutrition and Dietetics Strengthened
Nutrition sensitive	7. Nutrition in Agriculture and Food Security scaled-up
	8. Nutrition in Education and Early Childhood Development (ECDE) promoted
	9. Nutrition in Water, Sanitation and Hygiene (WASH) promoted
	10. Nutrition in elderly persons and social protection promoted
Enabling Environment	11. Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management, Information Systems, Learning and Research Strengthened.
	12. Sectoral and multisectoral Nutrition Information Systems, Learning and Research strengthened
	13. Advocacy communication and social mobilization (ACSM) for nutrition program strengthened

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. ToC defines long-term goals and then maps backward to identify necessary preconditions. It describes and illustrates 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 theory of change. The ToC was used to develop a set of result areas that if certain strategies are deployed to implement prioritized activities using the appropriate then a set of results would be realized and if at scale, contribute to improved nutritional status of Kajiado residents. The logic framework outlining the key elements in the change process is captured in the Figure 3.1. The expected outcome, expected output and priorities activities in line with the process logic have been discussed in section 3.3.

Figure 3.1: The CNAP Logic Process



3.3 Key result areas, corresponding outcome, outputs, and activities

KRA 01. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up

Outcome
Improved nutrition status of women of reproductive age (15-49), and children infants 0-59 months)

Output 1
Strengthened capacity of health care workers to provide quality MIYCN services

Activities
1. Train male and female health care workers on BFHI
2. Train male and female health care workers on BFCI
3. Train male and female CHVs on CBFCI
4. Train male and female health care workers on BMS Act
5. Conduct OJT and mentorship for health care workers on BFCI/BFHI
6. Conduct training on practical skills on skin to skin contact to health care workers

7. Conduct BFHI/ BFCI assessment
8. Develop day care Centre (DCC) guidelines for nutrition
9. Train health care workers and care group volunteers (CGV) or CHVs on care group model for MIYCN promotion
10. Train male and female health care actors on effective gender mainstreaming for improved provision and implementation of transformative nutrition and health care services and programming.

Output 2
Improved knowledge of mothers and influencers on MIYCN

Activities
1. Conduct community education sessions (targeting men and women across different ages and diversities) on complementary feeding including cooking demonstrations
2. Conduct community barazas on MIYCN
3. Conduct community dialogue and action days on MIYCN
4. Establish mother to mother and father to father support groups for MIYCN
5. Conduct home visits by CHV to pregnant and lactating mothers to counsel and educate them on MIYCN
6. Conduct community health and nutrition education targeting men for their increased engagement on their role and support on MIYCN.
7. Advocate for enforcement of school re-entry policy for teenage mothers at least 1 year after delivery to allow uptake of EBF and optimal complementary feeding.

Output 3
Increased advocacy communication and social mobilization (ACSM) activities for MIYCN

Activities
1. Sensitize policy makers to prioritize MIYCN interventions
2. Mark and celebrate health and nutrition days (WBW, Malezi bora week)
3. Document community champions to advocate for adoption of optimal MIYCN behaviors
4. Strengthen the implementation of SBCC strategy on MIYCN.

Output 4
Promotion, protection and support of breastfeeding at workplace and community enhanced

Activities
1. Establish lactation rooms at workplace
2. Construct maternity waiting shelters at the community level to increase hospital deliveries
3. Conduct monitoring and enforcement of BMS act enforcement

KRA 02. Nutrition of older children, adolescent and adults Promoted

Outcome
Improved nutrition status of older children

Output 1
1.Increased knowledge of male and female health care workers and community health volunteers on nutrition for older children
2. Train male and female health care workers on nutrition policies and guidelines
3. Train community health volunteers on nutrition policies and guidelines

Output 2
Improved micronutrient intake for adolescent girls in schools

Activities
1. Sensitize Board of Management members on WIFA supplementation
2. Sensitize head teachers on WIFA supplementation
3. Sensitize stakeholders on WIFA
4. Sensitize adolescent girls, parents and other community members and leaders on WIFA.
5. Train teachers on WIFA
6. Supplement adolescents with WIFAs

Output 3
Malnourished children in schools and community detected early for treatment and referral

Activities
1. Conduct nutrition assessment at the identified/mapped schools
2. Refer malnutrition cases to the link facility

KRA 03. Prevention, control and management of Micronutrient Deficiencies Scaled up

Outcome
Improved micronutrient status of the population

Output 1
Increased intake of diverse nutrient micronutrient rich foods b the populations

Activities
1. Conduct health education to the community (equally targeting men and women across different ages and diversities) on dietary diversity, bio-fortified foods
2. Educate the community on production, preservation and consumption of micronutrient rich foods at household level

Output 2
Increased coverage of micronutrient supplementation among women of reproductive age and children 6-59 months

Activities
1. Sensitize opinion leaders, health workers, CHVs, line ministries and other stakeholders' available guidelines and policies e.g. vitamin A, IFAS, micronutrient supplements.
2. Quantify, forecast and procure micronutrient supplements (vitamin A capsules, Zinc tablets, Iron Folic tablets required, micronutrient powders).
3. Supplement children aged 6 - 59 months with vitamin A and MNPs.
4. Supplement pregnant mothers with IFAS.

5. Strengthen documentation and micronutrient reporting system of Vitamin A, IFAS and MNPS from the community level up to the DHIS.

Output 3
Increased intake of fortified foods by the population

Activities
1. Sensitize the community members on identification of fortified foods.
2. Train public health officers on relevant guidelines on food fortification.
3. Conduct yearly surveillance and monitoring of the uptake of fortified foods with a logo by the community.
4. Conduct yearly surveillance and monitoring of the uptake of fortified foods by the public health officers at household and factories.

KRA 04. Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled up

Outcome
Prevention, control and management of NCDs through nutrition strengthened

Output 1
1. Strengthened, capacity of health care workers to detect, manage and treat diet related NCDs
2. Conduct training on prevention and control of NCDs to health care workers at all levels

Output 2
Early detection of NCDs enhanced

Activities
1. Conduct gender integrated periodic surveys and operational research of nutrition related risk factors for NCDs
2. Screening of public to detect and treat NCDs
3. Procure nutrition equipment

KRA 05. Integrated Management of Acute Malnutrition and nutrition emergencies Strengthened

Outcome
Increased coverage of gender responsive IMAM services

Outcome 1
1. Strengthened capacity of health care workers on provision of quality IMAM
2. Disseminate at all levels IMAM guidelines, treatment protocols and sops
3. Conduct IMAM training for health care workers at all levels
4. Monitor adherence to IMAM program SOPS, guidelines and protocols by health and nutrition workforce
5. Train CHVs and Health care workers to effectively identify, document and address underlying social cultural and economic factors contributing to malnutrition, affecting optimal adherence to IMAM services and relapse by MAM/SAM patients.
6. Conduct IMAM program performance reviews; cure, defaulter, death coverage with M&E

Output 2
Strengthened integration of gender responsive IMAM with other services at community and facility

Activities
1. Integrate gender responsive IMAM services with other programs (WASH, livelihood, social protection and food security)
2. Integrate implementation on IMAM in public and private partnership
3. Promote improved linkage with programs on behavioral change awareness, creation or for prevention strategies at community and HH level including MIYCN, social protection and livelihood support strategies

Output 3
Availability of nutrition commodities, supplies and equipment enhanced

Activities
1. Procure IMAM commodities
2. Procure IMAM equipment's

Output 4
Improved nutrition status of vulnerable groups during emergencies

Activities
1. Conduct gender integrated assessment and monitoring for response of the affected populations during emergency
2. Develop commodity management plan
3. Ensure access to high impact nutrition gender responsive interventions in emergencies, in health facilities and outreaches
4. Put supply contingency system in place

KRA 06. Clinical Nutrition and Dietetics Strengthened

Expected outcome
Improved access to quality clinical nutrition and dietetics services

Output 1
Enhanced capacity of health care workers to offer quality services for clinical nutrition

Activities
1. Disseminate clinical nutrition and dietetics manual.
2. Conduct training forums and workshops on nutrition care process
3. Train health care workers on enteral and parenteral feeding for critical ill patients

Output 2
Knowledge, skills and competencies of health care workers in disease management and dietetics services enhanced

Activities
1. Train health care workers on management of pre-term and low birth weight
2. Train nutritionist in specialized postgraduate courses in clinical nutrition (pediatric oncology, renal, diabetes etc.)
3. Train nutritionist in specialized short courses in clinical nutrition (pediatric oncology, renal, diabetes etc.)

Output 3
Enhanced standards for provision of quality nutrition and dietetics services for inpatients and general hospital services

Activities
1. Conduct orientation meeting on development of standard operating procedure for provision of clinical nutrition services.
2. Develop individualized standards operating procedures for clinical nutrition and dietetics
3. Develop county specific gender and age responsive inpatient feeding protocol
4. Conduct dissemination meetings for inpatient feeding protocol
5. Conduct Quality assurance field visit to hospitals on clinical nutrition
6. Conduct review meetings to discuss quality assurance result findings

Output 4
Strengthened monitoring and reporting of clinical nutrition and dietetics services from all facilities

Activities
1. Conduct data quality review meetings clinical nutrition
2. Print and disseminate tools for clinical nutrition
3. Print and disseminate tools for TB and HIV

Output 5
Strengthened capacity of health care providers to provide quality nutrition services for HIV and TB clients

Activities
1. Train health care workers on TB and HIV
2. Training on LMIS
3. Train PMTCT service providers on complementary feeding course
4. Conduct integrated OJT and mentorship for health care workers on nutrition for HIV and TB patients

Output 6
Availability of commodities, equipment's for clinical nutrition, TB and HIV ensured

Activities
1. Procure equipment's for diet modification.
2. Procure therapeutic and supplementary feeds
3. Procure enteral parenteral feeds

KRA 07. Nutrition in Agriculture and Food Security scaled-up

Outcome
Strengthened linkages with nutrition and Agriculture

Output
Increased knowledge of male and female farmers and community (equally targeting men and women across different ages and diversities) on quality safe farm produce

Activities
1. Train male and female farmers on aflatoxins control, Maximum residue levels (MRLs)and safe use of chemicals
2. Train male and female health care workers and farmers groups on Agri nutrition
3. Train male and female farmers on food bio fortification
4. Sensitization on bio fortified foods.
5. Train male and female community peer to peer support groups across different ages and diversities on SMART-climate Agri--nutrition livelihoods activities (kitchen gardens/ animal husbandry) and IGAs and link them to productive livelihood-based sectors and financial institutions for support.
6. Support targeted male and female community-based groups to establish nutrition sensitive kitchen gardens and animal husbandry technologies
7. Conduct joint monitoring and evaluation of Agri-nutrition activities

KRA 08. Nutrition in Education and Early Childhood Development (ECDE) promoted

Outcome
Improved nutrition status for ECDE and school going children

Output
1. Strengthened linkages with nutrition and education.
2. Conduct school health activities through provision VAS and deworming
3. Revive and establish school health clubs.
4. Sensitize school, teachers and students on dietary diversity.
5. Sensitize teachers on nutrition assessment for school going children.

KRA 09: Nutrition in Water, Sanitation and Hygiene (WASH) promoted

Expected outcome
Promote capacity for nutrition and WASH

Output 1
Improved knowledge of health care workers and school going children on WASH

Activities
1. Sensitize school going children on WASH and nutrition
2. Train male and female health care workers and CHVs on WASH
3. Conduct sensitization forums on WASH and nutrition in institutions
4. Sensitize male and female food handlers and school boards on WASH and food safety

Output 2
Health and safe food environment in schools, other learning institutions and community promote.

Activities
1. Conduct training of teacher and patrons on PHASE (personal hygiene and sanitation education)
2. Sensitize food handlers, Parent–Teacher Associations (PTA) on healthy and safe food environment conducted
3. Conduct sensitization on safe and hygienic practices during food preparation and storag
4. Conduct integrated CLTS in the village at household level equally targeting men and women across different ages and diversities to promote environmental hygiene.

Output 3
Increased uptake of WASH and nutrition by the community, institutions

Activities
1.Advocate for resource mobilization to impellent WAS and nutrition activities
2. Commemorate Global and National days on WASH and nutrition
3. Develop and customize WASH and nutrition policies and strategy

KRA 10. Nutrition in elderly persons and social protection promoted

Outcome
To improve the nutrition status for elderly persons (> 65) according to KNBS 2014 Kajiado County has 16,766 elderly persons

Output 1
Nutrition integrated in social protection system for the elderly within the county

Activities
1. Enhance participation of nutrition stakeholders in social protection coordination mechanisms
2. Scale up social safety nets in times of crisis e.g. during drought, disease outbreak and flash floods
3. Adopt, disseminate and implement criteria for nutrition in social protection programmes for OVC persons living with disability
4. Mobilize financial resources for nutrition interventions in social protection programmes
5. Sensitize opinion leaders, officers in social protection programmes, health, institutions, administrators on importance of good nutrition and related health.
6. Sensitize the public and vulnerable persons on health and nutrition.

Output 2
Improved knowledge of health care workers and the community members on health diets and lifestyle for the elderly

Activities
1. Conduct awareness campaigns on health diet and lifestyle for the elderly
2. Train community members targeting men and women across different ages and diversities on healthy diet and lifestyle

3. Train male and female health care workers on policies and guidelines; healthy diets and lifestyle guidelines for elderly persons

KRA 11. Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened

Outcome
Efficient and effective nutrition governance, coordination and legal frameworks in place

Output 1
Implementation of the available regulatory Acts i.e. BMS Act 2012, Health Act 2017, food fortification standards and regulations enhanced

Activities
1. Conduct joint meetings with enforcement bodies and regulatory bodies to sensitize them on the existing legislations on nutrition
2. Develop joint monitoring plan.
3. Enhance the regulatory act and policies (Hardcopies)

Output 2
Multisectoral partnership and collaboration strengthened

Activities
1. Conduct CNTF at the county level
2. Conduct sectoral coordination forums at the sub-county level

KRA 12. Sectoral and multisectoral Nutrition Information Systems, Learning and Research strengthened

Expected outcome
Data collection from multisectoral departments and line ministries strengthened

Output 1
Improved data quality for decision making

Activities
1. Conduct quarterly field visits at the NDMA sentinel sites
2. Hold bi annual multisectoral nutrition collaboration TWG meetings and monitoring of TWG plan
3. Conduct quarterly joint field visits to the sub counties for data quality audit at the facility level

Output 2
Evidence based decision making enhanced

Activities
1. Conduct gender integrated KPC survey
2. Conduct midterm evaluation review of CNAP
3. Conduct gender integrated SMART survey
4. Establish a gender sensitive research repository for nutrition and dietetic

5. Hold forums to disseminate research findings and information sharing through conferences, workshops and meetings
6. Promote knowledge sharing through publication e.g. Quarterly nutrition bulletin

Output 3
Data quality at sectoral level improved

Activities
1. Conduct monthly DHIS / LMIS quality audits at the county level
2. Conduct quarterly county, sub county support supervision
3. Conduct quarterly data quality audits at health facility
4. Hold monthly meetings for evaluation of gender sensitive integrated report at the sub county
5. Conduct routine quarterly sub county data review and feedback meetings
6. Conduct evidence-based actions/research for MIYCN
7. Hold meetings to develop an integrated gender sensitive work plan

KRA 13. Advocacy communication and social mobilization (ACSM) for nutrition program strengthened

Outcome
Enhanced commitment and continued prioritization of nutrition in county agenda.

Output 1
Enhanced implementation of regulatory acts

Activities
1. Create awareness on regulatory acts and policies e.g. BMS act, workplace support
2. Conduct sensitization meetings to policy makers, parliamentarians and health care workers on regulatory acts and policies
3. Conduct sensitization meetings to the community on regulatory acts

Output 2
Increased human resource for nutrition, equipment and commodities ensured

Activities
1. Conduct advocacy meetings with MCA, county budgetary allocation committee and executive committee members in the county to advocate for increased resource allocation for NCDs, commodities, equipment and human resource
2. Hold advocacy meetings with county policy and decision makers to lobby for employment of additional male and female clinical nutrition staff
3. Participate in the budgetary planning meetings
4. Hold meetings to advocate for institutionalization of CHVs motivation within county strategic documents
5. Conduct nutrition awareness sessions for caregivers, teachers and BOM on optimal nutrition

Output 3
Awareness creation on healthy diet and physical, general optimal nutrition activities intensified

Activities

1. Incorporate awareness session creation on physical activity and lifestyle habits with the local media
2.Customize and disseminate relevant policies and guidelines on health diets and NCDs
3. Hold awareness sessions on healthy feeding habits to adolescent boys and girls across all divers ties
4. Hold education awareness forums on lifestyle and dietary diversification
5. Conduct community participation forums equally targeting men and women across different ages and diversities.
6. Conduct nutrition awareness sessions on good nutrition to the community
7. Design, develop, print and disseminate IEC materials for nutrition
8. Train male and female CHVs on community nutrition module 8

4 CHAPTER 4: MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL) FRAMEWORK

4.1 Introduction

This chapter provides guidance on the Monitoring, Evaluation, Accountability and Learning process, and how the monitoring process will inform the county nutrition action plan. The CNAP will evolve as the county assesses data gathered through monitoring.

Monitoring and evaluation systematically track the progress of suggested interventions, and assesses the effectiveness, efficiency, relevance and sustainability of these interventions. Monitoring is the ongoing, routine collection of information about a programs activity in order to measure progress toward results.

That information tells us if a change occurred (the situation got better or worse) which, in turn, helps in making more informed decisions about what to do next. Regular monitoring helps in detection of obstacles resulting in data-driven decisions, on how to address them. A program may remain on course or change significantly based on the data obtained through monitoring. Monitoring and evaluation 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 generated from it. In order to ensure ownership and accountability, the nutrition program 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. Involvement of stakeholders 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.

An assessment of the technical M&E capacity of the program within the county is crucial. This includes the data collection systems that may already exist and the level of skill of the staff in M&E. It is recommended that approximately 10% of a programs 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 attainment of the nutrition goals described in the global commitment e.g. WHA, SDGs, NCDs, and national priorities outlined in the KNAP and Food and Nutrition Security Policy. It also described the priority strategies and interventions necessary to achieve the outcomes, 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 MEAL Plan aims to provide strategic information needed for evidence-based decisions at county level through development of 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, and 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, how and by whom data will be collected, and suggests the frequency and the timeline for collective, program performance reviews with stakeholders.

Elements to be monitored include:

- Service statistics
- Service coverage/Outcomes
- Client/Patient outcomes (behavior change, morbidity)
- Clients' equitable access to and uptake of quality and gender responsive quality of health services responsive to the specific needs of men and women across different ages and diversi ty.
- Impact of interventionism response to the specific nutrition and health needs of men and women across different ages and diversities.

The evaluation plan will elaborate on the periodic performance reviews/surveys and special research that complement the knowledge base of routine monitoring data. Evaluation questions, sample and sampling methods, research ethics, data collection and analysis methods, timing/schedule, data sources, variables and indicators are discussed.

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 between 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, age and diversity. Similarly, positive influences and outcomes from the interventions supporting gender equality for improved nutrition and health outcomes shall be documented and learned from to improve and optimize interventions. Other measures that will be in place to ensure a gender responsive MEAL plan will include:

- Development / review 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 diver sity can help in accessing different groups within a community.
- Reviewing existing data to identify gender roles, relations and issues prior to design of nutri tion programming to help set a baseline.
- Holding separate interviews and FGDs with women and men across different gender, age and diversities including other socio-economic variations.

- Inclusion of verifiable indicators focused on the benefits of the nutrition programming for women and men.
- Integration of gender-sensitive indicators to point out 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 program to the department of health and the overall county intersectoral government M&E will be through the county 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 program will share their quarterly progress reports with the County Department of Health (CDOH) M&E unit, who will take lead in the joint performance reviews at sub national level. The county management teams will prepare the quarterly reports and in collaboration with county stakeholders and organize the county quarterly 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 jointly review the performance of the health sector for the year under review.

For a successful monitoring of this action plan, the county will have to strengthen their M&E function by investing in both the infrastructure and the human resource for M&E. Technical capacity building for data analysis could be promoted through collaboration with research institutions or training that target the county M&E staff. Low reporting from other sectors on nutrition sensitive indicators is still a challenge due to the use different reporting systems that are not inter-operational. Investment on Health Information System (HIS) infrastructure to facilitate e-reporting is therefore key. Timely collection and quality assurance of health data will improve with a team dedicated to this purpose.

4.5 Logic Model

The logic model looks at what it takes to achieve intended results, thus linking result expected, with the strategies, outputs an input, for shared understanding of the relationships between the results expected, activities conducted and resources required.

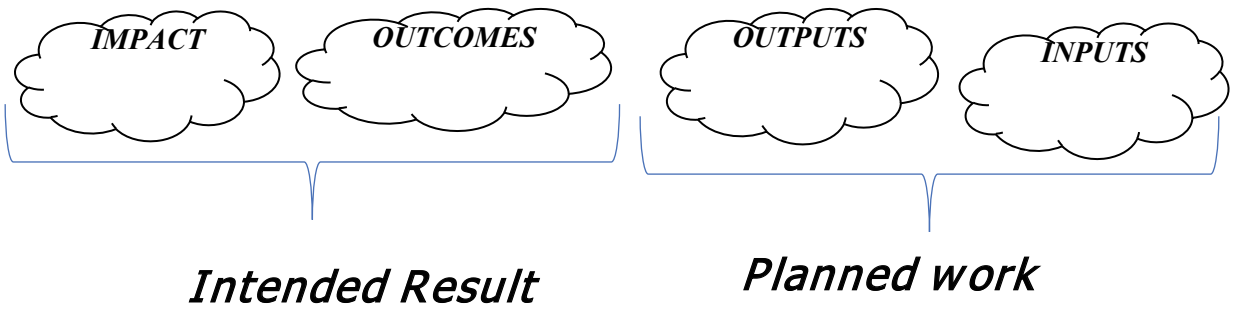


Figure 4.1: The Logic Model

Table 4.1: Results Framework

OUTCOMES	**Outcome 1. Reduction in under nutrition** - Reduce prevalence of stunting among children under five years by 40%; -Reduce and maintain childhood wasting to less than 5%; -Reduce and maintain childhood underweight to less than 10%; -Increase dietary diversity by 90%. -Maintain mortality rates at below 3% for MAM and 10% for SAM	**Outcome 2. Reduction micronutrient deficiencies:** -Reduce the prevalence of anemia in pregnant women (%) -Reduce the prevalence of iodine deficiency in children <5 years (%) -Reduce the prevalence of zinc deficiency in children <5 years (%)	**Outcome 3. Reduction of dietary related NCDs** -Reduce the prevalence of overweight/obesity in adults (18-69 years) -Reduce the mortality attributable to dietary risk factors	**Outcome 4. Reduction of hospital-based malnutrition** - Reduce proportion of patients with hospital-based malnutrition by 20%	**Outcome 5. Halt/ Increased financing for nutrition** Increased domestic financing for nutrition
OUTPUTS	**Output 1. Strengthened Health Care Worker capacity to better deliver nutrition services** **Indicators:** -Number of male and female policy makers sensitized on MIYCN - Number of male and female policy makers sensitized on BFCI - Number of male and female policy makers sensitized on BFHI - Number of male and female health care workers trained on prevention and control of NCDs - Proportion of male and female healthcare workers trained on IMAM - Number of male and female health workers trained on MIYCN-e - Number of male and female HCWs trained on parenteral and enteral feeding	**Output 2: Improved knowledge of the community on proper nutrition practices.** **Indicators:** **-**Number of cooking demonstrations conducted at the community level - Number of meetings held for sensitization of community on establishment of modern kitchen gardens/animal husbandry - Number of mothers to mother/father to father support groups formed - Number of male and female community health workers trained on dietary diversity, bio fortification	**Output 3: Improved nutrition commodity management** **Indicators** **-**	**Output 4: Improved multisectoral coordination** **Indicators:** -Number of joint planning and progress review meetings held. - Number of coordination forums held at the county level - Number of multisectoral coordination forums held at the county level **-**Number of joint nutrition performance review meetings with other sectors	**Output 5. Improved nutrition monitoring and evaluation** **Indicators** - Number of gender integrated KAP survey done - Number of genders integrated SMART surveys done - Availability of nutrition and dietetics repository
INPUTS	1. Organization of service delivery for nutrition; 2. Human Resource for Nutrition; 3. Nutrition infrastructure; 4. Nutrition products and Technology; 5. Nutrition Information; 6. Nutrition Financing;			7. Nutrition research; 8. Nutrition leadership; 9. Household access to better quality and quantity of resources; 10. Financial, human, physical and social capital; 11. Socio cultural, economic and political context	

4.6 Implementation Plan

The implementation of MEAL framework will be spearheaded by the county in collaboration with development partners and stakeholders. This will ensure successful implementation of the CNAP.

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

a) Develop standard operating procedures for management of data, monitoring, evaluation and learning among all stakeholders.
b) Improve performance monitoring and review process
c) Enhance sharing of data and use of information for evidence-based decision making

4.7 Monitoring process

In order 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 makes implementation effective to guide 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; and impact assessment.

The key monitoring processes as outlined in Figure 2 will involve:

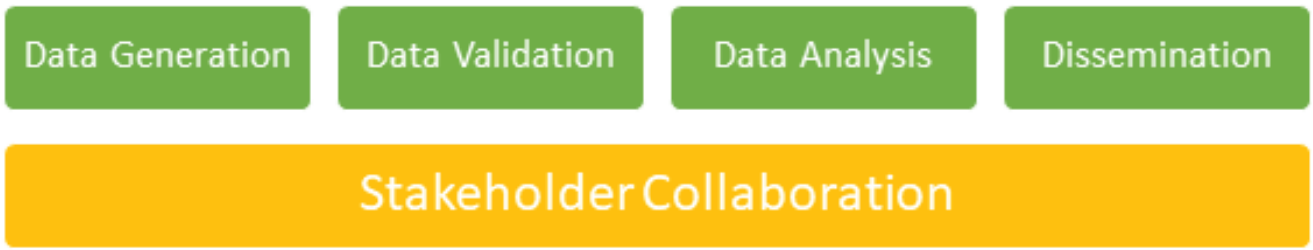


Figure 4.2: Monitoring Process

i. Data Generation

- Various types of data will be collected from different sources to monitor the implementation progress. These data are 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 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 should reach MOH by agreed timelines for all levels.

ii. Data Validation

- Data validation through checking or verifying whether or not 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 assessment. Annual and Quarterly verification process should be carried out, to review the data across all the indicators.

iii. Data analysis

• This step ensures transformation of data into information which can be used for decision making at all levels.

iv. 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.

v. Stakeholder Collaboration

• There is need 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 these stakeholders is collectively required for the overall assessment of sector performance.

4.8 Monitoring Reports

The following are the monitoring reports and their periodicity:

Table 4.2: Monitoring Reports

Process/Report	Frequency	Responsible	Timeline
Annual Work Plans	Yearly	All departments	End of June
Surveillance Reports	Weekly	DSSC and health facility in charges	COB Friday
Health Data Reviews	Quarterly	All departments	End of each quarter
Monthly reports submissions	Monthly	Facilities, CUs	5th of every month
Quarterly reports	Quarterly	All departments	After 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	5th of every month
Surveys and assessments	As per need	Nutrition program	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.

Updating of the Framework

Regular update of the M&E framework will be done based on learning experienced along the implementation way.

It will be adjusted to accommodate new interventions to achieve any of the program-specific objectives. A mid-term review of the framework will be conducted in 2020/21 to measure progress of its implementation and hence facilitate necessary amendments.

Indicators and Information Sources

The indicators that will guide monitoring of the implementation of CNAP a will be captured and outlined in the Common Results and Accountability Framework 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 both the accountability of various stakeholders and facilitates learning with a view to improving the relevance and performance of the health sector over time.
A midterm review and an end evaluation will be undertaken to determine the extent to which the objectives of this CNAP are met.

Evaluation Criteria

To carry out an effective evaluation of the CNAP, there will be need for clear evaluation questions. Evaluators will analyze relevance, efficiency, effectiveness and sustainability for the CNAP. The proposed evaluation criterion is elaborated on below;

Relevance: The extent to which the objectives of the CNAP correspond to population needs including the vulnerable groups. It also includes an assessment of the responsiveness in light of 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 the 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 an outlined intervention after its termination and the commitment of the beneficiaries leverage on those benefits.
The CNAP will be evaluated through a set on indicators outlined in the Common Results and Accountability Framework in Table 4.3

Common Results and Accountability Framework

Table 4.3: Common Results and Accountability Framework

KAJIADO CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018-2022							
KEY RESULT AREA 1: Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Reduce prevalence of stunting among children under five years by 40%	Prevalence of stunting in children 0-59 months (%)	25.2% (2018)	19%	14%	SMART survey	Every 2 Years	Nutrition Program
Reduce the prevalence of low birth weight by 30%	Prevalence of birth weight of 2.5 kg and below (%)	10%	6%	2%	KHIS	Annual	Nutrition Program
Increase the rate of exclusive breastfeeding in the first six months by 20% and above	Prevalence of exclusive breastfeeding in children 0-6 months (%)	40% (2017)	44%	46%	GBD/KDHS	Annual	Nutrition Program
Reduce and maintain childhood wasting to less than 5%	Prevalence of wasting (W/H >2SD) in children 0-59 months (%)	5% (2015)	5%	4.50%	GBD/KDHS	Annual	Nutrition Program
Reduce and maintain childhood underweight to less than 10%	Prevalence of underweight (W/A <2SD) in children 0-59 months	11% (2015)	10%	9.50%	GBD/KDHS	Annual	Nutrition Program
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Strengthened capacity of health care workers to provide quality MIYCN services	Number of male and female policy makers sensitized on MIYCN	0	40	80	Program reports	Annual	Nutrition Program
	Number of male and female health care workers trained on BFHI	No data	100	200	Program reports	Annual	Nutrition Program
	Number of male and female CHVs trained on BFCI	88	248	408	Program reports	Annual	Nutrition Program

KEY RESULT AREA 1: Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
	Number of health facilities certified as Baby friendly	0	4	8	Program reports	Annual	Nutrition Program
Improved knowledge of mothers and influencers on MIYCN	Number of cooking demonstrations conducted at the community level	0	16	32	Program reports	Annual	Nutrition Program
	Number of meetings held for sensitization of community on establishment of modern kitchen gardens/animal husbandry	0	16	32	Program reports	Annual	Nutrition Program
Increased advocacy communication and social mobilization (ACSM) activities for MIYCN	Number of mothers to mother/father to father support groups formed	7	11	15	Program reports	Annual	Nutrition Program
	Number of health and nutrition days marked	2	8	14	Program reports	Annual	Nutrition Program
	Number of documentaries for community champions to advocating for adoption of optimal MIYCN behaviors	0	4	8	Program reports	Annual	Nutrition Program
Promotion, protection and support of breastfeeding at workplace and community enhanced	Number of lactation rooms established at workplace and social amenities	0	4	8	Program reports	Annual	Nutrition Program
KEY RESULT AREA 2: Nutrition of older children, adolescent and adults Promoted							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Increased knowledge of health care workers and community health volunteers on nutrition for older children	Proportion of community identified malnourished children disaggregated by age and sex referred and received in link facilities	No data	70%	90%	Program reports	Annual	Nutrition Program

KEY RESULT AREA 2: Nutrition of older children, adolescent and adults Promoted							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Improved micronutrient intake for adolescent girls in schools	Number of male and female teachers trained on WIFAs	0	100	250	Program training reports	Annual	Nutrition Program
Malnourished children in schools and community detected early for treatment and referral	Number of gender, age and diversity sensitive nutrition assessments conducted for older children in schools	0	4	8	Program reports	Annual	Nutrition Program
	Number of nutrition awareness and education sessions conducted for caregivers in schools	0	7	15	Program reports	Annual	Nutrition Program
KEY RESULT AREA 3: Prevention, control and management of Micronutrient Deficiencies Scaled up							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Reduce anemia in pregnant women by 40% or more	Prevalence of anemia in pregnant women (%)	36%	30%	25%	KDHS	Every 5 years	Nutrition Program/KNBS
Reduce Iodine deficiency among children <5 years by over 50%	Prevalence of Iodine deficiency in children <5 years (%)	22	15	<10	KMNS	Every 5 years	Nutrition Program
Reduce prevalence of Zinc deficiency in pre-school children by 40%	Prevalence of Zinc deficiency in children <5 years (%)	83	75	50	KMNS	Every 5 years	Nutrition Program
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Increased intake of diverse micronutrient rich foods by the populations	Number of male and female community health workers trained on dietary diversity, bio fortification	No Data	100	250	Program data	Annual	Nutrition program
	Proportion of population with an acceptable household food consumption score (Minimum dietary Diversity (MDD).	88.8%	92%	95%	KDHS	Every 5 years	Nutrition program

KEY RESULT AREA 3: Prevention, control and management of Micronutrient Deficiencies Scaled up							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Increased coverage of micronutrient supplementation among women of reproductive age and children 6-59 months	Proportion of male and female HCWs sensitized on relevant micronutrient guidelines and policies	6%	26%	46%	Program Reports	Annual	Nutrition Program
	Vitamin A coverage	65%	68%	72%	KHIS	Quarterly	Nutrition Program
	Proportion of children 6 - 23 months disaggregated by sex supplemented with micro nutrition powder	25%	50%	100%	Program Reports	Annual	Nutrition Program
	IFAs coverage	78%	82%	88%	KHIS	Quarterly	Nutrition Program
Increased intake of fortified foods by the population	Proportion of factories surveyed and monitored on production of fortified food	No data	50%	100%	Program Reports	Annual	Nutrition Program
	Proportion of male and female public health officers trained on food fortification guidelines	105	20%	30%	Program Reports	Annual	Nutrition Program
Strengthened documentation and micronutrient reporting system of Vitamin A, IFAS and MNPS from the community level up to the DHIS	Proportion of facilities reporting on Vitamin A	50%	72%	100%	KHIS	Monthly	Nutrition Program
	Proportion of facilities reporting on iron and folic supplementation	95%	97%	100%	KHIS	Monthly	Nutrition Program
	Proportion of facilities reporting on micronutrient powders	0%	50%	100%	KHIS	Monthly	Nutrition Program
KEY RESULT AREA 4: Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled up							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Halt and reverse the rise in obesity by 30%	Prevalence of overweight/obesity in adults (18-69 years)	28	25	20	Stepwise Survey 2015	Every 5 years	Nutrition /NCD Program
Reduce mortality due to dietary risk factors by 20%	Mortality attributable to dietary risk factors	31/100,000	28/100000	26/100000	GBD 2015	Every 2 years	Nutrition Program

KEY RESULT AREA 4: Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled up							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Strengthened, capacity of health care workers to detect, manage and treat diet related NCDs	Number of male and female health care workers trained on prevention and control of NCDs through nutrition related interventions	100	200	400	Program reports	Annual	Nutrition/NCD Program
Early detection of NCDs	Number of gender integrated operational researches on nutrition related risk factors for NCDs conducted	0	2	2	Program reports	Every 3-5 years	Nutrition/NCD Program
KEY RESULT AREA 5: Integrated Management of Acute Malnutrition and nutrition emergencies Strengthened							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Maintain mortality rates at below 3% for MAM and 10% for SAM	Proportion of deaths among acutely children (%)	0.2 MAM/1.7 SAM	0.2 MAM/1.7 SAM	0.2 MAM/1.7 SAM	KDHS 2014	Every 5 years	Nutrition Program/KNBS
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Strengthened capacity of health care workers on provision of quality IMAM	Proportion of IMAM guidelines, treatment protocols and SOPs disseminated	17%	30%	60%	Program reports	Every 2 years	Nutrition Program
	Proportion of male and female healthcare workers trained on IMAM	10%	30%	50%	Program reports	Annual	Nutrition Program

KEY RESULT AREA 5: Integrated Management of Acute Malnutrition and nutrition emergencies Strengthened							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Strengthened integration of IMAM with other services at community and facility	Number of sensitization meetings held on integrating gender responsive IMAM services with other programs (WASH, Livelihood, social protection and food security)	0	8	16	Program reports	Annual	Nutrition Program
	Number of IMAM sites established in public and private health facilities	0	20	40	Program reports	Annual	Nutrition Program
Availability of nutrition commodities, supplies and equipment enhanced	Number of advocacy meetings held to increase resource allocation for IMAM implementation including commodities, equipment and equitable male and female human resource	0	2	4	Program reports	Annual	Nutrition Program
Monitor the performance and quality of services provided by the IMAM program	Proportion of facilities adhering to IMAM program SOPS	10%	30%	50%	Facility assessments	Every 2 years	Nutrition Program
Improved nutrition status of vulnerable groups during emergencies	Contingency plan developed	No	Yes	Yes	Program reports	Every three years	Nutrition program
	Number of emergency response meetings held	No data	24	48	Program reports	Annual	Nutrition Program
	Number of male and female health workers trained on MIYCN-e	No data	100	200	Program reports	Annual	Nutrition Program

KEY RESULT AREA 6: Clinical Nutrition and Dietetics Strengthened							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Reduce proportion of patients with hospital-based malnutrition by 20%	Proportion reduction of hospital-based malnutrition	No data	15%	30%	Program Reports	Annual	Nutrition Program
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
	Proportion of population screened and assessed for nutrition status while accessing healthcare services	No data	15%	30%	Program Reports	Annual	Nutrition Program
	Number of male and female HCWs trained on parenteral and enteral feeding	0	120	240	Program training report	Annual	Nutrition program
	Number of training conducted on nutrition care process	0	4	8	Program reports	Annual	Nutrition Program
Knowledge, skills and competencies of health care workers in disease management and dietetics services enhanced	Number of male and female nutritionists trained on specialized short courses in clinical nutrition (pediatric oncology, renal, diabetes etc.)	2	6	10	Program reports	Annual	Nutrition Program
Enhanced standards for provision of quality nutrition and dietetics services for inpatients and general hospital services	Number of quality service assessment on clinical nutrition conducted	0	4	8	Program reports	Annual	Nutrition Program
	Number of hospitals utilizing parenteral feeds.	1	3	5	Program reports	Annual	Nutrition Program
	Number of hospitals utilizing enteral feeds	3	5	7	Program reports	Annual	Nutrition Program
	Number of hospitals implementing the inpatient feeding protocol	5	12	22	Program reports	Annual	Nutrition Program

KEY RESULT AREA 6: Clinical Nutrition and Dietetics Strengthened							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Strengthened monitoring and reporting of clinical nutrition and dietetics services from all facilities	Proportion of hospitals with tools for clinical nutrition	0	20%	80%	Facility surveys	Every 2 years	Nutrition program
Strengthened capacity of health care providers to provide quality nutrition services for HIV and TB clients	Number of facilities offering individual counseling on complementary feeding	0	30	70	Program reports	Annual	Nutrition Program
	Number of training conducted to PMTCT service providers on complementary feeding	0	2	4	Program reports	Annual	Nutrition Program
Availability of commodities, equipment for clinical nutrition, TB and HIV ensured	Number of facilities offering therapeutic feeds for TB and HIV	45	63	83	Program reports	Annual	Nutrition Program
KEY RESULT AREA 7: Nutrition in Agriculture and Food Security scaled-up							
Increased knowledge of male and female farmers, HCWs and community on quality safe farm produce	Number of male and female farmers groups trained on safe use of chemicals	1	11	21	Program reports	Annual	Nutrition Program/Department of Agriculture
	Number of community (male and female across different ages and diversities sensitization meetings on MRLs and aflatoxins	25	85	145	Program reports	Annual	Nutrition Program/Department of Agriculture
Integrated joint planning, monitoring and evaluation with the department of agriculture	Number of joint planning and progress review meetings held.	2	10	18	Program reports	Annual	Nutrition Program/Department of Agriculture

KEY RESULT AREA 8: Nutrition in Education and Early Childhood Development (EECD) promoted							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Strengthened linkages with nutrition and education	Number of trainings conducted for male and female teachers on nutrition assessment	0	2	4	Activity reports	Bi-annual	Nutrition Program/Department of Education
	Proportion of schools linked for VAS and deworming	19%	40%	70%	Activity reports	Bi-annual	Nutrition Program/Department of Education
KEY RESULT AREA 9: Nutrition in Water, Sanitation and Hygiene (WASH) promoted							
Improved knowledge of health care workers and school going children on WASH	Number of sensitization sessions on safe and hygienic practices conducted to households and institutions	16	100	200	Reports	Quarterly	Nutrition Program/WASH
Health and safe food environment in schools, other learning institutions and community promoted	Number of sensitization sessions conducted on healthy environment and food safety	22	82	142	Reports	Annually	Nutrition Program/WASH
KEY RESULT AREA 10 Nutrition in elderly persons and social protection promoted							
Nutrition integrated in social protection system for the elderly within the county.	Proportion of male and female officers sensitized on relevant guidelines and policies	0%	50%	100%	Training reports	Annually	Nutrition Program
	Number of vulnerable persons disaggregated by age, sex and diversity receiving safety nets	9634	11634	13634	Payrolls	Quarterly	Nutrition Program
	Number of OVCs, disabled and elders disaggregated by age and sex linked to nutrition and social protection	0	11634	13634	Payrolls and minutes	Quarterly	Nutrition Program

KEY RESULT AREA 10 Nutrition in elderly persons and social protection promoted							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Improved knowledge of health care workers and the community members on health diets and lifestyle for the elderly	Number of support groups for male and female elderly formed	0	25	25	Activity reports	Quarterly	Nutrition Program
KEY RESULT AREA 11: Sectoral and multi-sectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened							
Implementation of the available regulatory Acts i.e. BMS Act 2012, Health Act 2017, food fortification standards and regulations enhanced	Number of coordination forums held at the county level	1	4	4	Activity reports	Quarterly	Nutrition program
Multi-sectoral partnership and collaboration strengthened	Number of coordination forums held at the sub-county level	1	8	16	Activity reports	Quarterly	Nutrition program
	Number of multi-sectoral coordination forums held at the county level	5	13	21	Activity reports	Quarterly	Nutrition program
	Number of proposal/ concept papers developed and forwarded for funding	3	7	11	Activity reports	Annually	Nutrition program
KEY RESULT AREA 12 Sectoral and multi-sectoral Nutrition Information Systems, Learning and Research strengthened							
Improved data quality for decision making	Number of data quality audits done at health facility on nutrition indicators	1	8	16	Data audit reports	Quarterly	Nutrition program
	Number of joint nutrition performance review meetings with other sectors	0	8	8	Program reports	Annual	Nutrition program
	Number of quarterly multi-sectoral M&E meetings	0	8	16	Multi-sectoral minutes	Quarterly	Nutrition program
	Number quarterly joint field visits done	0	8	16	Field reports	Quarterly	Nutrition program

KEY RESULT AREA 12 Sectoral and multi-sectoral Nutrition Information Systems, Learning and Research strengthened							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Evidence based decision making enhanced	Number of gender integrated KAP survey done	0	1	2	Survey report	Every 2 Years	Nutrition program
	Number of genders integrated SMART surveys done	1	3	5	Survey report	Annually	Nutrition program
	Availability of a gender sensitive research sub committee	No	Yes	Yes	Minutes	Annually	Nutrition program
	Availability of nutrition and dietetics repository	No	Yes	Yes	Library	Annually	Nutrition program

5 CHAPTER 5: CNAP RESOURCE MOBILIZATION AND COSTING FRAMEWORK

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, programs and resources can be better directed to strategically compliment the health financing already in place, advocate for financing of needed health priorities, and aid populations to access available health services.

Costing is a 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.

This is a process that allocates costs of inputs based on each intervention and activity with an aim of achieving set goals /results. It attempts to identify what causes the cost to change (cost drivers). All costs of activities are traced and attached to the intervention or service for which the activities are performed.
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

Financial resources need for the CNAP was estimated by costing all the activities necessary to achieve each of expected outputs in each of Key Result Area (KRA). The costing of the CNAP used result-based costing to estimate the total resource need to implement the action plan for the next five years. The action plans were brought to cost using the Activity-Based Costing (ABC) approach.

The ABC uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve Strategic plan targets. ABC is a process that allocates costs of inputs based on each activity, it 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 methodology under the ABC approach will be as follow; (i) The activities require inputs, such as labour, conference hall etc.; (ii) These inputs are required in certain quantities, and with certain frequencies; (iii) It is the product of the unit cost, the quantity, and the frequency of the input that gave the total input cost; (iv) The sum of all the input costs gave the Activity Cost. These were 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 Strategic plan was brought to cost using the Activity Based Costing (ABC) approach. The ABC uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve planned targets for the financial years of 2018/19 – 2022/23. The cost over time for all the Key Result Areas provides important details that will initiate debate and allow County health management and development partners to discuss priorities and decide on effective resource allocation.

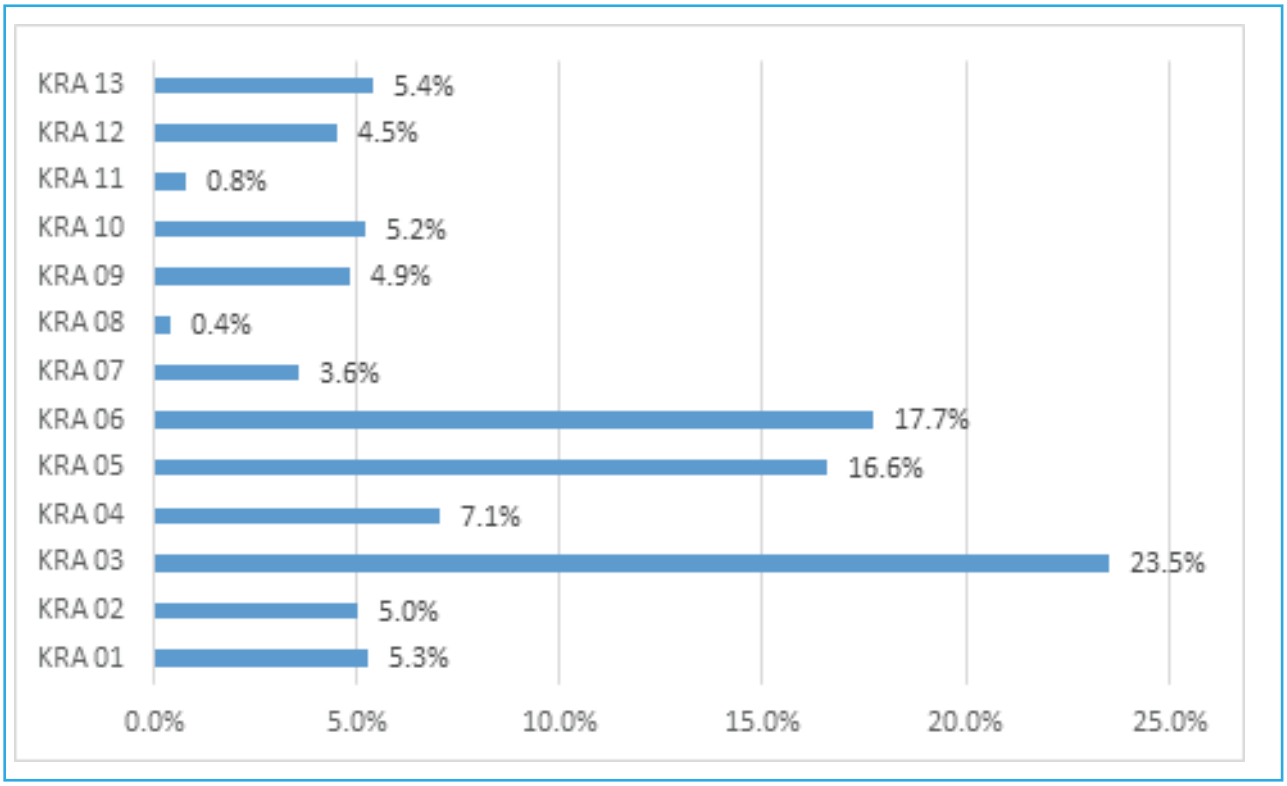
The KRAs provided targets to be achieved within the plan period and the corresponding inputs to support attainment of the targets. Based on the targets and unit costs for the inputs, the costs for the strategic plan were computed. The total cost of implementing Kajiado CNAP for the five years is estimated at KSh. 1.9 billion, See, and table 5.1. Further annual breakdown of cost requirement (s) is also presented by each of the output and activities is presented in annex Table A.

Table 5.1: Summary Cost per KRA

KRAs BY FOCUS AREAS	KEY RESULT AREAS (KRAs)	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Nutrition specific	KRA 01. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up	8,494,250	21,491,000	23,176,000	21,851,000	23,176,000	98,188,250
	KRA 02. Nutrition of older children, adolescent and adults Promoted	10,112,950	20,897,900	20,897,900	20,897,900	20,897,900	93,704,550
	KRA 03. Prevention, control and management of Micronutrient Deficiencies Scaled up	91,193,290	82,813,290	91,193,290	82,813,290	91,193,290	439,206,450
	KRA 04. Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled up	14,677,000	29,354,000	29,354,000	29,354,000	29,354,000	132,093,000
	KRA 05. Integrated Management of Acute Malnutrition and nutrition emergencies Strengthened	34,060,500	69,052,200	69,052,200	69,052,200	69,052,200	310,269,300
	KRA 06. Clinical Nutrition and Dietetics Strengthened	81,898,900	57,200,200	55,658,000	80,416,700	55,658,000	330,831,800
Nutrition sensitive	KRA 07. Nutrition in Agriculture and Food Security scaled-up	8,328,200	12,993,200	16,443,200	12,993,200	16,443,200	67,201,000
	KRA 08. Nutrition in the Health sector strengthened	925,250	1,850,500	1,850,500	1,850,500	1,850,500	8,327,250
	KRA 09. Nutrition in Education and Early Childhood Development (EECD) promoted	18,193,000	18,193,000	18,193,000	18,193,000	18,193,000	90,965,000
	KRA 10. Nutrition in Water, Sanitation and Hygiene (WASH) promoted	19,409,250	19,409,250	19,409,250	19,409,250	19,409,250	97,046,250
Enabling environment	KRA 11. Nutrition in elderly persons and social protection promoted	1,903,000	3,310,000	3,310,000	3,310,000	3,310,000	15,143,000
	KRA 12. Sectoral and multi-sectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened	18,456,000	13,956,000	13,956,000	21,943,750	16,583,550	84,895,300
	KRA 13. Sectoral and multi-sectoral Nutrition Information Systems, Learning and Research strengthened	14,690,860	21,500,780	21,500,780	21,500,780	21,500,780	100,693,980
Grand Total		**322,342,450**	**372,021,320**	**383,994,120**	**403,585,570**	**386,621,670**	**1,868,565,130**

The annual break down of cost key result areas is presented in Table 5.1. KRA 03: Prevention, control and management of Micronutrient Deficiencies Scaled up accounts for the highest proportion of total resources need accounting for 23.5%, while KRA 08. Nutrition in Education and Early Childhood Development (ECDE) promoted, accounts for the least at 0.4% of the total resource requirement (See, figure 5.1).

Figure 5.1: Proportion of resource requirements by KRA



5.4 Strategies to ensure available resources are sustained

Strategies to mobilize resources from new sources

- Lobbying for a legislative framework in the county assembly for resource mobilization and allocation
- Identification of potential donors both bilateral and multi-lateral
- Conducting stakeholder mapping
- Call the partners to a resource mobilization meeting
- Identification, appointment and accreditation of eminent persons in the community as resource mobilization good will ambassadors
- Strategies to ensure efficiency in resource utilization
- Through planning for utilization of the allocated resources (SWOT analysis)
- Implementation plans with timelines
- Continuous monitoring of impact process indicators
- Periodic evaluation objectives if they have been achieved as planned

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7. APPENDICES

Annex A: Summary Table Resources Needs by KRA, Outputs and Activities

KEY RESULT AREAS, OUTPUTS AND ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL
KRA 01. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up	**8,494,250**	**21,491,000**	**23,176,000**	**21,851,000**	**23,176,000**	**98,188,250**
Output 1: Strengthened capacity of health care workers to provide quality MIYCN services	7,215,750	16,801,000	20,259,000	16,801,000	20,259,000	81,335,750
Train male and female health care workers on BFHI	1,729,000	3,458,000	3,458,000	3,458,000	3,458,000	15,561,000
Train male and female health care workers on BFCI	1,940,250	3,880,500	3,880,500	3,880,500	3,880,500	17,462,250
Train male and female CHVs on CBFCI	1,066,500	2,133,000	2,133,000	2,133,000	2,133,000	9,598,500
Train male and female health care workers on BMS Act	-	2,369,500	2,369,500	2,369,500	2,369,500	9,478,000
Conduct OJT and mentorship for health care workers on BFCI/BFHI	126,000	252,000	252,000	252,000	252,000	1,134,000
Conduct training on practical skills on skin to skin contact to health care workers	2,500	5,000	5,000	5,000	5,000	22,500
Conduct BFHI/BFCI assessment	23,500	47,000	47,000	47,000	47,000	211,500
Develop DCC guidelines	2,172,000	4,344,000	4,344,000	4,344,000	4,344,000	19,548,000
Train health care workers and care group volunteers (CGV) or CHVs on care group model for MIYCN promotion	156,000	312,000	312,000	312,000	312,000	1,404,000
Train male and female health care actors on effective gender mainstreaming for improved provision and implementation of transformative nutrition and health care services and programming.	-	-	3,458,000	-	3,458,000	6,916,000
Output 2: Improved knowledge of mothers and influencers on MIYCN	349,500	2,832,000	1,059,000	3,192,000	1,059,000	8,491,500
Conduct community barazas on MIYCN	1,000	2,000	2,000	2,000	2,000	9,000
Establish mother to mother and father to father support groups for MIYCN	3,000	6,000	6,000	6,000	6,000	27,000
Conduct home visits by CHV to pregnant and lactating mothers to counsel and educate them on MIYCN	345,500	691,000	691,000	691,000	691,000	3,109,500

KEY RESULT AREAS, OUTPUTS AND ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL
KRA 01. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up	**8,494,250**	**21,491,000**	**23,176,000**	**21,851,000**	**23,176,000**	**98,188,250**
Output 2: Improved knowledge of mothers and influencers on MIYCN	349,500	2,832,000	1,059,000	3,192,000	1,059,000	8,491,500
Conduct community health and nutrition education targeting men for their increased engagement on their role and support on MIYCN.	-	2,133,000	-	2,133,000	-	4,266,000
Advocate for enforcement of school re-entry policy for teenage mothers at least 1 year after delivery to allow uptake of EBF and optimal complementary feeding.	-	-	360,000	360,000	360,000	1,080,000
Output 3 : Increased advocacy communication and social mobilization (ACSM) activities for MIYCN	929,000	1,858,000	1,858,000	1,858,000	1,858,000	8,361,000
Sensitize policy makers to prioritize MIYCN interventions	129,000	258,000	258,000	258,000	258,000	1,161,000
Mark and celebrate health and nutrition days (WBW, Malezi bora week)	750,000	1,500,000	1,500,000	1,500,000	1,500,000	6,750,000
Document community champions to advocate for adoption of optimal MIYCN behaviors	50,000	100,000	100,000	100,000	100,000	450,000
Output 4: Promotion, protection and support of breastfeeding at workplace and community enhanced	238,250	632,600	632,600	632,600	632,600	2,768,650
Establish lactation rooms at workplace	206,500	413,000	413,000	413,000	413,000	1,858,500
Construct maternity waiting shelters at the community level to increase hospital deliveries	31,750	63,500	63,500	63,500	63,500	285,750
Conduct monitoring and enforcement of BMS act enforcement	-	156,100	156,100	156,100	156,100	624,400
KRA 02. Nutrition of older children, adolescent and adults Promoted	**10,112,950**	**20,897,900**	**20,897,900**	**20,897,900**	**\ 20,897,900**	**93,704,550**
Output 1 : Increased knowledge of male and female health care workers and community health volunteers on nutrition for older children	2,056,000	4,112,000	4,112,000	4,112,000	4,112,000	18,504,000
Train male and female health care workers on nutrition policies and guidelines	816,000	1,632,000	1,632,000	1,632,000	1,632,000	7,344,000
Train community health volunteers on nutrition policies and guidelines	1,240,000	2,480,000	2,480,000	2,480,000	2,480,000	11,160,000
Output 2: Improved micronutrient intake for adolescent girls in schools	6,986,950	14,645,900	14,645,900	14,645,900	14,645,900	65,570,550
Sensitize BOM members on WIFA supplementation	946,250	1,892,500	1,892,500	1,892,500	1,892,500	8,516,250

KEY RESULT AREAS, OUTPUTS AND ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL
KRA 02. Nutrition of older children, adolescent and adults Promoted	**10,112,950**	**20,897,900**	**20,897,900**	**20,897,900**	**20,897,900**	**93,704,550**
Output 2: Improved micronutrient intake for adolescent girls in schools	6,986,950	14,645,900	14,645,900	14,645,900	14,645,900	65,570,550
Sensitize head teachers on WIFA supplementation	2,400,000	4,800,000	4,800,000	4,800,000	4,800,000	21,600,000
Sensitize stakeholders on WIFA	336,000	672,000	672,000	672,000	672,000	3,024,000
Sensitize adolescent girls, parents and other community members and leaders on WIFA.		672,000	672,000	672,000	672,000	2,688,000
Train teachers on WIFA	237,500	475,000	475,000	475,000	475,000	2,137,500
Supplement adolescents with WIFAs	3,067,200	6,134,400	6,134,400	6,134,400	6,134,400	27,604,800
Output 3: Malnourished children in schools and community detected early for treatment and referral	1,070,000	2,140,000	2,140,000	2,140,000	2,140,000	9,630,000
Conduct nutrition assessment at the identified/mapped schools	70,000	140,000	140,000	140,000	140,000	630,000
Refer malnutrition cases to the link facility	1,000,000	2,000,000	2,000,000	2,000,000	2,000,000	9,000,000
KRA 03. Prevention, control and management of Micronutrient Deficiencies Scaled up	**91,193,290**	**82,813,290**	**91,193,290**	**82,813,290**	**91,193,290**	**439,206,450**
Output 1: Increased intake of diverse nutrient micronutrient rich foods by the populations	4,900,000	4,900,000	4,900,000	4,900,000	4,900,000	24,500,000
Conduct health education to community equally targeting men & women across different ages and diversities on dietary diversity, bio-fortified foods	4,750,000	4,750,000	4,750,000	4,750,000	4,750,000	23,750,000
Educate community on production, preservation and consumption of micronutrient rich foods at household level	150,000	150,000	150,000	150,000	150,000	750,000
Output 2: Increased coverage of micronutrient supplementation among women of reproductive age and children 6-59 months	82,401,090	75,572,090	82,401,090	75,572,090	82,401,090	398,347,450
Sensitize opinion leaders, health workers, CHVs, line ministries and other stakeholders' available guidelines and policies e.g. vitamin A, IFAS, micronutrient supplements,	7,697,000	868,000	7,697,000	868,000	7,697,000	24,827,000
Quantify, forecast and procure micronutrient supplements (vitamin A capsules, zinc tablets, iron folic tablets required, micronutrient powders)	56,919,890	56,919,890	56,919,890	56,919,890	56,919,890	284,599,450
Supplement children aged 6 - 59 months with vitamin A and MNPs	17,577,200	17,577,200	17,577,200	17,577,200	17,577,200	87,886,000
Strengthen documentation and micronutrient reporting system of Vitamin A, IFAS and MNPS from the community level up to the DHIS	207,000	207,000	207,000	207,000	207,000	1,035,000

KEY RESULT AREAS, OUTPUTS AND ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL
KRA 03. Prevention, control and management of Micronutrient Deficiencies Scaled up	**91,193,290**	**82,813,290**	**91,193,290**	**82,813,290**	**91,193,290**	**439,206,450**
Output 3: Increased intake of fortified foods by the population	3,892,200	2,341,200	3,892,200	2,341,200	3,892,200	16,359,000
Sensitize the community members on identification of fortified foods	150,000	150,000	150,000	150,000	150,000	750,000
Train public health officers on relevant guidelines on food fortification	2,482,200	931,200	2,482,200	931,200	2,482,200	9,309,000
Conduct yearly surveillance and monitoring of the uptake of fortified foods with a logo by the community	630,000	630,000	630,000	630,000	630,000	3,150,000
Conduct yearly surveillance and monitoring of the uptake of fortified foods by the public health officers at household and factories	630,000	630,000	630,000	630,000	630,000	3,150,000
KRA 04. Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled up	**14,677,000**	**29,354,000**	**29,354,000**	**29,354,000**	**29,354,000**	**132,093,000**
Output 1: Strengthened, capacity of health care workers to detect, manage and treat diet related NCDs	1,677,000	3,354,000	3,354,000	3,354,000	3,354,000	15,093,000
Conduct training on prevention and control of NCDs to health care **workers at all levels**	1,677,000	3,354,000	3,354,000	3,354,000	3,354,000	15,093,000
Output 2 : Early detection of NCDs enhanced	13,000,000	26,000,000	26,000,000	26,000,000	26,000,000	117,000,000
Conduct gender integrated periodic surveys and operational research of nutrition related risk factors for NCDs	12,000,000	24,000,000	24,000,000	24,000,000	24,000,000	108,000,000
Screening of public to detect and treat NCDs	500,000	1,000,000	1,000,000	1,000,000	1,000,000	4,500,000
Procure nutrition equipment	500,000	1,000,000	1,000,000	1,000,000	1,000,000	4,500,000
KRA 05. Integrated Management of Acute Malnutrition and nutrition emergencies Strengthened	**34,060,500**	**69,052,200**	**69,052,200**	**69,052,200**	**69,052,200**	**310,269,300**
Outcome 1: Strengthened capacity of health care workers on provision of quality IMAM	2,310,500	5,552,200	5,552,200	5,552,200	5,552,200	24,519,300
Disseminate at all levels IMAM guidelines, treatment protocols and sops and Conduct IMAM training for health care workers at all levels	1,739,500	3,479,000	3,479,000	3,479,000	3,479,000	15,655,500

KEY RESULT AREAS, OUTPUTS AND ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL
KRA 05. Integrated Management of Acute Malnutrition and nutrition emergencies Strengthened	**34,060,500**	**69,052,200**	**69,052,200**	**69,052,200**	**69,052,200**	**310,269,300**
Outcome 1: Strengthened capacity of health care workers on provision of quality IMAM	2,310,500	5,552,200	5,552,200	5,552,200	5,552,200	24,519,300
Train CHVs and Health care workers to effectively identify, document and address underlying social cultural and economic factors contributing to malnutrition, affecting optimal adherence to IMAM services and relapse by MAM/SAM patients.		931,200	931,200	931,200	931,200	3,724,800
Monitor adherence to IMAM program SOPS, guidelines and protocols by health and nutrition workforce	3,000	6,000	6,000	6,000	6,000	27,000
Conduct IMAM program performance reviews; cure, defaulter, death coverage with M&E	568,000	1,136,000	1,136,000	1,136,000	1,136,000	5,112,000
Output 2 : Strengthened integration of gender responsive IMAM with other services at community and facility	291,500	583,000	583,000	583,000	583,000	2,623,500
Integrate gender responsive IMAM services with other programs (WASH, livelihood, social protection and food security)	208,500	417,000	417,000	417,000	417,000	1,876,500
Integrate implementation on IMAM in public and private partnership	43,000	86,000	86,000	86,000	86,000	387,000
Promote improved linkage with programs on behavioral change awareness, creation or for prevention strategies at community and HH level including MIYCN, social protection and livelihood support strategies	40,000	80,000	80,000	80,000	80,000	360,000
Output 3: Availability of nutrition commodities, supplies & equipment enhanced	29,312,500	58,625,000	58,625,000	58,625,000	58,625,000	263,812,500
Procure IMAM commodities	27,500,000	55,000,000	55,000,000	55,000,000	55,000,000	247,500,000
Procure IMAM equipment's	1,812,500	3,625,000	3,625,000	3,625,000	3,625,000	16,312,500
Output 4: Improved nutrition status of vulnerable groups during emergencies	2,146,000	4,292,000	4,292,000	4,292,000	4,292,000	19,314,000
Conduct gender integrated assessment & monitoring for response of the affected populations during emergency	622,000	1,244,000	1,244,000	1,244,000	1,244,000	5,598,000
Development of commodity management plan	852,000	1,704,000	1,704,000	1,704,000	1,704,000	7,668,000
Ensure access to high impact nutrition gender responsive interventions in emergencies, health facilities and outreaches	668,000	1,336,000	1,336,000	1,336,000	1,336,000	6,012,000
Put supply contingency system in place	4,000	8,000	8,000	8,000	8,000	36,000

KEY RESULT AREAS, OUTPUTS AND ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL
KRA 06. Clinical Nutrition and Dietetics Strengthened	**81,898,900**	**57,200,200**	**55,658,000**	**80,416,700**	**55,658,000**	**330,831,800**
Output 1: Enhanced capacity of health care workers to offer quality services for clinical nutrition	**4,306,000**	**2,641,000**	**2,581,000**	**4,306,000**	**2,581,000**	16,415,000
Disseminate clinical nutrition and dietetics manual.	185,000	185,000	125,000	185,000	125,000	805,000
Conduct training forums and workshops on nutrition care process	2,456,000	2,456,000	2,456,000	2,456,000	2,456,000	12,280,000
Train health care workers on enteral and parenteral feeding for critical ill patients	1,665,000	-	-	1,665,000	-	3,330,000
Output 2: Knowledge, skills & competencies of health care workers in disease management and dietetics services enhanced	**6,082,900**	**2,764,000**	**2,590,000**	**5,908,900**	**2,590,000**	19,935,800
Train health care workers on management of pre-term and low birth weight	1,473,900	-	-	1,473,900	-	2,947,800
Train nutritionist in specialized postgraduate courses in clinical nutrition (pediatric oncology, renal, diabetes etc.)	2,015,000	2,015,000	2,015,000	2,015,000	2,015,000	10,075,000
Train nutritionist in specialized short courses in clinical nutrition (pediatric oncology, renal, diabetes etc.)	2,594,000	749,000	575,000	2,420,000	575,000	6,913,000
Output 3: Enhanced standards for provision of quality nutrition and dietetics services for inpatients and general hospital services	**2,016,000**	**1,454,000**	**207,000**	**769,000**	**207,000**	4,653,000
Conduct orientation meeting on development of standard operating procedure for provision of clinical nutrition services.	972,000	972,000	-	-	-	1,944,000
Develop individualized standards operating procedures for clinical nutrition and dietetics	175,000	175,000	-	-	-	350,000
Develop county specific gender and age responsive inpatient feeding protocol	100,000	100,000	-	-	-	200,000
Conduct dissemination meetings for inpatient feeding protocol	207,000	207,000	207,000	207,000	207,000	1,035,000
Conduct Quality assurance field visit to hospitals on clinical nutrition	259,000	-	-	259,000	-	518,000
Conduct review meetings to discuss quality assurance result findings	303,000	-	-	303,000	-	606,000

KEY RESULT AREAS, OUTPUTS AND ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL
KRA 06. Clinical Nutrition and Dietetics Strengthened	**81,898,900**	**57,200,200**	**55,658,000**	**80,416,700**	**55,658,000**	**330,831,800**
Output 4: Strengthened monitoring and reporting of clinical nutrition and dietetics services from all facilities	4,278,800	280,000	280,000	4,278,800	280,000	9,397,600
Conduct data quality review meetings clinical nutrition	3,836,000	280,000	280,000	3,836,000	280,000	8,512,000
Print and disseminate tools for clinical nutrition	96,800	-	-	96,800	-	193,600
Print and disseminate tools for TB and HIV	346,000	-	-	346,000	-	692,000
Output 5: Strengthened capacity of health care providers to provide quality nutrition services for HIV and TB clients	7,351,000	-	-	7,351,000	-	14,702,000
Train health care workers on TB and HIV	1,310,000	-	-	1,310,000	-	2,620,000
Training on LMIS	3,240,000	-	-	3,240,000	-	6,480,000
Train PMTCT service providers on complementary feeding course	2,490,000	-	-	2,490,000	-	4,980,000
Conduct integrated OJT and mentorship for health care workers on nutrition for HIV and TB patients	311,000	-	-	311,000	-	622,000
Output 6: Availability of commodities, equipment for clinical nutrition, TB and HIV ensured	57,864,200	50,061,200	50,000,000	57,803,000	50,000,000	265,728,400
Procure equipment's for diet modification.	50,061,200	50,061,200	50,000,000	50,000,000	50,000,000	250,122,400
Procure therapeutic and supplementary feeds	2,747,800	-	-	2,747,800	-	5,495,600
Procure enteral parenteral feeds	5,055,200	-	-	5,055,200	-	10,110,400
KRA 07. Nutrition in Agriculture and Food Security scaled-up	**8,328,200**	**12,993,200**	**16,443,200**	**12,993,200**	**16,443,200**	**67,201,000**
Output 1: Increased knowledge of male and female farmers and community (equally targeting men and women across different ages and diversities) on quality safe farm produce	**8,328,200**	**12,993,200**	**16,443,200**	**12,993,200**	**16,443,200**	**67,201,000**
Train male and female farmers on aflatoxins control, Maximum residue levels (MRLs)and safe use of chemicals	688,800	1,774,800	1,774,800	1,774,800	1,774,800	7,788,000

KEY RESULT AREAS, OUTPUTS AND ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL
KRA 07. Nutrition in Agriculture and Food Security scaled-up	**8,328,200**	**12,993,200**	**16,443,200**	**12,993,200**	**16,443,200**	**67,201,000**
Output 1: Increased knowledge of male and female farmers and community (equally targeting men and women across different ages and diversities) on quality safe farm produce	**8,328,200**	**12,993,200**	**16,443,200**	**12,993,200**	**16,443,200**	**67,201,000**
Train male and female health care workers and farmers groups on Agri nutrition	6,192,400	6,528,400	6,528,400	6,528,400	6,528,400	32,306,000
Train male and female farmers on food bio fortification	480,000	2,208,000	2,208,000	2,208,000	2,208,000	9,312,000
Sensitization on bio fortified foods.	280,000	376,000	376,000	376,000	376,000	1,784,000
Output 2: Increased knowledge of male and female farmers and community (equally targeting men and women across different ages and diversities) on quality safe farm produce	**8,328,200**	**12,993,200**	**16,443,200**	**12,993,200**	**16,443,200**	**67,201,000**
Train male and female community peer to peer support groups across different ages and diversities on SMART-climate agri--nutrition livelihoods activities (kitchen gardens/ animal husbandry) and IGAs and link them to productive livelihood-based sectors and financial institutions for support.	-	-	3,450,000	-	3,450,000	6,900,000
Support targeted male and female community-based groups to establish nutrition sensitive kitchen gardens and animal husbandry technologies	312,000	1,206,000	1,206,000	1,206,000	1,206,000	5,136,000
Conduct joint monitoring and evaluation of Agrinutrition activities	375,000	900,000	900,000	900,000	900,000	3,975,000
KRA 08. Nutrition in Education and Early Childhood Development (ECDE) promoted	**925,250**	**1,850,500**	**1,850,500**	**1,850,500**	**1,850,500**	**8,327,250**
Output 1: Strengthened linkages with nutrition and education	925,250	1,850,500	1,850,500	1,850,500	1,850,500	8,327,250
Conduct school health activities through provision VAS and deworming	25,500	51,000	51,000	51,000	51,000	229,500
Revive and establish school health clubs	267,000	534,000	534,000	534,000	534,000	2,403,000
Sensitize school, teachers and students on dietary diversity	121,250	242,500	242,500	242,500	242,500	1,091,250
Sensitize teachers on nutrition assessment for school going children	511,500	1,023,000	1,023,000	1,023,000	1,023,000	4,603,500

KEY RESULT AREAS, OUTPUTS AND ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL
KRA 09. Nutrition in Water, Sanitation and Hygiene (WASH) promoted	**18,193,000**	**18,193,000**	**18,193,000**	**18,193,000**	**18,193,000**	**90,965,000**
Output 1: Improved knowledge of health care workers and school going children on WASH	**5,806,000**	**5,806,000**	**5,806,000**	**5,806,000**	**5,806,000**	**29,030,000**
Sensitize school going children on WASH and nutrition	160,000	160,000	160,000	160,000	160,000	800,000
Train male and female health care workers and CHVs on WASH	3,450,000	3,450,000	3,450,000	3,450,000	3,450,000	17,250,000
Conduct sensitization forums on WASH and nutrition in institutions	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	7,000,000
Sensitize male and female food handlers and school boards on WASH and food safety	796,000	796,000	796,000	796,000	796,000	3,980,000
Output 2: Health and safe food environment in schools, other learning institutions and community promoted	9,781,000	9,781,000	9,781,000	9,781,000	9,781,000	**48,905,000**
Conduct training of teacher and patrons on PHASE (personal hygiene and sanitation education)	1,590,000	1,590,000	1,590,000	1,590,000	1,590,000	7,950,000
Sensitize food handlers, Parent–Teacher Associations (PTA) on healthy and safe food environment conducted	1,075,000	1,075,000	1,075,000	1,075,000	1,075,000	5,375,000
Conduct sensitization on safe and hygienic practices during food preparation and storage	3,220,000	3,220,000	3,220,000	3,220,000	3,220,000	16,100,000
Conduct integrated CLTS in the village at household level equally targeting men and women across different ages and diversities to promote environmental hygiene.	3,896,000	3,896,000	3,896,000	3,896,000	3,896,000	19,480,000
Output 3: Increased uptake of WASH and nutrition by the community, institutions	**2,606,000**	**2,606,000**	**2,606,000**	**2,606,000**	**2,606,000**	**13,030,000**
Advocate for Resource mobilization to impellent WAS and nutrition activities	210,000	210,000	210,000	210,000	210,000	1,050,000
Commemorate Global and National days on WASH and nutrition	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000
Develop and customize WASH and nutrition policies and strategy	1,396,000	1,396,000	1,396,000	1,396,000	1,396,000	6,980,000
KRA 10. Nutrition in elderly persons and social protection promoted	**19,409,250**	**19,409,250**	**19,409,250**	**19,409,250**	**19,409,250**	**97,046,250**
Output 1: Nutrition integrated in social protection system for the elderly within the county	**1,778,250**	**1,778,250**	**1,778,250**	**1,778,250**	**1,778,250**	**8,891,250**
Enhance participation of nutrition stakeholders in social protection coordination mechanisms	396,000	396,000	396,000	396,000	396,000	1,980,000
Scale up social safety nets in times of crisis e.g. during drought, disease outbreak and flash floods	598,250	598,250	598,250	598,250	598,250	2,991,250

KEY RESULT AREAS, OUTPUTS AND ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL
KRA 10. Nutrition in elderly persons and social protection promoted	**19,409,250**	**19,409,250**	**19,409,250**	**19,409,250**	**19,409,250**	**97,046,250**
Output 1: Nutrition integrated in social protection system for the elderly within the county	**1,778,250**	**1,778,250**	**1,778,250**	**1,778,250**	**1,778,250**	**8,891,250**
Adopt, disseminate and implement criteria for nutrition in social protection programmes for OVC persons living with disability	504,000	504,000	504,000	504,000	504,000	2,520,000
Mobilize financial resources for nutrition interventions in social protection programmes	140,000	140,000	140,000	140,000	140,000	700,000
Sensitize opinion leaders, officers in social protection programmes, health, institutions, administrators on importance of good nutrition and related health.	140,000	140,000	140,000	140,000	140,000	700,000
Output 2: Improved knowledge of health care workers and the community members on health diets and lifestyle for the elderly	**17,631,000**	**17,631,000**	**17,631,000**	**17,631,000**	**17,631,000**	**88,155,000**
Conduct awareness campaigns on health diet and lifestyle for the elderly	5,200,000	5,200,000	5,200,000	5,200,000	5,200,000	26,000,000
Train community members targeting men and women across different ages and diversities on healthy diet and lifestyle	1,656,000	1,656,000	1,656,000	1,656,000	1,656,000	8,280,000
Train male and female health care workers on policies and guidelines; healthy diets and lifestyle guidelines for elderly persons	10,775,000	10,775,000	10,775,000	10,775,000	10,775,000	53,875,000
KRA 11. Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened	**1,903,000**	**3,310,000**	**3,310,000**	**3,310,000**	**3,310,000**	**15,143,000**
Output 1: Implementation of the available regulatory Acts i.e. BMS Act 2012, Health Act 2017, food fortification standards and regulations enhanced	**1,033,000**	**1,570,000**	**1,570,000**	**1,570,000**	**1,570,000**	**7,313,000**
Conduct joint meetings with enforcement bodies and regulatory bodies to sensitize them on the existing legislations on nutrition	345,000	690,000	690,000	690,000	690,000	3,105,000
Develop joint monitoring plan.	192,000	384,000	384,000	384,000	384,000	1,728,000
Enhance the regulatory act and policies (Hardcopies)	496,000	496,000	496,000	496,000	496,000	2,480,000

KEY RESULT AREAS, OUTPUTS AND ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL
KRA 11. Sectoral and multi-sectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened	**1,903,000**	**3,310,000**	**3,310,000**	**3,310,000**	**3,310,000**	**15,143,000**
Output 2: Multi-sectoral partnership and collaboration strengthened	**870,000**	**1,740,000**	**1,740,000**	**1,740,000**	**1,740,000**	**7,830,000**
Conduct CNTF at the county level	330,000	660,000	660,000	660,000	660,000	2,970,000
Conduct sectoral coordination forums at the sub-county level	540,000	1,080,000	1,080,000	1,080,000	1,080,000	4,860,000
KRA 12. Sectoral and multi-sectoral Nutrition Information Systems, Learning and Research strengthened	**18,456,000**	**13,956,000**	**13,956,000**	**21,943,750**	**16,583,550**	**84,895,300**
Output 1: Improved data quality for decision making	2,797,600	2,797,600	2,797,600	2,797,600	2,797,600	**13,988,000**
Conduct quarterly field visits at the NDMA sentinel sites	1,069,400	1,069,400	1,069,400	1,069,400	1,069,400	5,347,000
Hold bi annual multi-sectoral nutrition collaboration TWG meetings and monitoring of TWG plan	710,000	710,000	710,000	710,000	710,000	3,550,000
Conduct quarterly joint field visits to the sub counties for data quality audit at the facility level	1,018,200	1,018,200	1,018,200	1,018,200	1,018,200	5,091,000
Output 2: Evidence based decision making enhanced	**7,531,800**	**531,800**	**531,800**	**8,519,550**	**3,159,350**	**20,274,300**
Conduct gender integrated KPC survey	3,500,000	-	-	3,500,000	-	7,000,000
Conduct midterm evaluation review of CNAP	-	-	-	987,750	2,627,550	3,615,300
Conduct gender integrated SMART survey	3,500,000	-	-	3,500,000	-	7,000,000
Establish a gender sensitive research repository for nutrition and dietetic	120,000	120,000	120,000	120,000	120,000	600,000
Hold forums to disseminate research findings and information sharing through conferences, workshops and meetings	396,000	396,000	396,000	396,000	396,000	1,980,000
Promote knowledge sharing through publication e.g. Quarterly nutrition bulletin	15,800	15,800	15,800	15,800	15,800	79,000
Output 3: Data quality at sectoral level improved	**8,126,600**	**10,626,600**	**10,626,600**	**10,626,600**	**10,626,600**	**50,633,000**
Conduct monthly DHIS / LMIS quality audits at the county level	72,000	72,000	72,000	72,000	72,000	360,000
Conduct quarterly county, sub county support supervision	1,324,400	1,324,400	1,324,400	1,324,400	1,324,400	6,622,000

KEY RESULT AREAS, OUTPUTS AND ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL
KRA 12. Sectoral and multisectoral Nutrition Information Systems, Learning and Research strengthened	**18,456,000**	**13,956,000**	**13,956,000**	**21,943,750**	**16,583,550**	**84,895,300**
Output 3: Data quality at sectoral level improved	**8,126,600**	**10,626,600**	**10,626,600**	**10,626,600**	**10,626,600**	**50,633,000**
Conduct quarterly data quality audits at health facility	722,400	722,400	722,400	722,400	722,400	3,612,000
Hold monthly meetings for evaluation of gender sensitive integrated report at the sub county	2,760,000	2,760,000	2,760,000	2,760,000	2,760,000	13,800,000
Conduct routine quarterly sub county data review and feedback meetings	672,800	672,800	672,800	672,800	672,800	3,364,000
Conduct evidence-based actions/research for MIYCN	2,500,000	5,000,000	5,000,000	5,000,000	5,000,000	22,500,000
Hold meetings to develop an integrated gender sensitive work plan	75,000	75,000	75,000	75,000	75,000	375,000
KRA 13. Advocacy communication and social mobilization (ACSM) for nutrition program strengthened	**14,690,860**	**21,500,780**	**21,500,780**	**21,500,780**	**21,500,780**	**100,693,980**
Output 1: Enhanced implementation of regulatory acts	4,930,080	9,731,540	9,731,540	9,731,540	9,731,540	**43,856,240**
Create awareness on regulatory acts and policies e.g. BMS act, workplace support	3,955,080	7,891,540	7,891,540	7,891,540	7,891,540	35,521,240
Conduct sensitization meetings to policy makers, parliamentarians and health care workers on regulatory acts and policies	360,000	720,000	720,000	720,000	720,000	3,240,000
Conduct sensitization meetings to the community on regulatory acts	615,000	1,120,000	1,120,000	1,120,000	1,120,000	5,095,000
Output 2: Increased human resource for nutrition, equipment and commodities ensured	4,970,430	5,210,540	5,210,540	5,210,540	5,210,540	**25,812,590**
Conduct advocacy meetings with MCA, county budgetary allocation committee and executive committee members in the county to advocate for increased resource allocation for NCDs, commodities, equipment and human resource	2,683,100	3,085,600	3,085,600	3,085,600	3,085,600	15,025,500
Hold advocacy meetings with county policy and decision makers to lobby for employment of additional male and female clinical nutrition staff	1,275,000	360,000	360,000	360,000	360,000	2,715,000
Participate in the budgetary planning meetings	195,000	195,000	195,000	195,000	195,000	975,000

KEY RESULT AREAS, OUTPUTS AND ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	TOTAL
KRA 13. Advocacy communication and social mobilization (ACSM) for nutrition program strengthened	**14,690,860**	**21,500,780**	**21,500,780**	**21,500,780**	**21,500,780**	**100,693,980**
Output 2: Increased human resource for nutrition, equipment and commodities ensured	4,970,430	5,210,540	5,210,540	5,210,540	5,210,540	**25,812,590**
Hold meetings to advocate for institutionalization of CHVs motivation within county strategic documents	165,250	330,500	330,500	330,500	330,500	1,487,250
Conduct nutrition awareness sessions for caregivers, teachers and BOM on optimal nutrition	652,080	1,239,440	1,239,440	1,239,440	1,239,440	5,609,840
Output 3: Awareness creation on healthy diet and physical, general optimal nutrition activities intensified	**4,790,350**	**6,558,700**	**6,558,700**	**6,558,700**	**6,558,700**	**31,025,150**
Incorporate awareness session creation on physical activity and lifestyle habits with the local media	1,342,000	1,492,000	1,492,000	1,492,000	1,492,000	7,310,000
Customize and disseminate relevant policies and guidelines on health diets and NCDs	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000
Hold awareness sessions on healthy feeding habits to adolescents' boys and girls across all diversities	63,600	127,200	127,200	127,200	127,200	572,400
Hold education awareness forums on lifestyle and dietary diversification	331,500	663,000	663,000	663,000	663,000	2,983,500
Conduct community participation forums equally targeting men and women across different ages and diversities.	390,000	780,000	780,000	780,000	780,000	3,510,000
Conduct nutrition awareness sessions on good nutrition to the community	43,750	87,500	87,500	87,500	87,500	393,750
Design, develop, print and disseminate IEC materials for nutrition	830,000	830,000	830,000	830,000	830,000	4,150,000
Train male and female CHVs on community nutrition module.	789,500	1,579,000	1,579,000	1,579,000	1,579,000	7,105,500
GRAND TOTAL	**322,342,450**	**372,021,320**	**383,994,120**	**403,585,570**	**386,621,670**	**1,868,565,130**

8. LIST OF KEY CONTRIBUTORS

	NAME	DESIGNATION	ORGANIZATION
1.	ESTHER SOMOIRE	CECM - MEDICAL SERVICES & PUBLIC HEALTH	KAJIADO COUNTY
2.	JACOB SAMPEKE	C.O MEDICAL SERVICES	KAJIADO COUNTY
3.	EDDAH WAKAPA	C.O PUBLIC HEALTH	KAJIADO COUNTY
4.	DR. EZEKIEL KAPKONI	DIRECTOR – MEDICAL SERVICES & PUBLIC HEALTH	KAJIADO COUNTY
5.	R. BETTY MUSYOKA	AGRICULTURE OFFICER	KAJIADO COUNTY
6.	EVALYNE SOILA	SCNC	KAJIADO COUNTY
7.	EVANS SOLITEI	CWASH	KAJIADO COUNTY
8.	MARTIN KOOME	COUNTY PROGRAM COORDINATOR	NUTRITION INTERNATIONAL
9.	GRACE MUNENE	SCNC	KAJIADO COUNTY
10.	DAVID NDILAI	DEPUTY DIRECTOR	KAJIADO COUNTY
11.	THOMAS OLE KEEMPUA	CHRIO	KAJIADO COUNTY
12.	IRENE KATETE	D.SOCIAL SERVICES	KAJIADO COUNTY
13.	COLLINS LIKAU	SCNO	KAJIADO COUNTY
14.	LUISALBA NGOMA	P.O	K.R.C.S
15.	MONICA OBINY	CDH	KAJIADO COUNTY
16.	JONAH SIMANKA	C.H.A	KAJIADO COUNTY
17.	HARRIET NAMAIE	NUTRITIONIST	UNICEF
18	SAMUEL MASESE	CDCS	KAJIADO COUNTY
19.	RUTH NASINKOI	CNC	KAJIADO COUNTY
20.	GODFREY OGEMBO	SCNC	KAJIADO COUNTY
21.	SUSAN GITHINJI	SCNC	KAJIADO COUNTY
22.	PETER PUSHATI	L.O	KAJIADO COUNTY
23.	PAULINE KARIUKI	A.P.C	FEED
24.	MARY KIHARA	S.P.O	NUTRITION INTERNATIONAL