COUNTY GOVERNMENT OF NANDI

Department of Health and Sanitation

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

ELIUD KIPCHOGE

NANDI NUTRITION AMBASSADOR

Exercise Is King, Nutrition Is Queen.
Put Them Together And You've Got Kingdom

Run Clean

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

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS AND ACRONYMS

ACSM	ADVOCACY COMMUNICATION AND SOCIAL MOBILIZATION
ANC	ANTENATAL CARE
AMPATH	ACADEMIC MODEL PROVIDING ACCESS TO HEALTH
AWP	ANNUAL WORKPLAN
BFCI	BABY FRIENDLY COMMUNITY INITIATIVE
CHMT	COUNTY HEALTH MANAGEMENT TEAM
CIDP	COUNTY INTEGRATED DEVELOPMENT PLANS
CNAP	COUNTY NUTRITION ACTION PLAN
CSP	COUNTY STRATEGIC PLAN
DRNCDs	DIET RELATED NON COMMUNICABLE DISEASES
ECD	EARLY CHILDHOOD DEVELOPMENT
GNR	GLOBAL NUTRITION REPORT
HIV	HUMAN IMMUNO DEFICIENCY VIRUS
IFAS	IRON FOLIC ACID SUPPLEMENTATION
KDHS	KENYA HEALTH DEMOGRAPHIC HEALTH SURVEY
KNAP	KENYA NUTRITION ACTION PLAN
MAD	MINIMUM ACCEPTABLE DIET
NCD	NON-COMMUNICABE DISEASE
NCNAP	NANDI COUNTY NUTRITION ACTION PLAN
NI	NUTRITION INTERNATIONAL
SCHMT	SUB COUNTY HEALTH MANAGEMENT TEAM
UNICEF	UNITED NATIONS CHILDRENS FUND
URTI	UPPER RESPIRATORY TRACT INFECTION
WASH	WATER SANITATION AND HYGIENE

FOREWORD

The Nandi County Nutrition Action Plan is a product of a consultative process which involved stakeholders in addressing nutrition challenges in the county

The interactive process ensured that the NCNAP addresses the triple burden of malnutrition, drawing in global and national knowledge in nutrition. NCNAP has used result based approach and evidence based planning. This has not only brought a paradigm shift in our interventions but has also allowed us to mainstream nutrition in our CIDP.

The Nandi County Nutrition Action Plan (CNAP) 2018/19 – 2022/23 main objective is to accelerate and scale up efforts towards the elimination of malnutrition as a problem of public health significance.

The NCNAP will by focus on three areas of intervention, namely nutrition-specific; nutrition-sensitive; and enabling environment, putting emphasis on the need for strengthening multisectoral collaboration in addressing malnutrition.

On this note therefor the County Government of Nandi is committed to facilitate achievement of NCNAP results. We recognize and acknowledge the numerous challenges facing the county when it comes to resources. We believe this five-year plan will contribute to achieving the Development Agenda of Nandi County

H.E Stephen Sang
Nandi County Governor

PREFACE

Nandi County is among the counties with high level of malnutrition in Kenya. According KDHS 2014, the prevalence of stunting among children under five years was at 29.9% way above the national level of 26%; wasting was at 4% while underweight was at 11%. These figures are unacceptable.

This Nandi County Nutrition Plan (NCNAP) is geared to provide a road map to County Government and nutrition stakeholder's to address and reverse the trends of triple burden of malnutrition. This document is aligned to County strategic Plan (CSP), County Integrated Development Plan (CIDP), Annual Work Plan (AWP) and Kenya National Nutrition Action Plan (KNAP).

The NCNAP will be used as a document for financing nutrition interventions putting more emphasis on domestic financing which is key in sustainability of Nutrition programmes.

In this regard, therefore, my department of Health and Sanitation is committed to its full implementation so as to realize the planned objectives with full support of all the stakeholders. Am confident that Nandi County will manage to reduce levels of malnutrition to lower levels hence contribute to Nutrition security and optimal health

HON RUTH KOECH
County Executive Member For Health

ACKNOWLEDGEMENT

Nandi County takes this opportunity to thank everyone who participated in the drafting and development of the Nandi County Nutrition Action Plan (CNAP) 2018/19 – 2022/23

The NCNAP could not have been finalized without the contributions and commitment of the members from different working groups drawn from both the government and development partners. The support from the county government of Nandi through the Ministry of Health 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 led by Joy Kiruntimi, Sarah Kihianyu and Kirorei Kiprotich, for the immense technical leadership support in the entire process of developing the CNAP 2018/19 – 2022/23. In addition, we acknowledge the technical contribution from the following partners United Nations Children's Fund (UNICEF), Baraton University of East Africa and Academic Model Providing Access to Healthcare (AMPATH). Our sincere gratitude and indebtedness to Departments of: Health; Education; Water and Sanitation; Social Protection; Agriculture, Livestock & Fisheries.
The contribution of the County Executive Committee Member (CECM), Chief Officers Medical and Public Health, the County Health Management Teams (CHMT), other Health Programme Officers and Sub-County Nutrition Coordinators (SCNCs) and Nutrition Officers during the development and/or validation of the CNAP is gratefully acknowledged. Special appreciation goes to Angeline Korir county nutrition coordinator for the ovrall 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 and M&E); and Agatha Muthoni (Gender specialist); for providing the technical support throughout the whole development process.

DR PAUL LAGAT
Chief Officer Health And Sanitation Nandi County

MESSAGE FROM THE DIRECTOR, HEALTH

Indeed nutrition is the glue that binds together; whether you are talking of prevention, control or management of acute medical conditions to the increasing burden of chronic diseases.

The County's preparedness and stability of its health system to progressively secure its residents thus is pegged on its willingness to plan and invest significantly in nutrition. It is the acknowledgement of this fact, that the Directorate is mobilizing all resources from human to financial in order to reap any successes present and future.

The realization of NCNAP implementation will go a long way towards achievement of this important milestone in healthcare.

DR. DAVID BUNGEI.

CHAPTER 1: INTRODUCTION

1.1 Background information

1.1.1 Location and size

Nandi County is in the North Rift region of Kenya. It covers an area of 2,884.4 Km2; and borders Kakamega County to the West, Uasin Gishu County to the North East, Kericho County to the South East, Kisumu County to the South and Vihiga County to the South West.

1.1.2 Administrative and subdivision

The county has 5 administrative Sub-Counties and 11 Divisions. Nandi County has a total of 99 locations and 299 sub-locations. The map below shows county's sub counties;

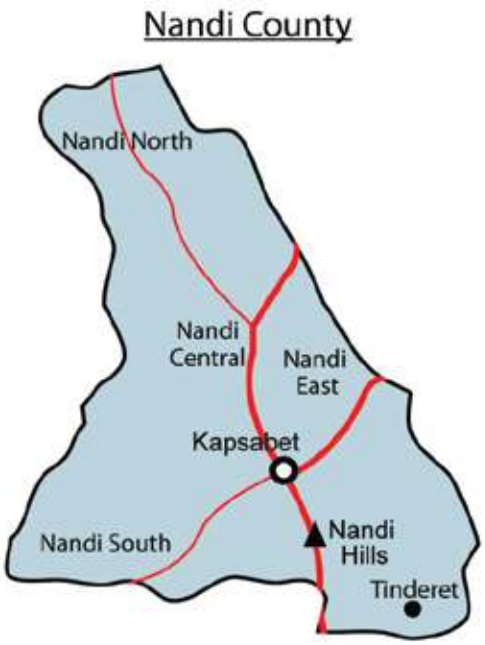


Figure 1.1: Geographical Map of Nandi County

The projected population is as illustrated below with an annual growth rate of 2.9% (CIDP 2013-2017):

2016	2017	2018	2019
964,480	999,201	1,035,172	1,072,438

Source: (KNBS, 2016)

1.2 Demographic profile

The population for the county is at 885,711, comprising of 441,259 males and 444,430 females as shown in the table below:

Table 1.2: Distribution of population by sex and sub-county

SUB COUNTY	*MALE*	*FEMALE*	*TOTAL*
Chesumei	*80,949*	*83,180*	*164,133*
Nandi central	*73,291*	*74,255*	*147,553*
Nandi east	*59,899*	*59,271*	*119,173*
Nandi north	*82,512*	*83,656*	*166,171*
Nandi south	*85,718*	*87,029*	*172,750*
Tinderet	*58,890*	*57,039*	*115,931*
TOTALS	*441,259*	*444,430*	*885,711*

Source: (KNBS, 2019)

1.3 Health Access

The health department is mandated to provide essential and comprehensive quality health services which is achieved through provision of promotive, preventive, curative and rehabilitative services to the residents of the county.

Nandi county has six (6) hospitals, 21 health centers and 116 dispensaries. Table 1.3 illustrates the distribution of health facilities per Sub County

Table 1.3: Health Facility Distributions per Sub County

Sub County/Health Facility	Hospitals			Health Centres			Dispensaries			Clinics	Total
	GOK	*FBO*	*Private*	*GOK*	*FBO*	*Private*	*GOK*	*FBO*	*Private*		
Aldai	1	0	0	4	1	0	24	1	1	2	34
Chesumei	1	2	3	1	1	0	22	1	0	9	40
Emgwen	1	0	0	2	0	0	24	3	5	3	38
Mosop	2	0	0	1	3	0	18	1	0	0	25
Nandi Hills	1	0	0	2	0	0	15	1	23	2	44
Tinderet	1	0	0	3	0	0	15	1	1	2	23
County	7	2	3	13	5	0	118	8	30	18	204

1.4 National Nutrition situation

Kenya is experiencing unacceptably high levels of malnutrition with an emerging triple burden of malnutrition. According to the Global Nutrition Report 2018, Kenya is clustered among 41 countries experiencing the triple burden of malnutrition. This is characterized by the co-existence of undernutrition as manifested by stunting, wasting, underweight; micronutrient deficiencies; and overnutrition characterized by overweight and obesity including diet related non-communicable diseases.

Over the past years, Kenya has witnessed an improvement in the nutritional status of children with stunting declining from 35% in 2008-9 to 26% in 2014; wasting from 7% to 4% and underweight from 16% to 11% . Despite the reduction in childhood under nutrition, there are regional disparities with some counties having lower levels of stunting at 15% while others have higher levels of stunting at 45%. Nine (9) counties have a prevalence of stunting above 30%, a level categorized as very high in public health significance.

A total of 28 per cent of adults aged 18–69 years are either overweight or obese, with the prevalence in women being 38.5 per cent and men 17.5 per cent. The proportion of women who were overweight or obese increased from 25 per cent to 33 per cent and those who were obese increased from 7 per cent to 10 per cent Similar trends are seen with KDHS 2014.

Regarding micronutrient deficiencies, Zinc deficiency has been noted to be highest. Anaemia prevalence is also high, with the highest prevalence seen among pregnant women 41.6% and children 28.3%.

Nationally, 61 percent of mothers are exclusively breastfeeding for the first six months and 62 percent are initiated to the breast within one hour after birth. Only 22% of children aged 6-23 months consume a Minimum Acceptable Diet (MAD)

Ninety five (95) percent of adults aged 18–69 years did not consume the WHO daily recommended five servings of fruits and/or vegetables; fruits were consumed on average about 2.4 days in a week, and vegetables were consumed five days in a week Approximately 20 per cent of adults in this group add salt or salty sauce to their food before eating; 3.7 per cent consume processed foods high in salt; 83.5 per cent often add sugar when cooking or preparing beverages at home; and 28 per cent always add sugar to beverages..

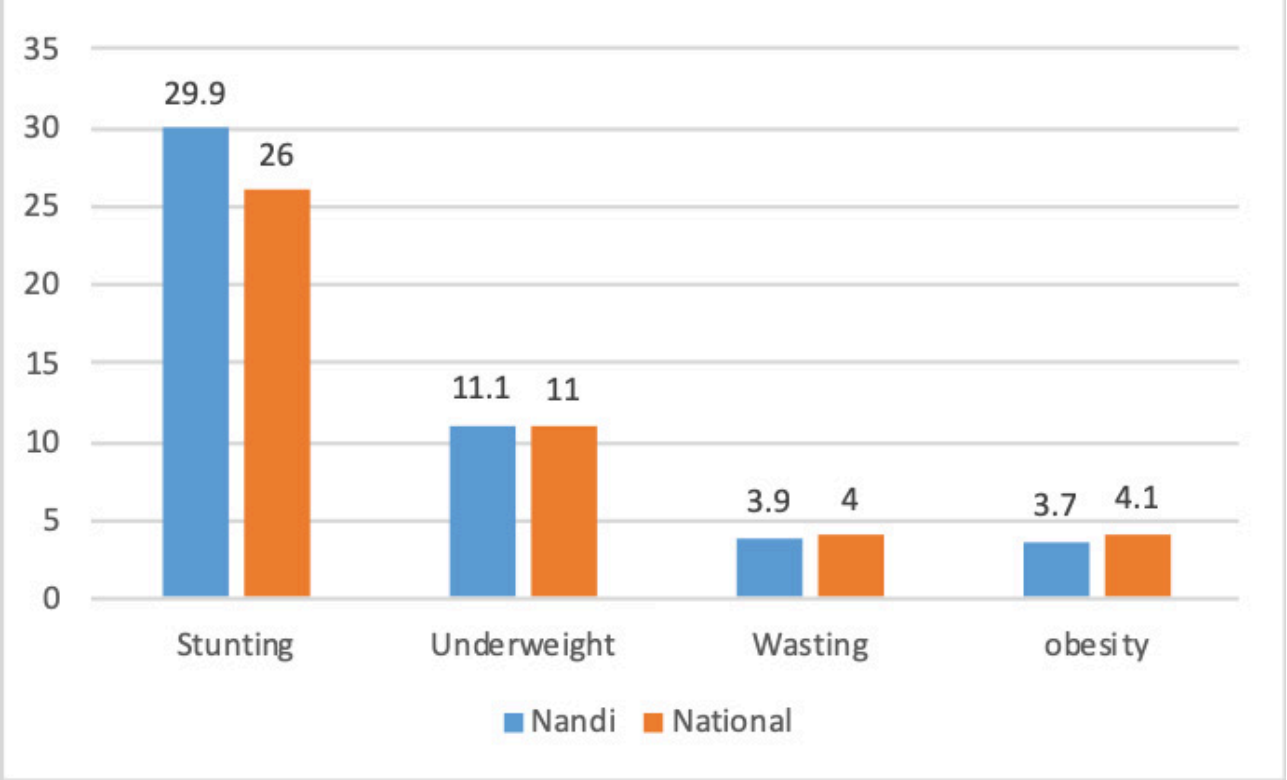
1.5 Health and nutrition situation in Nandi County.

Malnutrition is a challenge across Nandi County.

1.5.1 Undernutrition

An estimated 30 per cent of children below the age of 5 in Nandi County are stunted , as indicated in Figure 1.2, compared to 26 per cent nationally.

Figure 1.2: Stunting, Underweight, Wasting and Obesity for Children Under 5 years



Source: (KDHS, 2014)

The proportion of children who are underweight and wasting stands at 11 per cent and 3.9 per cent. The prevalence of obesity among the under-five is rising and currently stands at 3.7 per cent. One of the current priorities in the development agenda for Nandi is to reduce the high rates of malnutrition. Beyond poor diets and morbidity which are the immediate causes of malnutrition, underlies the socio-cultural, political and economic factors.

These include, but are not limited to household food insecurity; inadequate care of vulnerable household members including cultural norms and practices influencing food sharing and uptake; poor access to clean water, hygiene and sanitation; inadequate health services; poor health seeking behavior and 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, unequal access, use and control of benefits from productive assets disproportionately affecting women and girls including their discrimination in decision making on issues pertaining their nutrition and wellbeing, which must be addressed as part of effective and sustainable ways in addressing malnutrition.

1.5.2 Overweight, Obesity and Diet Related Non-Communicable Diseases (DRNCDs)

Nandi lacks population-based data on NCDs. However, increased burden of non-communicable diseases has been observed as it constitutes 10 percent of the patients seeking treatment at health facilities. There is lack of prioritization of non-communicable diseases. Generating sex and age disaggregated NCDs data depicting the gender dimensions and socio- cultural, economic determinants of NCDs would be a priority to inform a gender transformative programming towards achieving effective and sustainable nutrition and related health outcomes.Underweight among women of child bearing age is at 8.4 percent while overweight is 23.7 percent.

The prevalence of underweight among women of childbearing age is at 8.4 percent while that of overweight is 23.7 percent.

1.6 Micronutrient deficiencies

Micronutrient deficiency is still a challenge with only 67 percent of children aged 6-59 months receiving Vitamin A capsules compared to the national average of 72 percent (KDHS 2014).

There has been increased prevalence of anemia among women of reproductive age 15-49 years, with the prevalence among pregnant women standing at 55 percent. .
IFAS coverage is at 51 percent and only 30 percent of pregnant women attend four focused ANC visits, thus a large number of women would be missing IFAS supplementation, which is a key strategy for reducing the prevalence of anemia and low birth weight infants.

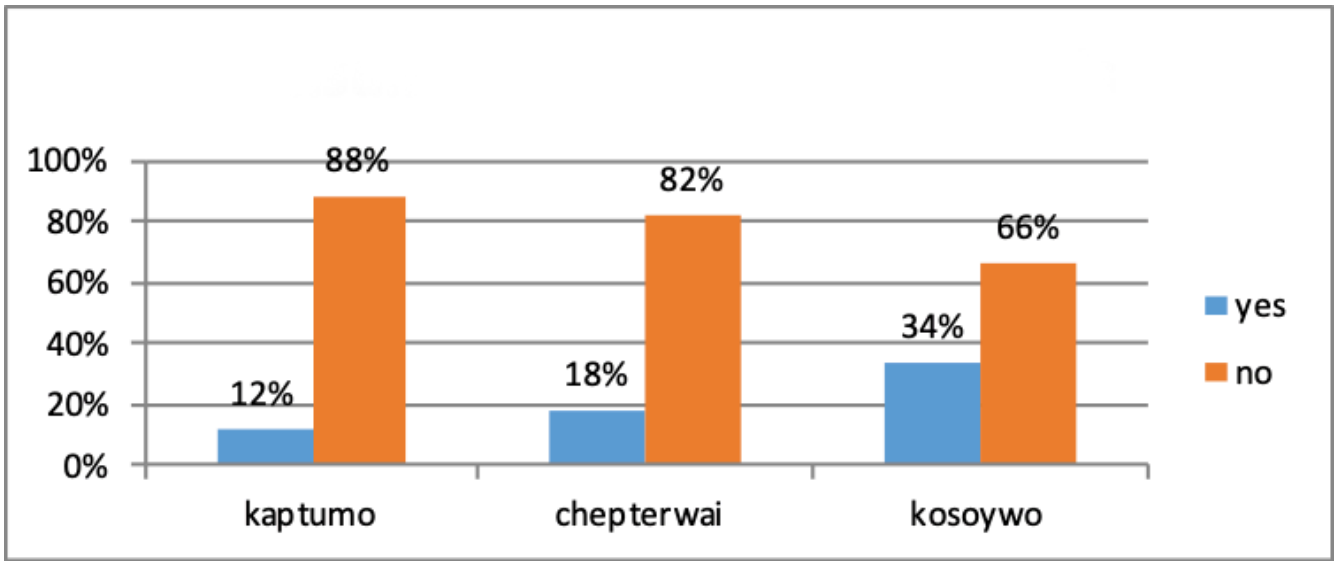
In addition to ensuring improved health service provision, incorporation of nutrition sensitive interventions is key in addressing the underlying non-medical social economic issues affecting increased uptake of micronutrients by mothers. Such issues include socio- economic vulnerabilities especially among women and girls leading to poor utilization and or frequency of antenatal health care services; long distances to the health facilities; age and literacy levels; low knowledge, inadequate counselling and clarity on the importance of different micronutrient supplements before, during and after pregnancy; beliefs against consuming medications during pregnancy; low/lack of male and community support on maternal and child health, including lack of support for teenage mothers to seek health services in a timely manner. Further, collection and use of context-based gender analysis on the underlying socio-cultural, economic and rights related issues affecting affordability and improved uptake of nutrition and related health services and practices to inform gender transformative nutrition interventions is paramount.

1.7 Feeding practices among children below five years and women of reproductive age

The proportion of children under 1 year who are exclusively breastfed is at 35 percent which is very low compared to the national rates of 61 percent . The rate of early initiation to breastmilk is at 44 percent compared to national of 61 percent. Prelacteal feeding is very common in Nandi with a prevalence of 34 percent in some regions like Kosoywo (figure 1.3).

[5]IHME 2017
[6]KDHS 2014

Figure 1.3: Percentages of Children Given Pre-Lacteal Feeds



Source: KDHS 2014

Nandi has been implementing strategies to improve maternal infant and young child nutrition feeding practices using different strategies such as Baby Friendly Hospital Initiative and Baby Friendly Community Initiative (BFCI).

BFCI works through the community units established under the community health strategy. In Nandi, 36 community units have been established out of the expected 214 for a total population of 1,972,438. Out of the 36 community units established, 15 of them implement BFCI. This leaves a gap in reaching mothers at the community to support infant and young child feeding. The growth monitoring coverage is at 35 percent posing a major challenge in early detection of malnutrition for children under five years. The county has not designated any facility to be baby friendly however there are efforts being towards accreditation of baby friendliness. The poor indicators on Infant Young Child Feeding (IYCF) are caused by among others: low staffing levels, inadequate and inconsistent information, faulty assessment tools, hard to reach areas and inadequate nutrition commodities.

1.7.1 Complementary feeding

Complementary feeding is defined as a process of introducing other foods in addition to breast milk at 6 months of age, when breast milk alone is no longer enough to meet the nutritional requirements of the infant. The introduction of complementary foods is done early to children less than 6 months. At 4 months, children are introduced to foods especially other liquids, plain water, soups and milk mainly due to inadequate knowledge. In a survey conducted in Nandi, up to 37 percent of mothers had not received information on complementary feeding while most source of information was from the mother in-laws.

Studies have shown 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 Gender analysis report, April 2017). Gender roles and responsibilities between men and women, result in overburdening of maternal workload for women and girls, with limited community and male support leading to limited 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 and food insecurity 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 such as food sharing and uptake related stereotypes, perceptions and practices affect 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 given especially by men and other key influencers within communities, which is key in prompting 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 and socio-economic issues across communities in Nandi county is prerequisite towards realizing improved MIYCF outcomes.

1.7.2 Mortality and morbidity trends

Upper Respiratory Tract Infection (URTI), malaria, diarrhea are the most common leading causes of morbidity for under-five. This is due to poor prevention practices, poor feeding, poor hygiene practices, inadequate health seeking behavior among other predisposing factors. The Maternal mortality rate stands at 300/100,000 live births as compared to 362/100,000 live births at National level.

1.7.3 Health services

World Health Organization (WHO) recommends a minimum of four antenatal visits. In Nandi County, 55.7 percent of expectant mothers attended first Antenatal visits and only 24.3 percent completed forth ANC visit in 2016. In the same reporting period, 42.3 percent of the expectant mothers were delivered by skilled personnel in the health facilities.

HIV prevalence in Nandi is lower than the national prevalence at 2.4% (Kenya HIV Estimates 2015). The HIV prevalence among women in the county is higher (3.5%) than that of men (2.1%). Nandi County contributed to 0.7% of the total number of people living with HIV in Kenya and is ranked the thirty second (32nd) nationally. Stigma and discrimination are the major challenge facing HIV/AIDS care and management.

1.8 Agriculture and food access

Agriculture is the mainstay of a large percentage of the county population thus any drop in agricultural production has adverse effects on the livelihoods in terms of reduced incomes and food insecurity. The County has a food poverty rate of 46.7 percent according to 2005/2006 KDHS. It depends primarily on agriculture and most farmers grow tea as the main cash crop. Most of the food crops are grown on a small-scale farms once per year. Unpredictable rainfall patterns, over fragmentation of land as a result of high population growth are some of the major factors leading to decline in agricultural production in the county. While the county has a great potential in agriculture, most of this has not been fully exploited due to low adoption of modern farming technologies and animal husbandry. The situation can also be attributed to the high cost of farm inputs and unpredictable market prices of the produce. High population growth has already created pressure on the inelastic agricultural land thus worsening the food situation in the county. Another main challenge to food security is mono-cropping as too much land being dedicated for tea farms. Food insecurity in the county calls for the need to encourage farmers to diversify food crops planted so as to include traditional varieties, enhance farmers' capacity, on on-farm value addition to their produce including dissemination of sustainable land use management practices to farmer groups for replication. Farmers should be sensitized on the need to farm two seasons as opposed to the current single season in a year and the importance of growing early maturing and disease resistant food varieties.

Rampant subdivision of agricultural land abutting built up areas has been experienced due to urbanization process. Land has been mutated to as low as 0.1 acre. This therefore means that a control mechanism is required to ensure that food production and urbanization is balanced. Good nutrition and access to safe food is a priority for Nandi County. Currently there are 27.4% households who are food insecure and the goal is to reduce this to 20% in the next four years. Gender equality and women empowerment is an important and long overdue stimulus to a more inclusive human development and accelerated economic growth. In Nandi county, Human Development Index (HDI) stands at 0.5828, Youth Development Index (YDI) at 0.5952, while Gender Development Index (GDI) rates at 0.4943 (Kenya National Human Development Report, 2009). HPI (0.2910) on the other hand is lower than the County's (0.3660), implying that Nandi County residents are poorer when compared with the rest of the nation.

There is a significant variation between the county's HDI and the GDI, HDI being higher. This implies that gender inequalities still abound in the county, and hence the need put in place policies and programmes to empower both men and women and reduce the gap. In Nandi county, existence of social systems, cultural norms and beliefs which are discriminative against women and girls forms part of the major 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% labour 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. Nandi County has a youthful population of 201,948 persons. Majority of the youth have missed out on formal education and have minimal enrolment in youth polytechnics therefore lack necessary skills to join the job market.

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. Meaningful and accelerated development growth can be realized when both men and women have access to resources and are involved at all levels of decision-making as well as in equal benefits from productive resources, services and opportunities. Hence, 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.

1.9 Education-Pre- School Education (Early Childhood Development Education)

The County has a total of 2,462 ECD centers with 79 percent of them being publicly owned. Mosop Sub-county has the highest number of privately owned ECD schools (85) followed by Emgwen (68). The total enrolment in ECD is 42,470 which represent a Gross Enrolment Rate (GER), of 32%. The current number of ECD learner's benefiting from school feeding and nutritional programme is at 165000 and it's projected to increase to 275,000 by 2022.

1.10 Human resource for nutrition

The human resource competencies needed to implement nutrition-specific and nutrition-sensitive activities that can reduce undernutrition is insufficient. There are currently inadequate nutrition staffs to be deployed in these sections of the hospital which requires clinical nutrition services. Additionally, there is need for training clinical nutrition specialties to offer services in these units as well as public health nutrition services including community nutrition as per the human resource norms and standards for the Ministry of health (IHRIS, 2019). The department will further collaborate with the county department for gender and other gender partners in the county to help build capacity of health care workers across all cadres to effectively mainstream gender for improved provision and implementation of gender transformative nutrition and health care services and programming.

The county situation on nutrition staff is hereby presented below outlining the availability, requirements and gaps in health facilities:

Table 1.4: Human Resources for Nutrition

No	Level of Health Facility	Number Required (Proposed establishment)	Number available (In post)	Gaps
1	Kapsabet County referral hospital	24	11	`13
2	County Hospital	18	7	11
3	5 sub county hospital	60	15	45
4	19 health centers	38	24	14
5	160 dispensaries	160	15	145
Totals		300	72	228

1.11 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:

- Inadequate allocation of funds
- Inadequate staffing as per the WHO staffing norms & standards
- Inadequate capacity of staff in terms of knowledge & skills (CPD)
- Inadequate community units (only 36) in the county to provide community nutrition support.
- Inadequate school health programs on nutrition education.
- Poor health seeking behavior among most community members (all cohorts)
- Sedentary lifestyles behavior among the population
- Inadequate advocacy, communication, social mobilization (ACSM) in the community
- High poverty level in some areas within the county
- Poor eating habits among the population especially adolescents, under five year and lactating mothers among others.
- Inadequate equipment's for nutrition assessment
- Lack of transport for nutritional activities (relies on borrowing)
- Inadequate space for nutrition activities within the health facilities
- Insufficient nutrition commodities
- High dependence on donor funds
- Ignorance and knowledge gap
- Low budgetary allocation
- Increasing trend of malnutrition
- No tracking of resources for nutrition activities
- Low socio-Economic status
- Reducing donor support
- Growing of cash crop in expense of food crops
- subdivision of land due to high population causing low production of food crops
- uncoordinated nutrition across the multisectors
- upsurge of non-communicable diseases
- Increased gender based violence
- Increased alcohol and drug abuse
- Increased school dropouts
- Increased teenage pregnancies
- Increased unemployment
- Low level of education
- Retrogressive cultural practices

CHAPTER 2: COUNTY NUTRITION ACTION PLAN (CNAP) FRAMEWORK

2.1 Introduction.

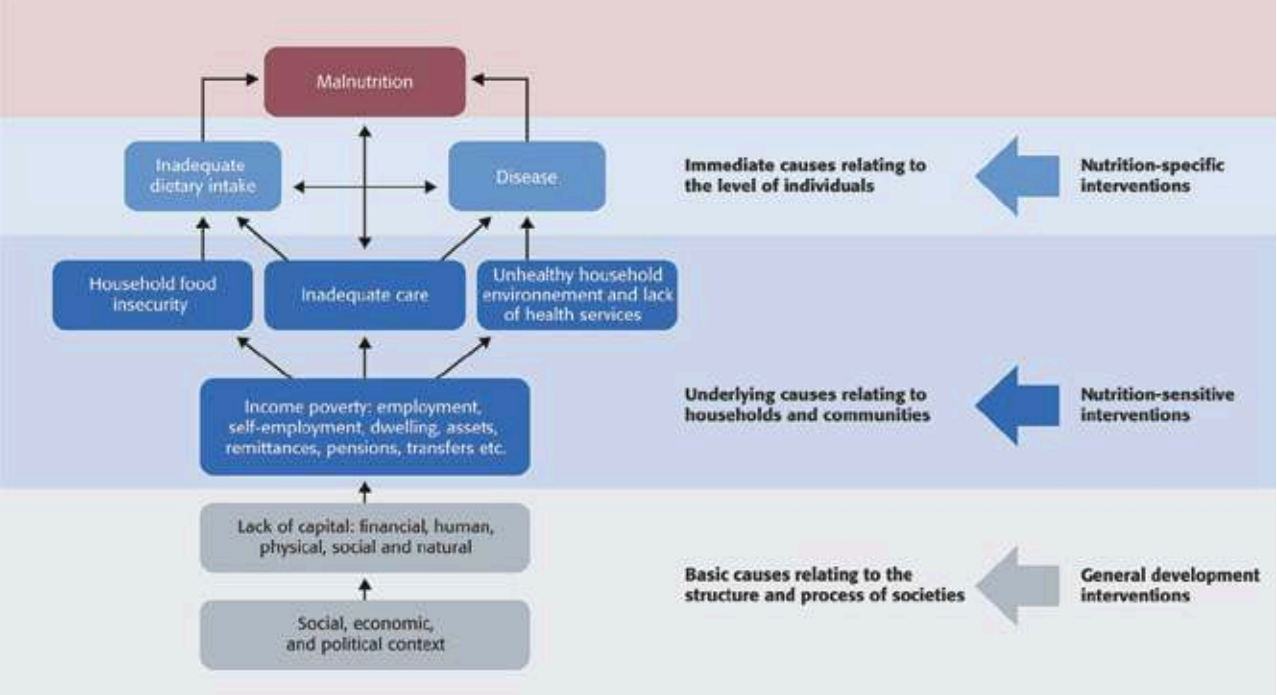
Malnutrition is caused by factors which are broadly categorized as immediate, underlying and basic. Immediate causes of malnutrition include disease and inadequate food intake; this means that disease can affect nutrient intake and absorption, leading to malnutrition, while not taking enough quantities 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 lack of access to enough, 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 basic causes of malnutrition which act at 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 basic or root causes of malnutrition.

Nutrition is neither a sector nor a domain of one ministry or discipline but a Multisectoral 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 basic) requires Triple-duty actions that have the potential to improve nutrition outcomes across the spectrum of malnutrition, through integrated initiatives, policies and programmes. The potential for triple-duty actions emerges from the shared drivers behind different forms of malnutrition, and from shared platforms that can be used to address these various forms. Examples of shared platforms for delivering triple-duty actions include health systems, agriculture and food security systems, education systems, social protection systems, 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



Conceptual framework for malnutrition, UNICEF

2. 2 Vision and mission for Nutrition in Nandi County

2.2.1 Vision

County free from Malnutrition

2.2.2 Mission

To reduce all forms of malnutrition in Nandi county

2.3 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 (Article 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 trans fats) is also key legislation central to the control of 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;

Further in line with the SDGs and the aforementioned nutrition specific legal and policy framework, the CNAP has integrated other cross cutting and nutrition sensitive sector based legislations, policy, plans and guidelines in support of an enabling environment through addressing poverty alleviation, gender equality and empowerment of women, child and maternal health, reducing HIV/AIDS and communicable diseases and environmental sustainability. This is with a major aim to achieving effective and sustainable food and nutrition security leading to improved nutrition and health related outcomes.

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 CNAP. The counties will have a key role in implementing, monitoring and enforcement

2.4 Rationale

Lack of nutrition action plan is a key constraint to effective nutrition programming, therefore causing slow movement towards the achievement of county, national and global targets for nutrition. Without a plan it's hard to resource mobilize for funding for nutrition activities.

The action plan brings in different stakeholders to one common platform to engage in nutrition activities. There are many emerging key nutrition issues including weak coordination, capacity development, food systems and agriculture, lack of advocacy to prioritize nutrition. The key strategies and intervention activities are derived from the situation analysis through the established steering and technical committees at county level.

2.5 Purpose of Nandi County Nutrition Action Plan

The purpose of the NCNAP is to accelerate and scale up efforts towards the elimination of malnutrition in Nandi in line with Kenya's Vision 2030 and sustainable development goals, focusing on specific achievements by 2022 aligned to the KNAP 2018-2022. The expected result or desired change for the NCNAP is that 'All citizens achieve optimal nutrition for a healthier and better quality of life and improved productivity for the county's accelerated social and economic growth'.

This plan has been developed to operationalize the strategies outlined in the Food Security and Nutrition Policy 2012 and the Kenya National Nutrition Action Plan (KNAP 2018-2022). It seeks to provide a roadmap for establishing the Nutrition sector at the County level and improve service delivery reaching the most vulnerable population in Nandi County. It also serves as a reference point for stakeholders to designing and prioritizing appropriate interventions.

2.6 CNAP Objectives

The objective of the County Nutrition Action Plan is to contribute to the national agenda on ending malnutrition in all its forms in line with Kenya's Vision 2030 and Sustainable Development Goals focusing on specific achievements by 2022.

The expected result or desired change for the CNAP is that 'The entire population of Nandi county achieve optimal nutrition for a healthier and better quality of life and improved productivity for the county's accelerated social and economic growth'.

2.7 Strategies

- Coordination and partnerships: sectoral and multisectoral approaches to enhance programming across various levels and sectors
- Integration which takes into account the various platforms in place to deliver gender transformative nutrition responsive to the specific nutrition and health related needs of populations across different gender age and diversities, e.g., health centers, schools and at the community level.
- Capacity strengthening for implementation of nutrition services responsive to the specific needs of men and women across different ages and diversities targeting service providers and related systems
- Advocacy, communication and social mobilization: acknowledging that nutrition improvements require political goodwill for increased investments and raising population-level awareness, their increased support and participation for improved food and nutrition security for all.
- Promoting equity and human rights especially among vulnerable and marginalized populations in effort to ensure that every person is free from hunger and have adequate food of acceptable quality including equitable access to quality health services. Resilience and risk-informed programming: focus on anticipating, planning and reducing disaster risks to effectively protect persons, communities, livelihoods and health
- Monitoring, evaluation, learning and accountability: promotion of use of the triple A (assessment, analysis & action) cyclic process to provide feedback, learn lessons and adjust strategy as appropriate
- Sustainability: empowerment for sustainability of results – the need to ensure predictable flow of resources, develop technical and managerial capacity of implementers, motivate implementers, ensure vertical and horizontal linkages, and gradual exit when exiting an intervention.

2.8 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 to in order capture nutritional requirements of individuals or groups across different gender, age and diversities living in the county. The NCNAP 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 age, gender and diversity-appropriate nutrition during all stages of the life cycle cannot be overlooked. It is against this background that this action plan is development taking into consideration nutrition needs per specific appropriate stages of life to capture and optimize the heterogeneity of nutrition needs with regard to gender, age and diversities, other socio- economic factor cultural and physiological determinants and dimensions. .

2.9 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 undernutrition, both acute and chronic undernutrition. Gender equality is firmly linked to enhanced productivity, better development outcomes for future generations, and improvements in the functioning of institutions Studies examining the relationship between gender inequality, nutrition and health have consistently shown that gender-related factors have an effect on nutrition and health related outcomes.

The domains of gender equality such as gender roles and responsibilities leading to overburdening maternal roles and responsibilities among women and girls, limited opportunities to engage in competitive and skilled productive work especially among women and youth; beliefs, attitudes and norms pertaining to the way women and men relate to each other within the household or community; lack of autonomy in decision-making, power and idea sharing; unequal access to, use and control over productive economic resources, services and opportunities by women and girls and attitudes about or experience of gender-based violence disproportionately affecting women, girls and children have been observed to have an far-reaching influence on nutrition and health related outcomes.

In any given society, men and women across different ages and diversities equally have a role to play in realizing good nutrition and health. However, the distinct roles and relations of women, girls, men and boys of different ages and diversities in a given culture, may bring about differences that give rise to inequalities in access to and uptake of optimal nutrition and health related services and practices, especially for women, girls and children.

Other factors such as child/forced marriages and teenage pregnancy in the county has a strong nexus to malnutrition both for the vulnerable teenage mothers and their new-borns. In addition, other socio-economic and cultural factors such as poverty, girls' levels of education with non-schooling adolescents and those with primary school level education being more vulnerable, marriage has significant influence on the probability of increased incidences of teenage pregnancies which remain a key driver of school drop outs among girls and consequently leading to a cycle of poverty which is a serious prerequisite for malnutrition.

CHATER 3: KEY RESULT AREAS (KRAs), OUTPUTS AND ACTIVITIES

3.1 Introduction

The overall expected result and 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 12 Key Result Areas (KRAs) have been defined for Nandi 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 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	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.Integrated Management of Acute Malnutrition strengthened
	5.Nutrition in Tuberculosis (TB) and HIV strengthened
	6. Clinical nutrition and dietetics scaled up
	7.. Nutrition in sports strengthened
Nutrition sensitive	8. Nutrition in Education, Agriculture, WASH, and social services scaled up.
Enabling Environment	**9.** Supply chain management for nutrition commodities and equipment strengthened
	10. Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened
	11. County Sectoral and multisectoral Nutrition Information Systems, Learning and Research strengthened
	12**.** Advocacy, Communication and Social Mobilization (ACSM) strengthened

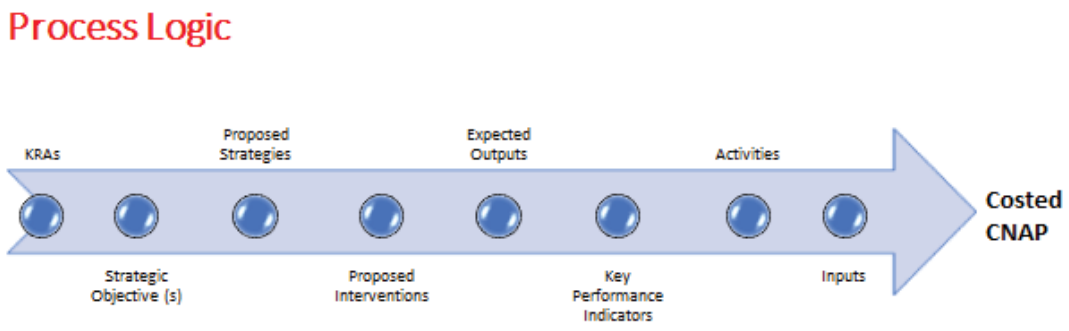
3.2 Theory of change and CNAP logic framework.

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 Nandi 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 has been discussed in section 3.3.

Figure 3.1: The CNAP Logic Process



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

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

Expected outcome

Improved nutrition status of women of reproductive age and children aged 0-59 month

Output 1

Strengthened capacity of health care providers and CHVs to deliver quality MIYCN services

Activities

1. Disseminate MIYCF related guidelines, SOPs and policies
2. Sensitize CHMT/SCHMT/HMT on BFHI
3. Train health care workers on BFHI
4. Conduct CME, OJT and mentorship on BFHI to health care workers
5. Conduct BFHI self and external assessment to high volume facilities with maternity services.
6. Train health care workers on BFCI
7. Train CHVs on C-BFCI
8. Train health care workers on MIYCF
9. Print & distribute BFCI tools and Job Aids to HCW, CHV and caregivers
10. Train health care workers to effectively mainstream gender in nutrition programming for improved provision and implementation of gender responsive nutrition and health services and interventions.

Output 2
Improved access to MIYCN information by the caregivers, influencers and the community

Activities
1.Develop and disseminate county specific complementary feeding recipe book, and complementary feeding IEC materials like brochures, posters, etc.
2.Conduct nutrition education on dietary diversity and consumption of fortified food to the caregivers and the community
3.Conduct health education on dietary and micronutrient intake to pregnant and lactating women attending the facility.
4.Conduct visits to the community to sensitize and mobilize mothers on seeking early ANC and nutrition services in health facilities
5.Conduct visits to the community to sensitize and mobilize mothers on seeking early ANC and nutrition services in health facilities
6.Conduct bi-monthly baby friendly gatherings for influencers, pregnant and lactating mothers at the community
7.Conduct community health and nutrition education targeting men for their increased engagement on their role and support on MIYCN.
8.Train male and female community support groups on agri-nutrition livelihoods activities and IGAs and link them to productive livelihood-based sectors and financial institutions for support.
9.Advocate for enforcement of school re-entry policy for teenage mothers at least 1 year after delivery to allow uptake of EF and optimal complementary feeding at the community level.
10.Sensitize the community on dietary diversification including production, preparation and uptake of locally available nutritious traditional foods
.

Output 3
Strengthened community systems for offering quality MIYCN services
Activities
1.Establish breast feeding resource centres in the community units
2.Conduct bi-monthly review meetings for CHVs
3.Conduct mentorship and support supervision for CBFCI CHEWs and CHVs

Output 4
Enhanced adherence to policies, legislations protecting, promoting and supporting breastfeeding at workplace and general population

Activities
1. Sensitize employers in Nandi County on the health Act 2017 article 71 & 72 and workplace breastfeeding guidelines
2.Establish 12 workplace lactation centres in formal and informal sectors
3.Sensitize county managers and CHMT/SCHMT, partners, agencies on BMS act
4.Train public health officers and nutritionist on enforcement of the BMS Act
5.Advocate for enforcement of school re-entry policy for teenage mothers at least 1 year after delivery to allow uptake of EF and optimal complementary feeding

KRA 02. Nutrition of older children, adolescent, adults and older persons promoted

Output 1
Increased WIFAS intake among adolescent girls

Activities
1.Sensitize education directors, BOMs and head teachers on the WIFs program and nutrition for older children (boys and girls) and adolescent (boys and girls)
2.Sensitize Teachers in primary schools on the WIFs program and nutrition for older children (boys and girls) and adolescent (boys and girls)
3.Carry out WIFs supplementation among the adolescent's girls
4.Conduct quarterly Monitoring and evaluation of WIFs program in collaboration with education department
5.Sensitize parents and community members (men and women) across different ages and diversities on the importance of WIFs and nutrition for older children (boys and girls) and adolescent (boys and girls)
6.Sensitize CHMT, SCHMT and health care workers on geriatric nutrition

Output 2
Increased knowledge of health workers and the community on optimal nutrition for adults and older persons

Activities
1. Sensitize CHMT,SCHMT and health care workers on geriatric nutrition
2. Sensitize CHMT,SCHMT and health care workers on healthy diets & lifestyle guidelines
3. Sensitize male and female CHVs on geriatric nutrition
4. Sensitize male and female CHVs on healthy diets & lifestyle guidelines
5. Sensitize community (men and women) across different ages and diversities on healthy diets & lifestyle guidelines through organized community forums

KRA 3. Clinical nutrition and dietetics scaled up

Expected outcome

Improved micronutrient status of the population

Output 1
Enhanced access to quality non-communicable diseases prevention, control and management services

Activities
1. Carry out periodic gender integrated surveys on DRNCDs and the associated risk factors
2. Develop key messages targeting men and women across different ages and diversities on DRNCDs for the community
3. Carry out health talks on healthy diets at community, work place and institutions
4. Carry out screening on NCDs in the community
5. Do mass screening of Diet related NCDs
6. Establish NCD related support groups,
7. Establish NCD SUPPORT GROUPS at the community
8. Carry out bi-annual advocacy meetings on prioritization of resources for DRNCDs-to be taken to advocacy
9. Advocate for integration of monitoring nutrition related risk factors for NCDs

Output 2
Increased knowledge of health care workers and CHVs on importance of micronutrient intake

Activities
1. Train HCW on MNPs
2. Train HCW on nutrition VAS
3. Train HCWs on IFAS
4. Trai HCWs, teachers, CHVs on M&E
5. Conduct CHVs sensitization meetings on micronutrients
6. Train/sensitize on micro nutrient policies
7. Conduct CHVs sensitization meetings on micronutrients
8. Sensitize CHVs on micronutrients supplementation for children and pregnant women for demand creation and referral

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

Activities
1. Develop inpatient feeding guidelines responsive to the specific nutrition needs for men and women across different ages and diversities
2. Develop individualized SOPs for provision of clinical nutrition and dietetics
3. Conduct clinical nutrition QA in the health facilities
4. Pilot clinical nutrition and dietetics monitoring and reporting tools
5. Print and distribute monitoring and reporting tools

KRA 04. Integrated Management of Acute Malnutrition Strengthened

Output 1
Strengthened capacity of healthcare workers to provide integrated management of acute malnutrition (IMAM).

Activities:
1. Train male and female healthcare workers on IMAM including affective identification, documentation and addressing underlying social cultural and economic factors contributing to malnutrition, affecting optimal adherence to IMAM services and relapse by MAM/SAM patients.
2. Train male and female HCW on LMIS for IMAM
3. Conduct monthly CME to HCWs on IMAM
4. Train male and female CHVs on CMAM
5. Monitor adherence to IMAM programs SOPs, guidelines and protocols by HCWs

Output 2
Strengthen linkages and referral to the facility and community

Activities
1. Sensitize the community members (men and women) across different ages and diversities on IMAM through community forums.
2. Link and refer malnourished clients to facility/community.

KRA 05. Nutrition in Tuberculosis (TB) and HIV Strengthened

Expected outcome
Reduced impact of HIV related co-morbidities among people living with HIV through targeted nutrition therapy

Output 1
Strengthened capacity of health care workers and care givers to provide quality nutrition services for HIV and TB clients
Activities
1. Train HCWs on integrated HIV curriculum
2. Train HCWs on nutrition in TB management
3. Sensitize care givers on nutrition and drugs

Output 2
Improved access to quality HIV and TB services to all clients

Activities
1. Carry out nutrition assessment counselling and support (NACS) to HIV and TB clients
2. Provide supplementary and therapeutic feeds to malnourished HIV patients
3. Provide supplementary and therapeutic feeds to malnourished TB patients
4. Link malnourished HIV Patients to other programs (social protection, Agriculture)
5. Link malnourished TB Patients to other programs (social protection, Agriculture)

KRA 6. Nutrition in WASH, Education, Agriculture, and social services scaled up
Expected outcome
Improved access to quality clinical nutrition and dietetics services

Output 1
Integration of WASH into nutrition strengthened

Activities.
1. Train TOTs on CLTS and integrate nutrition to promote integrated WASH nutrition practices (Hand washing at critical times, latrine use, food safety and hygiene, water treatment and storage, environmental hygiene) in collaboration with public health
2. Train health care workers on integrated WASH nutrition practices (Hand washing at critical times, latrine use, food safety and hygiene, water treatment and storage, environmental hygiene)
3. Train CHVs on integrated WASH nutrition practices (Hand washing at critical times, latrine use, food safety and hygiene, water treatment and storage, environmental hygiene)
4. Conduct Dialogue days and Action days in collaboration with WASH department
5. Conduct clean up days in the community in collaboration with environmental health
6. Sensitize teachers integrated WASH nutrition practices
7. Conduct quarterly joint monitoring and evaluation of integrated WASH nutrition activities

Output 2
Increased uptake of growth monitoring and micronutrient supplements in schools for optimal health of children
Activities
1. Carry out an inception meeting targeting county directors of education, BOM, head teachers and teachers on growth monitoring among children under 5 years in ECD centres
2. Sensitize ECD teachers on growth monitoring, VIT A supplementation and deworming
3. Train CHVs on growth monitoring, VIT A supplementation and deworming
4. Conduct bi annual VIT A supplementation and deworming exercises in ECDE during the Malezi bora months

Activities

1. Conduct mapping exercise for all ECDE centres and assess the Implementation of school meals guidelines in ECDE centres
2. Sensitize BOMs, directors and school heads on school meals guidelines
3. Sensitize ECDE school teachers and primary schools on school meals guidelines
4. Conduct quarterly Joint Support supervision - (MOE and MOH) on nutrition activities in ECDs
5. Generate monthly reports on nutrition activities conducted in ECDs

Output 4: Production of diversified crops of nutrient dense enhanced

Activities:

1. Train Agri nutrition TOTs
2. Train health care workers and agriculture extension staff on Agri nutrition
3. Train male and female Youth Groups, Women groups and male and female farmers groups across different ages and diversities on agri nutrition
4. Sensitize the community members (men and women) across different ages and diversities on Agri nutrition through chief baraza, churches and mosques and other community forums
5. Sensitize of male and female farmers across different ages and diversities on post-harvest management and aflatoxin management in collaboration with the nutrition department

Output 5: Increased intake of diversified diet in the households

Activities:

1. Conduct food demonstrations, value addition and kitchen gardening in the community and cascaded to the household at the community through organized groups in collaboration with agriculture department
2. Conduct household visits for follow-up of Agri nutrition activities in collaboration with agriculture department
3. Participate in Agricultural shows and trade fare to promote Agri nutrition
4. Conduct quarterly joint monitoring and evaluation of Agri nutrition activities

Output 6: Improved nutrition for vulnerable groups at the community and children's homes

Activities:

1. Sensitize social protection officers on importance of nutrition for OVC, elderly and PLWDs
2. Sensitize the community members (men and women) across different ages and diversities through community organized forums on nutrition for OVCs, elderly and PLWDs
3. Sensitize children homes management on nutrition for OVCs in collaboration with social service department
4. Link and refer OVCs, elderly and PLWD with nutritional challenges to health facilities for management

KRA 07. Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened.

Expected outcome:

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

Output 1

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

Activities:

1. Disseminate nutrition policies and guidelines on nutrition to stakeholders, partners and line ministries
2. Operationalize County Nutrition Technical forum
3. Establish county nutrition steering group (CNSG)
4. Sensitize MCAs on Nutrition policies
5. Validate CNAP

KRA 08. County Sectoral and multisectoral Nutrition Information Systems, Learning and Research strengthened

Expected outcome

Nutrition linkages with other sensitive sectors strengthened

Output 1

Output 1: Enhanced evidence-based data for planning and programming

Activities

1. Conduct nutrition capacity assessment
2. Conduct SMART survey
3. Carry out a gender integrative baseline survey on nutrition among male and female adolescents across different diversities.

Output 2

Output 2: Research for nutrition strengthened

Activities

1. Establish learning and research committee
2. Sensitize learning institutions on research priorities for nutrition

Output 3

Data quality for nutrition ensured

Activities

1. Carry out data quality audit in health facilities for nutrition services
2. Carry out support supervision and mentorship
3. Avail M&E tools
4. Train health workers on nutrition information systems

KRA 09. Advocacy, Communication and Social Mobilization (ACSM) strengthened

Output 1:

Advocacy communication and social mobilization for nutrition enhanced

Activities:

1. Develop ACSM plan for nutrition
2. Train a pool of advocacy champions for nutrition in the county
3. Develop an award program for male and female nutrition champions across different ages and diversities in the county
4. Identify and recognize male and female nutrition champions across different ages and diversities in the county

Output 2:

Enhanced political commitment and continued prioritization of nutrition in national and county agenda

1. Conduct high level advocacy meeting with political arm and key decision makers in health to lobby for allocation of resources to nutrition
2. Conduct high level advocacy meeting with governors, county budgetary allocation committee, MCAs, decision makers in health for lobbying of employment of male and female nutritionists
3. Conduct joint advocacy meetings to the county political and decision makers, local leaders to implement community health strategy
4. Commemorate world health days (world breastfeeding week, nutrition week, hypertension, diabetes and cancer days
5. Sensitize male and female community leaders across different ages and diversities on participation in nutrition activities

Output 3:
Increased human resource for nutrition
Activities:
1. Recruit more male and female nutritionist and dietitians
2. Conduct orientation meetings of new staff on nutrition service delivery.

Output 4:
Nutrition content for advocacy availed
Activities :
1. Develop different key message targeting men and women across different ages and diversities for nutrition to be used for advocacy
2. Develop and disseminate age, gender and diversity sensitive Nutrition IEC materials and videos
3. Disseminate key nutrition messages targeting men and women across different ages and diversities through different channels and platforms

Output
Increased visibility of nutrition in media channels
Activities:
1. Conduct sensitization meeting for media journalists and editors on priorities for Nandi CNAP to give it visibility
2. Establish media network for journalist who promote nutrition (breast feeding, work place complimentary feeding)

KRA 10. Supply chain management for nutrition commodities and equipment strengthened

Output 1:
Increased capacity of health care providers to manage commodities for nutrition
Activities:
1. Train HCW on forecasting and quantification of nutrition commodities
2. Train HCW on nutrition LMIS (for TB, HIV, IMAM, clinical nutrition, micronutrients)
3. Conduct OJT and mentorship for selected facility staff on forecasting and quantification for nutrition commodities
4. Hold bi-annual nutrition commodity partner stake holder meetings
5. Hold monthly Nutrition Commodity TWG meetings

Output 2:
Quality of all nutrition commodities and equipment ensured
Activities:
1. Do inventory of all available anthropometric equipment. Repair broken equipment.
2. Repair broken equipment.
3. Carry out bi-annual preventive maintenance of anthropometric equipment
4. Train maintenance personnel on anthropometric/kitchen equipment in collaboration with medical engineering department
5. Renovate/construct sub-county nutrition commodity stores
6. Carry out nutrition commodity DQA

Output 3:
Availability of nutrition commodities, equipment, resources and management of supply chain ensured
1.Procure nutrition anthropometric and kitchen equipment
2.Procure micronutrient supplements (VAS, IFAS, MNPS)
3.Procure therapeutic and supplementary feeds for IMAAM, TB/HIV
4.Procure enteral, parenteral nutrition commodities and kitchen equipment
5.Print and distribute monitoring and reporting tools- for nutrition (M&E, micronutrients, clinical, MIYCN etc.)

KRA 11. Prevention, control and management of Micronutrient Deficiencies Scaled up

Output 1:

Increased micronutrient intake through dietary diversification

Activities:

1.Sensitize community on consumption of diverse food groups through the community forums
2.Train HCWs on strategies for anaemia prevention

Output 2:

Increased knowledge of health care workers and CHVs on importance of micronutrient intake

1. Train HCW on MNPs
2. Train HCW on nutrition VAS
3. Train HCWs on IFAS
4. Train/sensitize on micro nutrient policies
5. Conduct CHVs sensitization meetings on micronutrients
6. Sensitize CHVs on micronutrients supplementation for children and pregnant women for demand creation and referral
7. Increased consumer awareness on fortified foods
8. Sensitize the community members (men and women) across different ages and diversities on consumption of fortified foods
9. Train CHVs and PHOs on food fortification.
10. Conduct market level surveillance for fortified foods
11. Carry out household salt sampling and testing for iodized salts in the community
12. Conduct joint supervision and mentorship on micronutrient supplementation at health facilities

KRA 12: Nutrition in sports strengthened

Output 1:

Quality data on sports nutrition generated for evidence-based programming

1. Conduct gender integrated baseline Survey and Situational analysis on Status of Nutrition and health for the athletes
2. Conduct exchange learning visits for policy makers and implementers in Countries with best practices on Sports Nutrition

Output 2:

Improved access to and use of information on sports nutrition for improved performance and quality programming

1. Develop county specific guidelines, standards and SOPs on Sports nutrition
2. Develop sports nutrition training package for athlete
3. Develop IEC materials for micronutrients supplements and nutrition ergogenic aids
4. Train Health Care Workers on Sports Nutrition
5. Sponsor male and female Health Care Workers to Specialize in Sports nutrition
6. Develop sports nutrition advocacy package for athletes
7. Develop guidelines for optimal post-injury nutrition for athletes

Output 3:

Increased performance of athletes and other sportsmen and women

1. Map and integrate sports nutrition in existing training centres, camps and clubs nutrition component
2. Sensitize athletes and Community on Sports Nutrition
3. Conduct nutritional Screening and Assessment for athletes
4. Hold Nutrition Counselling Sessions to athletes in Training Centres, Camps and Clubs
5. Establish separate Nutrition Counselling and recovery Centre for athletes

Output 4:

Advocacy for sports nutrition enhanced

1.Advocate for a budget line for sports nutrition to address procurement and distribution of sports nutrition commodities

2.Hold high level Sensitization meetings for policy makers on sports nutrition

3.Promote collaboration with other health sector interventions to promote sports nutrition (MOALF&I, gender, MOH, Industry, Finance, Gender, Sports) and the private sector.

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

4.1 Introduction:

This chapter provides guidance on the monitoring, evaluation, accountability and learning (MEAL) process, and how the monitoring process will inform the county nutrition action plan. Monitoring and evaluation of this CNAP will entail systematically tracking the progress of suggested interventions, and assesses the effectiveness, efficiency, relevance and sustainability of these interventions. The task will involve routine collection of information on identified indicators to measure progress toward results envisioned in this CNAP. An assessment of the technical M&E capacity of the program within the county is key. 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.
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.

4.2 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 desegregated by sex and age
- Service coverage/Outcomes
- Client/Patient outcomes (behavior change, morbidity)
- Clients equitable Access to and uptake of quality services
- Quality of health services responsive to the specific health and nutrition needs for men and women across different ages and diversities.
- Impact of interventions in 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, uarterl, 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 diversity can help in accessing different groups within a community.
- Reviewing existing data to identify gender roles, relations and issues prior to design of nutrition 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.

4.3 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 subnational 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.

4.4 Logic Model

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

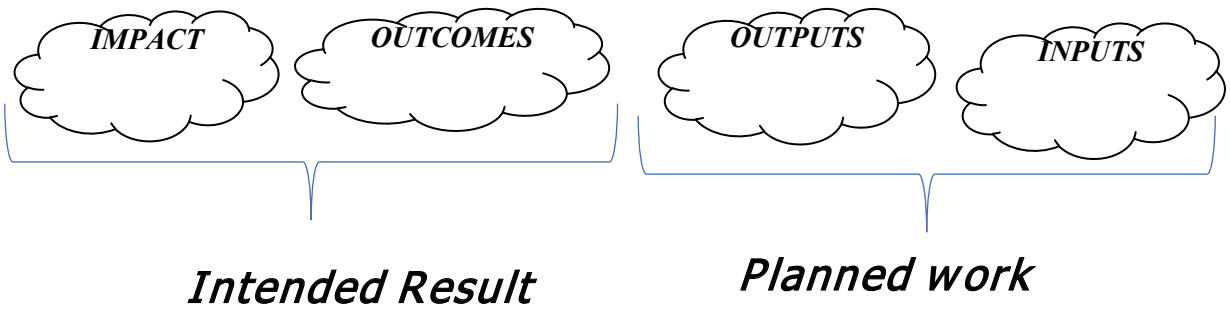


Figure 4.1: The Logic Model.

Table 4.1: RESULTS FRAMEWORK

OUTCOMES	**Outcome 1.Reduction in undernutrition:** -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%; -Reduce malnutrition among older children and adolescent by 15%	**Outcome 2. Reduction of micronutrient deficiencies** -Reduce anemia in children 0-59 months by 30% - Reduce anemia in adolescent girls by 30% - Reduce folic acid deficiency among non-pregnant women by 50% - Reduce vitamin A deficiency in children by 50% - Reduce iodine deficiency among children <5 years by over 50% - Reduce prevalence of zinc deficiency among pregnant women by 10% -Reduce anemia in adolescent girls by 30%	**Outcome 3.Reduction in overnutrition** -No increase in childhood overweight/obesity. -Reduce mortality due to dietary risk factors by 20%	**Outcome 4. Improved leadership, governance, and coordination** -Increased domestic financing for nutrition -Improved monitoring, evaluation research and learning for nutrition and dietetics activities -Improvedmulti-level and multisectoral capacity for risk preparedness, reduction and mitigation against impact of disasters -Increased human resource for nutrition	**Outcome 5. Reduction in mortality and morbidity due to diseases through nutrition interventions.** -Reduce proportion of patients with hospital-based malnutrition by 20%	**Outcome 5. Reduction in mortality and morbidity due to acute malnutrition** -Maintain mortality rates at below 3% for MAM and 10% for SAM
OUTPUTS	**Outputs** -Strengthened capacity of health care providers and CHVs to deliver quality MIYCN services - Improved access to MIYCN information by the caregivers, influencers and the community -Strengthened community systems for offering quality MIYCN services -Enhanced adherence to policies, legislations protecting, promoting and supporting breastfeeding at workplace and general population	**Outputs** - Increased micronutrient intake through dietary diversification - Increased knowledge of health care workers and CHVs on importance of micronutrient intake and supplementation. - Increased consumer awareness on fortified foods -Increased WIFAS intake among adolescent girls - Production of diversified crops of nutrient dense enhanced	**Outputs** -Increased knowledge of health workers and the community on optimal nutrition for adults and older persons	**Outputs** - Integration of WASH into nutrition strengthened - Increased uptake of growth monitoring and micronutrient supplements in schools for optimal health of children - Increased knowledge of teachers and stakeholders such as BOM, directors, decision makers at the county on optimal feeding for school going children -Efficient and effective nutrition governance, coordination and legal frameworks in place. -Efficient and effective nutrition governance, coordination and legal frameworks in place. - Enhanced evidence-based data for planning and programming. - Research for nutrition strengthened - Data quality for nutrition ensured -Advocacy communication and social mobilization for	**Outputs** -Strengthened capacity of health care workers and care givers to provide quality nutrition services for HIV and TB clients -Improved access to quality HIV and TB services to all clients Activities -Increased knowledge of health workers and the community on optimal nutrition for adults and older persons - Enhanced access to quality non communicable diseases prevention, control and management services. - Improved competencies, skills and knowledge of nutritionists and dietitians - Enhanced standards of quality of nutrition and dietetics services for inpatients and general hospital services	**Outputs** -Increased coverage on Strengthened capacity of healthcare workers to provide integrated management of acute malnutrition (IMAM). - Strengthen linkages and referral to the facility and community

4.5 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 thus making 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:

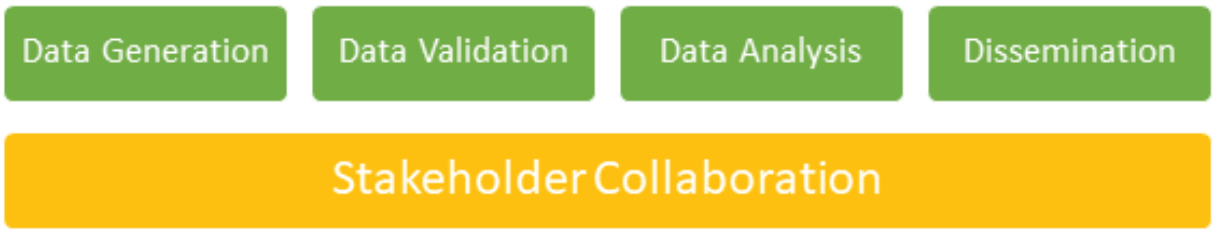


Figure 4.2 Monitoring Process

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 ensure 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

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

4.7 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 uarter relevance, efficiency, effectiveness and sustainability for the CNAP. The proposed evaluation criteria 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 a outlined interventions after its termination.

Table 4.3: Common Results and Accountability framework 2018-2022

NANDI 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 (%)	27%	20%	16.20%	GBD (2015)	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 (%)	35%	38%	42%	GBD (2017)	Annual	Nutrition Program
Reduce and maintain childhood wasting to less than 5%	Prevalence of wasting (W/H >2SD) in children 0-59 months (%)	4%	4%	4%	GBD (2015)	Annual	Nutrition Program
Reduce and maintain childhood underweight to less than 10%	Prevalence of underweight (W/A <2SD) in children 0-59 months	11%	10%	9.50%	GBD (2015)	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 providers and CHVs to deliver quality MIYCN services	Pregnant women attending ANC supplemented with IFAS	86.50%	88%	90%	DHIS2	Monthly	Nutrition Program
	Proportion of infants initiated to the breast within the first one hour after delivery.	86.60%	92%	100%	DHIS2	Monthly	Nutrition Program
	Number of HCWs trained on BFHI	60	80	100	Program reports	Annual	Nutrition Program
	Number of HCW trained on BFCI	80	160	200	Program reports	Annual	Nutrition Program

NANDI CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018-2022							
	Number of CHVs trained on BFCI	150	450	750	Program reports	Annual	Nutrition Program
	Proportion children 24-59 months dewormed	38%	58%	80%	DHIS2	Monthly	Nutrition Program
Improved access to MIYCN information by the caregivers, influencers and the community	County specific complementary feeding book developed	No	Yes	Yes	Program Reports	Annual	Nutrition Program
Strengthened community systems for offering quality MIYCN services	Number of community units accredited as BFCI	0	7	17	Program reports	Annual	Nutrition Program
	Proportion of children 24-59 months, disaggregated by age, supplemented with vitamin A	68%	76%	80%	DHIS2	Monthly	Nutrition Program
Enhanced adherence to policies, legislations protecting, promoting and supporting breastfeeding at workplace and general population	No. of lactation rooms established	0	4	12	Program reports	Annual	Nutrition Program
KEY RESULT AREA 2: Nutrition of older children, adolescent, adults and older persons promoted							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
No increase in childhood overweight/obesity	Prevalence of overweight/ obesity (W/A >2SD) of children <5 years (%)	No Data	<5%	<5%	STEPWise Survey	Every 5 Years	Nutrition Program/NCD Program
Reduce mortality due to dietary risk factors by 20%	Mortality attributable to dietary risk factors	No Data	Reduction by 10%	Reduction by 20%	STEPWise Survey	Every 5 Years	Nutrition Program/NCD Program
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**

NANDI CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018-2022							
Increased WIFAS intake among adolescent girls	Baseline adolescent nutrition survey	No	Yes	Yes	Program reports	Annually	Nutrition Program
	Proportion of adolescents supplemented with IFAS in schools	No data	60%	75%	Program reports	Annually	Nutrition Program/Department of Education
Increased knowledge of health workers and the community on optimal nutrition for adults and older persons	Number of Integrated Geriatric clinics established	0	3	5	Program reports	Annually	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 children 6-59 months by 30%	Prevalence of anemia in children 0-59 months (%)	No Data	By 10%	By 30%	KNMS	Every 5 years	Nutrition Program
Reduce anaemia in pregnant women by 40% or more	Prevalence of anaemia in pregnant women (%)	No Data	By 20%	By 40%	KNMS	Every 5 years	Nutrition Program
Reduce anaemia in adolescent girls by 30%	Prevalence of anaemia in girls 15-19 years (%)	No Data	By 10%	By 30%	KNMS	Every 5 years	Nutrition Program
Reduce folic acid deficiency among non-pregnant women by 50%	Proportion of non-pregnant women with folic acid deficiency (%)	No Data	By 20%	By 50%	KNMS	Every 5 years	Nutrition Program
Reduce vitamin A deficiency in children by 50%	Prevalence of VAD in children 0-59 months (%)	No Data	By 20%	By 50%	KNMS	Every 5 years	Nutrition Program
Reduce iodine deficiency among children <5 years by over 50%	Prevalence of iodine deficiency in children <5 years (%)	No Data	By 20%	By 50%	KNMS	Every 5 years	Nutrition Program
Reduce iodine deficiency among non-pregnant women by over 50%	Prevalence of iodine deficiency in non-pregnant women (%)	No Data	By 20%	By 50%	KNMS	Every 5 years	Nutrition Program
Reduce prevalence of zinc deficiency in pre-school children by 40%	Prevalence of zinc deficiency in children <5 years (%)	No Data	By 20%	By 40%	KNMS	Every 5 years	Nutrition Program

NANDI CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018-2022							
Reduce prevalence of zinc deficiency among pregnant women by 10%	Prevalence of zinc deficiency among pregnant women (%)	No Data	By 50%	By 10%	KNMS	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 micronutrient intake through dietary diversification	No. of CHVs trained on consumption of diverse food groups.	0	120	250	Nutrition program reports	Annually	Nutrition Program
Increased knowledge of health care workers and CHVs on importance of micronutrient intake	number of HCWs trained on micronutrients	No data	150	250	Program reports	Annual	Nutrition Program
Increased consumer awareness on fortified foods	No of market surveillance done on food fortification	0	3	6	Program Reports	Annual	Nutrition Program
KEY RESULT AREA 4: Strengthening Integrated Management of Acute Malnutrition							
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 (%)	No Data	<3% MAM/<10% for SAM	<3% MAM/<10% for SAM	SMART Survey	Every 2 years	Nutrition Program
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Increased coverage on Strengthened capacity of healthcare workers to provide integrated management of acute malnutrition (IMAM).	Number of healthcare workers trained on IMAM	120	520	720	Program reports	Annual	Nutrition Program
	number of facilities adhering to IMAM program performance based on IMAM supervision checklist	150	400	600	Program reports	Annual	Nutrition Program

NANDI CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018-2022							
Strengthen linkages and referral to the facility and community	number of CHVs trained on CMAM	100	250	350	Program reports	Annual	Nutrition Program
	Number of IMAM referrals	80	120	180	Program reports	Annual	Nutrition Program
	number of SMART surveys done	0	2	4	Program reports	Annual	Nutrition Program
KEY RESULT AREA 5: Strengthening Nutrition in Tuberculosis (TB) and HIV							
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 and care givers to provide quality nutrition services for HIV and TB clients	proportion of malnourished TB patients, receiving nutrition commodities	No Data	70%	85%	Nutrition/TB Program reports	Quarterly	Nutrition/TB Program
	Number of healthcare workers trained on nutrition in TB /HIV management	No Data	240	460	Program reports	Annual	Nutrition Program/TB Program
Improved access to quality HIV and TB services to all clients Activities	proportion of malnourished HIV patients receiving nutrition commodities	30%	40%	80%	Program reports	Annual	Nutrition Program/HIV Program
KEY RESULT AREA 6: Clinical nutrition and dietetics scaled up							
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%	Prevalence of hospital-based malnutrition	No Data	50%	30%	Clinical Nutrition Survey	Every two years	Nutrition Program
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**

NANDI CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018-2022							
Enhanced access to quality non communicable diseases prevention, control and management services	No of staff trained on specialized nutrition	0	2	5	Program reports	Annual	Nutrition Program/NCD Program
Improved competencies, skills and knowledge of nutritionists and dietitians	No of staff sensitized on clinical nutrition guidelines	0	120	240	Program reports	Annual	Nutrition Program
	No of health care workers trained on nutrition care process	0	160	160	Program reports	Annual	Nutrition Program
Enhanced standards of quality of nutrition and dietetics services for inpatients and general hospital services	No of quality monitoring conducted	0	2	4	Program reports	Annual	Nutrition Program
	Clinical nutrition reporting tools developed	No	Yes	Yes	Program reports	Annual	Nutrition Program
	No. of health workers trained on nutrition management of preterm	0	120	240	Program reports	Annual	Nutrition Program
KEY RESULT AREA 7: Supply chain management for nutrition commodities and equipment strengthened							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**

NANDI CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018-2022							
Increased capacity of health care providers to manage commodities for nutrition	No of nutrition commodity review meetings held	0	24	48	Program reports	Annual	Nutrition Program
	No. of HCWs trained on LMIS	No data	100	200	Program reports	Annual	Nutrition Program
	No of staff trained on quantification and forecasting	No data	100	200	Program reports	Annual	Nutrition Program
Quality of all nutrition commodities and equipment ensured	No of preventive maintenance done on anthropometric equipment	0	8	12	Program reports	quarterly	Nutrition Program
Availability of nutrition commodities, equipment, resources and management of supply chain ensured	Proportion of facilities reporting no stock outs of nutrition commodities	No data	60%	80%	Program reports	Annual	Nutrition Program
KRA 8: Nutrition in Education, Agriculture, WASH, and social services scaled up							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**

NANDI CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018-2022							
Integration of WASH into nutrition strengthened	proportion of CHVs trained on WASH in each community unit	30	60	100	Program reports	Annual	Nutrition Program/department of WASH
	number of clean up days	50	60	70	Program reports	Quarterly	Nutrition Program/department of WASH
	number of nutrition assessments done among PLWD	18	36	60	Program reports	Quarterly	Nutrition Program/department of Social Protection
	No. of care givers sensitized on proper nutrition	100	200	300	Program reports	Quarterly	Nutrition Program/department of Social Protection
	Proportion of children homes and orphanages sensitized on nutrition	No Data	70%	90%	Program reports	Quarterly	Nutrition Program/department of Social Protection
Increased uptake of growth monitoring and micronutrient supplements in schools for optimal health of children	Proportion of children under five in ECDEs, done nutritional assessment	14%	40%	80%	Program reports	Quarterly	Nutrition Program/ECDE
Increased knowledge of teachers and stakeholders such as BOM, directors, decision makers at the county on optimal feeding for school going	Proportion of schools implementing school meals guidelines	No Data	60%	100%	Program reports	Annual	Nutrition Program/ECDE

NANDI CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018-2022							
children	Proportion of adolescent girls (10 years and above) in primary school receiving iron folates in selected sub counties	30%	50%	80%	Program reports	Quarterly	Nutrition Program/ECDE
Production of diversified crops of nutrient dense enhanced	Number of trainings on food diversification targeting youth and women groups conducted	20	60	100	Program reports	Quarterly	Nutrition Program/department of Agriculture
	Number of demonstrations on food utilization, value addition and home gardens done	30	45	60	Program reports	Quarterly	Nutrition Program/department of Agriculture
	Number of field visits on interventional nutrition conducted	100	300	600	Program reports	Quarterly	Nutrition Program/department of Agriculture
	number of public barazas on nutrition issues conducted	6	18	30	Program reports	Quarterly	Nutrition Program/department of Agriculture
	number of trainings conducted on post harvest management and aflatoxin control	30	45	60	Program reports	Annual	Nutrition Program/department of Agriculture
KEY RESULT AREA 9: Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**

NANDI CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018-2022							
Efficient and effective nutrition governance, coordination and legal frameworks in place.	CSG established in the county within the first year	1	1	1	Program reports	Annual	Nutrition Program
	number of Quarterly meetings held by the CNTF	4	12	20	Program reports	Quarterly	Nutrition Program
	number of sensitization meetings on nutritional services targeting the MCAs	2	6	10	Program reports	Annual	Nutrition Program
	Validation of the CNAP	1	1	1	Program reports	Annual	Nutrition Program
	number disseminated meeting for policies and guidelines to the relevant audience	2	6	10	Program reports	Annual	Nutrition Program
KEY RESULT AREA 10: County Sectoral and multisectoral 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**
Enhanced evidence-based data for planning and programming.	Nutrition capacity assessment conducted	No	Yes	Yes	Program reports	Every 3 years	Nutrition Program
	No. of SMART Survey undertaken	0	1	2	Program report	Every 2 years	Nutrition Program
Research for nutrition strengthened	county research and learning committee established within the first year	No	Yes	Yes	Program reports	Annual	Nutrition Program
	Number of learning institutions sensitized on nutrition research per year	1	3	4	Program reports	Annual	Nutrition Program

NANDI CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018-2022							
Data quality for nutrition ensured	No. of nutrition staff trained on M&E	40	75	100	Program reports	Annual	Nutrition Program
KEY RESULT AREA 11: Advocacy, Communication and Social Mobilization (ACSM) strengthened							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Increased budgetary allocation to nutrition	Proportion of health budget allocated to nutrition	No data	5%	8%	County Finance reports	Annual	Nutrition Program/department of Finance
	Number of nutrition sensitive sectors with a budget line for nutrition	No data	1	4	County Finance reports	Annual	Nutrition Program/department of Finance
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Advocacy communication and social mobilization for nutrition enhanced	ACSM plan developed	No	yes	Yes	Program reports	Annual	Nutrition Program
Enhanced political commitment and continued prioritization of nutrition in national and county agenda	Number of high-level advocacy meeting conducted	2	6	10	Program reports	Annual	Nutrition Program
	Number of nutrition days marked	4	12	20	Program reports	Annual	Nutrition Program
Increased human resource for nutrition	No. of additional nutritionists employed		10	15	Program reports	Annual	Nutrition Program
Increased visibility of nutrition in media channels	No. of sensitization meetings conducted for media and journalists and editors	0	32	64	Program reports	Annual	Nutrition Program
KEY RESULT AREA 12: Strengthened sport nutrition							

NANDI CNAP COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK 2018-2022							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Quality data on sports nutrition generated for evidence-based programming	Number of Policies, strategies, standards and guidelines on sports nutrition developed and reviewed	0	1	2	Program reports	Annual	Nutrition Program/department of Sports
Improved access to and use of information on sports nutrition for improved performance and quality programming	Number of baseline survey/situation analysis on status of nutrition and health for the athletes conducted	0	1	1	Program reports	Annual	Nutrition Program/department of Sports
Increased performance of athletes and other sportsmen and women	Proportion of athletes screened and assessed on nutrition status	No data	30%	70%	Program reports	Annual	Nutrition Program/department of Sports
	Number of nutrition counselling sessions conducted in the training centers, camps and clubs	No data	20	60	Program reports	Annual	Nutrition Program/department of Sports
	proportion of Athletes requiring additional food and nutrition Supplementation, supported	No data	70%	80%	Program reports	Annual	Nutrition Program/department of Sports
	Number of health Workers Trained on Sports nutrition	0	0	80	Program reports	Annual	Nutrition Program/department of Sports

4.8 Implementation Plan

The implementation of MEAL framework will be spearheaded by the county in collaboration withdevelopment 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

4.9 Roles and responsibilities of different actors in the implementation of CNAP:

Nutrition M&E Staff Members

- Ensuring overall design of the MEAL plan is technically sound
- Working with stakeholders to develop and refine appropriate outputs, outcomes, indicators and targets
- Providing technical assistance to create data collection instruments
- Helping program staff with data collection (including selection of appropriate methods, sources, enforcement of ethical standards)
- Ensuring data quality systems are established
- Analysing data and writing up the findings
- Aiding program staff to interpret their output and outcome data
- Promoting use of M&E data to improve program design and implementation
- Conducting evaluations or special studies

Management at program level

- Determining what resources, human and financial, should be committed to M&E activities
- Ensuring content of the M&E plan aligns with the overall vision and direction of the county
- Assuring data collected meet the information needs of stakeholders
- Tracking progress to confirm staff carry out activities in the M&E plan
- Improving project design and implementation based on M&E data
- Deciding how results will be used and shared
- Identifying who needs to see and use the data
- Deciding where to focus evaluation efforts
- Interpreting and framing results for different audiences

County Departments of health services

- Provision of technical services and coordination of M&E activities.
- Establishment and equipping of robust M&E units aligned to their respective departmental organograms
- Provide dedicated staff team comprised of the entire mix of M&E professionals needed to implement this scope (M&E, officers, HRIOs, Statisticians, planners, economics, epidemiologists.
- Coordinating and supervising the implementation of all M&E activities at the county and subcounty and facility levels

Nutrition M&E Staff Members

- Monitor and report on progress towards implementation of key activities that fall within their mandates in line with jointly agreed indicators
- Participate in high level M&E activities at the county
- Supporting surveys and evaluations needed to assess shared impact of joint interventions

Implementing partners and agencies

- Aligning all their M&E activities to realize the goals of this plan as well as the institutional M&E goals articulated in sectoral, programmatic and county specific M&E Plans
- Routine monitoring and evaluation of their activities
- Using existing systems/developing M&E sub systems that utilize existing structures at all levels of the health information system
- Utilization of the data collected for decision making within the institution

Development Partners

- Provide substantive technical and financial support to ensure that the systems are functional.
- Ensure that their reporting requirements and formats are in line with the indicators outlined in the M&E framework.
- Synchronize efforts with existing development partners and stakeholder efforts based on an agreed upon one county-level M&E system.
- Utilize reports generated in decision making, advocacy and engaging with other partners for resource mobilization.

Health Facilities

- Ensure that data collected, and reports generated are disseminated and used by the implementers to monitor trends in supply of basic inputs, routine activities, and progress made.
- Use this data in making decisions on priority activities to improve access and quality of service delivery.

Community Health Units

- Identification and notification to the health authority of all health and demographic events including M&E that occurs in the community.
- Generate reports through community main actors e.g. the CHWs, teachers and religious leaders through a well-developed reporting guideline Community Health Information System (CHIS)

4.10 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.

CHAPTER 5: CNAP RESOURCE MOBILIZATION AND COSTING FRAMEWORK

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 costed 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)

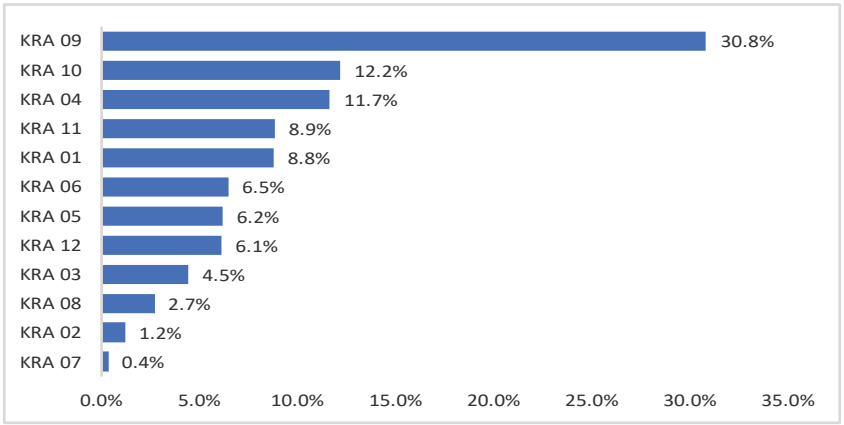
The plan was costed using the Activity Based Costing (ABC) approach. The ABC uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve planned targets for the financial years of 2018/19 – 2022/23. The cost over time for all the Key Result Areas provides important details 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 Nandi CNAP for the five years is estimated at KSh. 2.3 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 by KRA (KSH)

CATEGORY OF KRAs	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	41,010,100	42,020,100	44,697,600	42,201,100	42,897,100	**202,794,000**
	KRA 02. Nutrition of older children, adolescent, adults and older persons promoted	425,000	7,003,400	7,046,400	7,003,400	7,003,400	**28,481,600**
	KRA 03. Clinical nutrition and dietetics scaled up	648,800	28,906,600	23,461,200	24,369,600	25,361,600	**102,747,800**
	KRA 04. Integrated Management of Acute Malnutrition Strengthened	53,684,001	53,684,001	53,684,001	53,684,001	53,684,001	**268,420,005**
	KRA 05. Nutrition in Tuberculosis (TB) and HIV Strengthened	28,384,600	29,032,600	28,384,600	28,384,600	29,032,600	**143,219,000**
	KRA 06. Nutrition in WASH, Education, Agriculture, and social services scaled up	29,623,700	30,028,700	29,623,700	30,028,700	30,028,700	**149,333,500**
	KRA 12: Nutrition in sports strengthened	-	558,000	69,239,000	40,431,000	32,404,500	**141,540,500**
Nutrition sensitive	KRA 08. County Sectoral and multisectoral Nutrition Information Systems, Learning and Research strengthened	8,561,500	10,688,300	16,408,300	10,088,300	16,408,300	**62,754,700**
	KRA 07. Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened	1,374,500	2,285,500	1,374,500	1,974,500	1,374,500	**8,383,500**
Enabling Environment	KRA 09. Advocacy, Communication and Social Mobilization (ACSM) strengthened	140,744,500	142,692,000	143,639,500	141,489,500	141,489,500	**710,055,000**
	KRA 10. Supply chain management for nutrition commodities and equipment strengthened	12,837,400	67,335,400	66,657,400	66,657,400	66,657,400	**280,145,000**
	KRA 11. Prevention, control and management of Micronutrient Deficiencies Scaled up	40,796,000	40,796,000	40,796,000	40,796,000	40,796,000	**203,980,000**
TOTAL		**358,090,101**	**455,030,601**	**525,012,201**	**487,108,101**	**487,137,601**	**2,301,854,605**

Figure 5.1: Proportion of resource requirements by KRA



The annual break down of cost key result areas is presented in Table 5.1
KRA 09 on Advocacy, Communication and Social Mobilization (ACSM) strengthened utilized 30.8 percent of the resources required, followed by KRA 10 on Supply chain management for nutrition commodities and equipment strengthened at 12.2 percent. KRA 04. Integrated Management of Acute Malnutrition Strengthened constitute 11.7 percent of the requirement. (See, figure 5.1).
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.

REFERENCES

AAH. (April 2017). Action Against Hunger Gender Analysis Report.

KHIS. (July 2017). Kenya Health Information Software.

GNR. (2018). Global Nutrition Report 2018.

GOK, MOH. (2018). The Kenya Nutrition Action Plan 2018-2022.

IHME. (2017). Institute of Health Metrics and Evaluation.

IHRIS. (2019). Integrated Human Resource Information System .

KDHS. (2014). Kenya Demographic and Health Survey.

KNBS. (2016). Kenya National Bureau of Statistics.

KNBS. (2019). Kenya Population and Housing Census 2019.

CIDP. (2018.). Nandi County Integrated Development Plan (CIDP 2018-2022).

DHIS. (2018). District Health Information Software (DHIS 2).

GOK. (2011). Kenya Food and Nutrition Security Policy. Nairobi.

KHIS. (2019).

MOH. (2010). Kenya National Nutrition and Dietitics Reference Manual . Government of Kenya.

MOH. (2011). The Kenya National Micronutrient Survey. Nairobi.

APPENDIXES

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

KEY RESULT AREAS BY INTERVENTIONS BY ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	Total
KRA 01. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up	**41,010,100**	**42,020,100**	**44,697,600**	**42,201,100**	**42,897,100**	**202,794,000**
Output 1: Strengthened capacity of health care providers and CHVs to deliver quality MIYCN services	23,600,600	23,759,600	23,759,600	23,759,600	23,759,600	**118,639,000**
Disseminate MIYCF related guidelines, SOPs and policies	585,000	585,000	585,000	585,000	585,000	**2,925,000**
Sensitize CHMT/SCHMT/HMT on BFHI	2,155,600	2,155,600	2,155,600	2,155,600	2,155,600	**10,778,000**
Train male and female health care workers on BFHI	2,155,600	2,155,600	2,155,600	2,155,600	2,155,600	**10,778,000**
Conduct CME, OJT and mentorship on BFHI to male and female health care workers	582,400	582,400	582,400	582,400	582,400	**2,912,000**
Conduct BFHI self and external assessment to high volume facilities with maternity services.	2,380,000	2,380,000	2,380,000	2,380,000	2,380,000	**11,900,000**
Train male and female health care workers on MIYCFe	2,155,600	2,155,600	2,155,600	2,155,600	2,155,600	**10,778,000**
Train male and female health care workers on BFCI	5,016,000	5,175,000	5,175,000	5,175,000	5,175,000	**25,716,000**
Train male and female CHVs on C-BFCI	7,265,400	7,265,400	7,265,400	7,265,400	7,265,400	**36,327,000**
Print & distribute BFCI tools and Job Aids to HCW, CHV and caregivers	720,000	720,000	720,000	720,000	720,000	**3,600,000**
Train health care workers to effectively mainstream gender in nutrition programming for improved provision and implementation of gender responsive nutrition and health services and interventions.	585,000	585,000	585,000	585,000	585,000	**2,925,000**
Output 2: Improved access to MIYCN information by the caregivers, influencers and the community	**10,323,500**	**10,658,500**	**11,920,000**	**10,323,500**	**12,051,500**	**45,245,000**
Develop and disseminate county specific complementary feeding recipe book, and complementary feeding IEC materials like brochures, posters, etc.	-	335,000	1,596,500	-	-	**1,931,500**
Conduct nutrition education on dietary diversity and consumption of fortified food to the caregivers and the community	5,340,000	5,340,000	5,340,000	5,340,000	5,340,000	**26,700,000**
Conduct health education on dietary and micronutrient intake to pregnant and lactating women attending the facility.	576,000	576,000	576,000	576,000	2,304,000	**576,000**
Conduct visits to the community to sensitize and mobilize mothers on seeking early ANC and nutrition services in health facilities	720,000	720,000	720,000	720,000	720,000	**3,600,000**
Conduct visits to the community to sensitize and mobilize mothers on seeking early ANC and nutrition services in health facilities	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	**6,000,000**
Conduct bi-monthly baby friendly gatherings for influencers, pregnant and lactating mothers at the community	864,000	864,000	864,000	864,000	864,000	**4,320,000**
Conduct community health and nutrition education targeting men for their increased engagement on their role and support on MIYCN.	525,000	525,000	525,000	525,000	525,000	**2,625,000**
Train male and female community support groups on agri-nutrition livelihoods activities and IGAs and link them to productive livelihood-based sectors and financial institutions for support.	178,000	178,000	178,000	178,000	178,000	**890,000**
Advocate for enforcement of school re-entry policy for teenage mothers at least 1 year after delivery to allow uptake of EF and optimal complementary feeding at the community level.	310,000	310,000	310,000	310,000	310,000	**1,550,000**
Sensitize the community on dietary diversification including production, preparation and uptake of locally available nutritious traditional foods.	610,500	610,500	610,500	610,500	610,500	**3,052,500**
Output 3: Strengthened community systems for offering quality MIYCN services	**5,510,000**	**5,510,000**	**6,410,000**	**5,510,000**	**5,510,000**	**28,450,000**

KEY RESULT AREAS BY INTERVENTIONS BY ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Establish breast feeding resource centres in the community units	-	-	900,000	-	-	**900,000**
Conduct bi-monthly review meetings for CHVs	3,222,000	3,222,000	3,222,000	3,222,000	3,222,000	**16,110,000**
Conduct mentorship and support supervision for CBFCI CHEWs and CHVs	2,288,000	2,288,000	2,288,000	2,288,000	2,288,000	**11,440,000**
Output 4: Enhanced adherence to policies, legislations protecting, promoting and supporting breastfeeding at workplace and general population	**1,576,000**	**2,092,000**	**2,608,000**	**2,608,000**	**1,576,000**	**10,460,000**
Sensitize employers in Nandi County on the health Act 2017 article 71 & 72 and workplace breastfeeding guidelines	585,000	585,000	585,000	585,000	585,000	**2,925,000**
Establish 12 workplace lactation centres in formal and informal sectors	240,000	240,000	240,000	240,000	240,000	**1,200,000**
Sensitize county managers and CHMT/SCHMT, partners, agencies on BMS act	-	234,000	468,000	468,000	-	**1,170,000**
Train public health officers and nutritionist on enforcement of the BMS Act	451,000	733,000	1,015,000	1,015,000	451,000	**3,665,000**
Advocate for enforcement of school re-entry policy for teenage mothers at least 1 year after delivery to allow uptake of EF and optimal complementary feeding	300,000	300,000	300,000	300,000	300,000	**1,500,000**
KRA 02. Nutrition of older children, adolescent, adults and older persons promoted	425,000	7,003,400	7,046,400	7,003,400	7,003,400	**28,481,600**
Output 1: Increased WIFAS intake among adolescent girls	**425,000**	**3,227,400**	**3,227,400**	**3,227,400**	**3,227,400**	**13,334,600**
Sensitize education directors, BOMs and head teachers on the WIFs program and nutrition for older children (boys and girls) and adolescent(boys and girls)	-	1,065,400	1,065,400	1,065,400	1,065,400	**4,261,600**
Sensitize Teachers in primary schools on the WIFs program and nutrition for older children (boys and girls) and adolescent(boys and girls)	-	876,000	876,000	876,000	876,000	**3,504,000**
carry out WIFs supplementation among the adolescents girls	-	1,000	1,000	1,000	1,000	**4,000**
conduct quarterly Monitoring and evaluation of WIFs program in collaboration with education department	-	48,000	48,000	48,000	48,000	**192,000**
Sensitize parents and community members (men and women) across different ages and diversities on the importance of WIFs and nutrition for older children (boys and girls) and adolescent(boys and girls)	425,000	425,000	425,000	425,000	425,000	**2,125,000**
Sensitize CHMT,SCHMT and health care workers on geriatric nutrition	-	812,000	812,000	812,000	812,000	**3,248,000**
Output 2: Increased knowledge of health workers and the community on optimal nutrition for adults and older persons	**-**	**3,776,000**	**3,819,000**	**3,776,000**	**3,776,000**	**15,147,000**
Sensitize male and female CHMT,SCHMT and health care workers on geriatric nutrition	-	812,000	812,000	812,000	812,000	**3,248,000**
Sensitize male and female CHMT,SCHMT and health care workers on healthy diets & lifestyle guidelines	-	812,000	812,000	812,000	812,000	**3,248,000**
Sensitize male and female CHVs on geriatric nutrition	-	576,000	576,000	576,000	576,000	**2,304,000**
Sensitize male and female CHVs on healthy diets & lifestyle guidelines	-	576,000	576,000	576,000	576,000	**2,304,000**
Sensitize community members (men and women) across different ages and diversities on healthy diets & lifestyle guidelines through organized community forums	-	1,000,000	1,043,000	1,000,000	1,000,000	**4,043,000**
KRA 03. Clinical nutrition and dietetics scaled up	648,800	28,906,600	23,461,200	24,369,600	25,361,600	**102,747,800**
Output 1: Enhanced access to quality non communicable diseases prevention, control and management services	**-**	**4,470,000**	**3,002,000**	**3,470,000**	**3,002,000**	**13,944,000**
Carry out periodic gender integrated surveys on DRNCDs and the associated risk factors	-	468,000	-	468,000	-	**936,000**
Develop key messages targeting men and women across different ages and diversities on DRNCDs for the community	-	1,000,000	-	-	-	**1,000,000**
Carry out health talks on healthy diets at community, work place and institutions	-	2,400,000	2,400,000	2,400,000	2,400,000	**9,600,000**
Carry out screening on NCDs in the community	-	120,000	120,000	120,000	120,000	**480,000**

KEY RESULT AREAS BY INTERVENTIONS BY ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Establish NCD related support groups,	-	-	-	-	-	-
Establish NCD SUPPORT GROUPS at the community	-	72,000	72,000	72,000	72,000	**288,000**
Carry out bi-annual advocacy meetings on prioritization of resources for DRNCDs-to be taken to advocacy	-	210,000	210,000	210,000	210,000	**840,000**
Advocate for integration of monitoring nutrition related risk factors for NCDs		200000	200000	200000	200000	**800000**
Output 2 : Improved competencies, skills and knowledge of nutritionists and dietitians	**-**	**23,550,800**	**19,710,800**	**20,250,800**	**21,710,800**	**85,223,200**
Disseminate nutrition and dietetics reference manual	-	3,840,000	-	540,000	-	**4,380,000**
Train male and female nutritionists and dietitians on specialized short courses (oncology, renal, critical care, neonatology)	-	2,000,000	2,000,000	2,000,000	4,000,000	**10,000,000**
Train male and female HCW on nutrition care process	-	2,528,000	2,528,000	2,528,000	2,528,000	**10,112,000**
Train male and female HCW on enteral and parenteral nutrition	-	450,000	450,000	450,000	450,000	**1,800,000**
Conduct OJT, mentorship and sensitization of male and female health care workers on clinical nutrition and dietetics	0	292800	292800	292800	292800	**1171200**
Train male and female health workers on nutritional management of pre-terms and low birth weight infants	-	14,440,000	14,440,000	14,440,000	14,440,000	**57,760,000**
Output 3: Enhanced standards of quality of nutrition and dietetics services for inpatients and general hospital services	**648,800**	**885,800**	**748,400**	**648,800**	**648,800**	**3,580,600**
Develop inpatient feeding guidelines responsive to the specific nutrition needs for men and women across different ages and diversities	-	15,000	-	-	-	**15,000**
Develop individualized SOPs for provision of clinical nutrition and dietetics	-	18,000	-	-	-	**18,000**
Conduct clinical nutrition QA in the health facilities	624,000	624,000	624,000	624,000	624,000	**3,120,000**
Pilot clinical nutrition and dietetics monitoring and reporting tools	-	-	99,600	-	-	**99,600**
Print and distribute monitoring and reporting tools	24,800	228,800	24,800	24,800	24,800	**328,000**
KRA 04. Integrated Management of Acute Malnutrition Strengthened	53,684,001	53,684,001	53,684,001	53,684,001	53,684,001	**268,420,005**
Output 1: Strengthened capacity of healthcare workers to provide integrated management of acute malnutrition (IMAM).	**49,864,000**	**49,864,000**	**49,864,000**	**49,864,000**	**49,864,000**	**249,320,000**
Train male and female healthcare workers on IMAM including affective identification, documentation and addressing underlying social cultural and economic factors contributing to malnutrition, affecting optimal adherence to IMAM services and relapse by MAM/SAM patients.	9,894,000	9,894,000	9,894,000	9,894,000	9,894,000	**49,470,000**
Train male and female HCW on LMIS for IMAM	9,894,000	9,894,000	9,894,000	9,894,000	9,894,000	**49,470,000**
Conduct monthly CME to HCWs on IMAM	9,894,000	9,894,000	9,894,000	9,894,000	9,894,000	**49,470,000**
Train male and female CHVs on CMAM	5,144,000	5,144,000	5,144,000	5,144,000	5,144,000	**25,720,000**
Monitor adherence to IMAM programs SOPs, guidelines and protocols by HCWs	15,038,000	15,038,000	15,038,000	15,038,000	15,038,000	**75,190,000**
Output 2: Strengthen linkages and referral to the facility and community	**3,820,001**	**3,820,001**	**3,820,001**	**3,820,001**	**3,820,001**	**19,100,005**
Sensitize the community members (men and women) across different ages and diversities on IMAM through community forums	3,720,001	3,720,001	3,720,001	3,720,001	3,720,001	**18,600,005**
Link and refer malnourished clients to facility/community	100,000	100,000	100,000	100,000	100,000	**500,000**
KRA 05. Nutrition in Tuberculosis (TB) and HIV Strengthened	28,384,600	29,032,600	28,384,600	28,384,600	29,032,600	**143,219,000**
Output 1: Strengthened capacity of health care workers and care givers to provide quality nutrition services for HIV and TB clients	**11,361,000**	**11,361,000**	**11,361,000**	**11,361,000**	**11,361,000**	**56,805,000**
Train male and female HCWs on integrated HIV curriculum	5,436,000	5,436,000	5,436,000	5,436,000	5,436,000	**27,180,000**
Train male and female HCWs on nutrition in TB management	4,534,000	4,534,000	4,534,000	4,534,000	4,534,000	**22,670,000**
sensitize care givers on nutrition and drugs	1,391,000	1,391,000	1,391,000	1,391,000	1,391,000	**6,955,000**
Output 2: Improved access to quality HIV and TB services to all clients	**17,023,600**	**17,671,600**	**17,023,600**	**17,023,600**	**17,671,600**	**86,414,000**
Carry out nutrition assessment counselling and support (NACS) to HIV and TB		648,000			648,000	**1,296,000**

KEY RESULT AREAS BY INTERVENTIONS BY ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	Total
clients						
Provide supplementary and therapeutic feeds to malnourished HIV patients	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	**15,000,000**
Provide supplementary and therapeutic feeds to malnourished TB patients	13,723,600	13,723,600	13,723,600	13,723,600	13,723,600	**68,618,000**
Link malnourished HIV Patients to other programs (social protection, Agriculture)	150,000	150,000	150,000	150,000	150,000	**750,000**
Link malnourished TB Patients to other programs (social protection, Agriculture)	150,000	150,000	150,000	150,000	150,000	**750,000**
KRA 06. Nutrition in WASH, Education, Agriculture, and social services scaled up	29,623,700	30,028,700	29,623,700	30,028,700	30,028,700	**149,333,500**
Output 1: Integration of WASH into nutrition strengthened	**5,205,700**	**5,205,700**	**5,205,700**	**5,205,700**	**5,205,700**	**26,028,500**
Train TOTs on CLTS and integrate nutrition to promote integrated WASH nutrition practices (Hand washing at critical times, latrine use, food safety and hygiene, water treatment and storage, environmental hygiene) in collaboration with public health	67,500	67,500	67,500	67,500	67,500	**337,500**
Train health care workers on integrated WASH nutrition practices (Hand washing at critical times, latrine use, food safety and hygiene, water treatment and storage, environmental hygiene)	127,000	127,000	127,000	127,000	127,000	**635,000**
Train CHVs on integrated WASH nutrition practices (Hand washing at critical times, latrine use, food safety and hygiene, water treatment and storage, environmental hygiene)	3,847,200	3,847,200	3,847,200	3,847,200	3,847,200	**19,236,000**
Conduct Dialogue days and Action days in collaboration with WASH department	648,000	648,000	648,000	648,000	648,000	**3,240,000**
Conduct clean up days in the community in collaboration with environmental health	-	No cost			-	**-**
Sensitize teachers integrated WASH nutrition practices	276,000	276,000	276,000	276,000	276,000	**1,380,000**
Conduct quarterly joint monitoring and evaluation of integrated WASH nutrition activities	240,000	240,000	240,000	240,000	240,000	**1,200,000**
Output 2: Increased uptake of growth monitoring and micronutrient supplements in schools for optimal health of children	**7,133,000**	**7,538,000**	**7,133,000**	**7,538,000**	**7,538,000**	**36,880,000**
Carry out an inception meeting targeting county directors of education, BOM, head teachers and teachers on growth monitoring among children under 5 years in ECD centres	155,000	155,000	155,000	155,000	155,000	**775,000**
Sensitize ECD teachers on growth monitoring, VIT A supplementation and deworming	-	405,000	-	405,000	405,000	**1,215,000**
Train CHVs on growth monitoring, VIT A supplementation and deworming	6,975,000	6,975,000	6,975,000	6,975,000	6,975,000	**34,875,000**
Conduct bi annual VIT A supplementation and deworming exercises in ECDE during the Malezi bora months	3,000	3,000	3,000	3,000	3,000	**15,000**
Output 3: Increased knowledge of teachers and stakeholders such as BOM, directors, decision makers at the county on optimal feeding for school going children	**1,045,000**	**1,045,000**	**1,045,000**	**1,045,000**	**1,045,000**	**5,225,000**
Conduct mapping exercise for all ECDE centres and assess the Implementation of school meals guidelines in ECDE centres	42,000	42,000	42,000	42,000	42,000	**210,000**
Sensitize BOMs, directors and school heads on school meals guidelines	357,500	357,500	357,500	357,500	357,500	**1,787,500**
Sensitize ECDE school teachers and primary schools on school meals guidelines	357,500	357,500	357,500	357,500	357,500	**1,787,500**
Conduct quarterly Joint Support supervision -(MOE and MOH) on nutrition activities in ECDs	270,000	270,000	270,000	270,000	270,000	**1,350,000**
Generate monthly reports on nutrition activities conducted in ECDs	18,000	18,000	18,000	18,000	18,000	**90,000**
Output 4: Production of diversified crops of nutrient dense enhanced	**14,101,500**	**14,101,500**	**14,101,500**	**14,101,500**	**14,101,500**	**70,507,500**
Train agrinutrition TOTs	645,500	645,500	645,500	645,500	645,500	**3,227,500**
Train health care workers and agriculture extension staff on agrinutrition	2,385,000	2,385,000	2,385,000	2,385,000	2,385,000	**11,925,000**
Train male and female Youth Groups ,Women groups and male and female	7,207,000	7,207,000	7,207,000	7,207,000	7,207,000	**36,035,000**

KEY RESULT AREAS BY INTERVENTIONS BY ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	Total
farmers groups across different ages and diversities on agri nutrition						
Sensitize the community members (men and women) across different ages and diversities on agrinutrition through chief baraza, churches and mosques and other community forums	2,052,000	2,052,000	2,052,000	2,052,000	2,052,000	**10,260,000**
Sensitize of male and female farmers across different ages and diversities on post-harvest management and aflatoxin management in collaboration with the nutrition department	1,812,000	1,812,000	1,812,000	1,812,000	1,812,000	**9,060,000**
Output 5 : Increased intake of diversified diet in the households	**1,242,000**	**1,242,000**	**1,242,000**	**1,242,000**	**1,242,000**	**6,210,000**
Conduct food demonstrations, value addition and kitchen gardening in the community and cascaded to the household at the community through organized groups in collaboration with agriculture department	372,000	372,000	372,000	372,000	372,000	**1,860,000**
Conduct household visits for follow-up of agrinutrition activities in collaboration with agriculture department	600,000	600,000	600,000	600,000	600,000	**3,000,000**
Participate in Agricultural shows and trade fare to promote agrinutrition	30,000	30,000	30,000	30,000	30,000	**150,000**
Conduct quarterly joint monitoring and evaluation of agrinutrition activities	240,000	240,000	240,000	240,000	240,000	**1,200,000**
Output 6: Improved nutrition for vulnerable groups at the community and children's homes	896,500	896,500	896,500	896,500	896,500	**4,482,500**
Sensitize social protection officers on importance of nutrition for OVC, elderly and PLWDs	280,500	280,500	280,500	280,500	280,500	**1,402,500**
Sensitize the community members (men and women) across different ages and diversities through community organized forums on nutrition for OVCs, elderly and PLWDs	200,000	200,000	200,000	200,000	200,000	**1,000,000**
Sensitize children homes management on nutrition for OVCs in collaboration with social service department	416,000	416,000	416,000	416,000	416,000	**2,080,000**
Link and refer OVCs, elderly and PLWD with nutritional challenges to health facilities for management	-	No Cost			-	**-**
KRA 07. Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened	1,374,500	2,285,500	1,374,500	1,974,500	1,374,500	**8,383,500**
Output: Efficient and effective nutrition governance, coordination and legal frameworks in place.	1,374,500	2,285,500	1,374,500	1,974,500	1,374,500	**8,383,500**
Disseminate nutrition policies and guidelines on nutrition to stakeholders, partners and line ministries	451,000	451,000	451,000	451,000	451,000	**2,255,000**
Operationalize County Nutrition Technical forum	97,000	97,000	97,000	97,000	97,000	**485,000**
Establish county nutrition steering group (CNSG)	132,000	132,000	132,000	132,000	132,000	**660,000**
Sensitize MCAs on Nutrition policies	507,000	507,000	507,000	507,000	507,000	**2,535,000**
Validate CNAP	187,500	1,098,500	187,500	787,500	187,500	**2,448,500**
KRA 08. County Sectoral and multisectoral Nutrition Information Systems, Learning and Research strengthened	8,561,500	10,688,300	16,408,300	10,088,300	16,408,300	**62,754,700**
Output 1: Enhanced evidence-based data for planning and programming	3,520,000	800,000	6,520,000	200,000	6,520,000	**18,160,000**
Conduct nutrition capacity assessment	-	-	3,000,000	-	3,000,000	**6,000,000**
Conduct SMART survey	3,520,000	200,000	3,520,000	200,000	3,520,000	**10,960,000**
Carry out a gender integrative baseline survey on nutrition among male and female adolescents across different diversities.	-	600,000			600,000-	**1,200,000**
Output 2: Research for nutrition strengthened	881,500	881,500	881,500	881,500	881,500	**4,407,500**
Establish learning and research committee	49,000	49,000	49,000	49,000	49,000	**245,000**
Sensitize learning institutions on research priorities for nutrition	832,500	832,500	832,500	832,500	832,500	**4,162,500**
Output 3: Data quality for nutrition ensured	4,160,000	9,006,800	9,006,800	9,006,800	9,006,800	**40,187,200**
Carry out data quality audit in health facilities for nutrition services	-	1,300,800	1,300,800	1,300,800	1,300,800	**5,203,200**

KEY RESULT AREAS BY INTERVENTIONS BY ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Carry out support supervision and mentorship	-	3,546,000	3,546,000	3,546,000	3,546,000	**14,184,000**
Avail M&E tools	3,272,000	3,272,000	3,272,000	3,272,000	3,272,000	**16,360,000**
Train health workers on nutrition information systems	888,000	888,000	888,000	888,000	888,000	**4,440,000**
KRA 09. Advocacy, Communication and Social Mobilization (ACSM) strengthened	140,744,500	142,692,000	143,639,500	141,489,500	141,489,500	**710,055,000**
Output 1: Advocacy communication and social mobilization for nutrition enhanced	-	1,567,500	2,365,000	400,000	400,000	**4,732,500**
Develop ACSM plan for nutrition	-	1,567,500	1,567,500	-	-	**3,135,000**
Train a pool of advocacy champions for nutrition in the county	-	-	397,500	-	-	**397,500**
Develop an award program for male and female nutrition champions across different ages and diversities in the county	-	-	400,000	400,000	400,000	**1,200,000**
Identify and recognize male and female nutrition champions across different ages and diversities in the county	-	No Cost			-	**-**
Output 2: Enhanced political commitment and continued prioritization of nutrition in national and county agenda	5,446,500	5,631,500	5,631,500	5,446,500	5,446,500	**27,602,500**
Conduct high level advocacy meeting with political arm and key decision makers in health to lobby for allocation of resources to nutrition	5,000	95,000	95,000	5,000	5,000	**205,000**
Conduct high level advocacy meeting with governors, county budgetary allocation committee, MCAs, decision makers in health for lobbying of employment of male and female nutritionists	-	95,000	95,000	-	-	**190,000**
Conduct joint advocacy meetings to the county political and decision makers, local leaders to implement community health strategy	1,892,000	1,892,000	1,892,000	1,892,000	1,892,000	**9,460,000**
Commemorate world health days (world breastfeeding week, nutrition week, hypertension, diabetes and cancer days	3,129,500	3,129,500	3,129,500	3,129,500	3,129,500	**15,647,500**
Sensitize male and female community leaders across different ages and diversities on participation in nutrition activities	420,000	420,000	420,000	420,000	420,000	**2,100,000**
Output 3: Increased human resource for nutrition	135,298,000	135,298,000	135,298,000	135,298,000	135,298,000	**676,490,000**
Recruit more male and female nutritionist and dietitians	134,400,000	134,400,000	134,400,000	134,400,000	134,400,000	**672,000,000**
Conduct orientation meetings of new staff on nutrition service delivery.	898,000	898,000	898,000	898,000	898,000	**4,490,000**
Output 4: Nutrition content for advocacy availed	8,570,000	8,570,000	8,570,000	8,570,000	8,570,000	**42,850,000**
Develop different key message targeting men and women across different ages and diversities for nutrition to be used for advocacy	10000	10000	10000	10000	10000	**50000**
Develop and disseminate age, gender and diversity sensitive Nutrition IEC materials and videos	2,500,000	2,500,000	2,500,000	2,500,000	2,500,000	**12,500,000**
Disseminate key nutrition messages targeting men and women across different ages and diversities through different channels and platforms	6,060,000	6,060,000	6,060,000	6,060,000	6,060,000	**30,300,000**
Output 5: Increased visibility of nutrition in media channels	-	195,000	345,000	345,000	345,000	**1,230,000**
Conduct sensitization meeting for media journalists and editors on priorities for Nandi CNAP to give it visibility	-	45,000	45,000	45,000	45,000	**180,000**
Establish media network for journalist who promote nutrition (breast feeding, work place complimentary feeding)	-	150,000	300,000	300,000	300,000	**1,050,000**
KRA 10. Supply chain management for nutrition commodities and equipment strengthened	12,837,400	67,335,400	66,657,400	66,657,400	66,657,400	**280,145,000**
Output 1: Increased capacity of health care providers to manage commodities for nutrition	-	5,438,000	5,438,000	5,438,000	5,438,000	**21,752,000**
Train HCW on forecasting and quantification of nutrition commodities	-	2,936,000	2,936,000	2,936,000	2,936,000	**11,744,000**
Train HCW on nutrition LMIS (for TB, HIV, IMAM, clinical nutrition, micronutrients)	-	450,000	450,000	450,000	450,000	**1,800,000**
Conduct OJT and mentorship for selected facility staff on forecasting and	-	732,000	732,000	732,000	732,000	**2,928,000**

KEY RESULT AREAS BY INTERVENTIONS BY ACTIVITIES	2018/19	2019/20	2020/21	2021/22	2022/23	Total
quantification for nutrition commodities						
Hold bi-annual nutrition commodity partner stake holder meetings	-	60,000	60,000	60,000	60,000	**240,000**
Hold monthly Nutrition Commodity TWG meetings	-	1,260,000	1,260,000	1,260,000	1,260,000	**5,040,000**
Output 2: Quality of all nutrition commodities and equipment ensured	-	16,920,000	16,242,000	16,242,000	16,242,000	**65,646,000**
Do inventory of all available anthropometric equipment. Repair broken equipment.	0	11200	11200	11200	11200	**44800**
Repair broken equipment.	-	4,483,000	4,144,000	4,144,000	4,144,000	**16,915,000**
Carry out bi-annual preventive maintenance of anthropometric equipment	-	4,483,000	4,144,000	4,144,000	4,144,000	**16,915,000**
Train maintenance personnel on anthropometric/kitchen equipment in collaboration with medical engineering department	-	732,000	732,000	732,000	732,000	**2,928,000**
Renovate/construct sub-county nutrition commodity stores	-	6,000,000	6,000,000	6,000,000	6,000,000	**24,000,000**
Carry out nutrition commodity DQA	-	1,210,800	1,210,800	1,210,800	1,210,800	**4,843,200**
Output 3: Availability of nutrition commodities, equipment, resources and management of supply chain ensured	12,837,400	44,977,400	44,977,400	44,977,400	44,977,400	**192,747,000**
Procure nutrition anthropometric and kitchen equipment	-	11,250,000	11,250,000	11,250,000	11,250,000	**45,000,000**
Procure micronutrient supplements (VAS, IFAS, MNPS)	11,597,400	12,487,400	12,487,400	12,487,400	12,487,400	**61,547,000**
Procure therapeutic and supplementary feeds for IMAAM, TB/HIV	-	20,000,000	20,000,000	20,000,000	20,000,000	**80,000,000**
Procure enteral, parenteral nutrition commodities and kitchen equipment	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	**5,000,000**
Print and distribute monitoring and reporting tools- for nutrition (M&E, micronutrients, clinical, MIYCN etc.)	240,000	240,000	240,000	240,000	240,000	**1,200,000**
KRA 11. Prevention, control and management of Micronutrient Deficiencies Scaled up	40,796,000	40,796,000	40,796,000	40,796,000	40,796,000	**203,980,000**
Output 1: Increased micronutrient intake through dietary diversification	13,413,000	13,413,000	13,413,000	13,413,000	13,413,000	**67,065,000**
Sensitize community on consumption of diverse food groups through the community forums	609,000	609,000	609,000	609,000	609,000	**3,045,000**
Train HCWs on strategies for anaemia prevention	12,804,000	12,804,000	12,804,000	12,804,000	12,804,000	**64,020,000**
Output 2: Increased knowledge of health care workers and CHVs on importance of micronutrient intake	27,383,000	27,383,000	27,383,000	27,383,000	27,383,000	**136,915,000**
Train HCW on MNPs	360,000	360,000	360,000	360,000	360,000	**1,800,000**
Train HCW on nutrition VAS	6,135,000	6,135,000	6,135,000	6,135,000	6,135,000	**30,675,000**
Train HCWs on IFAS	6,135,000	6,135,000	6,135,000	6,135,000	6,135,000	**30,675,000**
Train/sensitize on micro nutrient policies	435,000	435,000	435,000	435,000	435,000	**2,175,000**
Conduct CHVs sensitization meetings on micronutrients	435,000	435,000	435,000	435,000	435,000	**2,175,000**
Sensitize CHVs on micronutrients supplementation for children and pregnant women for demand creation and referral	69,000	69,000	69,000	69,000	69,000	**345,000**
Increased consumer awareness on fortified foods	6,615,000	6,615,000	6,615,000	6,615,000	6,615,000	**33,075,000**
Sensitize the community members (men and women) across different ages and diversities on consumption of fortified foods	5,405,000	5,405,000	5,405,000	5,405,000	5,405,000	**27,025,000**
Train CHVs and PHOs on food fortification.	1,210,000	1,210,000	1,210,000	1,210,000	1,210,000	**6,050,000**
Conduct market level surveillance for fortified foods	174,000	174,000	174,000	174,000	174,000	**870,000**
Carry out household salt sampling and testing for iodized salts in the community	198,000	198,000	198,000	198,000	198,000	**990,000**
Conduct joint supervision and mentorship on micronutrient supplementation at health facilities	212,000	212,000	212,000	212,000	212,000	**1,060,000**
KRA 12: Nutrition in sports strengthened	-	558,000	69,239,000	40,431,000	32,404,500	**141,540,500**
Output 1: Quality data on sports nutrition generated for evidence-based programming	-	-	52,632,000	45,500	-	**52,677,500**
Conduct gender integrated baseline Survey and Situational analysis on Status of Nutrition and health for the athletes	-	-	946,500	45,500	-	**992,000**

Conduct exchange learning visits for policy makers and implementers in Countries with best practices on Sports Nutrition	-	-	51,685,500	-	-	51,685,500
Output 2: Improved access to and use of information on sports nutrition for improved performance and quality programming	**0**	**0**	**1680000**	**28180500**	**28180500**	**58041000**
Develop county specific guidelines, standards and SOPs on Sports nutrition	-	-	-	8,824,500	8,824,500	17,649,000
Develop sports nutrition training package for athlete	-	-	-	8,584,500	8,584,500	17,169,000
Develop IEC materials for micronutrients supplements and nutrition ergogenic aids	-	-	600,000	2,606,000	2,606,000	5,812,000
Train Health Care Workers on Sports Nutrition	-	-	-	4,184,000	4,184,000	8,368,000
Sponsor male and female Health Care Workers to Specialize in Sports nutrition	-	-	1,080,000	1,080,000	1,080,000	3,240,000
Develop sports nutrition advocacy package for athletes	-	-	-	2,901,500	2,901,500	5,803,000
Develop guidelines for optimal post-injury nutrition for athletes	-	-	-	-	-	-
Output 3: Increased performance of athletes and other sportsmen and women	**0**	**558,000**	**12,215,000**	**9,901,000**	**1,920,000**	**25,710,000**
Map and integrate sports nutrition in existing training centres, camps and clubs nutrition component	-	558,000	-	1,116,000	-	2,790,000
Sensitize athletes and Community on Sports Nutrition	-	-	-	**1,920,000**	**1,920,000**	**3,840,000**
Conduct nutritional Screening and Assessment for athletes	-	-	**945,000**	**945,000**	-	**1,890,000**
Hold Nutrition Counselling Sessions to athletes in Training Centres, Camps and Clubs	-	-	**795,000**	**795,000**	-	**1,590,000**
Establish separate Nutrition Counselling and recovery Centre for athletes	-	-	**10,475,000**	**5,125,000**	-	**15,600,000**
Output 4: Advocacy for sports nutrition enhanced	**0**	**0**	**2,712,000**	**2,304,000**	**2,304,000**	**5,112,000**
Advocate for a budget line for sports nutrition to address procurement and distribution of sports nutrition commodities	-	-	1,080,000	1,080,000	1,080,000	1,032,000
Hold high level Sensitization meetings for policy makers on sports nutrition	-	-	1,440,000	1,080,000	1,080,000	3,600,000
Promote collaboration with other health sector interventions to promote sports nutrition (MOALF&I , gender, MOH, Industry, Finance, Gender, Sports) and the private sector.	-	-	192,000	144,000	144,000	480,000
GRAND TOTAL	**364,570,601**	**461,311,101**	**530,662,701**	**492,758,601**	**490,610,101**	**2,335,029,105**

REFERENCES

LIST OF KEY CONTRIBUTORS

NAME	DESIGNATION	ORGANIZATION
1. Ruth Koech	CECM - Health	Nandi County
2. Dr Paul Kiplagat	Chief Officer – Public Health & Sanitation	Nandi County
3. Dr. David Bungei	County Director Health	Nandi County
4. Angeline Korir	County Nutrition Coordinator	Nandi County
5. Emily Tarus	Sub County Nutrition Officer	Nandi County
6. Doreen Toroitich	Sub County Nutrition Officer	Nandi County
7. Sally Meliley	C.H.O	Nandi County
8. Lagat Vincent	Economist	Nandi County
9. Dr Terer Erick	Sub County M.O.H	Nandi County
10. Salome Sang	SCNDO	Nandi County
11. Philip Kogo Kibor	C.H.A.O	Nandi County
12. Dr Andrew Kisang	County Pharmacist	Nandi County
13. Dr Wanyonyi Alfred Wandeba	Sub County M.O.H	Nandi County
14. Alfred Bichiy	County Public Health Officer	Nandi County
15. Irebe Berenge	C.R.H.C	Nandi County
16. Goretty Rotich	C.H.R.H	Nandi County
17. Emily Maswai	Sub County Health Education Officer	Nandi County
18. Ezekiel Kisorio	C.H.R.I.O	Nandi County
19. Laban Talam	D.C.N.O	Nandi County
20. Elvis Kirui	S.H.R.I.O	Nandi County
21. Gladys Jepkemoi	DNM	Ampath
22. Kirorei Kiprotich	County Program Coordinator	Nutrition International
23. Susan Jobando	Nutrition Officer	Unicef
24. Albert Wakoli	Lecturer	Baraton University