COUNTY GOVERNMENT OF VIHIGA

DEPARTMENT OF HEALTH SERVICES

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

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

Table of Contents

TABLE OF CONTENTS		**iv**
LIST OF TABLES		**vi**
LIST OF FIGURES		**vi**
LIST OF ABBREVIATIONS AND ACRONYNMS		**vii**
FOREWORD		**ix**
PREFACE		**x**
ACKNOWLEDGEMENT		**xi**
CHAPTER 1: INTRODUCTION		**12**
1.1	Geographic Location, Population and Demographics	12
1.1.1	Location	12
1.1.2	Population of Vihiga	12
1.2	Nutrition situation	14
1.2.1	Overweight, Obesity and diet related non-communicable diseases (DRNCDs)	14
1.3	Micronutrient deficiencies situation	15
1.3.1	Iron folic supplementation (IFAS)	15
1.3.2	Vitamin A supplementation among children under five years	15
1.4	Infant and young child feeding practices	16
1.5	Mortality and morbidity caused by malnutrition	17
1.6	Agriculture and access to food.	17
1.7	Human resource for nutrition	18
1.7.1	Nutrition specialties training need	18
1.8	Constraints/ challenges	18
1.9	PESTEL analysis in managing risks related to nutrition	19
1.9.1	Political factors	19
1.9.2	Economic factors	19
1.9.3	Social-economic factors	20
1.9.4	Technological factors	20
1.9.5	Legal Factors	21
CHAPTER 2: COUNTY NUTRITION ACTION PLAN (CNAP) FRAMEWORK		**22**
2.1	Introduction	22
2.2	Mission, Vision and Goals for Nutrition in Vihiga County	23
2.2.1	Vision	23
2.2.2	Mission	23
2.3	Policy and Legal Context of the CNAP	23
2.4	Rationale	24
2.5	Objectives of CNAP	24
2.6	Nutrition through the life course approach	25
2.7	Gender mainstreaming	25
2.8	Target audience for CNAP	27

CHAPTER 3: KEY RESULT AREAS (KRAs), STRATEGIES AND INTERVENTIONS **28**
3.1 Introduction 28
3.2 Theory of change and CNAP logic framework 28
3.3 Key result areas, corresponding outcome, outputs, and activities 29

CHAPTER 4: MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL) FRAMEWORK **36**
4.1 Introduction 36
4.2 Purpose of the MEAL Plan 36
4.3 MEAL Team 37
4.4 Logic Model 37
4.5 CNAP Implementation Plan 39
4.6 Roles and responsibilities of different actors in the implementation of CNAP 39
4.7 Calendar of key M&E Activities 40
4.8 Monitoring process 49
4.9 Monitoring Reports 50
4.10 Evaluation of the CNAP 50

CHAPTER 5: CNAP RESOURCE MOBILIZATION AND COSTING FRAMEWORK **53**
5.1 Introduction 53
5.2 Costing Approach 53
5.3 Total Resource Requirements (2018/19–2022/23) 53
5.4 Strategies to ensure available resources are sustained 55

6 APPENDIXES **56**

7 LIST OF KEY CONTRIBUTORS **65**

8 REFERENCES **66**

List of Tables

Table 1.1:	Population Trends per Sub-County 2018-2023	13
Table 1.2:	Population Description Vihiga County 2018-2022	13
Table 1.3:	Morbidity by malnutrition Vihiga County	17
Table 1.4:	Nutrition staff distribution per facility	18
Table 1.5	Nutrition specialties needs	18
Table 3.1:	Prioritized KRAs per Focus Area	28
Table 4.1:	The Logic Model	38
Table 4.2:	Vihiga CNAP common results and accountability framework	41
Table 4.3:	Monitoring Reports	42
Table 4.4:	Common Results and Accountability Framework	44
Table 5.1:	Summary Cost by KRA	54

List of Figures

Figure 1.1:	Population by gender and age	12
Figure 1.2:	Map of Vihiga County	13
Figure 1.3:	Trends in nutrition and health situation in Kenya	14
Figure 1.4:	Overweight, Obesity and Diet Related Non-Communicable Diseases (DRNCDs)	14
Figure 1.5:	Iron Folic Supplementation	15
Figure 1.6:	Vitamin A uptake in Vihiga County	16
Figure 1.7:	Proportion of newborn babies initiated on breastmilk within the first hour after delivery per Sub-County in Vihiga County	16
Figure 2.1:	Conceptual framework for malnutrition	23
Figure 3.1:	The CNAP Logic Process	29
Figure 4.1:	Monitoring Process	41
Figure 5.1:	Proportion of resource requirements by KRA	54

List of Abbreviations and Acronyms

ABC	ACTIVITY BASED COSTING
ANC	ANTENATAL CLINIC
ACSM	ADVOCACY, COMMUNICATION, SOCIAL MOBILIZATION
BFCI	BABY FRIENDLY COMMUNITY INITIATIVE
BFHI	BABY FRIENDLY HOSPITAL INITIATIVE
CDOH	COUNTY DEPARTMENT OF HEALTH.
CECM	COUNTY EXECUTIVE COMMITTEE MEMBER
CHIS	COMMUNITY HEALTH INFORMATION SYSTEM
CHMT	COUNTY HEALTH MANAGEMENT TEAM
CHV	COMMUNITY HEALTH VOLUNTEERS
CHW	COMMUNITY HEALTH WORKERS
CIDP	COUNTY INTEGRATED DEVELOPMENT PLANS
CIP	COMPREHENSIVE IMPLEMENTATION PLAN
CLTS	COMMUNITY LED TOTAL SANITATION
CMAM	COMMUNITY MANAGEMENT AND MALNUTRITION AND MALNUTRITION
CMEs	CONTINUOUS MEDICAL EDUCATION
CNAP	COUNTY NUTRITION ACTION PLAN
CRAF	COMMON RESULT AND ACCOUNTABILITY FRAMEWORK
CSO	CIVIL SOCIETY ORGANIZATION
CU	COMMUNITY UNIT
DHIS	DISTRICT HEALTH INFORMATION SYSTEM
DRNCD	DIET RELATED NON COMMUNICABLE DISEASES
HB	HEMOGLOBIN
HCW	HEALTH CARE WORKERS
HIV/AIDS	HUMAN IMMUNO-DEFICIENCY VIRUS/ ACQUIRED IMMUNE DEFICIENCY SYNDROME
ICN	INTERNATIONAL CONFERENCE ON NUTRITION
IHRIS	INTEGRATED HUMAN RESOURCES INFORMATION SYSTEM
IMAM	INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION
IFAS	IRON/ FOLATE SUPPLEMENTATION
KDHS	KENYA DEMOGRAPHIC AND HEALTH SURVEY
KHP	KENYA HEALTH POLICY
KNAP	KENYA NUTRITION ACTION PLAN
KRA	KEY RESULT AREAS
LBW	LOW BIRTH WEIGHT
LMIS	LOGISTICS MANAGEMENT INFORMATION SYSTEM
M&E	MONITORING AND EVALUATION
MEAL	MONITORING EVALUATION ACCOUNTABILITY AND LEARNING
MIS	MANAGEMENT INFORMATION SYSTEM
MIYCN	MATERNAL INFANT AND YOUNG CHILD NUTRITION
MOH	MINISTRY OF HEALTH

MTP	MID-TERM PLAN
NEMA	NATIONAL ENVIRONMENTAL MANAGEMENT AGENCY
NEMIS	NATIONAL EDUCATION MANAGEMENT INFORMATION SYSTEM
NI	NUTRITION INTERNATIONAL
NCD	NON-COMMUNICABLE DISEASES
NFNSP	NATIONAL FOOD AND NUTRITION SECURITY POLICY.
PESTEL	POLITICAL ECONOMIC SOCIAL TECHNOLOGICAL ECOLOGICAL AND LEGAL
PLW	PREGNANT AND LACTATING WOMEN
RMNCAN	REPRODUCTIVE MATERNAL NEWBORN CHILD ADOLESCENT NUTRITION
RTI	RESPIRATORY TRACT INFECTION
SDGs	SUSTAINABLE DEVELOPMENT GOALS
SOP	STANDARD OPERATING PROCEDURE
SUN	SCALING UP NUTRITION
SWOT	STRENGTH, WEAKNESS, OPPORTUNITY AND THREATS.
TB	TUBERCULOSIS
TSC	TEACHERS SERVICE COMMISSION
TWG	TECHNICAL WORKING GROUP
UHC	UNIVERSAL HEALTH COVERAGE.
UNICEF	UNITED NATIONS CHILDREN'S FUND
VCNAP	VIHIGA COUNTY NUTRITION ACTION PLAN
WASH	WATER, SANITATION AND HYGIENE
WHA	WORLD HEALTH ASSEMBLY
WHO	WORLD HEALTH ORGANIZATION
WRA	WOMEN OF REPRODUCTIVE AGE

FOREWORD

KENYA is a signatory to several nutrition-related global agreements and mechanisms including, the Scaling Up Nutrition (SUN) movement, the World Health Assembly (WHA) 2025 nutrition targets, the Sustainable Development Goals (SDGs), the United Nations (UN) Decade of Action on Nutrition (2016–2025), the second International, Conference on Nutrition (ICN2) Declaration and Plan of Action. The agreements lay down the foundation for addressing the immediate, underlying and basic causes of malnutrition including expanding the political, economic, socio-cultural, human capital, technological and gender equality space for nutrition actions.

The Constitution of Kenya article 43 (1) gives every person the right to the highest attainable standard of health, freedom from hunger and access to adequate food of acceptable quality. Both the county and the national governments are committed to creating an enabling environment for citizens to realize these rights as evidenced in the Vision 2030, Kenya Health Policy (2014–2030) and the National Food and Nutrition Security Policy 2012. Food and nutrition security is characteristic of people's physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences. This translates to how well the citizens (men and women across all ages and diversities) are equitably empowered and provided with an equitable and enabling environment to meaningfully participate and contribute as strong agents of change, in addressing the key long-term drivers of food and nutrition security. To achieve this there is need to understand the unique needs and vulnerabilities of women, men, girls and boys across all diversities in the county. This will help design tailor made nutrition programming while equitably building on their capacities, knowledge, experiences and directing resources where best needed.

The Kenya Health Policy (2014-2030) and the National Food and Nutrition Security Policy (2017-2022) outline some of the key measures the government will put in place for realization of the Vision 2030. This is to be achieved through supporting the provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans. The government commitment to providing a high quality of life to all its citizens was further affirmed by the declaration of His Excellency President Uhuru Kenyatta's Big Four Agenda in 2017 in which universal health coverage (UHC) by the year 2022 is prioritized. In the manifesto of H.E Governor DR. WILBER KHASILWA OTTICHILO, health and food security have been given top priority.

Several legislations covering key aspects of nutrition interventions have been enacted by the National Assembly; for example, in addressing micronutrient deficiencies, salt iodization and mandatory fortification of vegetable fats and oils and packaged wheat and maize flours. Additionally, the Breast Milk Substitutes (Regulation and Control Act) 2012 and Article 71 and 72 of the Health Act 2017 provide for promotion, protection and support of breastfeeding.

The 2014 Kenya Demographic and Health Survey reported the prevalence of stunting, wasting and underweight as 23.5 per cent, 2.6 per cent and 5.9 per cent respectively as compared to 26.4 per cent, 2.6 per cent and 14.8 per cent in 2009 respectively in the former western province.

The main objective of the CNAP is to accelerate and scale up efforts towards the elimination of malnutrition as a problem of public health significance in Kenya by 2030, focusing on specific achievements by 2022/23. The CNAP focuses on three areas of intervention, namely nutrition-specific; nutrition-sensitive; and enabling environment, putting emphasis on the need for strengthening multi-sectoral collaboration in addressing malnutrition. We believe this five-year plan will contribute to achieving the Kenyan Development Agenda.

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PREFACE

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QUALITY health care forms the foundation for a nation's accelerated overall national development agenda. Vision 2030 envisages Kenya as a globally competitive middle-income country by 2030. To realize this dream, the health sector must institutionalize its planning processes in order to operate efficiently, effectively and cohesively. To this effect, the President made a declaration in November 2017 to include the provision of quality and affordable health care as part of the government's 'Big Four' agenda for the 2017–2022 medium-term plan (MTP) period. The Ministry of Health is taking the lead in implementing the President's action plan on Universal Health Coverage and food & nutrition security.

Nutrition is a vital building block in the foundation of human health and development. Nutrition has a direct relationship with child survival, physical and mental growth, learning capacity, adult productivity and overall social and economic development. Unacceptably, high levels of malnutrition remain a public health concern and a hindrance to achieving the country's developmental agenda; with an emerging triple burden of malnutrition, where undernutrition (underweight, stunting and wasting), overweight and obesity and micronutrient deficiencies are on the increase in addition to the burden of Non-Communicable Diseases (KDHS), 2014.

The Vihiga County Nutrition Action Plan (VCNAP) 2018/19–2022/23 is the second action plan, which will build on the success, limitations and opportunities of the previous five years CNAP. It applies a multi-sectoral approach and promotes cross sectoral collaboration. It also addresses the social determinants of malnutrition sustainably with an overall aim of ensuring 'Optimal Nutrition for the people of Vihiga county' by ensuring that the roles and responsibilities of different sectors are clear and each carries out its action in cognizance that addressing the triple burden of malnutrition.

Both the National and County Government drove the process of developing of the VCNAP 2018/19–2022/23, through a sector-wide approach that involved broad-ranging consultations within and across the sector. Critical to note is the engagement of other departments and partners, and the alignment with the KNAP in the development VCNAP. A series of dedicated meetings were held with sub counties, the steering committee and the task force during the entire development process. The process further brought together a broad range of actors that included the government line ministries.

In line with the spirit devolution, VCNAP will provide an umbrella framework and guidance to the department of health, health related sectors, partners and other relevant non-state actors interested in the implementation of nutrition objectives. Additionally, it will provide a critical catalyst for enhancing accountability, multi-sectoral collaboration and coordination, linking the county government with national government, and tracking progress of the VCNAPs results. The VCNAP is aligned to the CIDP (2018/19-2022/23) and the CHSSIP (2018-2028) and the Governor's manifesto to facilitate mainstreaming of nutrition budgeting. Key priorities to be implemented during the five years from 2018/19 to 2022/23 have been identified. It is our expectation that in working together, the overall objectives of the VCNAP will be achieved.

ACKNOWLEDGEMENT

THE Health department takes this opportunity to appreciate everyone who participated in the development of the County Nutrition Action Plan (CNAP) 2018–2022. The CNAP could not have been finalized without the valuable contributions and full commitment of the technical committee members of different working groups drawn from both the government and partner organizations. The support from the Ministry of health, division of Nutrition &Dietetics unit 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 to 2022. The contributions of the following ministries in providing overall leadership and technical inputs to the CNAP are also highly appreciated: This particularly goes to Ministries of but not limited to Health; Education; Water and Sanitation; Gender, Youth, Culture, sports, Social and Children services, Agriculture and Livestock. The contribution of the County Executive Committee Member (CECM), Chief Officers Medical and public health, the county health management teams (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.

Lastly, the County department of health greatly appreciates the technical support from the National government specifically Betty Samburu and the consulting team; Dr.Daniel Mwai, lead consultant (costing, resource mobilization legal and institutional environment), David Njuguna (policy, costing, financial tracking and resource mobilization), Dr. Wangia Elizabeth (M&E and accountability plan) and Clementina Ngina (nutrition expert) for providing the technical support throughout the whole VCNAP development process

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Dr. Bernandus Quido Ahindukha

County Director of Health Services

CHAPTER 1: INTRODUCTION

1.1 Geographic Location, Population and Demographics

1.1.1 Location

Vihiga County is located in the Western region of Kenya, in the Lake Victoria Basin. The County covers a total area of 531.0 Km2. The County is comprised of five sub counties (Emuhaya, Hamisi, Luanda, Sabatia and Vihiga) and 25 wards.

1.1.2 Population of Vihiga

Vihiga County has a population of 590,013 according to the 2019 National Population and Housing census, with a population density of 1,047 persons per square km. The male population accounts for 48.1 % while the female population accounts for 51.9%. The population is projected to grow to 604,777persons by 2023.

At least 50% of the county population constitutes young people aged 15 years and below. Life expectancy at birth (years) is 56 years which is slightly lower than the national average of 58 years.

Figure 1.1: Population by gender and age

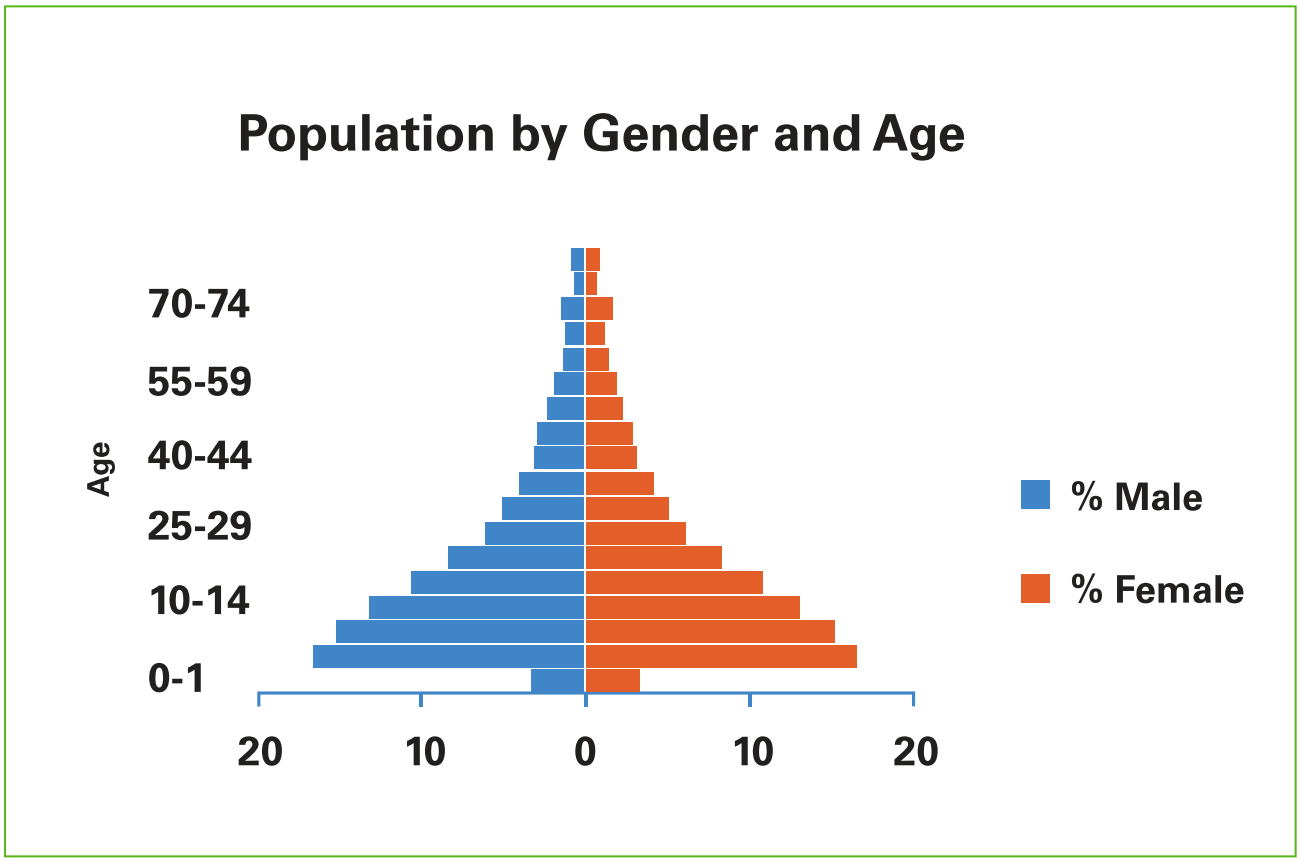


Figure 1.2: Map of Vihiga County

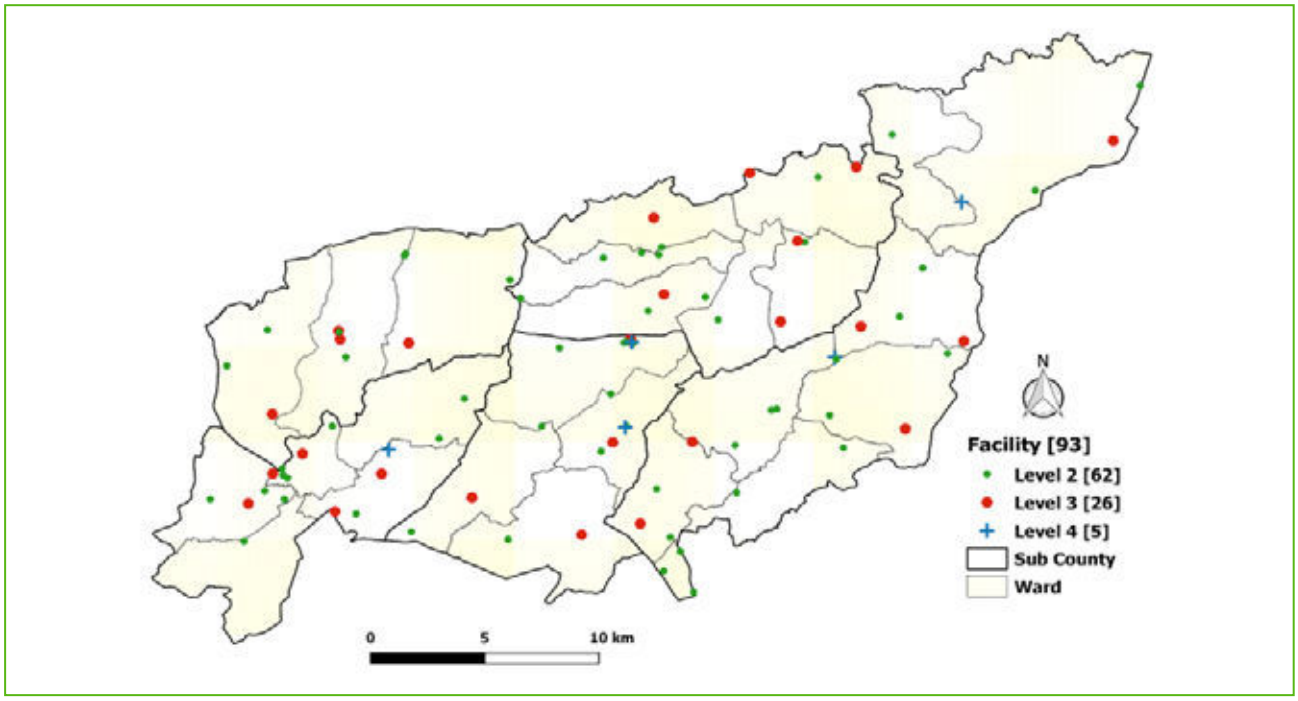


Table 1.1: Population Trends per Sub-County 2018-2023

No.	Sub-County	Population Trends			
		2019	2020	2021	2022
1.	Emuhaya	97,141	98,350	98,961	99,575
2.	Luanda	106,694	108,022	108,692	109,367
3.	Hamisi	159,241	161,223	162,224	163,230
4.	Sabatia	131,628	133,267	134,093	134,926
5.	Vihiga	95,292	96,478	97,077	97,679
Total		590,013	597,341	601,047	604,777

Source: KNBS 2019

Table 1.2: Population Description Vihiga County 2018-2022

No.	Description	Proportions	Estimates				
			2018	2019	2020	2021	2022
1	Total population		**-**	**589,996**	**597,341**	**601,047**	**604,777**
2	Total Number of Households		-	143,902	144,797	145,697	146,603
3	Children under 1 year (12 months)	3.6%	-	21,240	21,504	21,638	21,772
4	Children under 5 years (60 months)	17.5%	-	103,249	104,535	105,183	105,836
5	Under 15 year population	47.1%	-	277,888	281,347	283,093	284,850
6	Women of child bearing age (15 – 49 Years)	22.8%	-	134,519	136,194	137,039	137,889
7	Estimated Number of Pregnant Women	3.6%	-	21,240	21,504	21,638	21,772
8	Estimated Number of Deliveries	3.6%	-	21,240	21,504	21,638	21,772
9	Estimated Live Births	3.6%	-	21,240	21,504	21,638	21,772
10	Total number of Adolescent (15-24)	20.1%	-	118,589	120,065	120,810	121,560
11	Adults (25-59)	27.4%	-	161,659	163,671	164,687	165,709
12	Elderly (60+)	8.4%	-	49,560	50,177	50,488	50,801

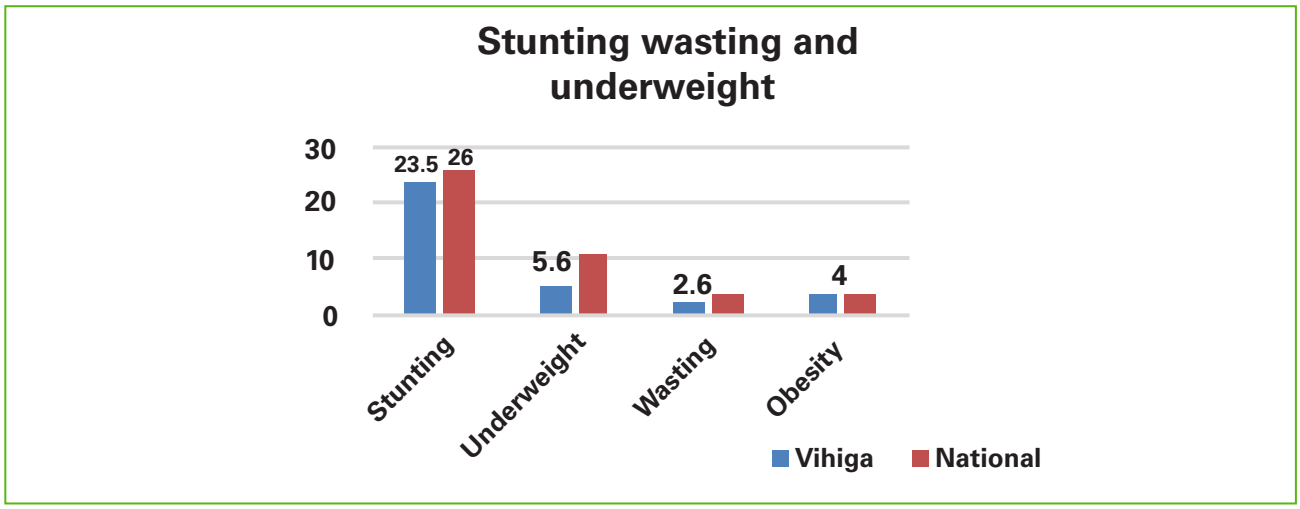
Source: CIDP, 2018 - 2022

1.2 Nutrition situation

Under nutrition and over nutrition in children under-five in Vihiga county

Vihiga has stunting levels of 23.5 percent which are categorized as high according to the WHO and UNICEF new thresholds. A total of 2.6 percent children under-fives are wasted and 4 percent are obese (KDHS 2014). Beyond poor diets and morbidity which are the immediate causes of malnutrition, underlies the socio-cultural, political and economic factors. These include but not limited to family 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.

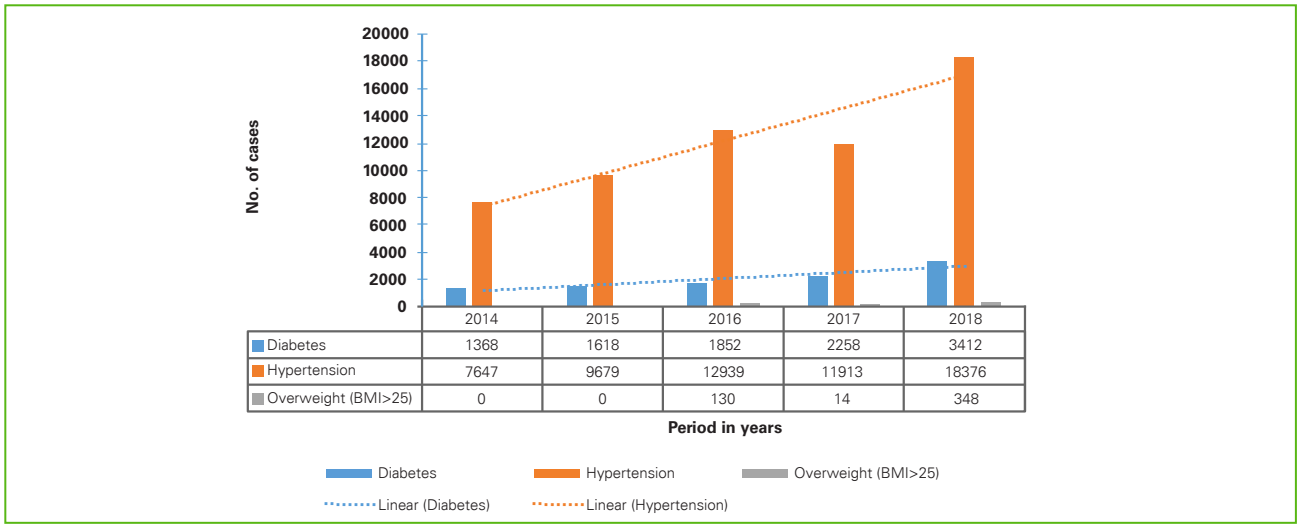
Figure 1.3: Trends in nutrition and health situation in Kenya



Source: CIDP, 2018 - 2022

1.2.1 Overweight, Obesity and diet related non-communicable diseases (DRNCDs)

Figure 1.4: Overweight, Obesity and Diet Related Non-Communicable Diseases (DRNCDs)



Source: CIDP, 2018 - 2022

[1] *DHIS2 2018*

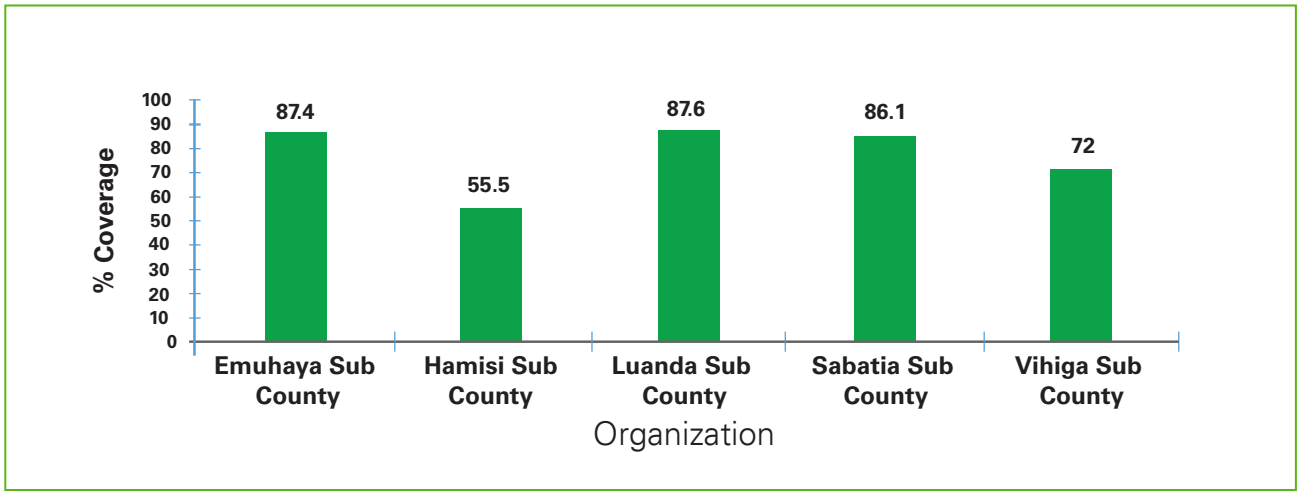
1.3 Micronutrient deficiencies situation

Micronutrient deficiency is a critical challenge affecting mostly the children under five, women of reproductive age and ANC mothers. Among sick children, under five years of age attending health facilities in Vihiga County for treatment, 23.1% were found with severe Anemia with HB levels below 8gm/d[1] . Those above five years attending various health facilities due to illness, 21 percent were found to have a HB below 8gm/dL. In addition to ensuring improved health service provision, it is important to incorporate nutrition sensitive interventions to address the underlying non-medical issues affecting increased uptake of micronutrients by mothers. These 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.

1.3.1 Iron folic supplementation (IFAS)

According to DHIS2 2018, supplementation of mothers attending ANC in Vihiga County with combined Iron and Folic Acid was at 74.5%. The highest coverage was Luanda sub-county at 87.6% as a result of support from Anzilisha project whereas the lowest was Hamisi at 55.5%.

Figure 1.5: Iron Folic Supplementation

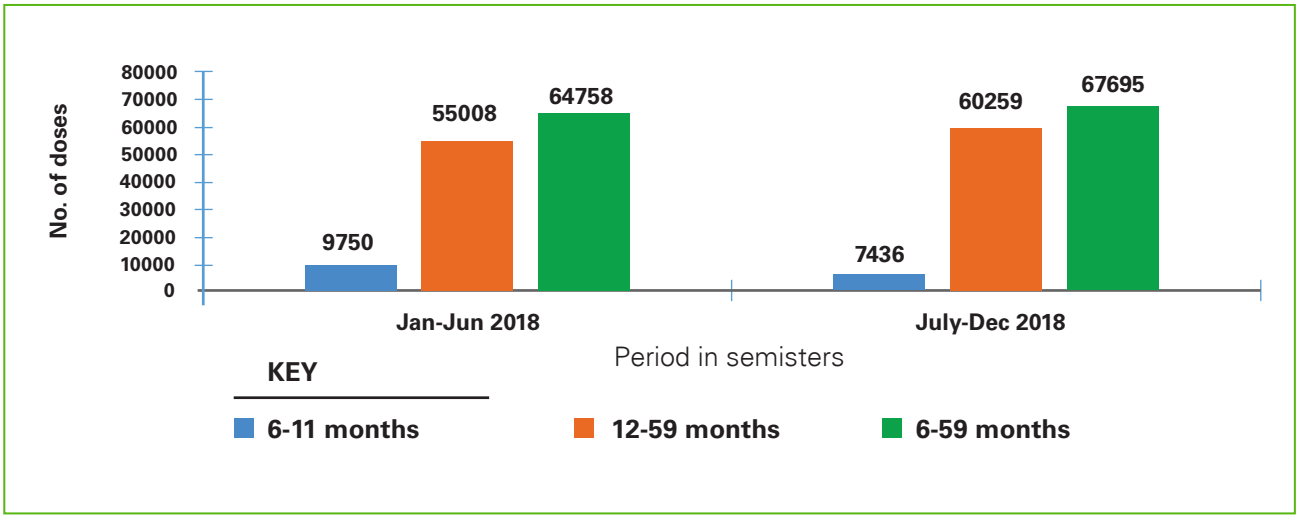


Data source; DHIS2 2018,

1.3.2 Vitamin A supplementation among children under five years

Vitamin A plays an important role in child survival. The government of Kenya recommends vitamin A supplementation for children 6-59 months after every 6 months. Supplementation in semester two was higher than in semester one, for children 12-59 months and overall 6-59 months as shown in the figure below

Figure 1.6: Vitamin A uptake in Vihiga County

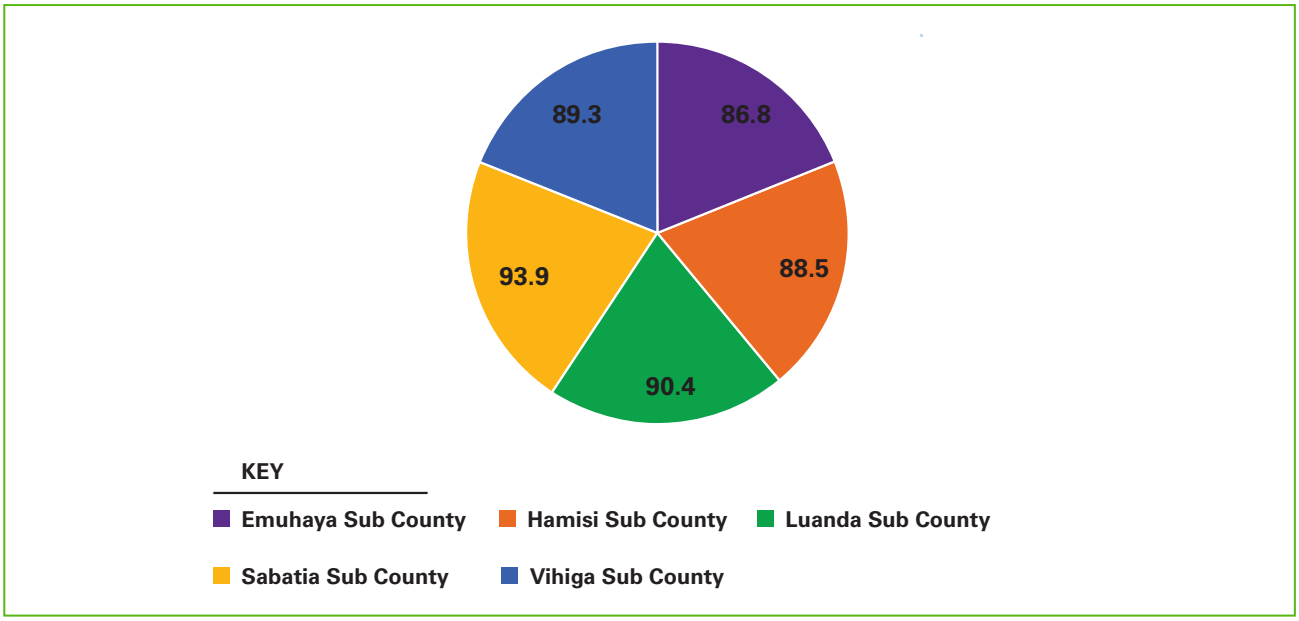


Data source; DHIS2 2018

1.4 Infant and young child feeding practices

The maternal, infant, young child nutrition (MIYCN) policy 2019 states that infants should be put on the mother's breast within 1 hour of delivery. Immediate breast feeding helps in ensuring constant milk flow in preparation for exclusive breast feeding, thermal regulation for the baby by introducing skin to skin contact and aids in prevention of postpartum hemorrhage (PPH).The figure below shows proportion of newborn babies imitated on breastmilk within the first hour after delivery per sub county in Vihiga county

Figure 1.7: Proportion of newborn babies initiated on breastmilk within the first hour after delivery per Sub-County in Vihiga County



Data source; DHIS2 2018

94% of newborns in Sabatia sub-county were breast fed within 1 hour of delivery with Emuhaya sub-county being the least at 86.8%. The overall performance for Vihiga County was 89.7% (DHIS2 2018)

1.5 Mortality and morbidity caused by malnutrition

Malnutrition accounts for more than a half of deaths among under-fives. Malnourished children, particularly those with severe acute malnutrition, have a higher risk of death from common childhood illness such as diarrhoea, pneumonia, and malaria. Non-breastfed infants and children have a 7 fold and 5 fold greater risk of death from diarrhea diseases and RTI respectively. More than half of under-5 child deaths are due to diseases that are preventable and treatable through simple, affordable interventions. Strengthening health systems to provide such interventions to all children will save many young lives. The table below shows morbidity by malnutrition for Vihiga County from 2014 to 2018

Table 1.3: Morbidity by malnutrition Vihiga County

Period (year)	Morbidity due to Malnutrition
2014	489 (0.06%)
2015	807 (0.10%)
2016	840 (0.11%)
2017	264 (0.04%)
2018	421 (0.037%)

Source; DHIS2 2018

1.6 Agriculture and access to food

The average farm size in the county is 0.4 ha for small scale and 3 ha for large scale farming. In terms of land use, 98.7 % of the arable land is under farming, mostly subsistence, while 1.3% is under housing. The main land use types include livestock, crop farming, tree planting fish farming and settlements. Other land use activities include; soil mining for brick making, pot making, house construction, sand harvesting and stone mining.

The proportion of households without land is 3%. Landlessness has been contributed by forceful acquisition of land and increasing population. The arable land is 404.8 Km2 representing 76% of County size. The major cash crops in the county include tea (1,530ha), coffee, bananas (998ha) and horticulture. The main food crops include maize (30,300ha), beans, cassava, sweet potatoes, vegetables, millet and sorghum. Majority of farmers plant at least two crops for food through intercropping.

The area under food and cash crop production in the County is approximately 40,000 ha and 8,000 ha respectively. The continuous planting of eucalyptus trees has not only reduced acreage under food crops but has had a deteriorating effect on the productivity of the land in the region. Existence of cultural norms and beliefs that are discriminative against women and girls forms part of the major detrimental factors to improved food and nutrition in the county. For example, women are considered temporary members in the family and therefore they should not own land or even get much education. In addition, women and girls have limited autonomy and unequal participation in major decision-making processes as strong agents for improved food and nutrition security. In as much as women contribute to close to 80% labor in crop production, they have unequal access to, use and control over benefits from productive assets such as land and livestock, unequal access and inclusion in use of new food production systems and technologies as well as inadequate access to affordable credit and farm inputs. This further complicated by climate change are some of the contributing factors for the low agricultural productivity leading to food and nutrition insecurity in the county.

1.7 Human resource for nutrition

The department has 37 nutrition officers attached to various health facilities across the county. This accounts to only 5% of the required nutritionist in the county as per MOH staffing standard norms. The department appreciates the support from partners in increasing their staff through employment. The nutrition staffs have various trainings specialties including clinical nutrition, community nutrition and human nutrition &dietetics. The department still has a wide staffing gap according to the Human resource for health staffing norms (2014-2018). The two tables below indicate the nutrition staff distribution per facility level as well the existing gaps and the nutrition staff establishment per designation

Table 1.4: Nutrition staff distribution per facility

Facility Level	No. of Facilities	No.of staff required	No. Available	Deficit
Management Units		10	3	7
Level Five	1	36	8	28
Level Four	4	88	8	80
Level Three	16	128	16	112
Level Two	38	114	2	112
Level One	112(Community Unit)	224	0	224
Total		**600**	**37**	**563**

IHRIS, 2019

1.7.1 Nutrition specialties training need

The department recognizes gaps in knowledge and skills in clinical Nutrition, Community Nutrition and Public Health Nutrition. This requires intervention of the county department of health to equip its staff with the necessary updates, skills and training in readiness to meeting patient management objectives and enhanced service delivery.

There is requirement of staff in the following specialties:

- Oncology nutrition
- Pediatric nutrition
- Renal nutrition
- Intensive care unit nutrition
- Surgical nutrition
- Diabetes nutrition

Table 1.5 Nutrition specialties needs

S/NO	AREA OF SPECIALITY	NO AVAILABLE	NO REQUIRED
1	Oncology Nutrition	0	3
2	Pediatric Nutrition	0	10
3	Renal Nutrition	0	3
4	Intensive care unit Nutrition	0	3
5	Surgical Nutrition	0	3
6	Diabetes Nutrition	0	10

Source: IHRIS, 2019

1.8 Constraints/ challenges

Nutrition department aims at offering quality, accessible, responsive and optimum nutrition services to the population of Vihiga County. In spite of some improvements noted since the development of the first CNAP [2014-2018] barriers still exists hindering provision of quality nutrition services within the county and country at large. The poverty level in the County is estimated at 39% [VIHIGA CIDP,

2018-2022] and it's the most populated county with a population density of 1045 per square km and an average population growth rate of 2.54% [KNBS, 2009] annually. This leads to continued land subdivision resulting to limited agricultural productivity hence increased consumption of exotic foods as opposed to the indigenous foods which are nutritious. Global warming and climate change were also identified as a significant indirect challenge affecting quality nutrition of the population.

Access to quality nutrition services remains a challenge due to inadequate human resource for nutrition, knowledge gaps among the nutrition workforce, erratic and inadequate supply of nutrition commodities, supplies and equipment's, Poor referral services in the county especially community to facility as well as poor monitoring and evaluation within the nutrition programs. The prevalence rates of NCDs and HIV/AIDs remains undesirably increasing hence a major challenge and contributor to high mortality rates related to nutrition. Other challenges include weak inter-sectoral linkages, inadequate integration nutrition-gender analysis, inconsistent collection and use of sex-age disaggregated data to inform decision-making.

Other issues that merit focus are design of tailor made nutrition and health interventions responsive to the specific nutrition needs, priorities, challenges while building on the existing capacities, experience and knowledge among men and women of different age and diversities, deeply entrenched gender inequalities, retrogressive cultures and beliefs and delayed disbursement of funds from the national treasury.

1.9 PESTLE analysis in managing risks related to nutrition

The PESTLE analysis helps categorize the broad areas where the risk analysis can take place. This identification of broad areas is useful when developing a mitigation plan. The broad areas are categorized as follows:

Political: National and county political issues which may have an effect on the CNAP, either immediately or in the future.

Economic: GDP growth, financial allocations to nutrition, etc.

Social: The changes in lifestyle and buying trends, media, major events, ethics, advertising and publicity factors.

Technological: Innovations, access to technology, licensing and patents, manufacturing, research funding and communications.

Legal: Legislation, laws and regulations which have been passed or proposed and may come into effect and affect smooth implementation of the CNAP.

Environmental: Environmental issues (e.g., climate change) either locally or globally, and their impact on nutrition.

1.9.1 Political factors

The political factors can influence positively or negatively in the implementation of nutrition interventions in the county. In Vihiga, the county government key documents, County Integrated Development Plans (CIDP), Reproductive Maternal Newborn Child Adolescent Nutrition (RMNCAN), health sector plan among others has nutrition been mentioned and integrated. However, the support has been limited over the years and required targeted advocacy meetings with key political leaders in the county which have been captured in this VCNAP.

1.9.2 Economic factors

Economic factors influences production, access and utilization of health foods leading to poor nutrition status among individuals in the community. Vihiga County has several economic factors that affect the nutrition status of households; the County CIDP (2018-2022) shows that there is both high unemployment and under employment rate posing a challenge in consuming nutritious food. According to Kenya National Bureau of Statistics the current poverty index is placed at 39% compared to the national one of 36.1% hence difficulties in acquiring adequate nutrition. Furthermore, the limited, subdivided land and the declining soil fertility is also a threat to nutrition because

of the reduced agricultural production. The National and County government provision of farm inputs is limited thus failing to reach out to many families. Low health insurance uptake leads to high out of pocket health expenditure and catastrophic medical expenditure which forces household to redirect the funds they would have used on nutritious food. Gender equality and women empowerment is an important and long overdue stimulus to a more inclusive human development and accelerated economic growth. It is against this backdrop that the Action plan integrates nutrition sensitive strategies to address some of the economic barriers, compromising the populations' ability to exploit their capacity for their meaningful participation and contribution to economic growth towards improved food and nutrition security in the county.

1.9.3 Social-economic factors

Social economic factors have a direct impact on nutrition status of the population. Poor Health seeking behavior and consciousness has led to poor nutrition status and further aggravated by retrogressive cultural beliefs and practices. High literacy levels in Vihiga have not translated to improved nutrition status of the population. Inadequate knowledge on food diversity, food selection and food preparation has contributed to the population not meeting Recommended Daily Allowance. The productive age cohorts abuse alcohol and drug substance leading to low Agricultural/food yields and food insecurity as farming is left for the old people. Unequal power dynamics in decision-making coupled with unequal access to, use and control over benefits from productive resources, service and opportunities in the county which is majorly a preserve for men, is a major leading factor to socio-economic vulnerability especially among women and girls. This leads to women and girls being left out in major decision-making including in issues directly affecting them and their inability to fully and meaningfully utilize their potential as strong agents of change in contributing to increased household food and nutrition security.

Additionally, despite having the above-mentioned socio-economic privileges, men are inadequately involved in nutrition related interventions thus the disconnect on their important role and support for increased food and nutrition security within the county.

1.9.4 Technological factors

Advanced technology and communications has greatly influenced nutrition awareness of the community. Mass media has enabled easy and quick sharing of information through radios and television e.g. educative programmes like *shamba* shape up. The communities are growing more connected hence use of mobile phones in disseminating information is the way to go; e-Extension in agriculture being one of the mostly used methods of sharing information through text messages and formation of common interest WhatsApp groups.

Another good example is Boresha Afya ya mtoto na mama MIS, where mothers are educated on the best ways of breast feeding, via SMS.

The Action plan will integrate collaborative strategies with other productive livelihood-based sectors to equitably identify age and gender responsive nutrition sensitive and climate SMART agri-nutrtion technologies through a community based participatory approach. This will further include equitable capacity enhancement and inclusion of men and women across all ages and diversities to access, use and equitable benefit from affordable gender and age responsive technologies.

1.9.5 Environmental factors.

The county requires adequate rain through the year to create a conducive and suitable environment for Agri-nutrition activities hence availing nutritive food substances that are required by the Vihiga people.

The enactment of key laws by the national Government which addresses environmental issues are critical in ensuring that environmental conditions are not polluted by human activities thus affecting good nutrition to the people of Vihiga. The Acts in place include among other; Constitution of Kenya, 2010, Environmental Management and Coordination Act (EMCA), 1999., Environmental (Impact Assessment and Audit) Regulations, 2003, EMCA (Waste Management Regulations), 2006 , Occupational Safety and Health Act, 2007, Public Health Act (Cap 242), Food, drug and substance ACT(Cap

254) and national environmental policy among others.

Lack of public sewer in the major urban centers of the county, public cemetery and weak community led total sanitation activities are serious environmental impediments that affect safe nutrition in the county and need to be addressed.

1.9.6 Legal Factors

There are no specific by-laws for nutrition in the county. The health workforce has limited understanding of the existing Kenya health Acts specifically the ones directly related to nutrition such as the Breastmilk substitute (regulation and control) Act, 2012 and mandatory law on food fortification which had led to lack of monitoring and enforcement by the public health workers. .

Gender equality on the other hand is important for the achievement of effective and sustainable results in efforts to address malnutrition and improved health. Women and girls in Vihiga County are prone to vulnerability due to poverty, rigid social and cultural norms and practices, and some institutional policies and legal frameworks, which are unfavorable to women and girls' empowerment and gender equality. In line with the sustainable development goal 5 of achieving gender equality and empowerment of women and girls.

The government of Kenya is a signatory to several conventions that target elimination of hunger and malnutrition including the Convention of the Rights of the Child, Convention on Elimination of all forms of Discrimination against Women and the Declaration of the Human Rights. At the national level, the government has a gender policy, which was created in 2008, a national food and nutrition security policy, the Constitution of Kenya (2010) which recognizes the rights of every person to be free from hunger and have adequate food of acceptable quality.

CHAPTER 2: COUNTY NUTRITION ACTION PLAN (CNAP) FRAMEWORK

2.1 Introduction.

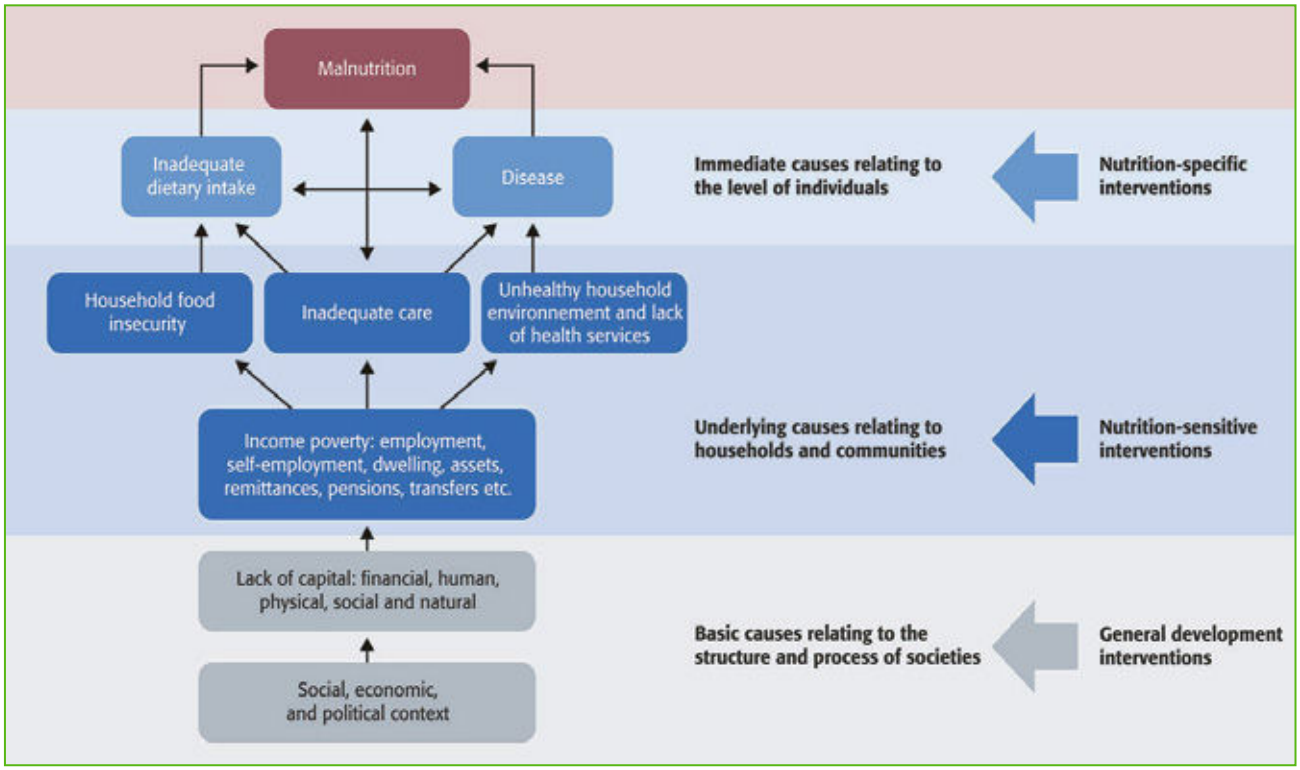
Malnutrition is caused by factors which are broadly categorized as immediate, underlying and basic. Immediate causes of malnutrition include disease and inadequate food intake; this means that disease can affect nutrient intake and absorption, leading to malnutrition, while not taking sufficient quantities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

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

Lastly, the 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, gender equality and 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 Mission, Vision and Goals for Nutrition in Vihiga County

2.2.1 Vision

An efficient high quality nutrition service that is accessible and equitable to all.

2.2.2 Mission

To reduce all forms of malnutrition in Vihiga county using well-coordinated multi-sectoral, health facility and community-centered approaches for optimal health of all the people and the county's economic growth

2.3 Policy and Legal Context of the CNAP

This CNAP is aligned to several relevant policies and legislations and it's guided by several provisions in the constitution of Kenya 2010. It therefore ensures that every nutrition or nutrition related activity in Vihiga County upholds the constitutional rights of all individuals and clients. The CNAP is aligned and guided by the following policies and articles:

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 2017 article 71 & 72.
5. The Food, Drugs and Chemical Substances Act (food labelling, 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;

Some of the specific articles in the constitution that impact directly on nutrition within the constitution are:

- Article 26 (1-4) "every person has a right to life"
- Article 43.a "every person has the right to the highest attainable standard of health care and reproductive health"
- Article 43.c "the Citizens have the right to freedom from hunger and to have adequate food of acceptable quality"
- Article 43e "every person has the right to social security"- Diet is governed and influenced by social cultural norms and it is a critical component of nutrition
- Article 53 (1) "every child has a right to basic nutrition, shelter and health care"
- Article 10 (1) The national values and principles of governance in this Article bind all State organs, State officers, public officers and all person
- Article 20 (1) The Bill of Rights applies to all law and binds all State organs and all persons. 5 (b) in allocating resources, the State shall give priority to ensuring the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals;
- Article 21 (3) All State organs and all public officers have the duty to address the needs of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalized communities, and members of particular ethnic, religious or cultural communities.
- Article 56 (e) The State shall put in place affirmative action programs designed to ensure that minorities and marginalized groups have reasonable access to water, health services and infrastructure.

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

Kenya is a signatory of key global and regional initiatives to address malnutrition in all its forms and is committed to their realization and implementation through sector specific action plans. Key global frameworks include: The six World Health Assembly (WHA) 2025 nutrition targets endorsed by WHO Member States in 2012 for improving Maternal, Infant and Young Child Nutrition (MIYCN) with its Comprehensive Implementation Plan (CIP) and its tracking tools; The Kenya nutrition action plan has adopted all the 6 WHA nutrition targets and the NCD targets. It's envisioned that the implementation happens at the county level contributing to the national and global achievements.

The 2030 global agenda on Sustainable Development Goals (SDGs) adopted in September 2015. Goal 2 is specific on nutrition: End hunger, achieve food security and improve nutrition and promote sustainable agriculture, with target 2.2 calling for ending all forms of malnutrition. This includes achieving the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons by 2025.

Three targets of the 9 Voluntary Global NCD 2025 Targets (with 2010 as baseline year) and Global NCD Action Plan by WHA adopted in 2013 - target 3 on physical activity, 4 on salt/sodium intake and 7 on diabetes and obesity – efforts will continue to be made through health and other strategies and plans to promote progress towards the achievement of all targets. The implementation and tracking progress for all these activities will happen at the county level where implementation takes place

In the light of devolution and the functions ascribed to the two levels of government, the Kenya Nutrition Action Plan (KNAP) 2018–2022 provides an umbrella framework and guidance to counties, to develop their own County Nutrition Action Plans (CNAPs) which should be aligned with the KNAP's strategic framework

2.5 Objectives of CNAP

The objective of the CNAP is to contribute to the national agenda for KNAP in accelerating

and scaling up efforts towards the elimination of malnutrition in Kenya 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 Vihiga county achieve optimal nutrition for a healthier and better quality of life and improved productivity for the county's accelerated social and economic growth. The key strategies that will be adopted in the implementation of CNAP will include;

- Life-course approach to nutrition programming which is a holistic approach to nutrition issues for all population groups
- Gender mainstreaming towards ensuring consistent application of gender transformative approaches across all interventions in all sectors
- Coordination and partnerships targeting sectoral and multisectoral approaches to enhance programming across various levels and sectors,
- Integration which will take into account the various platforms in place to deliver nutrition, e.g., health centers and schools
- 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 thus acknowledging that nutrition improvements require political goodwill for increased investments and raising population-level awareness and support 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.
- Resilience and risk-informed programming that focus on anticipating, planning and reducing disaster risks to effectively protect persons, communities, livelihoods and health
- Monitoring, evaluation, accountability and learning (MEAL) hence promotion of use of the triple A (assessment, analysis & action) cyclic process to provide feedback, learn lessons and adjust strategy as appropriate
- 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.

2.6 Nutrition through the life course approach

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

The development of this CNAP had been through intensive consultation to in order capture nutritional requirements of individuals or groups living in the county. The CNAP 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-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 needed per specific appropriate stages of life to captures and optimized the heterogeneity of nutrition need regardless gender, age and other social economics factor.

2.7 Gender mainstreaming

GGender and nutrition are inextricable parts of the vicious cycle of poverty and it is an

important crosscutting issue. Gender inequality are a cause as well as an effect of malnutrition and hunger. 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 could led 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 , 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 accounting for 13% in the county has a strong nexus to malnutrition both for the vulnerable teenage mothers and for their newborns. The other hand, early and forced marriage leading to increased incidences of teenage pregnancies 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.

In line with the sustainable development goal 5 of achieving gender equality and empowerment of women and girls. The government of Kenya is a signatory to several conventions that target elimination of hunger and malnutrition including the Convention of the Rights of the Child, Convention on Elimination of all forms of Discrimination against Women and the Declaration of the Human Rights. At the national level, the government has a gender policy which was created in 2008, a national food and nutrition security policy, the Constitution of Kenya (2010) which recognizes the rights of every person to be free from hunger and have adequate food of acceptable quality.

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

- The use of the life cycle approach "all residents of Vihiga, throughout their life-cycle enjoy at all times safe food in sufficient quantity and quality to satisfy their nutritional needs for optimal health". Using the life-course approach, the action identifies key nutrition interventions for each age cohort and provides the linkages of nutrition to food production and other relevant sectors that impact on nutrition.
- Ensuring nutrition programming at all levels in Vihiga County is consistently informed by context based gender analysis defining the gender issues and relations relating to the specific nutrition needs and priorities of men and women of different ages and diversities across the county.
- Specific strategies, interventions and activities are prioritized within the CNAPs to address the socio-cultural, economic, technology, political context and barriers to achieving gender equality. This relate to in areas human rights, equal participation of men and women in key decision on nutrition and wellbeing, equal access, use and control over resource development including equal benefits by men and women from

the resources to adequately respond to the specific nutrition and health related needs of women and men across all ages and diversities.

- Strengthening health systems to improve delivery of gender responsive health services by health care workers as well as increased demand and equitable uptake of optimal nutrition and health services and practices, by men and women of all ages and diversities in Vihiga County.
- The CNAP development process has mainstreamed gender in its development process by making sure both females and males are invited and make meaningful participation all the stages of CNAP development, this include active participation in the inception meeting, writing and interventions prioritization meetings including validation, making the process inclusive and participatory with women and men having equal opportunity to in setting Nutrition agenda for Vihiga county.
- The common result and accountability framework for Vihiga CNAP has intentionally included indicator that are meant to monitor and evaluate gender transformative interventions for improved and sustainable nutrition and health related outcomes..
- Accountability for results is enhanced to improve transparency, leadership and the quality of statistics and information made available to the various stakeholders and the public by collecting sex and age disaggregated data at all levels.

2.8 Target audience for CNAP

The target Audience for the CNAP involves organizations that will help in the implementation of the CNAP. Vihiga county nutrition action plan (VCNAP) will cuts across policy makers and decision makers both at national and county governments, donors and implementing partners of both nutrition specific and sensitive interventions, line ministries, county health management team, sub county health management teams, nutrition workforce in health and other departments that influence and provide enabling environment for nutrition to be achieved and the communities at the grassroots level. This will enable them to understand what the county government is doing to ensure optimal nutrition for the entire population and what they can do individually to contribute to the effort.

National and County government will mobilize resources for implementation of the CNAP and will be involved in monitoring and Evaluation to track progress. Research and training institution will mobilize resources to address critical gaps in nutrition research.

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

3.1 Introduction

The overall expected result or desired change for the CNAP is to contribute to the goal of KNAP 2018-2022 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 10 key result areas (KRAs) have been defined for Vihiga County. The KRAs are categorized into three focus areas: (a) Nutrition-specific (b) Nutrition-sensitive and (c) Enabling environment, See, Table 3.1. The KRAs have been matched with corresponding set of expected outcomes and outputs, as well priorities activities per each of the KRA presented in see, section 3.3).

Table 3.1: Prioritized KRAs per Focus Area

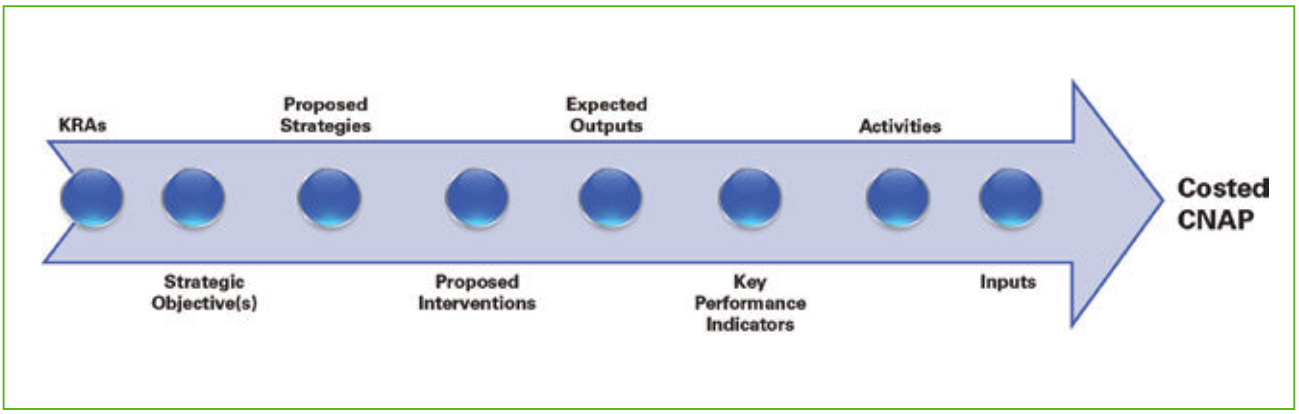
CATEGORY OF KRAs BY FOCUS AREAS	KEY RESULT AREAS (KRAs)
Nutrition specific	1. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up
	2. Nutrition of older children, adolescent, adults and elderly promoted.
	3.Prevention, control and management of Micronutrient Deficiencies Scaled up
	4.Integrated Management of Acute Malnutrition Strengthened
	5.Nutrition in and HIV and Tuberculosis (TB) strengthened
	6.Clinical nutrition and dietetics, prevention, control & management of diet related non-communicable diseases scaled up
Nutrition sensitive	7. Multi-sectoral approach in key nutrition sensitive sectors promoted:-Agriculture, Food Security, social protection, education and water and Sanitation(WASH)
	8. Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership, Management, Information Systems, Learning and Research Strengthened.
Enabling Environment	9: Advocacy, Communication and Social Mobilization (ACSM) strengthened
	10. Supply chain management for nutrition commodities and equipment's 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. The 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 were deployed to implement prioritized activities a set of results would be realized and if at scale, contribute to improved nutritional status of Vihiga residents.

The logic framework outlining the elements and process used to integrate ToC in VCNAP development is captured in 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, corresponding 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 months

Expected output 1

Strengthened capacity for health care providers and CHVs to deliver quality Maternal, Infant, and Young Child Nutrition (MIYCN) services

Activities

i. Train HCWs and CHVs on BFHI and BFCI
ii. Conduct self and external assessment for community BFCI accreditation
iii. Conduct self and external assessment for hospital BFHI accreditation
iv. Train HCWs and CHVs on MIYCN and how to effectively mainstream gender in nutrition programming

Expected output 2

Intensified advocacy, communication & social mobilization (ACSM) activities for improved MIYCN

Activities

i. Conduct community integrated outreaches
ii. Establish community support group is e.g. mother-to-mother, father-to-father support groups to be used as platforms for peer-to-peer support and health education on MIYCN.
iii. Conduct community health and nutrition education and increased male engagement on their role and increased support on MIYCN.
iv. Strengthen the implementation of SBCC strategy on MIYCN.

Conduct community integrated outreaches

Expected output 3

Enhanced support for breastfeeding female employees in both formal and informal sector.

Activities

i. Establish lactation rooms by employers at workplace

KRA 02 Nutrition of older children and adolescent promoted

Expected outcome

Improved nutrition status of older children, adolescents, adults and older persons

Expected output 1

Increased nutrition awareness on healthy diets among older children (5-9 years), adolescents (10-19 years), adults and older persons.

Activities.

i. Hold quarterly TWG meetings with relevant stakeholders on healthy diets diets at county level
ii. Train CHMT, SCHMT, health care workers,

and teachers on healthy diets and lifestyle

iii. Sensitize community members, leaders and other influential members in the community on healthy diets and lifestyle

iv. Advocate for establishment of youth friendly centers.

v. Support the development and implementation of standardized recipes for older children and adolescents in institutions and families.

Expected output 2

Micronutrient intake among older children and adolescents promoted in schools

Activities

i. Conduct inception meeting to disseminate nutrition policies and guidelines to the CHMT, SCHMT, health care workers and teachers in schools

ii. Sensitize teachers on the importance of WIFs

iii. Conduct monitoring of WIFs in schools

iv. Procure IFAS for adolescent girls in schools

v. Procure/order Vitamin A for supplementation at ECD centres

vi. Train HCWs on nutrition LMIS for micronutrient supplementation

KRA 03 Prevention, control and management of micronutrient deficiencies scaled up

Expected outcome

Improved micronutrient status of the population

Expected output 1

Increased intake of micronutrient through dietary diversification for the population

Activities.

i. Conduct health education on dietary diversity to organized community groups (mother to mother support group, farmer groups)

ii. Collaborate with agriculture extension staff to train and promote integrated household gender sensitive and climate SMART agri-nutrition technologies through community support groups.

iii. Sensitize the community support groups (mother to mother, father to fathers, youth and farmers groups) on income generating activities and link them to productive livelihood sectors and financial institutions for support.

iv. Sensitize health care workers and CHVs on dietary diversification

Expected output 2

Increased coverage of micronutrient supplementation

Activities

i. Conduct health talks on micronutrient supplementation at the health facility level

ii. Train/sensitize health care workers and CHVs on micronutrient supplementation (IFAS, VIT A, MNPS, IODINE, ZINC)

iii. Procure and distribute micronutrient supplements (IFAS, VIT A, MNPS, IODINE, ZINC)

iv. Procure/order for Vitamin A

Expected output 3

Increased intake of fortified foods by the populations

Activities

i. Train public health workers on monitoring and surveillance of fortified foods in the market (wheat, maize, fats, oils and salt)

ii. Conduct annual monitoring of salt iodization at household level (2 schools per sub county)

iii. Sensitize HCWs and CHVs on food fortification

KRA 04 Integrated management of acute malnutrition strengthened

Expected outcome

Improved management of acute malnutrition

Expected output

Increased coverage of integrated management of acute malnutrition (IMAM) services.

Activities.

i. Disseminate IMAM guidelines and policies to CHMT, SCHMT and health care workers

ii. Train HCWs on IMAM
iii. Train health care workers on IMAM surge model
iv. Train CHVs on CMAM
v. Conduct CME/OJT/mentorship to health care workers on IMAM
vi. Conduct home visits by CHVs and screen children for malnutrition and refer to health facility for management
vii. Carry out defaulter tracing of malnourished children and refer to health facility
viii. Carry out support supervision for IMAM program
ix. Conduct rapid gender integrative nutrition assessment among children under five and pregnant women in emergency affected/ vulnerable areas.
x. Conduct quarterly data review and data quality audits meeting for IMAM program

KRA 05 Nutrition in Tuberculosis (TB) and HIV strengthened

Expected outcome

Improve nutrition status of TB, HIV and AIDS clients

Expected output

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

Activities.

i. Hold quarterly TWG meetings with relevant stakeholders on nutrition in TB and HIV
ii. Train 400 HCWs on nutrition LMIS for TB and HIV
iii. Construct 56 offices for TB and HIV nutrition assessment counselling and support (NACS) services

KRA 06 Prevention, control and management of diet related non-communicable diseases (DRNCDs) and clinical nutrition scaled up

Expected outcome

Improved access to quality services for diet related non communicable diseases, clinical nutrition and dietetics services

Expected output 1

Prevention, management and control of non-communicable diseases strengthened

Activities.

i. Train health care providers on NCDS
ii. Sensitize HCWs on NCD data tools
iii. Conduct CMEs to health care workers and the community on NCDs
iv. Conduct targeted community outreaches on NCDs
v. Conduct radio shows on NCDs
vi. Conduct periodic gender integrated surveys on nutrition related NCDs
vii. Strengthen the collection, analysis and use of sex, age and diversity disaggregated data detailing the specific needs and priorities of men and women across different age and diversities for improved prevention and management of diet related NCDs and clinical nutrition.

Expected output 2

Scaled-up services and practices related to clinical nutrition and dietetics for disease prevention, control and management

Activities

i. Disseminate clinical nutrition guidelines
ii. Train health care workers on clinical nutrition and dietetics services/nutrition care process
iii. Conduct monthly CMEs at the facility on nutrition in diseases management
iv. Develop individualized SOPs on clinical nutrition and dietetics services for officers in 60 facilities
v. Develop and sensitize health care workers on food service protocol
vi. Train nutrition and dietetics staff on specialized short courses for clinical nutrition
vii. Train nutrition and dietetics staff on specialized post basic training for clinical nutrition (postgraduate)
viii. Train health care workers on nutrition management of preterm and LBW babies

ix. Conduct quality assurance assessments and review meetings for clinical nutrition services
x. Conduct exchange visit to 4 facilities for benchmarking on clinical nutrition and dietetics services

Expected output 3

Health systems for provision of clinical nutrition and dietetics services strengthened through infrastructure improvement

Activity

i. Forecast, quantify and budget for inpatient supplementary and therapeutic diets informed by sex, age disaggregated data based on the specific needs and priorities of men and women across different ages and diversities.
ii. Construct 20 nutrition offices in level 4 facilities
iii. Construct model kitchens 6 facilities within the county

KRA 07 Multi-sectoral approach in key nutrition sensitive sectors promoted:-Agriculture, Food Security, social protection, education, water and sanitation (WASH)

Expected outcome

Improved linkages between nutrition and other nutrition sensitive programmes

Expected output 1

Multisectoral coordination strengthened

Activitie(s)

i. Hold joint county multisectoral coordination forums

Expected output 2

Strengthened linkages between nutrition, agriculture and food security

Activities

i. Hold joint meeting with nutrition and agriculture stakeholders
ii. Conduct training, supervision and monitoring of male and female farmers across different ages and diversities on crop and animal husbandry diversification, value addition and kitchen gardening
iii. Conduct demonstration to male and female farmers across different ages and diversities on value addition techniques
iv. Conduct demonstration to male and female farmers on current gender and age responsive and climate SMART farming technologies
v. Disseminate nutrition messages to facilities and community
vi. Sensitize community on food utilization through community groups and forums

Expected output 3

Nutrition strengthened in education

Activities

i. Conduct screening for malnutrition in schools
ii. Enforce by-laws on school feeding programme
iii. Establish school feeding programme
iv. Sensitize teachers on nutrition for school going children
v. Conduct nutrition and health education in schools.
vi. Conduct joint monitoring and evaluation of school nutrition activities.

Expected output 4

Integration of nutrition into WASH activities scaled up

Activities

i. Train health personnel on WASH
ii. Sensitize and train health care personnel on wash and nutrition
iii. Hold joint meeting with key partners to promote WASH and nutrition activities
iv. Sensitize and train health care personnel on wash, nutrition and the important role of integrating women in decision making around issues pertaining installation of water supplies, hygiene and sanitation in contributing to reduced maternal workload for improved uptake of optimal maternal and child care and feeding practices.
v. Advocate for equal participation of men and women across different ages

and diversities in design, planning and implementation of WASH interventions to ensure they equitably respond to their specific WASH-nutrition related needs and priorities within the community.

vi. Sensitize WASH personnel on the important role of integrating women in decision making around issues pertaining installation of water supplies in contributing to reduced maternal workload for improved uptake of optimal maternal, childcare, and feeding practices.

Expected output 5

Integration of nutrition in social protection programs strengthened

Activities

i. Train stakeholders (SDAs) on nutrition education
ii. Conduct sensitization meetings for Inua Jamii beneficiaries on nutrition education
iii. Carry out joint monitoring and evaluation of nutrition activities under social protection program

KRA 08 Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership, Management strengthened, Information Systems, Learning and Research Strengthened.

Expected outcome

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

Expected output

Sector and multisector governance and co-ordination mechanism for implementation of nutrition programmes strengthened

Activities.

i. Establish nutrition based multisectoral committees
ii. Conduct quarterly meetings to strengthen county stakeholder forum and Nutrition Technical working group (TWG)
iii. Hold annual meetings for nutrition work plan review and development
iv. Develop multi-sectoral and cross sectoral Budgets

Expected output 2

Legal, policy and regulatory frameworks among the nutrition related sectors and partners strengthened

Activities

i. Review existing segmented policies and regulations and
ii. Develop framework for consultative policy formulation and implementation nutrition and dietetics

Expected output 3

Enhanced generation of evidence based data for nutrition programming

Activities

i. Train health care providers on monitoring and evaluation for nutrition programming
ii. Conduct gender integrative nutrition capacity assessment
iii. Strengthen collection, analysis and use of sex-age disaggregated data based to inform nutrition programming responsive to the specific nutrition needs and priorities of men and women across different ages and diversities in Vihiga County.
iv. Conduct joint quarterly support supportive supervision for gender transformative nutrition services.
v. Conduct joint quarterly data Quality audit
vi. Conduct nutrition information system capacity assessment for interoperability
vii. Procure adequate nutrition data management tools
viii. Procure and install nutrition information-based system

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

Expected output 1

Enhanced political commitment and continued

prioritization of nutrition in county agenda

Activities

i). Sensitize county leadership and management on MIYCN

ii). Sensitize the community on MIYCN

iii). Conduct advocacy meetings to agencies, Health care providers, employers, employees and communities for implementation of BMS Act and workplace support legislations

iv). Conduct ACSM activities to promote health diets amongst the older children, adolescent, adult and elderly

v). Conduct advocacy meetings with county leaders and managers on NCDs

vi). Hold quarterly advocacy meetings with county leadership for resource mobilization to implement clinical nutrition and dietetics services

vii). Develop, launch and disseminate the developed CNAP

vii) Enhance capacity and nutrition advocacy through radio talk shows and during multisectoral calendar events such as gender calendar events

ix) Integrate gender equality and increased engangement of women and girls organisations and CBOs to advocate for prioritization of food and nutrition security related support and interventions in the county agenda.

Expected output 2

Enhanced and sustained multisectoral collaboration, social accountability and financial resources allocated across relevant sectors at national and county levels.

Activities

i). Hold advocacy forums to stakeholders on nutrition information system linkage

ii). Hold resource mobilization meetings with potential donors and partners

Expected output 3

Increased and strengthened human capital and capacity for nutrition advocacy

Activity

i). Advocate for Recruitment and training of 58 nutrition staff

Expected output 4

Evidence-based nutrition advocacy and knowledge management promoted

Activities

i). Develop, print, disseminate and distribute gender and age responsive and culturally sensitive IEC materials.

ii). Print IEC materials on NCD prevention and management

Expected output 5

Effective engagements with media built and maintained.

Activities

i). Mark the celebration of WBW, Malezi Bora weeks and world prematurity days.

ii). Integrate gender equality and nutrition advocacy through radio talk shows and during multisectoral calendar events such as gender calendar events.

iii). Conduct radio talks and radio spot

iv). Commemorate world health days

v). Hold radio talks shows to promote nutrition and wash activities

KRA 10 Supply chain management for nutrition commodities and equipment's strengthened

Expected outcome

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

Expected output

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

Activities

i. Forecast, quantify and procure commodities and equipment

ii. Procure fabricated branded containers to store nutrition commodities

iii. Train health care workers on LMIS

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.

In effort to ensure gender integration at all levels of the CNAP, all data collected, analyzed, and reported on will be broken down (disaggregated) by sex and age toprovide 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. 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 mainstream gender in the MEAL plan will include:

- Develop / 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 over time.

4.2 Purpose of the MEALPlan:

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 tonutrition,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 and utilization disaggregated by sex, age and diversity of the target population.
- Service coverage/Outcomes
- Client/Patient outcomes (behavior change, morbidity)
- Clients' equitable Access to and uptake of services
- Quality of healthand nutrition services responsive to the specific needs of men and women across different ages and diversity.
- Impact of interventions responsive to the specific nutrition and health needs of men and women across different ages and diversity.
- Satisfaction of users

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.

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 to M&E for VCNAP

Monitoring and evaluation will follow a logical model looking 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.

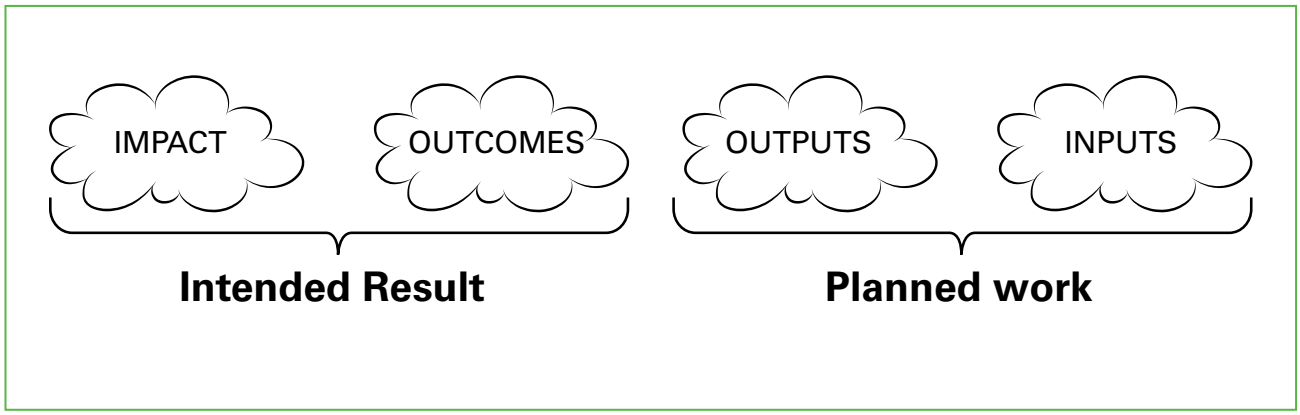


Table 4.1: The Logic Model

<table>
<tr><td rowspan="2">OUTCOMES</td><td>Outcome 1.
Reduction of micro-nutrient deficiencies
• 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%;</td><td>Outcome 2.
Reduction in under-nutrition:
• Reduce prevalence of stunting among children under five years by 40%;
• Reduce and maintain childhood wasting to less than 5%;
• Reduce and maintain childhood underweight to less than 10%;
• Increase dietary diversity by 90%.</td><td>Outcome 3.
Strengthened cross sectoral collaborations
Increased collaboration with all nutrition sensitive sectors</td><td>Outcome 4.
Increased financing for nutrition
Increased domestic financing for nutrition</td><td>Outcome 6.
Halt/ Reverse the rising cases of over-nutrition
<u>Indicators</u>
No increase in childhood overweight/obesity;</td></tr>
<tr><td colspan="2">Output 1.
Better access to food at household level</td><td colspan="2">Output 2.
Improved care for mothers and children and better feeding practices</td><td>Output 3.
Sufficient health services and a healthy environment</td></tr>
<tr><td>OUTPUTS</td><td colspan="4"></td></tr>
<tr><td rowspan="6">INPUTS</td><td colspan="3">1. Organization of service delivery for nutrition;</td><td colspan="2">7. Nutrition research;</td></tr>
<tr><td colspan="3">2. Human Resource for Nutrition;</td><td colspan="2">8. Nutrition leadership;</td></tr>
<tr><td colspan="3">3. Nutrition infrastructure;</td><td colspan="2">9. Household access to better quality and quantity of resources;</td></tr>
<tr><td colspan="3">4. Nutrition products and Technology;</td><td colspan="2">10. Financial, human, physical and social capital;</td></tr>
<tr><td colspan="3">5. Nutrition Information;</td><td colspan="2">11. Socio cultural, economic and political context</td></tr>
<tr><td colspan="5">6. Nutrition Financing;</td></tr>
</table>

4.5 CNAP Implementation Plan

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

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

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

4.6 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 responsive to the needs and priorities of men and women across different ages and diversities in Vihiga County.
- 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 and gender equitable 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 sub county and facility levels

Nutrition Sensitive Sectors

- 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 sex-age disaggregated 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.
- Will utilize reports generated in decision making, advocacy and engaging with other partners for resource mobilization.

Health Facilities

- Ensure that data collected disaggregated by sex and age, 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 equitable access and quality of gender, age and diversity responsive 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)

4.7 Calendar of key M&E Activities

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

Updating of the Framework

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

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

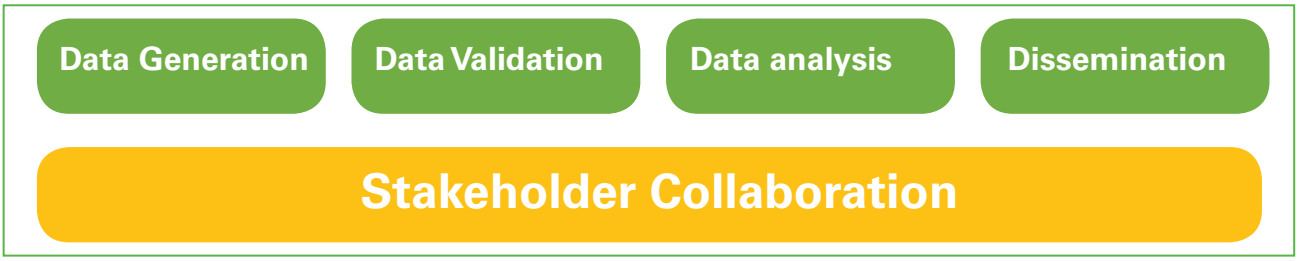
Indicators and Information Sources
The indicators that will guide monitoring of the implementation of CNAP.

4.8 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. All key monitoring process will be achieved through stakeholder collaboration.

The key monitoring processes as outlined Figure 4.1. will involve:

Figure 4.1: Monitoring Process



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 county level will be guided by gender sensitive reporting guidelines and SOPs.
- Data from all reporting entities should reach MOH by agreed timelines for all levels.

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.

Data analysis

- This step ensures transformation of data into information, which can be used for decision making at all, levels. This will be led by the nutrition M&E focal person in collaboration with all stakeholders

Information dissemination

- Information products developed will be routinely disseminated to key sector stakeholders and the public through appropriate channels to ensure equitable access by all as part of the quarterly and annual reviews to get feedback on the progress and plan for corrective measures.

Stakeholder Collaboration

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

4.9 Monitoring Reports

The following are the monitoring reports and their periodicity:

Table 4.3: Monitoring Reports

Process/Report	Frequency	Responsible	Timeline
Annual Work Plans		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

4.10 Evaluation of the CNAP

Evaluation is intended to assess if the results achieved can be attributed to the implementation of CNAP by all stakeholders.
Evaluation ensures both the accountability of various stakeholders and facilitates learning with a view to improving the relevance and performance of the health sector over time.
A midterm review and an end evaluation will be undertaken to determine the extent to which the objectives of this CNAP are met.

Evaluation Criteria

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

Relevance: *The extent to which the objectives of the CNAP correspond to population needs including 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 properly achieved with the appropriate amount of resources and provided explanation if not achieved.*

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

Sustainability: *The continuation of benefits from an outlined intervention after its termination and the commitment of the beneficiaries leverage on those benefits.*
The CNAP will be evaluated through a set on indicators outlined in the Common Results and Accountability Framework in Table 4.4

Common Results and Accountability Framework

Table 4.4: Common Results and Accountability Framework

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 (%)	23.5%	18%	15%	KDHS(2014)	Annually	Nutrition Program
Reduce and maintain childhood wasting to less than 5%	Prevalence of wasting (W/H >2SD) in children 0-59 months (%)	2.6%	2.0%	2.0%	KDHS(2014)	Annually	Nutrition Program
Reduce and maintain childhood underweight to less than 10%	Prevalence of underweight (W/A <2SD) in children 0-59 months	5.9%	4.0 %	3.5%	KDHS(2014)	Annually	Nutrition Program
Increase the rate of exclusive breastfeeding in the first six months by 20% and above							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Strengthened capacity for health care providers and CHVs to deliver quality Maternal, Infant, and Young Child Nutrition (MIYCN) services	Proportion of women attending first ANC registered in boreshaafyaprogramme.	60%	80%	90%	Program Health Information System	Monthly	Nutrition Program
	Proportion of women in the boreshaafyaprogramme attending 4 ANC visits	50%	65%	70%	Program Health Information System	Monthly	Nutrition Program

	Prevalence of exclusive breastfeeding in children 0-6 months (%)	No. Clear Data.(Conduct baseline survey)	50%	80%	GBD/KDHS	Annually	Nutrition Program
	Female Infants <6 Months Exclusive Breastfeeding(EBF)	77%	82%	88%	KHIS	Quarterly	Nutrition Program
	Male Infants <6 Months Exclusive Breastfeeding(EBF)	74.5%	80%	85%	KHIS	Quarterly	Nutrition Program
	Number of BFCI Established.	0	2	4	Nutrition programme report	Annual	Nutrition Program
	Number of BFHI Established.	0	2	4	Nutrition programme report	Annual	Nutrition Program
	Number of health care workers trained on BFCI/BFHI	60	240	300	Program report	Annual	Nutrition Program
Intensified advocacy, communication & social mobilization (ACSM) activities for improved MIYCN	No. of integrated community out reaches conducted	0	12	24	Program report	Annual	Nutrition Program
	Proportion of Under 5yrs attending CWC who are stunted	1.3% KHIS 2018	<1%	<1%	KHIS	Quarterly	Nutrition program
	Proportion of Newborn initiated on breast milk within the first one hour after delivery	89.7%	92%	95%	KHIS	Quarterly	Nutrition Program
Enhanced support for breastfeeding female employees in both formal and informal sector.	No. of lactation rooms established in the major hospitals	0	2	6	Program report	Monthly	Nutrition Program
KEY RESULT AREA 2: Nutrition of older children and adolescent promoted.							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**

Outcome	Indicator	Baseline (2018)	Mid-term Target (2020)	End-Term target (2022)	Data Source	Frequency of data collection	Responsible person
Improved nutrition status of older children, adolescents, adults and older persons	Proportion of adolescents and older children with a normal BMI	65%	70%	75%	STEPs Survey	Every 5 Years	Nutrition Program/ NCD Program
Reduced anemia in adolescent girls by 30%	Prevalence of anemia in girls 15-19 years (%)	55%	60%	74%	KDHS	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 nutrition awareness on healthy diets among older children (5-9 years), adolescents (10-19 years), adults and older persons.	Proportion of population with insufficient physical activity disaggregated by age and gender	6.5% STEPwise survey 2015	5%	3%	STEPwise survey	Every 5 years	Nutrition Program/NCD
	Proportion of schools/institutions sensitized on the standardized recipes for older children and adolescents	0	30%	50%	Program Reports	Annual	Nutrition Program/Department of Education
Micronutrient intake among older children and adolescents promoted in schools	Proportion of adolescent girls in schools receiving WIFs	No Data	70%	80%	Program reports	Annual	Nutrition Program/department of Education
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Reduce folic acid deficiency among non- pregnant women by 50%	Proportion of non-pregnant women with folic acid deficiency (%)	39%	28%	20%	KDHS	Every 5 years	Nutrition Program/ KDHS

Outcome	Indicator	Baseline (2018)	Mid-term Target (2020)	End-Term target (2022)	Data Source	Frequency of data collection	Responsible person
Reduce vitamin A deficiency in children by 50%	Prevalence of VAD in children 0-59 months (%)	9%	6%	4%	KNMS	Every 5 years	Nutrition Program/ KDHS
Reduce iodine deficiency among children <5 years by over 50%	Prevalence of iodine deficiency in children <5 years (%)	22%	15%	<10%	KNMS	Every 5 years	Nutrition Program/ KDHS
Reduce iodine deficiency among non-pregnant women by over 50%	Prevalence of iodine deficiency in non-pregnant women (%)	26%	15%	<10%	KNMS	Every 5 years	Nutrition Program/ KDHS
Reduce prevalence of zinc deficiency in pre-school children by 40%	Prevalence of zinc deficiency in children <5 years (%)	83%	65%	50%	KNMS	Every 5 years	Nutrition Program/ KDHS
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Increased intake of micronutrient through dietary diversification	Minimum Dietary Diversification (MDD) Score				KNBS	Every 5 years	Nutrition program
Increased coverage of micronutrient supplementation	Vitamin A Coverage for Children 6 - 59 Months	136% KHIS 2018	>100%	>100%	KHIS	Quarterly	Nutrition program
	Proportion of children aged 12-59 months dewormed	17.3% KHIS 2018	45%	75%	KHIS	Quarterly	Nutrition program
	Percentage of pregnant women attending ANC who received iron/folate	74.5% KHIS 2018	80%	85%	KHIS	Quarterly	Nutrition Program
	Proportion of children under five with diarrhea treated with zinc & ORS	53.8% KHIS 2018	70%	85%	KHIS	Quarterly	Nutrition Program
Increased intake of fortified foods	No of Public Health Officers Trained on surveillance of fortified foods	No Data	30	50	Program Training Reports	Annual	Nutrition program

Outcome	Indicator	Baseline (2018)	Mid-term Target (2020)	End-Term target (2022)	Data Source	Frequency of data collection	Responsible person
Maintain mortality rates at below 3% for MAM and 10% for SAM	Proportion of deaths among acutely children (%)	0.2% MAM	0.2% MAM	0.2% MAM	KDHS	Every 5 years	Nutrition Program
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Increased coverage of integrated management of acute malnutrition (IMAM) services.	Number of CHVs sensitized on IMAM screening, triage and referral.	No Data	500	750	Program reports	Annual	Nutrition Program/ Department of Agriculture
	No. of HCWs trained on IMAM	No data	300	400	Program reports	Quarterly	Nutrition Program
	Proportion of home visits requiring nutrition referral for facility management	No Data	30%	15%	KHIS	Annual	Nutrition Program
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Improved nutrition of HIV/ TB Patients	Proportion of HIV/TB Patients with normal BMIs	No data	60%	70%	HIV/TB Program data	Quarterly	Nutrition program/ TB/HIV Clinic
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	
Strengthened capacity of health care providers to provide quality nutrition services for HIV and TB clients	No of CCCs offering Nutrition Assessment, Counselling and Support services	No data	30	56	HIV/TB Program data	Quarterly	

KEY RESULT AREA 6: Prevention, control and management of diet related non-communicable diseases (DRNCDs) and clinical nutrition scaled up

Outcome	Indicator	Baseline (2018)	Mid-term Target (2020)	End-Term target (2022)	Data Source	Frequency of data collection	Responsible person
Improved access to quality services for diet related non communicable diseases, clinical nutrition and dietetics services	Prevalence of hospital-based malnutrition	60%	55%	30%	Nutrition Program data	Annual	Nutrition program
	Proportion of malnourished clients provided with Food by prescription	61.4% KHIS 2018	70%	80%	KHIS	Quarterly	Nutrition Program
Reduce mortality due to dietary risk factors by 20%	Mortality attributable to dietary risk factors	41.5/100,000	38%	33%	GBD	Annual	Nutrition Program

Output	Indicator	Baseline (2018)	Mid-term Target (2020)	End-Term target (2022)	Data Source	Frequency of data collection	Responsible person
Prevention, management and control of non-communicable diseases strengthened	Number of health care providers trained nutrition management of NCDs	0	500	1000	Program reports	Annual	Nutrition Program
Scaled-up services and practices related to clinical nutrition and dietetics for disease prevention, control and management	number of HCWS sensitized on clinical nutrition and dietetics	0	160	320	Program reports	Annual	Nutrition Program
	number of hospitals with SOPs in clinical nutrition	0	4	6	Program reports	Annual	Nutrition Program
	Number of health facilities with in patient food service protocols	0	35	70	Program reports	Annual	Nutrition Program
	Number of health care workers trained in specialized nutrition management	0	80	80	Program reports	Annual	Nutrition Program
Health systems for provision of clinical nutrition and dietetics services strengthened through infrastructure improvement	Number of hospitals/health facilities with model kitchens	0	3	6	Nutrition program reports	Annual	Nutrition Program

KEY RESULT AREA 7: Multi-sectoral approach in key nutrition sensitive sectors promoted: -Agriculture, Food Security, social protection, education, water and Sanitation (WASH)							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Improved linkages between nutrition and other nutrition sensitive programmes	No of nutrition sensitive sectors including nutrition in their strategic plans	0	2	5	Departmental reports	Biennially	Nutrition program/ All other nutrition sensitive sectors
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Multisectoral coordination strengthened	Number of joint meetings conducted to plan for nutrition related activities	0	10	20	Program reports	Annually	Nutrition program
Strengthened linkages between nutrition, agriculture and food security	Proportion of h/h with kitchen gardens	0	40%	50%	Program reports	Annual	Nutrition Program/ Department of Agriculture
	No of caregivers sensitized on dietary diversification in areas where the care givers have been identified.	No Data	720	960	Program reports	Annual	Nutrition Program/ Department of Agriculture
	Proportion of farmers producing nutritious foods. (Diversified foods)	No data	40%	70%	Program reports	Annually	Agriculture/Nutrition program

Outcome	Indicator	Baseline (2018)	Mid-term Target (2020)	End-Term target (2022)	Data Source	Frequency of data collection	Responsible person
	Number of farmers sensitized on food diversification	0	300	400	Program reports	Annual	Nutrition program
	proportion of farmers consuming value added food products	No Data	10%	20%	Program reports	Annual	Nutrition program
Nutrition strengthened in education	Proportion of schools implementing feeding programs	15%	45%	75%	Program reports	Annual	Nutrition Program/ Department of Education
	Proportion of ECD children screened for malnutrition	10%	40%	70%	Program reports	Annual	Nutrition Program/ Department of Education
Integration of nutrition into WASH activities scaled up	Number of communityoutreaches conducted to create awareness on water and sanitationactivities	12	25	50	Program reports	Annual	Nutrition Program/ WASH

	Number of trainings conducted on nutrition in WASH	10	20	40	Program reports	Annual	Nutrition Program/ WASH
	Number of Demonstrations conducted on hand washing	25	50	75	Program reports	Annual	Nutrition Program
Integration of nutrition in social protection programs strengthened	proportion of children with good nutrition status among inuajamii beneficiaries	20%	30%	40%	Program reports	Annual	Nutrition Program
	Proportion of community groups trained on nutrition education	20%	30%	40%	Program reports	Annual	Nutrition Program/ Social Protection
KEY RESULT AREA 8: Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership, Management strengthened, Information Systems, Learning and Research Strengthened.							
Outcome	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Efficient and effective nutrition governance, coordination and legal and M &E frameworks in place	No. of nutrition annual work plans developed with public participation	0	2	5	Program reports	Annually	Nutrition Program
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Sector and multisector governance and co-ordination mechanism for implementation of nutrition programmes strengthened	No. of scheduled nutrition TWG meetings held	1	8	16	Program reports	Annual	Nutrition Program

Outcome	Indicator	Baseline (2018)	Mid-term Target (2020)	End-Term target (2022)	Data Source	Frequency of data collection	Responsible person
	No. of high-level advocacy forums held	1	3	5	Program reports	Annual	Nutrition Program
	Nutrition capacity assessments conducted	No	Yes	Yes	Program reports	Annual	Nutrition Program

Outcome	Indicator	Baseline (2018)	Mid-term Target (2020)	End-Term target (2022)	Data Source	Frequency of data collection	Responsible person
Legal, policy and regulatory frameworks among the nutrition related sectors and partners strengthened	No. of existing policies reviewed	0	2	2	Program reports	Annual	Nutrition program
Enhanced generation of evidence-based data for nutrition programming	No. of harmonized multi-sectoral nutrition management information systems installed	0	1	1	Program reports	Annual	Nutrition program
	No. of joint research activities carried out	0	1	2	Program reports	Two-Yearly	Nutrition Program
	No. of nutrition interventions and investments informed by research recommendations and findings	No data	2	2	Program reports	Two-Yearly	Nutrition Program
	No. of quarterly joint data quality audits conducted	4	12	20	Program reports	Two-Yearly	Nutrition Program
	No. of officers trained in multi-sectoral nutrition M&E	0	100	200	Program reports	Two-Yearly	Nutrition Program
KRA 9: Advocacy, Communication and Social Mobilization (ACSM) strengthened							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Enhanced political commitment and continued prioritization of	No. of county leadership (Govenor, CECs, Directors, MCAs) sensitized in nutrition	No data	30	50	Program reports	Annual	Nutrition Program

Outcome	Indicator	Baseline (2018)	Mid-term Target (2020)	End-Term target (2022)	Data Source	Frequency of data collection	Responsible person
nutrition in county agenda							
Enhanced and sustained multisectoral collaboration, social accountability and financial resources allocated across relevant sectors at national and county levels.	No of resource mobilization meetings held with potential donors	No data	4	6	Program reports	Annual	Nutrition Program
Increased and strengthened human capital and capacity for nutrition advocacy	No of newly recruited nutritionists	0	25	58	Human resource data	Annual	Nutrition Program
KRA 10: **Supply chain management for nutrition commodities and equipment's strengthened**							
Output	**Indicator**	**Baseline (2018)**	**Mid-term Target (2020)**	**End-Term target (2022)**	**Data Source**	**Frequency of data collection**	**Responsible person**
Strengthened integrated supply chain management system for nutrition commodities, equipment's and allied tools	Proportion of facilities reporting no stock out of essential nutrition commodities	No data	70%	80%	HHFA	Every 5 years	Nutrition program

CHAPTER 5: CNAP RESOURCE MOBILIZATION AND COSTING FRAMEWORK

5.1 Introduction

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

Costing is a process of determining in monetary terms, the value of inputs that are required to generate a particular output. It involves estimating the quantity of inputs required by an activity/programme. Costing may also be described as a quantitative process, which involves estimating both operational(recurrent) costs and capital costs of a programme. The process ensures that the value of resources required to deliver services are cost effective and affordable.

This is a process that allocates costs of inputs based on each intervention and activity with an aim of achieving set goals /results. It attempts to identify what causes the cost to change (cost drivers). All costs of activities are traced and attached to the intervention or service for which the activities are performed. The chapter describes in detail the level of resource requirements for the strategic plan period, the available resources and the gap between what is anticipated and what is required.

5.2 Costing Approach

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

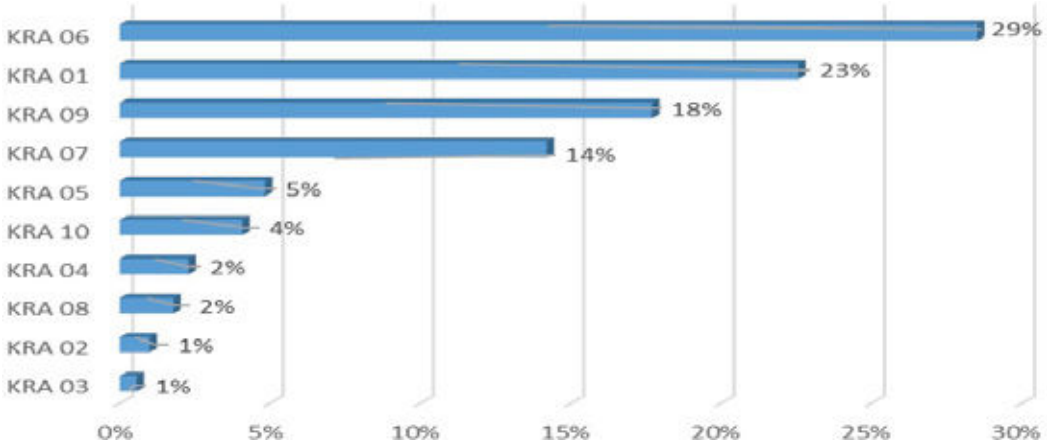
The total resources needed to implement VCNAP based on the targets and unit costs for the is estimated at KSh. 1.6 billion.

Further annual breakdown of cost requirement(s) disaggregated output and activitiesis presented in appendices TableA.

Table 5.1: Summary Cost by KRA

CATEGORY OF KRAs	Key Result Areas ,Outputs and Activities	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Nutrition specific	KRA 01. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up	5,933,000	99,454,790	91,771,510	92,563,360	83,308,790	**373,031,450**
	KRA 02. Nutrition of older children, adolescent, adult and elderly promoted	-	6,770,900	3,967,500	4,200,500	3,108,000	**18,046,900**
	KRA 03. Prevention, control and management of Micronutrient Deficiencies Scaled up	1,553,500	1,903,500	1,903,500	1,903,500	1,903,500	**9,167,500**
	KRA 04. Integrated management of acute malnutrition strengthened	180,000	9,678,000	9,468,000	9,468,000	9,468,000	**38,262,000**
	KRA 05. Nutrition in Tuberculosis (TB) and HIV strengthened	-	37,592,500	37,592,500	1,892,500	1,892,500	**78,970,000**
	KRA 06. Prevention, control and management of diet related non-communicable diseases (DRNCDs) and clinical nutrition scaled up	7,169,850	177,654,725	109,942,225	98,576,225	72,473,975	**465,815,500**
Nutrition sensitive	KRA 07. Multi-sectoral approach in key nutrition sensitive sectors promoted: -Agriculture, Food Security, social protection, education, water and Sanitation (WASH)	40,458,000	48,770,200	47,636,730	47,872,200	47,609,700	**232,346,830**
Enabling Environment	KRA 08. Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership, Management strengthened, Information Systems, Learning and Research Strengthened.	-	6,192,500	15,777,500	4,377,500	2,892,500	**29,240,000**
	KRA 09. Advocacy, communication and social mobilization strengthened	12,390,500	22,042,000	16,968,400	17,149,600	15,580,000	**84,597,500**
	KRA 10. Supply chain management for nutrition commodities and equipment's strengthened	53,939,565	69,710,565	61,049,165	65,849,165	60,849,165	**311,397,625**
	TOTAL	**121,624,415**	**479,769,680**	**396,077,030**	**343,852,550**	**299,086,130**	**1,640,875,305**

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 06. Prevention, control and management of diet related non-communicable diseases (DRNCDs) and clinical nutrition scaled up; KRA 01. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up and KRA 09. Supply chain management for nutrition commodities and equipment's strengthened, account for the highest proportion of total resources need accounting for 29 %, 23% and 18% respectively, while KRA 03. Prevention, control and management of Micronutrient Deficiencies Scaled up account for the least at 0.7% of the total resource requirement (See, figure 5.1).

5.4 Strategies to ensure available resources are sustained

Strategies to mobilize resources from new sources

- Lobbying for a legislative framework in the county assembly for resource mobilization and allocation
- Identification of potential donors both bilateral and multi-lateral
- Conducting stakeholder mapping
- Call the partners to a resource mobilization meeting
- Identification, appointment and accreditation of eminent persons in the community as resource mobilization good will ambassadors

Strategies to ensure efficiency in resource utilization

- Through planning for utilization of the allocated resources (SWOT analysis)
- Implementation plans with timelines
- Continuous monitoring of impact process indicators
- Periodic evaluation objectives if they have been achieved as planned.

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6 APPENDIXES

Annex A: Summary table resources needs KRA, Outputs and Activities

Key Result Areas, Outputs and Activities	2018/19	2019/20	2020/21	2021/22	2022/23	Total
KRA 01. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up	5,933,000	99,454,790	91,771,510	92,563,360	83,308,790	373,031,450
Output 1: Strengthened capacity for health care providers and CHVs to deliver quality MIYCN services	3,000	70,944,790	63,261,510	64,053,360	54,798,790	253,061,450
Train HCWs and CHVs on BFHI and BFCI	-	34,295,000	20,621,450	21,413,300	15,078,500	91,408,250
Conduct self and external assessment for community BFCI accreditation	3,000	32,050,000	37,187,750	37,187,750	35,120,500	141,549,000
Conduct self and external assessment for hospital BFHI accreditation	-	1,705,040	2,557,560	2,557,560	1,705,040	8,525,200
Train HCWs and CHVs on MIYCN and how to effectively mainstream gender in nutrition programming	-	2,894,750	2,894,750	2,894,750	2,894,750	11,579,000
Output 2: Intensified advocacy, communication & social mobilization (ACSM) activities for improved MIYCN	620,000	23,200,000	23,200,000	23,200,000	23,200,000	93,420,000
Conduct community integrated outreaches	-	22,230,000	22,230,000	22,230,000	22,230,000	88,920,000
Establish community support group is e.g. mother-to-mother, father-to-father support groups to be used as platforms for peer-to-peer support and health education on MIYCN.	180,000	180,000	180,000	180,000	180,000	900,000
Conduct community sensitization on their health and nutrition education and increased male engagement on their role and increased support on MIYCN.	-	350,000	350,000	350,000	350,000	1,400,000
Conduct sensitization among men and male youths on their important role and increased engagement and support on MIYCN.	440,000	440,000	440,000	440,000	440,000	2,200,000
Output 3: Enhanced support for breastfeeding female employees in both formal and informal sector.	5,310,000	5,310,000	5,310,000	5,310,000	5,310,000	26,550,000
Establish lactation rooms by employers at workplace	5,310,000	5,310,000	5,310,000	5,310,000	5,310,000	26,550,000
KRA 02. Nutrition of older children, adolescent, adult and elderly promoted	-	6,770,900	3,967,500	4,200,500	3,108,000	18,046,900
Output 1: Increased nutrition awareness on healthy diets among older children (5-9 years), adolescents (10-19 years), adults and older persons.	-	2,683,500	2,508,000	2,508,000	2,508,000	10,207,500
Train CHMT, SCHMT, health care workers, and teachers on healthy diets and lifestyle	-	2,683,500	2,508,000	2,508,000	2,508,000	10,207,500
Output 2: Micronutrient intake among older children and adolescents promoted in schools	-	4,087,400	1,459,500	1,692,500	600,000	7,839,400
Conduct inception meeting to disseminate nutrition policies and guidelines to the CHMT, SCHMT, health care workers and teachers in schools	-	2,979,900	-	-	-	2,979,900
Sensitize teachers on the importance of WIFs to adolescent girls	-	15,000	859,500	-	-	874,500
Conduct monitoring of WIFs in schools	-	-	600,000	600,000	600,000	1,800,000

Key Result Areas, Outputs and Activities	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Procure/order Vitamin A for supplementation at ECD centers	-	-			Cost included in KRA 9	-
Train HCWs on nutrition LMIS for micronutrient supplementation	-	1,092,500	-	1,092,500	-	2,185,000
KRA 03. Prevention, control and management of Micronutrient Deficiencies Scaled up	1,553,500	1,903,500	1,903,500	1,903,500	1,903,500	9,167,500
Output 1: Increased intake of micronutrient through dietary diversification for the population	-	350,000	350,000	350,000	350,000	1,400,000
Sensitize health care workers and CHVs on dietary diversification	-	350,000	350,000	350,000	350,000	1,400,000
Output 2: Increased coverage of micronutrient supplementation	888,500	888,500	888,500	888,500	888,500	4,442,500
Carry out health talks on micronutrient supplementation at the health facility level	1,000	1,000	1,000	1,000	1,000	5,000
Train/sensitize health care workers and CHVs on micronutrient supplementation (IFAS, VIT A, MNPS, IODINE, ZINC)	880,000	880,000	880,000	880,000	880,000	4,400,000
Distribute micronutrient supplements (IFAS, VIT A, MNPS, IODINE, ZINC)	7,500	7,500	7,500	7,500	7,500	37,500
Procure/order for Vitamin A	-			Cost included in KRA 9	-	-
Output 3: Increased intake of fortified foods by the populations	665,000	665,000	665,000	665,000	665,000	3,325,000
Train public health workers on monitoring and surveillance of fortified foods in the market (wheat, maize, fats, oils and salt)	125,000	125,000	125,000	125,000	125,000	625,000
Conduct annual monitoring of salt iodization at household level (2 schools per sub county)	100,000	100,000	100,000	100,000	100,000	500,000
Sensitize HCWs and CHVs on food fortification	440,000	440,000	440,000	440,000	440,000	2,200,000
KRA 04. Integrated management of acute malnutrition strengthened	180,000	9,678,000	9,468,000	9,468,000	9,468,000	38,262,000
Output: Increased coverage of integrated management of acute malnutrition (IMAM) services.	180,000	9,678,000	9,468,000	9,468,000	9,468,000	38,262,000
Disseminate IMAM guidelines and policies to CHMT, SCHMT and health care workers	-	210,000	-	-	-	210,000
Train HCWs on IMAM	-	2,970,000	2,970,000	2,970,000	2,970,000	11,880,000
Train health care workers on IMAM surge model	-	990,000	990,000	990,000	990,000	3,960,000
Train CHVs on CMAM	-	864,000	864,000	864,000	864,000	3,456,000
Conduct CME/OJT/mentorship to health care workers on IMAM	-	506,000	506,000	506,000	506,000	2,024,000
Carry out defaulter tracing of malnourished children and refer to health facility	-	750,000	750,000	750,000	750,000	3,000,000
Conduct rapid gender integrative nutrition assessment among children under five and pregnant women in emergency affected or vulnerable areas.	180,000	180,000	180,000	180,000	180,000	900,000
Carry out support supervision for IMAM program	-	2,208,000	2,208,000	2,208,000	2,208,000	8,832,000
Conduct quarterly data review and data quality audits meeting for IMAM program	-	1,000,000	1,000,000	1,000,000	1,000,000	4,000,000
KRA 05. Nutrition in Tuberculosis (TB) and HIV strengthened	-	37,592,500	37,592,500	1,892,500	1,892,500	78,970,000
Output: Strengthened capacity of health care providers to provide quality nutrition services for HIV and TB clients	-	37,592,500	37,592,500	1,892,500	1,892,500	78,970,000
Train 400 HCWs on nutrition LMIS for TB and HIV	-	1,892,500	1,892,500	1,892,500	1,892,500	7,570,000
Construct 56 offices for TB and HIV nutrition assessment counselling and support (NACS) services	-	35,700,000	35,700,000	-	-	71,400,000
KRA 06. Prevention, control and management of diet related non-communicable diseases (DRNCDs) and clinical nutrition scaled up	7,169,850	177,654,725	109,942,225	98,576,225	72,473,975	465,815,500
Output 1: Prevention, management and control of non- communicable	1,579,850	10,259,725	8,259,725	10,259,725	7,313,475	37,672,500

Key Result Areas, Outputs and Activities	2018/19	2019/20	2020/21	2021/22	2022/23	Total
diseases strengthened						
Train health care providers on NCDS	-	1,892,500	1,892,500	1,892,500	1,892,500	7,570,000
Sensitize HCWs on NCD data tools	946,250	2,365,625	2,365,625	2,365,625	1,419,375	9,462,500
Conduct CMEs to health care workers and the community on NCDs	-	996,000	996,000	996,000	996,000	3,984,000
Conduct targeted community outreaches on NCDs	-	2,260,000	2,260,000	2,260,000	2,260,000	9,040,000
Conduct radio shows on NCDs	-	32,000	32,000	32,000	32,000	128,000
Conduct periodic surveys on nutrition related NCDs	-	2,080,000	80,000	2,080,000	80,000	4,320,000
Conduct operational research on nutrition related risk factors	633,600	633,600	633,600	633,600	633,600	3,168,000
Output 2: Scaled-up services and practices related to clinical nutrition and dietetics for disease prevention, control and management	180,000	42,217,000	37,464,500	30,154,500	27,318,500	137,333,000
Disseminate clinical nutrition guidelines	-	309,000	-	-	-	309,000
Train health care workers on clinical nutrition and dietetics services/nutrition care process	-	4,104,000	4,104,000	4,104,000	1,368,000	13,680,000
Conduct monthly CMEs at the facility on nutrition in diseases management	180,000	180,000	180,000	180,000	180,000	900,000
Develop individualized SOPs on clinical nutrition and dietetics services for officers in 60 facilities	-	344,000	-	-	-	344,000
Develop and sensitize health care workers on food service protocol	-	3,575,000	3,575,500	3,575,500	3,575,500	14,300,000
Train nutrition and dietetics staff on specialized short courses for clinical nutrition	-	3,510,000	3,510,000	2,340,000	2,340,000	11,700,000
Train nutrition and dietetics staff on specialized post basic training for clinical nutrition (postgraduate)	-	18,720,000	18,720,000	12,480,000	12,480,000	62,400,000
Train health care workers on nutrition management of preterm and LBW babies	-	7,375,000	7,375,000	7,375,000	7,375,000	29,500,000
Conduct quality assurance assessments and review meetings for clinical nutrition and dietetics services	-	100,000	-	100,000	-	200,000
Conduct exchange visit to 4 facilities for benchmarking on clinical nutrition and dietetics services	-	4,000,000	-	-	-	4,000,000
Expected output 3: Health systems for provision of clinical nutrition and dietetics services strengthened through infrastructure improvement	5,410,000	125,178,000	64,218,000	58,162,000	37,842,000	290,810,000
Forecast, quantify and budget for inpatient supplementary and therapeutic diets	5,410,000	5,410,000	5,410,000	5,410,000	5,410,000	27,050,000
Construction of 20 nutrition offices in level 4 facilities	-	101,600,000	40,640,000	40,640,000	20,320,000	203,200,000
Construct model kitchens in 6 facilities within the county	-	18,168,000	18,168,000	12,112,000	12,112,000	60,560,000
KRA 07. Multi-sectoral approach in key nutrition sensitive sectors promoted: -Agriculture, Food Security, social protection, education, water and Sanitation (WASH)	40,458,000	48,770,200	47,636,730	47,872,200	47,609,700	232,346,830
Output 1: Multisectoral coordination strengthened	-	175,000	-	175,000	-	350,000
Hold joint county multisectoral coordination forums	-	175,000	-	175,000	-	350,000
Output 2: Strengthened linkages between nutrition, agriculture and food security	-	5,883,000	5,638,000	5,638,000	5,638,000	22,797,000
Hold joint meeting with nutrition and agriculture stakeholders	-	245,000	-	-	-	245,000
Conduct training, supervision and monitoring of farmers on crop diversification, value addition and kitchen gardening	-	4,195,000	4,195,000	4,195,000	4,195,000	16,780,000

Key Result Areas, Outputs and Activities	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Conduct demonstration to farmers on value addition techniques	-	600,000	600,000	600,000	600,000	2,400,000
Conduct demonstration to farmers on current farming technologies	-	600,000	600,000	600,000	600,000	2,400,000
Disseminate nutrition messages to facilities and community	-	243,000	243,000	243,000	243,000	972,000
Output 3: Nutrition strengthened in education	40,258,000	40,408,000	39,876,000	39,876,000	39,876,000	200,294,000
Conduct screening for malnutrition in schools.	280,500	280,500	280,500	280,500	280,500	1,402,500
Enforce by-laws on school feeding programme	25,000	25,000	25,000	25,000	25,000	125,000
Establish school feeding programme	39,802,500	39,802,500	39,270,500	39,270,500	39,270,500	197,416,500
Sensitize teachers on nutrition for school going children	50,000	100,000	100,000	100,000	100,000	450,000
Conduct joint monitoring and evaluation of school nutrition activities.	100,000	200,000	200,000	200,000	200,000	900,000
Output 4: Integration of nutrition into WASH activities scaled up	-	1,718,700	1,722,730	1,695,700	1,695,700	6,832,830
Train health personnel on WASH	-	1,125,500	1,125,500	1,125,500	1,125,500	4,502,000
Sensitize and train health care personnel on wash , nutrition and the important role of integrating women in decision making around issues pertaining installation of water supplies, hygiene and sanitation in contributing to reduced maternal workload for improved uptake of optimal maternal and child care and feeding practices	-	488,200	515,230	488,200	488,200	1,979,830
Hold joint meeting with key partners to promote WASH and nutrition activities	-	47,000	47,000	47,000	47,000	188,000
Advocate for equal participation of men and women across different ages and diversities in design, planning and implementation of WASH interventions to ensure they equitably respond to their specific WASH-nutrition related needs and priorities within the community	-	58,000	35,000	35,000	35,000	163,000
Output 5: Integration of nutrition in social protection programs strengthened	200,000	585,500	400,000	487,500	400,000	2,073,000
Train stakeholders (SDAs) on nutrition education	-	98,000	-	-	-	98,000
Conduct sensitization meetings for Inua Jamii beneficiaries on nutrition education	-	87,500	-	87,500	-	175,000
Carry out joint monitoring and evaluation of nutrition activities under social protection program	200,000	400,000	400,000	400,000	400,000	1,800,000
KRA 08. Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership, Management strengthened, Information Systems, Learning and Research Strengthened.	-	6,192,500	15,777,500	4,377,500	2,892,500	29,240,000
Output 1: Sector and multisector governance and co- ordination mechanism for implementation of nutrition programmes strengthened	-	1,320,000	8,820,000	1,320,000	1,320,000	12,780,000
Establish nutrition based multisectoral committees	-	-	7,500,000	-	-	7,500,000
Conduct quarterly meetings to strengthen county stakeholder forum and nutrition technical working group (TWG)	-	378,000	378,000	378,000	378,000	1,512,000
Hold annual meetings for nutrition work plan review and development	-	552,500	552,500	552,500	552,500	2,210,000
Develop multi-sectoral and cross sectoral Budgets	-	389,500	389,500	389,500	389,500	1,558,000

Key Result Areas, Outputs and Activities	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Output 2: Legal, policy and regulatory frameworks among the nutrition related sectors and partners strengthened	-	272,500	157,500	257,500	272,500	960,000
Develop framework for consultative policy formulation and implementation of nutrition and dietetics	-	157,500	157,500	197,500	157,500	670,000
Review and harmonize existing segmented policies and regulations for nutrition within and across sectors	-	115,000	-	60,000	115,000	290,000
Output 3: Enhanced generation of evidence based data for nutrition programming	-	4,600,000	6,800,000	2,800,000	1,300,000	15,500,000
Train health care providers on monitoring and evaluation for nutrition programming	-	530,000	530,000	530,000	530,000	2,120,000
Conduct nutrition capacity assessment	-	1,800,000	-	-	-	1,800,000
Conduct joint quarterly support supportive supervision for nutrition services	-	270,000	270,000	270,000	270,000	1,080,000
Conduct joint quarterly data quality audit	-	137,500	137,500	137,500	137,500	550,000
Conduct nutrition information system capacity assessment for interoperability	-	-	1,500,000	-	-	1,500,000
Procure adequate nutrition data management tools	-	1,862,500	362,500	1,862,500	362,500	4,450,000
Procure and install nutrition information-based system	-	-	4,000,000	-	-	4,000,000
KRA 09. Advocacy, communication and social mobilization strengthened	12,390,500	22,042,000	16,968,400	17,149,600	15,580,000	84,597,500
Output 1: Enhanced political commitment and continued prioritization of nutrition in county agenda	5,786,000	11,297,500	6,223,900	6,405,100	4,955,500	35,135,000
Sensitize county leadership and management on MIYCN	2,603,000	2,603,000	2,603,000	2,603,000	2,603,000	13,015,000
Sensitize the community on MIYCN	-	7,153,000	2,079,400	2,260,600	811,000	12,304,000
Conduct advocacy meetings to agencies, Health care providers, employers, employees and communities for implementation of BMS Act and workplace support legislations	467,000	467,000	467,000	467,000	467,000	2,335,000
Conduct ACSM activities to promote health diets amongst the older children, adolescent, adult and elderly	-	302,500	302,500	302,500	302,500	1,210,000
Conduct advocacy meetings with county leaders and managers on NCDs	-	149,000	149,000	149,000	149,000	596,000
Hold quarterly advocacy meetings with county leadership for resource mobilization to implement clinical nutrition and dietetics services	-	156,000	156,000	156,000	156,000	624,000
Conduct capacity building and engagement of women's and girls' organizations and CBOs to advocate for prioritization of increased human resource and budget allocation to food and nutrition security related support and interventions in the county agenda.		467,000	467,000	467,000	467,000	2,335,000
Develop, launch and disseminate the developed CNAP	2,716,000	-	-	-	-	2,716,000
Output 2: Enhanced and sustained multisectoral collaboration, social accountability and financial resources allocated across relevant sectors at national and county levels.	-	210,000	210,000	210,000	210,000	840,000
Hold advocacy forums to stakeholders on nutrition information system linkage	-	105,000	105,000	105,000	105,000	420,000
Hold resource mobilization meetings with potential donors and partners	-	105,000	105,000	105,000	105,000	420,000
Output 3: Increased and strengthened human capital and capacity for nutrition advocacy	-	2,124,000	2,124,000	2,124,000	2,124,000	8,496,000
Advocate for Recruitment of 58 nutrition staff	-	2,124,000	2,124,000	2,124,000	2,124,000	8,496,000
Output 4: Evidence-based nutrition advocacy and knowledge management	773,5	853,5	853,5	853,50	733,5	4,067,5

Key Result Areas, Outputs and Activities	2018/19	2019/20	2020/21	2021/22	2022/23	Total
promoted	00	00	00	0	00	00
Develop, print, disseminate and distribute IEC materials	733,500	733,500	733,500	733,500	733,500	3,667,500
Print IEC materials on NCD prevention and management	40,000	120,000	120,000	120,000	-	400,000
Output 5: Effective engagements with media built and maintained.	5,831,000	7,557,000	7,557,000	7,557,000	7,557,000	36,059,000
Mark the celebration of WBW, Malezi Bora weeks and world prematurity days.	3,495,000	3,495,000	3,495,000	3,495,000	3,495,000	17,475,000
Conduct radio talks and radio spots	-	806,000	806,000	806,000	806,000	3,224,000
Commemorate world health days	2,336,000	2,836,000	2,836,000	2,836,000	2,836,000	13,680,000
Hold radio talks shows to promote nutrition and wash activities	-	420,000	420,000	420,000	420,000	1,680,000
KRA 10. Supply chain management for nutrition commodities and equipment's strengthened	53,939,565	69,710,565	61,049,165	65,849,165	60,849,165	311,397,625
Output: Strengthened integrated supply chain management system for nutrition commodities, equipment's and allied tools	53,939,565	69,710,565	61,049,165	65,849,165	60,849,165	311,397,625
Forecast, quantify and procure commodities and equipment	52,439,565	55,125,565	52,639,565	52,439,565	52,439,565	265,083,825
Procure fabricated branded containers for storage of nutrition commodities	-	2,100,000	2,100,000	2,100,000	2,100,000	8,400,000
Procure Nutrition utility vehicles	-	5,000,000	-	5,000,000	-	10,000,000
Procure parenteral/enteral feeds	1,500,000	5,550,000	5,050,000	5,050,000	5,050,000	22,200,000
Procure IFAS for adolescent girls in schools	-	-	85,000	85,000	85,000	255,000
Train health care workers on LMIS	-	1,935,000	1,174,600	1,174,600	1,174,600	5,458,800
Grand Total	**121,624,415**	**479,769,680**	**396,077,030**	**343,852,550**	**299,086,130**	**1,640,875,305**

7 LIST OF KEY CONTRIBUTORS:

	NAME	DESIGNATION	ORGANIZATION
1.	Dr. Amos Kutwa	County Executive Committee Member	Vihiga County
2.	Dr. Arnold Mamadi	Chief Officer- Medical Services	Vihiga County
3.	Mr. Wycliffe Clement Manyulu	Chief Officer- Public Health	Vihiga County
4.	Dr.Ahindukha Quido	County Director Of Health	Vihiga County
5.	Mr.Elsham Ambale	Deputy Chief Public Health Officer	Vihiga County
6.	Ms.Caren Onchwari	County Nutrition Coordinator	Vihiga County
7.	Mr.Opiyo Polycarp	Health Partners Coordinator	Vihiga County
8.	Ms.Esther Odera	County Community Nutrition Coordinator	Vihiga County
9.	Mrs. Esolio Rebeca	Head Of Nursing Services	Vihiga County
10.	Mr.Ahindukha Kizito	Sub-County ECDE Director	Vihiga County
11.	Mrs.Patience Sudi	Nutritionist- VCRH	Vihiga County
12.	Ms.Hilder Mimo	Children Officer	Vihiga County
13.	Mr.Wafula Chengoli	Deputy County Health Records Information Officer	Vihiga County
14.	Dr. Wycliffe Obao	Medical Superintendent Emuhaya Sub-County Hospital	Vihiga County
15.	Ms.Patricia Majani	Nutrition Officer- Huduma centre	Vihiga County
16.	Ms.Evelyne Omunjalu	Deputy Chief Public Health Officer	Vihiga County
17.	Ms.Josphine Mwaniga	Sub-County Social Development Officer	Vihiga County
18.	Mrs.Everlyne Mwango	County Health Promotion Officer	Vihiga County
19.	Ms.Dorothy Audi	Crops Development officer(Dept-Agriculture)	Vihiga County