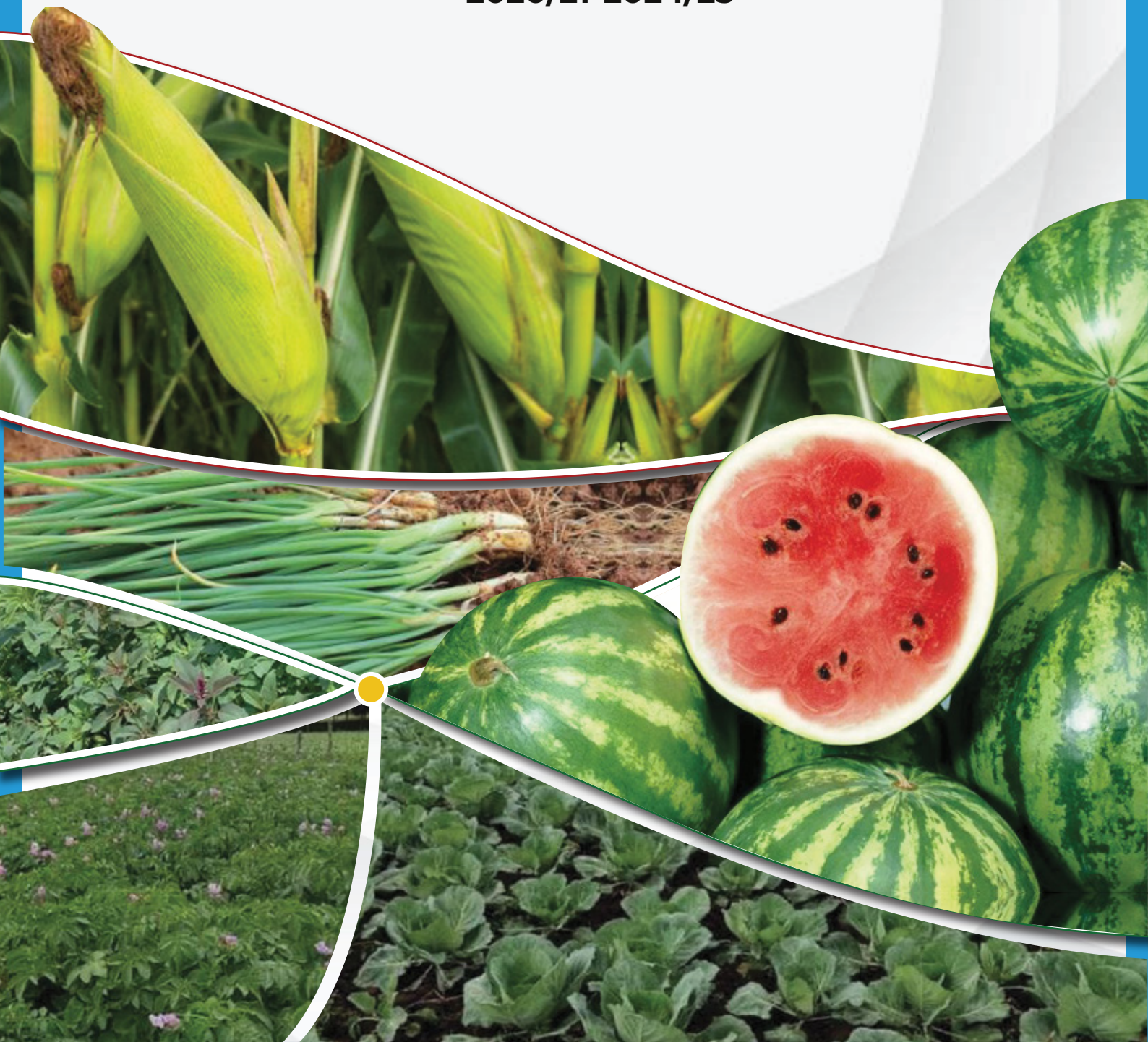
# DEPARTMENT OF MEDICAL SERVICES & PUBLIC HEALTH

## BOMET COUNTY NUTRITION ACTION PLAN 2020/21-2024/25



# COUNTY NUTRITION ACTION PLAN (CNAP) 2020/21-2024/25

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| | |
|---|---|
| **ABC** | Activity Based Costing |
| **ACSM** | Advocacy, Communication and Social Mobilization |
| **AIDS** | Acquired Immunodeficiency Syndrome |
| **ANC** | Antenatal Care |
| **ARI** | Acute Respiratory Infections |
| **AWP** | Annual Work Plan |
| **BCC** | Behaviour Change Communication |
| **BCNAP** | Bomet County Nutrition Action Plan |
| **BFCI** | Baby Friendly Community Initiative |
| **BFHI** | Baby Friendly Hospital Initiative |
| **BMI** | Body Mass Index |
| **BMS** | Breast Milk Substitute |
| **C-BFCI** | Community Baby Friendly Community Initiatives |
| **CCC** | Comprehensive Care Center |
| **CCI** | Child Care Institutions |
| **CHMT** | County Health Management Team |
| **CHVs** | Community Health Volunteers |
| **CME** | Continuous Medical Education |
| **CMSGs** | Community Mother Support Groups |
| **CNAP** | County Nutrition Action Plan |
| **CSO** | Civil Society Organization |
| **CUs** | Community Units |
| **DD** | Diarrheal Disease |
| **DRNCDs** | Diet Related Non-Communicable Diseases |
| **ECDE** | Early Childhood Development Education |
| **FAO** | Food and Agriculture Organization |
| **FBF** | Fortified Blended Flour |
| **FBO** | Faith Based Organization |
| **FGD** | Focus Group Discussion |
| **GBV** | Gender Based Violence |
| **GDP** | Gross Domestic Product |
| **GMP** | Growth Monitoring and Promotion |
| **GOB** | Government of Bangladesh |
| **HCWs** | Health Care Workers |
| **HR** | Human Resource |
| **ICN2** | International Congress of Nutrition |

| | |
|---|---|
| **IDA** | Iodine Deficiency Anaemia |
| **IEC** | Information, Education, and Communication |
| **IFAD** | International Fund for Agricultural Development |
| **IFAS** | Iron Folic Acid Supplementation |
| **IMAM** | Integrated Management of Acute Malnutrition |
| **KAP** | Knowledge, Attitude and Practices |
| **KHIS** | Kenya Health Information System |
| **KHSSP** | Kenya Health Sector Strategic Plan |
| **KM** | Kilometer |
| **KNAP** | Kenya Nutrition Action Plan |
| **KNBS** | Kenya National Bureau of Statistics |
| **KRA** | Key Result Area |
| **KRCS** | Kenya Red Cross Society |
| **LMIS** | Logistic Management Information System |
| **MAM** | Moderate Acute Malnutrition |
| **M&E** | Monitoring and Evaluation |
| **MCH** | Maternal Child Health |
| **MDG** | Millennium Development Goal |
| **MIYCN** | Maternal, Infant, Young Child Nutrition |
| **MIYCN-E** | Maternal, Infant, Young Child Nutrition Emergency |
| **MNCH** | Maternal, New-born and Child Health |
| **MNPs** | Micronutrient Powders |
| **MOALF&C** | Ministry of Agriculture, Livestock, Fisheries and, Cooperatives |
| **MOE** | Ministry of Education |
| **MOH** | Ministry of Health |
| **MTEF** | Medium Term Expenditure Framework |
| **MTMSGs** | Mother to Mother Support Groups |
| **MTP** | Medium Term Plan |
| **NACS** | Nutrition Assessment Counselling and Support |
| **NFNSP** | National Food and Nutrition Security Policy |
| **NFNSP-IF** | National Food and Nutrition Security Policy Implementation Framework |
| **NGO** | Non-Governmental Organization |
| **NHIF** | National Hospital Insurance Fund |
| **NI** | Nutrition International |
| **NIP** | Nutrition Information Platform |
| **NIS** | Nutrition Information System |
| **NMR** | Neonatal Mortality Rates |

| | |
|---|---|
| **PHOs** | Public Health Officers |
| **PLHIV** | People Living with HIV |
| **PNC** | Post-Natal Care |
| **PWDs** | People With Disabilities |
| **SAM** | Severe Acute Malnutrition |
| **SBCC** | Social Behavior Change Communication |
| **SCHMT** | Sub-County Health Management Team |
| **SCNCs** | Sub-County Nutrition Coordinators |
| **SDG** | Sustainable Developmental Goal |
| **SMART** | Standardized Monitoring and Assessment in Relief and Transition |
| **SNI** | Special Needs Institution |
| **SQUEAC** | Semi-Quantitative Evaluation of Access and Coverage |
| **SWOT** | Strengths, Weaknesses, Opportunities and Threats |
| **TAN** | Technical Assistance for Nutrition |
| **TB** | Tuberculosis |
| **TOC** | Theory of Change |
| **TOR** | Terms of Reference |
| **UHC** | Universal Health Coverage |
| **UN** | United Nations |
| **WASH** | Water Sanitation and Hygiene |
| **WHA** | World Health Assembly |
| **WHO** | World Health Organization |
| **WIFAS** | Weekly Iron and Folic Acid Supplements |
| **WRA** | Women of Reproductive Age |

# FOREWORD

Bomet County Nutrition Action Plan (BCNAP) was developed through a consultative process which involved development partners and key stakeholders in addressing challenges of malnutrition in Bomet County.

The process ensured that the plan is evidence informed, result-based and provides for a common results and accountability framework for performance-based monitoring and evaluation (M&E.)

Bomet County Nutrition Action plan is aligned with the Kenya Nutrition Action Plan (KNAP) 2018 - 2022, Bomet County Integrated development Plan (CIDP) 2018 – 2023 and the Constitution of Kenya 2010 which recognizes food security as a constitutional right in Article 43 (1) (c) - the right of every Kenyan to be free from hunger and a right to adequate food of acceptable quality.

The objective of Bomet County Nutrition Action Plan is to accelerate and scale 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 2023. The BCNAP identified three thematic areas of intervention which includes nutrition specific, nutrition sensitive and enabling environment putting emphasis on the need for strengthening multisectoral collaboration in addressing malnutrition. The BCNAP has provided priority multi-sectoral nutrition actions for each sector, targets for each intervention, monitoring and accountability framework as well as costed interventions which the County government will use to mainstream Nutrition within the CIDP.

The County Government of Bomet is committed to support the implementation of the BCNAP for the achievements of the targets laid out. We shall work through enhanced coordination and partnerships to prioritize the elimination of malnutrition in Bomet County.

H.E Hon Dr. Hillary Barchok
The Governor
County Government of Bomet

# PREFACE

The burden of malnutrition in Bomet County is characterized by the co-existence of under nutrition as manifested by stunting of 36%, wasting of 2%, underweight 12%, overweight 4% including Diet-Related Non-Communicable Diseases (DRNCDs) (KDHS, 2014).

Bomet County Nutrition Action Plan (CNAP) 2020/21-2024/25 is a wide-ranging framework for coordination, implementation, and mobilization of resources for nutrition interventions in health and other key line departments.

The plan has incorporated priorities in the County Integrated Development Plan 2018 - 2022 (CIDP) and County Health Sector Strategic and Implementation Plan 2018-2023, The Kenya Nutrition Action Plan (KNAP) 2018-2022 and the County Annual Work Plans (AWPs).

The main aim of this County Nutrition Action Plan (CNAP) is to contribute to the Kenya Nutrition Action Plan (KNAP) 2018-2022 goal of achieving optimal nutrition for a healthier and better quality of life and improved productivity for the country's accelerated social and economic growth. Bomet CNAP has been developed to address County-specific nutrition issues and interventions that are appropriate for the local context while recognizing the role of County governments in ensuring the successful implementation of sustainable nutrition actions.

My Department of Public Health and Medical Services is therefore committed to support implementation of interventions put in place in every Key Result Area (KRA) for the realization of set objectives. We encourage our key stakeholders and development partners to support us in resource mobilization to ensure successful implementation of the plan.

Dr. Joseph K. Sitonik
The County Executive Committee Member - Health

# ACKNOWLEDGEMENT

The County Government of Bomet takes this opportunity to thank the County leadership, the development and implementing partners and all the stakeholders who participated in the development of the Bomet County Nutrition Action Plan (BCNAP) 2020/21-2024/25.

The Bomet CNAP was realized with efforts and contributions from the members of the County Government of Bomet drawn from various sectors and from the implementing partners. Special regards to the County Government of Bomet through the Ministry of Health.

This CNAP was developed with technical and financial support from Nutrition International (NI) under the Technical Assistance for Nutrition (TAN) project, funded by UK aid from the UK government. Special thanks go to Nutrition International staff led by the Country Director, Martha Nyagaya and Deputy Country Director, Joy Kiruntimi for the immense technical & leadership support in the entire process of developing the CNAP 2020/21-2024/25. The technical support of other partners such as World Vision and Kenya Red Cross Society towards the development of the Bomet CNAP, is also highly appreciated.

The contributions of the following ministries in providing technical inputs to the CNAP are also highly appreciated:

This particularly goes to Ministries of but not limited to; Health, Finance and Economic Planning, Education; Water and Sanitation; Gender, Youth, Culture, Sports, Social and Children Services, Agriculture and Livestock.

The contribution of the County Executive Committee Member (CECM) Health, Chief Officer of Public Health, Chief Officer Medical Service, the County Health Management Team (CHMT), Sub-County Nutrition Coordinators (SCNCs) and other Program Officers during the development and/or validation of the CNAP is gratefully acknowledged. Special appreciation goes to Salina Kimwa; Assistant Director for Nutrition Services and Fancy Chepkoech; County Nutrition Coordinator for the overall leadership throughout the entire process.

Lastly, County Department of Health greatly appreciates the technical support of Leila Akinyi (Division of Nutrition and Dietetics - MoH) and the consulting team led by Dr. Daniel Mwai, lead consultant (Health financing and strategic planning expert), Njuguna David (Health systems strengthening and costing expert), Dr. Elizabeth Wangia (Monitoring and evaluation expert), Clementina Ngina (Nutrition technical expert), Tabitha Kinyanjui and Agatha Muthoni (Gender experts) and Edna Muthoni (Programme Assistant) for providing technical support throughout the whole development process.

Zaddy Chepkorir Chumo
Chief Officer – Public Health

Dr. Joyce Tonui
Chief Officer – Medical Services

## MESSAGE FROM THE DIRECTOR PUBLIC HEALTH

Stunted children may suffer irreversible brain damage, impeding them from reaching their complete developmental potential.

They have a shorter adult height and a higher susceptibility to chronic diseases in adulthood, lower attained schooling and reduced adult income. Stunted and wasted children also have a higher mortality risk, which is increased when the two conditions coexist in the same population. (WHO, 2018).

The County Government of Bomet is fully committed to invest in Nutrition to reverse the negative trends of malnutrition specifically stunting which is a chronic form of malnutrition.

Micah Koech
Director Public Health

# 1 INTRODUCTION

## 1.1 Location and size

Bomet County is in the highlands of the South Rift Valley Region of Kenya. It borders Kericho to the North, Narok to the South, Nakuru to the North East and Nyamira to the West. It is located between Latitude 0°29′ and 1° 03′ to the South and Longitude 35°05′ and 35°35′to the East. The County has a land surface of 2,507.1 $Km^2$ and is subdivided into 5 sub-counties namely Chepalungu Sub-County (460.5 $Km^2$); Sotik Sub-County (544.3 $Km^2$); Konoin Sub-County (392.5 $Km^2$); Bomet East Sub-County (305 $Km^2$); and Bomet Central Sub-County (286.1$Km^2$).

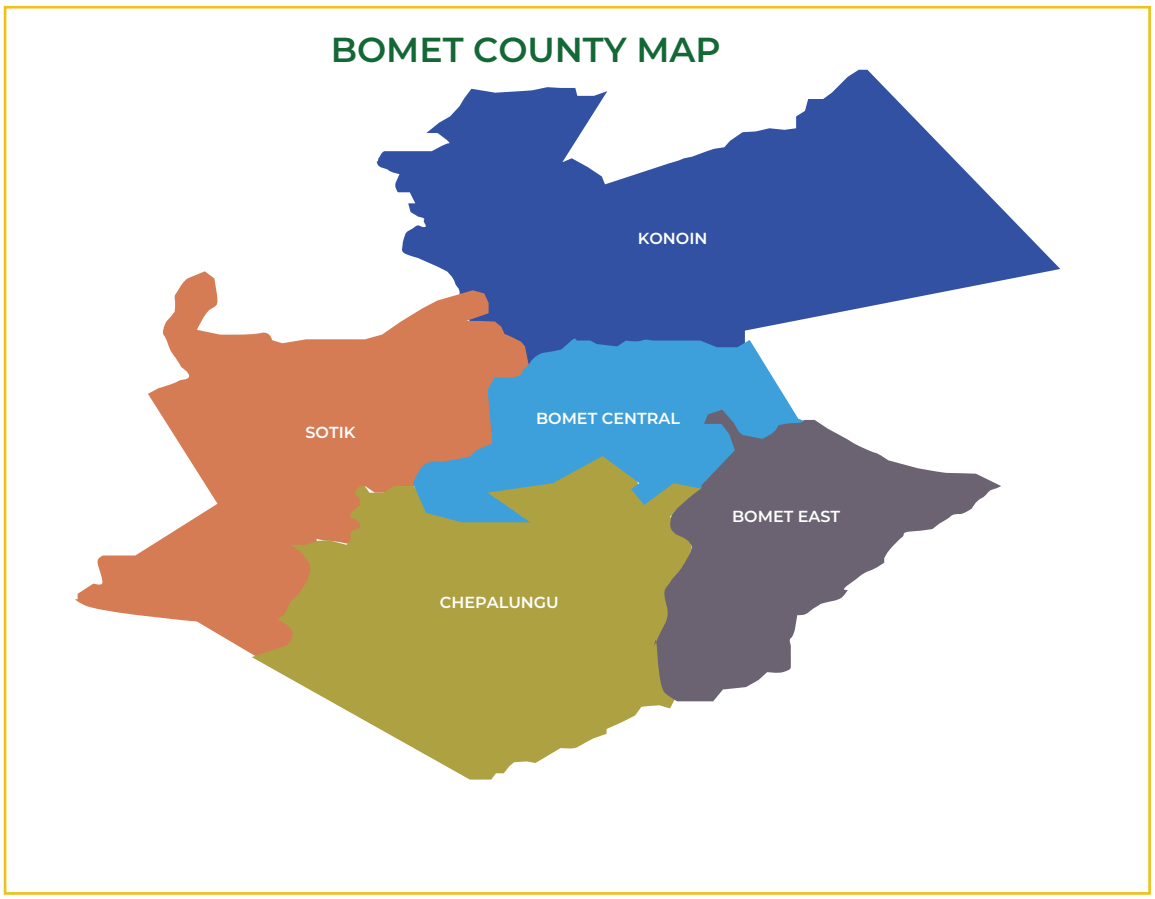



*Figure 1: Map of Bomet County, showing the 5 Sub-Counties*

*Source: County Economic Planning Office*

## 1.2 Population distribution per Sub-County

The total population of Bomet County is at 875,689 with an inter-censual growth rate of 1.9%. The total population comprises of 434,287 males, 441,379 females and 23 intersex. (KPHC, 2019). Half (49.7%) of the total population is below 15 years and 769,282 people live in the rural areas. The County has a total of 187,641 households with an average household size of 4.7 members. About 50.3% of the County's population is in the economically active age group. However, a total of 160,583 persons are unemployed.

Population density varies in each sub County with Bomet Central Sub-County having the highest density of 613 people per $Km^2$ while Chepalungu has the lowest at 358 people per $Km^2$. Factors contributing to high population density in the County include attractive economic opportunities, such as the rich agricultural land, commercial activities, and having the largest urban centre (Bomet town), which is also the administrative centre in the County. The literacy level in the County is high with female literacy standing at 76% and male literacy at 64.7%.

*Table 1:Population density and distribution per Sub-County (2019 Population Census)*

| Sub-County | Male | Female | Intersex | Total | Area | Density |
|---|---|---|---|---|---|---|
| Bomet Central | 87,782 | 87,429 | 4 | 175,215 | 286.1 | 613 |
| Bomet East | 71,095 | 73,172 | 8 | 144,275 | 305 | 473 |
| Sotik | 112,369 | 115,482 | 4 | 227,855 | 544.3 | 419 |
| Konoin | 83,120 | 80,384 | 3 | 163,507 | 392.5 | 417 |
| Chepalungu | 79,921 | 84,912 | 4 | 164,837 | 460.5 | 358 |
| **Total** | **434,287** | **441,379** | **23** | **875,689** | **1988.4** | **440** |

*Source: (KPHC, 2019)*

*Table 2: Bomet County population distribution disaggregated by age and sex*

| AGE | MALE | FEMALE | TOTAL | ESTIMATED POPULATION* | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | 2020 | 2021 | 2022 | 2023 | 2024 |
| 0-4 years | 56,267 | 54,709 | 110,976 | 113,417 | 115,913 | 118,463 | 121,069 | 123,732 |
| 5-9 years | 62,410 | 60,050 | 122,460 | 125,154 | 127,908 | 130,721 | 133,597 | 136,536 |
| 10-14 years | 65,946 | 65,402 | 131,348 | 134,238 | 137,191 | 140,209 | 143,294 | 146,446 |
| 15-19 years | 56,100 | 53,909 | 110,009 | 112,429 | 114,903 | 117,430 | 120,014 | 122,654 |
| 20-24 years | 38,235 | 42,957 | 81,192 | 82,978 | 84,804 | 86,669 | 88,576 | 90,525 |
| 25-29 years | 30,834 | 35,152 | 65,986 | 67,438 | 68,921 | 70,438 | 71,987 | 73,571 |
| 30-34 years | 28,889 | 34,198 | 63,087 | 64,475 | 65,893 | 67,343 | 68,825 | 70,339 |
| 35-39 years | 21,777 | 17,259 | 39,036 | 39,895 | 40,772 | 41,669 | 42,586 | 43,523 |
| 40-44 years | 18,625 | 17,586 | 36,211 | 37,008 | 37,822 | 38,654 | 39,504 | 40,373 |
| 45-49 years | 16,332 | 16,009 | 32,341 | 33,053 | 33,780 | 34,523 | 35,282 | 36,059 |
| 50-54 years | 9,458 | 9,360 | 18,818 | 19,232 | 19,655 | 20,088 | 20,529 | 20,981 |
| 55-59 years | 8,555 | 9,696 | 18,251 | 18,653 | 19,063 | 19,482 | 19,911 | 20,349 |
| 60-64 years | 6,935 | 7,191 | 14,126 | 14,437 | 14,754 | 15,079 | 15,411 | 15,750 |
| 65-69 years | 5,089 | 5,578 | 10,667 | 10,902 | 11,142 | 11,387 | 11,637 | 11,893 |
| 70-74 years | 4,035 | 4,470 | 8,505 | 8,692 | 8,883 | 9,079 | 9,279 | 9,483 |
| 75-79 years | 1,956 | 2,860 | 4,816 | 4,922 | 5,030 | 5,141 | 5,254 | 5,370 |
| 80-84 years | 1,319 | 2,208 | 3,527 | 3,605 | 3,684 | 3,765 | 3,848 | 3,932 |
| 85-89 years | 858 | 1,440 | 2,298 | 2,349 | 2,400 | 2,453 | 2,507 | 2,562 |
| 90-94 years | 348 | 772 | 1,120 | 1,145 | 1,170 | 1,196 | 1,222 | 1,249 |
| 95-99 years | 243 | 364 | 607 | 620 | 634 | 648 | 662 | 677 |
| 100+ | 73 | 207 | 280 | 286 | 292 | 299 | 305 | 312 |
| Not Stated | 3 | 2 | 5 | 5 | 5 | 5 | 5 | 6 |
| **TOTAL** | **434,287** | **441,379** | **875,666** | **894,931** | **914,619** | **934,741** | **955,305** | **976,322** |

*Source: (KPHC Vol III, 2019).*

## 1.3 Population Segmentation in health

Healthcare needs-based population segmentation was used to help understand the needs of the population so that services can be better planned and delivered. It also enables the development and evaluation of integrated healthcare service models that meet the specific healthcare needs of men and women across different ages and diversities as well as informs policy-makers in developing gender, age, and diversity responsive health service programmes.

*Table 3: Key population segments*

| | Description | Population Segment Estimates | 2019 Population Census | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|
| 1. | Total population in County | | 875,689 | 894,954 | 914,643 | 934,765 | 955,330 | 976,347 |
| 2. | Total Number of Households | | 187,641 | 178,991 | 182,929 | 186,953 | 191,066 | 195,270 |
| 3. | Children under 1 year (12 months) | 2.20% | 19,265 | 19,689 | 20,122 | 20,565 | 21,017 | 21,479 |
| 4. | Children under 5 years (60 months) | 12.67% | 111,213 | 113,660 | 116,160 | 118,716 | 121,327 | 123,997 |
| 5. | Under 15-year population | 41.26 | 405,444 | 414,364 | 423,480 | 432,796 | 442,318 | 452,049 |
| 6. | Women of child-bearing age (15 – 49 years) | 24% | 217,083 | 221,859 | 226,740 | 231,728 | 236,826 | 242,036 |
| 7. | Estimated Number of Pregnant Women | 2.20% | 19,265 | 19,689 | 20,122 | 20,565 | 21,017 | 21,479 |
| 8. | Estimated Number of Deliveries | 2.20% | 19,265 | 19,689 | 20,122 | 20,565 | 21,017 | 21,479 |
| 9. | Estimated Live Births | 2.1 | 18,389 | 18,794 | 19,207 | 19,630 | 20,061 | 20,503 |
| 10. | Total number of Adolescents (15-24) | 25.50% | 218,047 | 222,844 | 227,747 | 232,757 | 237,878 | 243,111 |
| 11. | Adults (25-59) | 34.10% | 298,610 | 305,179 | 311,893 | 318,755 | 325,768 | 332,935 |
| 12. | Elderly (60+) | 3% | 26,271 | 26,849 | 27,440 | 28,043 | 28,660 | 29,291 |

*Source: (KPHC Vol III, 2019)*

### 1.3.1 Health facilities distribution per Sub-County

The County has five sub-counties with five levels of health care facilities, including a County referral hospital which is a level 5 hospital, Sub - County hospitals (level 4), health centres (level 3), dispensaries (level 2) and 247 community units (level 1). The County also has one outreach support through the Beyond Zero Mobile Clinic and one community outreach supported by Tenwek Mission Hospital, a level 5 hospital.

There are initiatives which have been put in place to accelerate the provision of health care. They include free maternity services, removal of user fees and health insurance programme & medical support for the elderly and people with severe disability. Moreover, one referral hospital has been equipped with diagnostic equipment.

*Table 4: Distribution of health facilities by ownership per Sub-County*

| Sub-County/ Health Facility | Hospitals (Level 4 or 3) | | | Health Centres (level 2) | | | Dispensaries (level 2) | | | Clinics | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | GOK | FBO | Private | GOK | FBO | Private | GOK | FBO | Private | | |
| **Bomet Central** | 1 | 1 | 0 | 3 | 0 | 5 | 23 | 1 | 0 | 7 | 41 |
| **Bomet East** | 1 | 0 | 0 | 6 | 0 | 1 | 14 | 1 | 0 | 1 | 24 |
| **Chepalungu** | 1 | 1 | 0 | 4 | 1 | 1 | 30 | 0 | 0 | 4 | 42 |
| **Sotik** | 1 | 1 | 0 | 8 | 0 | 0 | 30 | 1 | 3 | 2 | 46 |
| **Konoin** | 1 | 0 | 0 | 5 | 0 | 0 | 22 | 0 | 9 | 4 | 41 |
| **County** | **5** | **3** | **0** | **26** | **1** | **7** | **119** | **3** | **12** | **18** | **194** |

*Source: (CIDP, 2018)*

## 1.4 Trends of malnutrition in Kenya

In Kenya, the situation of undernutrition is like the global one. Out of 7.22 million children under five years, 26% are stunted, 4% are wasted and 11% are underweight as per KDHS, 2014. However, there are geographical and social -economic, and cultural demographic variations in the severity of malnutrition. For example, the prevalence of stunting is 15% in Kiambu and Nyeri Counties compared to 46% in Kitui County and West Pokot County. However, Bomet County is among the counties with the highest rates of stunting at 36%.

According to WHO (2018), stunting decreases with the level of education of the mother, with women who have not completed primary school having children who are twice as likely to suffer from stunting (34%) as mothers with secondary or higher education (17%). Although the KHIS showed the nutrition status of Women of Reproductive Age (WRA) being a triple burden, the trend indicated a reduction of undernutrition while overweight and obesity increased.

## 1.5 Bomet County nutrition situation

Food and Nutrition security has been prioritized by the County Government of Bomet to address malnutrition of children under 5 and women of reproductive age (WRA). The Bomet County Integrated Development plan 2018-2022 prioritizes nutrition services, maternal health care, immunization, access to family planning services and HIV/AIDS, which all contributes to reduction of malnutrition in the County.

Malnutrition remains one of the biggest health challenges in Bomet County with a stunting rate of 36%, far higher than the national stunting rate of 26%. There are still vast gaps in the data available to help us better understand the nature and extent of malnutrition in all its forms. As we strive to end all forms of malnutrition by 2030, there is an urgent need to harness data to track progress, hold stakeholders accountable and foster rapid collaborations.

Further, collection and use of context-based gender integrated qualitative- nutrition 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. High-quality data providing the right inputs on the right indicators at the right time can galvanize decision-makers.

• The burden of malnutrition in Bomet County is characterized by the co-existence of under nutrition as manifested by stunting, wasting, underweight, overweight, obesity including Diet-Related Non-Communicable Diseases (DRNCDs). Beyond poor diets and morbidity which are the immediate causes of malnutrition, underlies the socio-cultural, political, and economic factors. These include but are not limited to;

• Inadequate care of vulnerable household members across different gender and age cohorts

• Household food insecurity

• Cultural norms and practices influencing food sharing and uptake with men being given a priority and larger food share as the household heads, traditional feeding practices related taboos and stereotypes all affecting optimal nutrition uptake and practices especially among women and children under five years.

• Women's lack of unequal access to, use and control over benefits from assets such as land and other productive assets, services and opportunities including inadequate access to affordable credit and farm inputs which hinders their capacity and effectiveness as strong agents for improved food and nutrition security.

• Women's limited autonomy and unequal participation in major decision-making processes on food security, nutrition and related health issues which in turn affect availability of adequate food and food choices, purchasing power of diversified foods and uptake as well as affordability, access and uptake of health services.

All these factors must be addressed as part of effective and sustainable ways in addressing malnutrition in realization of the County's vision and mission.

### 1.5.1 Trends in undernutrition

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

Undernutrition affects both children and women of reproductive age especially within the first 1000 days of life when nutrient demand is highest. In Bomet County, 36% of children are stunted, 12% are underweight, 2% are wasted and 0.6 % are overweight (KDHS, 2014) as illustrated in figure 2 comparing with the national undernutrition indicators.

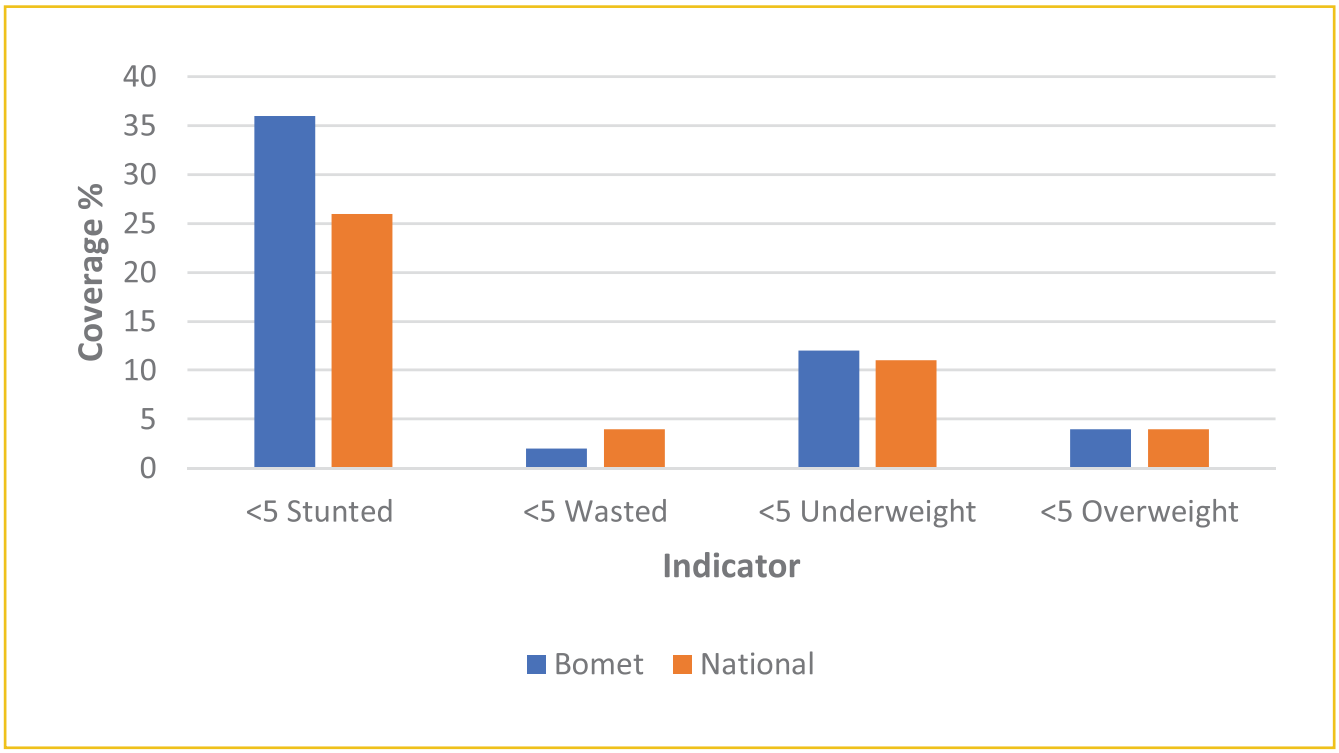



*Figure 2: Stunting, wasting, underweight and obesity among under 5*

*Source: (KDHS, 2014)*

## Drivers of nutrition trends

There are multiple drivers of the positive trends for stunting, wasting and underweight. They include:

1. Scaling up of a package of high impact interventions within the health system such as promotion of MIYCN practices, micronutrient supplementations, treatment of SAM and MAM among others
2. Scaling up nutrition sensitive interventions such as production and consumption of diversified foods, promoting WASH practices at all levels among others
3. Renewed focus on community-based programming for behavioural change

Improved enabling environment for nutrition including better policies such as CNAP and strategies, better nutrition governance, Gross Domestic Product (GDP) growth, and resilience programming, among others.

However, key to note is disparities in relation to geography, urban/rural, education level, household wealth and gender equality as some of the key determining factors for improved nutrition within a given population.

### 1.5.2 Trends in overweight, obesity and Diet-Related Non-communicable Diseases DRNCDs)

The Kenya 2015 STEPwise Survey, (STEPwise, 2015) confirmed an increasing rate of overweight/obesity and diet-related non-communicable diseases (DRNCDs) in adults. A total of 28 % of adults aged 18–69 years were either overweight or obese, with the prevalence in women being 38.5 % and men 17.5 %. Similar trends are seen in the KDHS 2014, where the proportion of women aged 15-49 years who are overweight and obese is 16% and 4.4% respectively.

The prevalence of overweight or obesity is higher in urban areas (43 %) than in rural areas (26 %); in women with higher education (38 %) than with low education (18 %); and higher in women in the highest wealth quintile (50 %) compared with those in the lowest wealth quintile (12 %) as a result of sedentary lifestyle among other factors.

Kenya, as a developing country, has been in a process of transition between traditional and modern lifestyles. The population is dispersed by different ethnic, ecological, and economic backgrounds. Different food habits within the country and the traditions are influenced in different ways by modern influences. For example, there is a growing perception that traditional nutritious foods are inferior to processed, imported foods. These processed, imported foods being more expensive than local vegetables, people have come to perceive local crops as food for the poor. As a result, many mothers go to the extent of selling their vegetables in order to buy processed foods for their children under the impression that these foods are more healthful than traditional vegetables. Additionally, influenced by the need to meet other family needs, lack of awareness regarding family nutritional needs or clever and persistent advertising, and greater choice, most people especially those in urban areas and more economically stable do not necessarily spend on nutritious food for themselves and their families. Instead they are increasingly preferring junk food and thus neglecting the need for nutritious foods (Oniang'o & Komokoti, 1999). In Bomet County 0.6 % of children under the age of 5 are overweight.

### 1.5.3 Trends in micronutrient deficiencies

According to the Kenya National Micronutrient Survey of 2011 (KNMS, 2011), significant progress is being made in reducing the prevalence of micronutrient deficiencies, except for Zinc deficiency. Micronutrients often referred to as vitamins and minerals, are vital to healthy development, disease prevention, and wellbeing. Although only required in small amounts, micronutrients are not produced in the body and must be derived from the diet. Micronutrient deficiencies can have devastating consequences. Iron deficiency is the most common and widespread nutritional disorder in the world as well as affecting many children and women in developing countries. Micronutrient deficiency in children can lead to growth impediments and an increased risk of infection.

According to KDHS, 2014, the coverage for Vitamin A among children 6-59 months was at 69.9% (KDHS 2014) and IFAS at 73.9% (KHIS 2019) for Bomet County. Effective interventions against micronutrient deficiencies includes supplementation, food fortification, dietary diversification, and public health measures such as parasite and diarrheal disease control which have been addressed in this County nutrition action plan based on age targets and general population.

In addition to ensuring improved health service provision, there is dire need to incorporate nutrition sensitive interventions to address the underlying non-medical issues affecting increased uptake of micronutrients especially by mothers and their children under the age of 5 years. Gender inequality, socio-economic vulnerabilities and cultural related issues such as age and literacy levels; poor dietary diversification; low knowledge and /or inadequate counselling and clarity on the importance of different micronutrient supplements for different age and gender cohorts; 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, are strongly linked to poor utilization and/or frequency of uptake of optimal nutrition and health related services and practices including in preventing micronutrient deficiencies.

### 1.5.3.1 Zinc deficiency

The 2011 National Micronutrient Survey established that pre-school children had the highest prevalence of Zinc deficiency (83.3 %) followed by non-pregnant women with a prevalence of 82.3 %, school age children (80.2 %), men (74.8 %) and finally pregnant women (68.3 %) with the lowest prevalence. The prevalence of zinc deficiency among preschool children, school age children and men were consistently higher among rural dwellers compared to their urban counterparts. Among pregnant women, the prevalence of zinc deficiency among urban and rural dwellers did not differ significantly.

### 1.5.3.2 Iron deficiency

According to the micronutrients survey (KNMS, 2011), the highest prevalence of anaemia, Iron deficiency and Iron Deficiency Anaemia (IDA) was observed in pregnant women at 46.1%, 36.1% and 26 % respectively and lowest in men (9.3%, 3.6%, and 2.9% respectively).

Pre-school children had a higher prevalence of anaemia, iron deficiency and Iron Deficiency Anaemia (26.3%, 21.8%, and 13.3% respectively) than school-age children (16.5%, 9.4%, and 4.9% respectively). Non-pregnant women on the other hand had a prevalence of 21.9% for anaemia, 21.3% for Iron deficiency and 14.0% for Iron Deficiency Anaemia comparable to that of preschool children. Differences in prevalence of anaemia, Iron deficiency and Iron Deficiency Anaemia were noted in different age groups of pre-school children.

### 1.5.4 Trends in feeding practices among children and adults

Exclusive breastfeeding is recommended during the first six months of life because breast milk contains all the nutrients required for development, growth, and child survival. Exclusive breastfeeding rates in Kenya have markedly improved from 32% in 2008–9 to 61% in 2014. County specific estimates, using local burden of disease data, puts breastfeeding prevalence in Bomet at 36.3%, which is significantly below the national average. It is recommended that infants be initiated to breastfeeding within one hour after birth. According to Lancet, 2016, this can save 22 % and 16 % of neonatal and infant deaths within the first hour of birth and 48 hours, respectively.

In Kenya, trends in early initiation of breastfeeding show an increase from 58% in 2008–9 to 62% in 2014. Routine hospital data indicates that 92.7% of children seen at the facility were initiated on breastmilk within an hour of delivery (KHIS 2019). Timely, adequate, and safe introduction of complementary foods is critical at six months when breast milk alone is no longer enough to meet the nutritional requirements of infants and young children.

However, only 22% of children aged 6 to 23 months were able to consume acceptable diet in Kenya while Bomet County (Rift Valley's average) was at 21% indicating a dire nutritional situation in this age group. There is behaviour change and communication (BCC) strategies and interventions that have been put in place to address complementary feeding problem focusing on social, cultural, and economic factors. Some of these BCC strategies include the roll out of the BFCI approach which is a community-based behaviour change to promote, protect, and support breastfeeding including timely introduction of safe, adequate, and appropriate complementary foods among other practices.

### 1.5.5 Mortality & morbidity trends

Nutrition is an underlying cause of mortality that contributes to one third of child deaths. All childhood mortality rates declined between 2003 and 2014 KDHS surveys with Neonatal Mortality Rates (NMR) exhibiting the slowest rate of decline. Local burden of disease estimates has shown improvement in the infant and under 5 mortality rates from 29.9 to 25.2 and from 40.8 to 33.5 respectively comparing 2000 and 2017. There has been progress in addressing communicable diseases, which precipitate undernutrition.

Progress in immunization and towards controlling and managing malaria, diarrhoea, acute respiratory diseases, pneumonia, and worms are particularly noteworthy given their major direct impact on undernutrition and micronutrient deficiencies. However, major challenges remain leading to an epidemiological and nutrition transition that is characterized by the coexistence of declining levels of communicable diseases and undernutrition, while the problem of non-communicable diseases and over nutrition are increasing.

## 1.6 Nutrition integration in agriculture

Food and nutrition security exist when all people are able to consume food in both sufficient quantity and quality to meet their dietary needs and food preferences, and they are supported by an environment with adequate sanitation, health services and care, allowing for a healthy and active life (FAO, 1996). Agriculture is fundamental to this widely held definition of food and nutrition security. Most agricultural producers also purchase foods to supplement their home production (GOB, June 2011). Unfortunately, little focus has been placed on the broader resolutions of nutrition through agriculture (including horticulture, fisheries, and animal husbandry) that play an important role in reducing undernutrition through food-based approaches as nutrition-sensitive interventions.

In Bomet County, there exist different topological zones that support different agricultural activities. The higher altitudes in the north eastern parts of the County are particularly suitable for tea and dairy farming. Leasing out of land and overutilization of land for tea growing may result in household food insecurity therefore exacerbating malnutrition. This results in a phenomenon known as “hunger within the green field”.

The community in Bomet is largely patriarchal and land is mainly under the control of men who have final decision on use of family resources which most of the time do not favour nutrition at household level. In addition, the tea plantations also attract large numbers of unskilled labour from the surrounding counties who often live in crowded deplorable settlements with limited access to preventive, promotive and curative health services including nutrition. The middle part of the County which lies 2,300m above sea level is suitable for tea, maize, pyrethrum, and coffee farming. In the southern parts of the County such as Sigor and parts of Longisa, the main economic activity is livestock production, while milk production is a major economic activity in Sotik Sub-County. Areas between 1,800m and 2,300m above sea level are mostly suitable for maize, pyrethrum, vegetables, and beef production (CIDP, 2018).

The agriculture sector is yet to be fully harnessed in Bomet County for the benefit of the local community. Mainstreaming nutrition in agriculture will help make sustainable improvements in nutrition within food systems. Gender equality and women empowerment is an important and long overdue stimulus to a more inclusive human development and accelerated economic growth.

Women contribute close to 80% labour in crop production, however they still have unequal access to, use and control over benefits from productive assets such as land and livestock, low access and inclusion in use of new food production systems and technologies as well as inadequate access to affordable credit and farm inputs. These form part of the major detrimental factors to improved social-economic development in the County. Youth currently constitute 37% of the total population (KPHC Vol III, 2019). Limited involvement of youth in gainful employment and economic participation as well as their exclusion and marginalization from decision making process and policies is a threat to the stability not only to the County but the entire nation.

In addressing malnutrition, agriculture's essential and singular role is to ensure that diverse, nutritious foods, adequate to meet the needs of people of all ages, are available and accessible at all times, either from the market or from farmers' own production (IFAD, 2014). Agriculture could be a significant contributor through access to rural households to improve their knowledge, provide information, and deliver improved practices. Strategies to equally train and engage men and women across different ages and diversities on climate-smart sustainable gardening technologies, enhancing their knowledge on the nutritional value of under-utilized traditional foods, recipes and preparation methods and sustainable income-generating activities will go a long way in realizing increased food security and improved dietary diversity as well as increased purchasing power of households, enhanced asset building mechanism, access to market and other social infrastructures. Provision of education to farmer families targeting both men and women across different ages and diversities about dietary diversity, food-based nutrition, as well as nutrition education to improve their overall nutritional status for healthy and productive lives has been well articulated in this CNAP.

## 1.7 Integration of nutrition in early childhood education

Malnutrition among school children may contribute to adverse health consequences such as non-communicable diseases, poor cognitive performance, psychological distress, and poor quality of life that may persist into adulthood. Young children with adequate nutrition, nurturing caregiving, and opportunities for early learning have the best chances of thriving. Even in the face of biological or environmental threats, adequate nutrition, caregiving, and learning can provide protection. In contrast, the lack of these essential factors can undermine children's individual potential, and the potential of entire societies. In order to prevent childhood malnutrition, intervention programmes that integrate nutrition education and healthy school food environment are needed to provide nutrition information and reinforce the skills on healthy eating behaviours in schools.

Bomet County Nutrition Action Plan has aligned education interventions based on the guidance provided within KNAP which outlines:

1. Governance and coordination structures that support integrated policies and programming
2. School-based nutrition interventions that promote healthy nutritional attitudes, knowledge, and behaviour, including eating and physical activity among school-aged children and adolescents
3. Guidance from implementation science, with attention to training, supervision, and monitoring, which will be instrumental in supporting schools, families and strengthening future generations

## 1.8 WASH integration with nutrition

There is a growing base of evidence that indicates that the WASH (Water, Sanitation, and Hygiene) environment can be critical in shaping children's nutritional outcomes. WASH programmes are often implemented on a large scale and therefore, can serve as a key delivery platform for enhancing the coverage and effectiveness of nutrition interventions. WASH has been recognized as a key sector for maximizing nutritional impact. Existing evidence suggests the linkages between WASH and nutrition may be stronger than previously understood. Inaccessibility to clean water can have dire implications on childcare and feeding practices especially for women and children, as a result of more time being spent covering long distances in search for water, coupled with traditional roles placing household hygiene and sanitation as a women's responsibility. Collaboration between the two sectors will ensure WASH programmes are designed to include the necessary nutrition-sensitive characteristics to effectively contribute to achieving better nutrition outcomes.

Bomet CNAP has addressed how WASH interventions can be adapted to include nutritional considerations, making them more nutrition-sensitive and more impactful on nutrition work more closely to achieve better outcomes. It has also addressed on how nutrition-specific programs can provide an alternative platform to deliver WASH services at scale and more cost-effectively.

## 1.9 Social services integration in nutrition

The Department of Social Services is geared towards improvement of welfare of vulnerable groups such as Persons with Disabilities (PWDs), the elderly, orphans, and children. It focuses on improving social and economic status of men and women through focused activities, effective capacity building, training, economic empowerment, reduction in gender disparities and reduction in harmful practices and retrogressive social and cultural practices.

A comprehensive protection system will bring out protective, preventive, promotive and transformative programmes with a view to improving dietary and nutritional status in the County. Safety nets that have direct bearing on nutrition include cash transfers for the elderly, orphans and vulnerable children, hunger and safety nets program such as "Mama na Kuku Initiative" which is run with a view to starting chicken projects for women as a source of income, table banking and financial literacy among others.

Other mitigating activities include: conducting age, gender and diversity integrated baseline survey and situation analysis on the status of nutrition among children in Special Needs Institutions(SNIs) and Child Care Institutions (CCIs), training of SNIs and CCIs managers on nutrition, mass enrolment for NHIF among vulnerable households, support PWDs with tools of trade and starting sustainable economic activities for them, carrying out sensitization activities against Gender Based Violence (GBV), economically empowering GBV survivors and enhancing women and girls access to education, assets and resources and undertaking progressive gender mainstreaming through collaborative actions between men and women so as to reduce power imbalance between them.

## 1.10 Human resource for nutrition

Health and nutrition are one of the important components of human resource development. The relationship between health-nutrition and human resource development is reciprocal. Even though there is global consensus on actions essential to address undernutrition, in Bomet County, the workforce needed to promote those actions is insufficient. There is need to strengthen human resources for nutrition with the goal of increasing the number of formally trained professional and frontline workers in nutrition. Gender equality and good nutrition are mutually reinforcing.

Despite the increasing awareness and call on the significance of integrating gender equality and women empowerment as a means to effective and sustainable ways to tackle food and nutrition insecurity among the communities we serve, there is frequently limited consideration in addressing gender dimensions. This can be largely linked to the lack of clear understanding of the concept of gender equality and improved nutrition and even where the concept is understood, there is often a lack of skills and techniques in the institution to mainstream the concept. Thus as part of efforts towards health-nutrition system strengthening, the health and nutrition department will collaborate with the County department for gender and other gender partners in the County to help build capacity of health care workers across all cadres to effectively mainstream gender for improved provision and implementation of gender transformative nutrition and health care services and programming. There are currently 56 nutrition officers (15 males and 41 females) offering services at all levels of care. However, this is inadequate and leaves a huge gap of 1,395 officers in reference to Ministry of Health Staffing Norms as shown in the below table.

*Table 5: Nutrition health workforce in Bomet County*

| NO. | Level of Health Facility | Number Required (Proposed establishment) | Number Available | Gaps |
|---|---|---|---|---|
| **1.** | County Referral Hospital | 24 | 7 | 17 |
| **2.** | Sub County Hospitals | 176 | 15 | 161 |
| **3.** | Health Centres | 432 | 30 | 402 |
| **4.** | Dispensaries | 327 | 2 | 325 |
| **5.** | Community Units | 492 | 2 | 490 |
| **TOTAL** | | **1,451** | **56** | **1,395** |

## 1.11 Constraints within the nutrition department

- Inadequate allocation of funding to Nutrition for programming
- Under-staffed Nutrition department to meet the demands of the health care system and at community level
- Inadequate equipment to conduct nutrition assessments
- Low motivation among nutrition staff due to poor renumeration such as risk allowance and other allowances (that they do not have).
- Inadequate capacity among nutrition and related health staff on the nexus between gender equality, socio- economic, cultural factors and nutrition, including integration in nutrition-health related policies and implementation.
- Increased teenage pregnancies and early marriages mostly associated with socio-economic vulnerability, which further aggravates the cycle of poverty among the affected girls and households, a key contributing factor to malnutrition.

- High sub-division of land due to high population
- Insufficient nutrition commodities
- Reducing donor support
- Emerging crop pests and diseases
- Increasing trends of Malnutrition
- Poor post-harvest handling and storage
- Low latrine coverage in the County
- Inadequate water supply in the community
- Unequal rights in access to, use and control over benefits from land and other productive assets, services, and opportunities especially for youths and women
- Poor health seeking behaviors among community members
- Poor enforcement of policies
- Poor eating habits among the population
- Growing of cash crops at the expense of food crops
- Sedentary lifestyle behavior among the population leading to increased overweight/obesity which is a risk factor to DRNCDs
- Inadequate Advocacy Communication and Social Mobilization (ACSM) for Nutrition activities
- Inadequate research information on food consumption patterns of Bomet population
- Increased gender-based violence affecting women and girls in their productive and reproductive years, compromising their capacity to be productive workers, earners, caregivers, thus reinforcing the vicious cycle of poverty and jeopardizing food and nutrition security.

# 2 BOMET COUNTY NUTRITION ACTION PLAN (CNAP) FRAMEWORK

## 2.1 Introduction

The main aim of County Nutrition Action Plan (CNAP) is to contribute to the Kenya Nutrition Action Plan (KNAP) 2018-2022 goal of achieving optimal nutrition for a healthier and better quality of life of the entire population and improved productivity for the country's accelerated social and economic growth. Bomet CNAP has been developed to address County-specific nutrition issues and interventions that are appropriate for the local context while recognizing the role of County governments in ensuring the successful implementation of sustainable nutrition actions.

According to the conceptual framework of malnutrition developed by UNICEF (UNICEF, June 2015), malnutrition occurs when dietary intake is inadequate and health is unsatisfactory, being the two immediate causes of malnutrition. In developing countries, infectious diseases, such as diarrheal diseases (DD) and acute respiratory infections (ARI), are responsible for most nutrition-related health problems. Readily available food, appropriate health systems and a "healthy" environment are ineffective unless these resources are used effectively. As a result, the absence of proper care in households and communities is an element of the underlying causes of malnutrition. This conceptual framework also recognizes that human and environmental resources, socio- economic systems, gender inequality, political and ideological factors are basic causes that contribute to malnutrition.

This model relates the causal factors for under-nutrition with different social-organizational levels. The immediate causes affect individuals, the underlying causes relate to families, and the basic causes are related to the community and the nation. As a result, the more indirect the causes, the wider the population whose nutritional status is affected. The food security and the malnutrition conceptual frameworks, which are the most used frameworks used in this field show significant differences. The food security framework emphasizes an economic approach in which food as a commodity is a central focus. The malnutrition framework adopts a biological approach in which the human being is the starting point. However, both frameworks have in common the promotion of an inter-disciplinary approach to ensuring food and nutrition security.

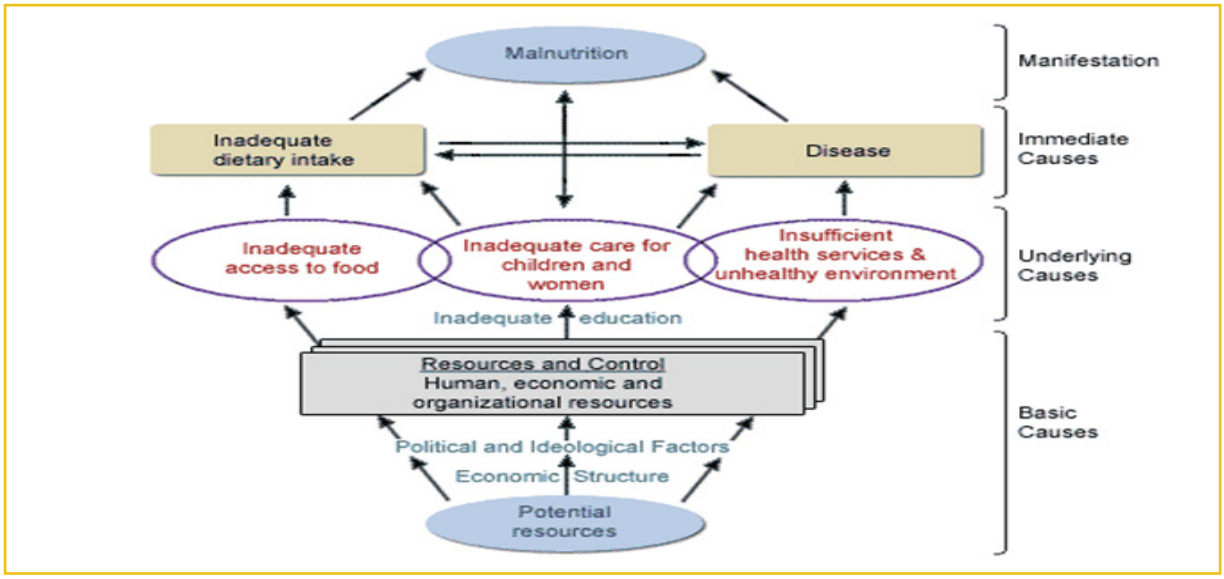



*Figure 3: Conceptual Framework of Malnutrition, UNICEF*

*Source: (UNICEF, June 2015)*

## 2.2 CNAP vision

A prosperous and competitive County in economic, social, and political development offering high quality nutrition services to men, women, boys and girls across all ages and diversities.

## 2.3 CNAP mission

To transform the nutrition status of Bomet County residents through innovative and dynamic leadership, efficient and effective mechanisms, viable partnerships while ensuring equity, integrity, and community participation in a clean, secure, and sustainable environment.

## 2.4 National policy and legal framework for CNAP

The CNAP adds to a series of strategic national policy actions that Kenya has taken over the last decade to improve the food and nutrition security of all Kenyans. The main policy framework derives from the 2012 National Food and Nutrition Security Policy (NFNSP) and its implementation framework (NFNSP-IF) 2017-2022.

The NFNSP mandates the government that all Kenyans, throughout their life cycle (course) always enjoy safe food in sufficient quantity and quality to satisfy their nutritional needs for optimal health. Using the lifecycle (course) approach, the policy 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.

Policy coherence between different spheres of policymaking is important, with policies across governments actively supporting, rather than undermining, nutrition goals. Collaboration and coordination across several actors (government, civil society, private sector, research, and national development partners) must exist to ensure coherence between policies, strategies, and action plans.

The KNAP 2018–2022 which applies a multisectoral approach and promotes cross sectoral collaboration to address the social determinants of malnutrition sustainably adds to a series of strategic national policy actions that Kenya has taken in the last decade to improve the food and nutrition security of all Kenyans. Considering 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 for a county like Bomet, to develop its own CNAP.

In addition, the CNAP derives its policy basis from several other sectoral national policies and frameworks and translates them into action. These sectors include Health and Sanitation, Agriculture, Livestock and Fisheries, Environment, Education, co-operatives, Gender and Social Protection, Water and Irrigation, Trade and Commerce, Devolution and Planning, and other nutrition related sectors.

One of the higher-level policy frameworks is the Big Four Agenda, which is at the heart of the government. The CNAP focuses on pillar two on Food and Nutrition Security and pillar three on Universal Coverage of Health Services. Other policies include the Medium-Term Plan III (MTP III), the Kenya Health Policy with its Kenya Health Strategic Plan (KHSSP), the "Roadmap towards Universal Health Coverage (UHC) in Kenya 2018-2022 and Vision 2030.

Moreover, the CNAP is also aligned with the 2010 Constitution of Kenya. The Bill of Rights recognizes Food Security as a Constitutional Right and the NFNSP is in conformity with the relevant provisions of the Constitution, namely: -

(1) Article 43 (1) (c) - the right of every Kenyan to be free from hunger and a right to adequate food of acceptable quality.

(2) Article 53 (l) (c) - the right of every child to basic nutrition, shelter, and health care

(3) Article 21 - establishes the progressive realization of social and economic rights and obligates the State to "observe, respect, protect, promote, and fulfil the rights and fundamental freedoms in the Bill of Rights."

(4) Article 27 (3) - women and men have the right to equal treatment including the right to equal opportunities in political, social, economic, and cultural spheres.

From the global policy perspective, Kenya is a state party to several nutrition related global agreements and mechanisms including the SUN Movement, the World Health Assembly (WHA) 2025 nutrition targets, the Sustainable Development Goals (SDGs) , the UN International Decade on Food and Nutrition, and the ICN2 Declaration and Plan of Action. Being high-level policy and strategy documents, they lay down the foundation for addressing the immediate, underlying, and basic causes of malnutrition including expanding the political, economic, social, and technological space for nutrition actions.

Given the goodwill demonstrated by the Kenya Government towards nutrition, it is likely that by tackling malnutrition and related development challenges, the CNAP can act as a catalyst to yield multiple benefits across the SDGs. By going beyond addressing the triple burden of malnutrition to laying the foundation for achievement of the other SDGs, the CNAP can be considered as a triple duty action plan.

The legal framework derives from the aspirations of the Kenya Constitution and Vision 2030, giving legislative force to some key aspects of nutrition interventions. These include prevention and control of micronutrient deficiencies by food fortification of food items such as cooking fats, oils, flour, and salt iodation, through the Food Drugs and Chemical Substances Act. Benefits of breastfeeding are protected through the Breast Milk Substitutes (Regulation and Control Act) 2012.

While the financing framework and implementation of nutrition activities is anchored in the broader County Integrated Development Plan (CIDP) and County financing systems, as informed by national and global policies, partners are called upon to make a significant contribution to the CNAP. The Medium-Term Expenditure Framework (MTEF), the three-year rolling investment and resource allocation process is guided by the priorities of the MTP. Food fortification, a flagship project of MTEF 2013-2017, resulted in fortified food items being readily available to consumers.

## 2.5 Key principles of Bomet CNAP

The key principles adopted and will be used in the implementation of CNAP include:

i. A rights-based approach - Recognizing and respecting human and reproductive health rights as envisioned in article 43 of Kenya constitution, this CNAP will seek to ensure inclusion of all residents of the County, including populations with special needs such as the adolescents and the people living with disability.

ii. Devolution- Embracing a devolved system of government, the plan recognizes the power of the County to make decisions that are focused and targeted for the benefit of the residents of Bomet County.

iii. A multi-sectoral approach - Recognizing that health is not just a health issue, but a larger development issue, a response coordinated by the County Department of Health will engage the different stakeholders including the different departments of the County government, private sector, religious leaders, youth leadership, civil society and the community at large, in initiatives to support nutrition services in the County.

iv.Integration - Described in this strategy, will ensure that nutrition information and services are provided within the same health facilities where all other health services are provided, and will make use of the community units, with effective referrals made for services that need more specialized skills from other health facilities in the County.

v. Evidence-based interventions - This CNAP will seek to address the real issues identified by the stakeholders and brought out by the data from different sources in the County.

vi. Gender mainstreaming – Recognizing that addressing gender in nutrition is critical due to the compelling evidence on the mutually reinforcing relationship between good nutrition and gender equality; this CNAP seeks to ensure that the nutrition and health related specific capacities, needs and concerns of both men and women, boys and girls are considered and addressed throughout the process.

## 2.6 Objectives of Bomet CNAP

The objective of Bomet County Nutrition Action Plan is to accelerate and scale 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 2023 in Bomet. The expected result or desired change for the Bomet CNAP is that 'All residents of Bomet County achieve optimal nutrition for a healthier and better quality of life and improved productivity for the country's accelerated social and economic growth'.

## 2.7 CNAP development process

The process was driven by County Department of Health, specifically the nutrition section and was widely consultative, involving all key nutrition stakeholders through a multisectoral process that was open, inclusive, and built on existing and emerging alliances, institutions, and initiatives. At the County level key nutrition-sensitive sectors, civil society organizations and NGOs participated in the process.

The process ensured that the plan is evidence informed, result-based and provides for a common results and accountability framework for performance-based M&E. Evidence was gathered through desk reviews of relevant documents and information from key sectors. The Bomet CNAP identified priority multi-sectoral nutrition actions for each sector, defining targets for each intervention, providing a monitoring and accountability framework as well as costing of interventions which the County government can use for subsequent planning and budgeting.

## 2.8 Target audience for the Bomet CNAP

The target audience includes health care planners and policy makers at national, County and Sub-County level, nutrition specific and-sensitive sectors, nutrition officers and managers at all levels, donors, development partners, NGOs, Civil Society Organizations (CSOs), Faith-Based Organizations (FBOs), the private sector, academia, research institutions, the media and the County at large.

This will enable them to understand what the County government is doing to ensure optimal nutrition for all residents and what they can do individually to contribute to the effort of reducing malnutrition.

## 2.9 Gender mainstreaming in Bomet CNAP

This CNAP links itself to the aspirations of the Bomet CIDP 2018 - 2022, Kenya's Vision 2030 and the National Policy on Gender and Development 2019 which call for gender mainstreaming across all policies and programmes as a strategy for tackling gender inequality and promoting better development outcomes.

Gender is critical in nutrition programming. Improved nutrition and gender equality are development priorities as reflected in several international, national, and County commitments. Gender and nutrition are inextricable parts of the vicious cycle of poverty. Gender inequalities are a cause as well as an effect of malnutrition and hunger (NI, 2018). Higher levels of gender inequality are associated with higher levels of undernutrition, both acute and chronic undernutrition (FAO, 2012).

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 influence nutrition and health related outcomes (Ndiku, Jaceldo-Siegl, Singh, & Sabaté, 2010).

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 (Ruth & Edith, 2002).

The socially constructed gender roles of men and women interact with their biological roles to affect the nutrition status of the entire family and of each age and gender.

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

Further, weak inter-sectoral linkages; inadequate gender integration in nutrition assessments, surveys/research; inconsistent collection and use of sex-age disaggregated nutrition data leads to lack of evidence-based decision making and the design of tailor made nutrition and health interventions, responsive to the specific nutrition needs, priorities, challenges while building on the existing capacities, experience and knowledge among men and women of different age and diversities.

In order to achieve effective and sustainable nutrition and health outcomes, this CNAP seeks to contribute to ongoing efforts at the County of tackling gender inequality by targeting to include both men and women across different ages and diversities throughout its development, implementation, monitoring and evaluation process. This is with an aim to promote an equal reach of the nutrition messages and services across the genders; and though it does not seek to obliterate the gender roles existing in the community it seeks to promote a more equal distribution of gender roles and responsibilities by advocating for increased male involvement in care work and other household work while equally advocating for greater and meaningful involvement of women in decision making. Using gender transformative IEC materials, this CNAP targets to transform community attitudes towards nutrition related roles and responsibilities. Gender sensitive indicators in the M&E framework provide for collection, analysis, reporting and use of sex disaggregated data to inform gender transformative programming.

# 3 KEY RESULT AREAS (KRAs), OUTCOME, STRATEGIES AND ACTIVITIES

## 3.1 Introduction

The overall expected result or desired change for the CNAP is to achieve optimal nutrition for the entire Bomet population thus, healthier and better-quality life and improved productivity for accelerated social and economic growth. To achieve the expected result a total of 10 key result areas (KRAs) have been defined. The KRAs are categorized into three focus areas: (a) Nutrition-specific (b) Nutrition-sensitive and (c) Enabling environment. Within the three focus areas are a set of key result areas with corresponding outcomes, outputs, strategies, interventions /activities that are further costed and presented within an implementation matrix.

*Table 6: Category of KRAs by focus area*

| CATEGORY OF KRAs BY FOCUS AREA | KEY RESULT AREAS (KRAs) |
|---|---|
| Nutrition specific interventions | 1. Maternal, Infant, Young Child Nutrition (MIYCN) and prevention, control and management of micronutrient deficiencies scaled up |
| | 1. Nutrition of older children, adolescents, adults and older persons promoted |
| | 2. Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled-up |
| | 3. Integrated management of acute malnutrition strengthened |
| | 4. Nutrition in emergencies strengthened |
| | 5. Clinical nutrition and dietetics in disease management including HIV and TB strengthened |
| Nutrition sensitive interventions | 7. Nutrition in Education, Agriculture, Water Sanitation &Hygiene (WASH) and Social Protection scaled - up |
| Enabling environment interventions | 8. Sectoral and multisectoral collaboration governance including co-ordination and legal/regulatory framework strengthened |
| | 9. Sectoral and multisectoral nutrition information systems, learning and research strengthened. |
| | 10. Advocacy, Communication and Social Mobilization (ACSM) strengthened |

## 3.2 Theory of Change and CNAP logic framework

The "Theory of Change" (ToC) is a specific type of methodology for planning, participation, and evaluation that is used to promote social change – in this case nutrition improvement. The ToC outlined below (Figure 4), defines long-term goals in this case in economic, social, and political development by offering high quality nutrition services to men, women, boys and girls across all ages and diversities by using innovative and dynamic leadership, efficient and effective mechanisms, viable partnerships and community participation. It then goes ahead to map backwards to identify necessary pre-conditions. It describes and illustrates how and why a desired change is expected to happen in a context.

The pathway of change for the Bomet CNAP is therefore best defined through the theory of change. The ToC was used to develop a set of result areas, that if certain strategies are deployed to implement the 10 prioritized activities, then a set of results which in extension contribute to the national and global nutrition impact results would be realized and if at scale, contribute to a transformed nutritional status of the Bomet residents. The logic framework outlining the key elements and process used to integrate "ToC" in the Bomet CNAP development is captured in Figure 4. The expected outcome expected output and priority activities in line with the process logic have been discussed in section 3.3.

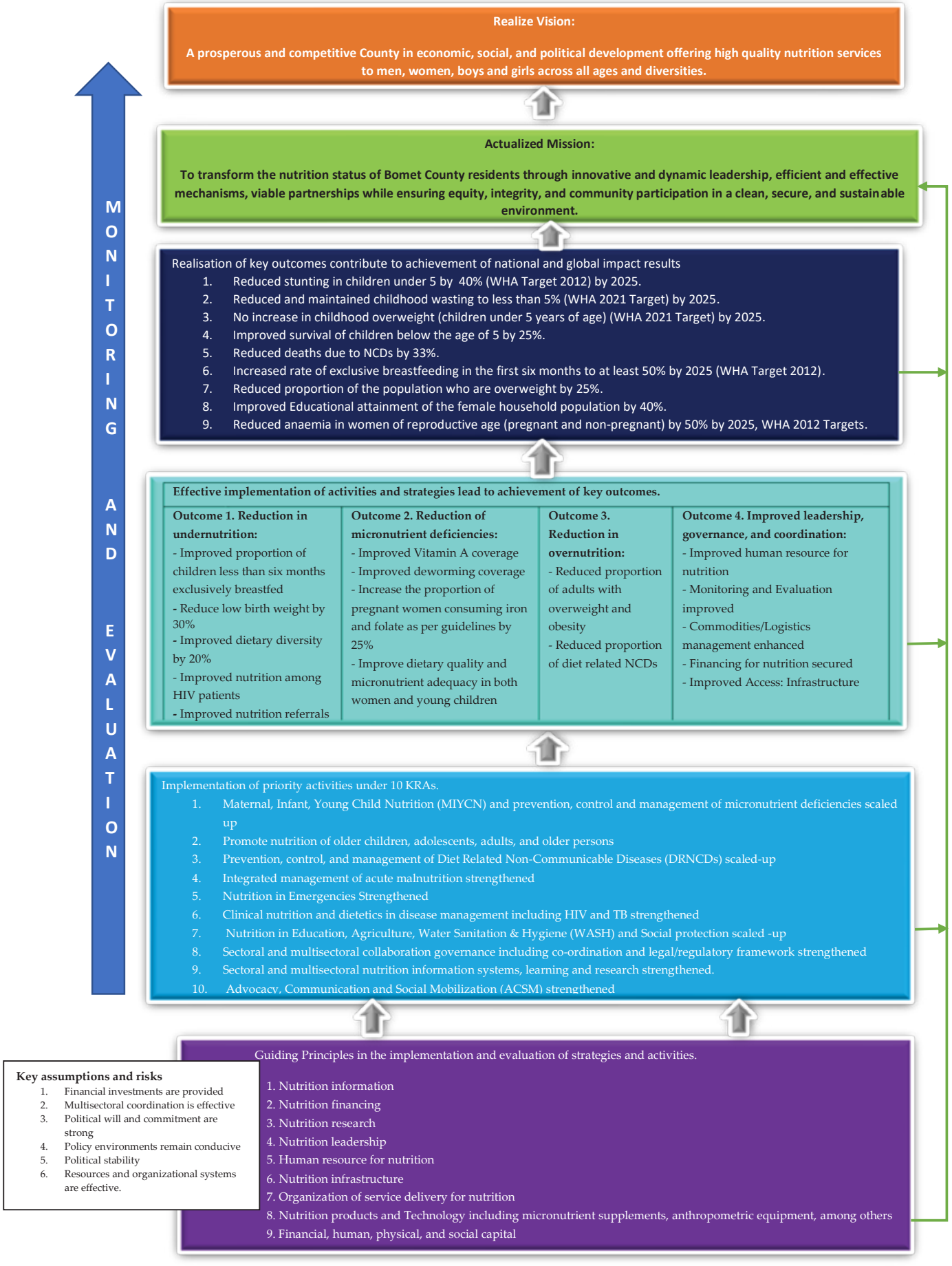



*Figure 4: Bomet CNAP theory of change*

## 3.3 Key Result Areas, corresponding outcome, outputs, and activities

### 3.3.1 KRA 1: Maternal, Infant, Young Child Nutrition (MIYCN) and prevention, control and management of micronutrient deficiencies scaled up

Expected outcome

Improved care practices and services for improved maternal, infant, and young child nutrition (MIYCN)

Output 1

Scaled - up implementation of Baby Friendly Community Initiative (BFCI)

Activities

- Sensitize male and female community health management team (CHMT) and sub County health management team (SCHMT) on BFCI
- Train male and female health care workers (HCWs) on BFCI and effectively mainstream gender in the implementation of BFCI initiatives.
- Sensitize male and female facility health committees on BFCI
- Train male and female CHVS in C-BFCI
- Form community mother support Groups (CMSGs) in cooperating both genders
- Conduct community household mapping within community units (CU) and establish MTMSGs consisting of mothers across different age categories and level of influence while promoting increased male support for sustainability.
- Sensitize men, community leaders and other key influencers on their important role in supporting BFCI as well as promoting increased uptake of MIYCN related services and practices by mothers and children.
- Conduct gender integrated BFCI baseline assessment at the community level
- Conduct monthly meetings with MTMSGs and targeted home visits by the CHVs
- Carry out continuous mentorship to male and female HCWs in the implementing CUs
- Continuous assessment of BFCI activities by C/SCHMT
- Conduct final external gender integrated BFCI assessment
- Establish gender, age, and diversity inclusive BFCI Committees in every CU implementing BFCI activities
- Carry out bi-monthly BFCI meetings
- Establish gender, age, and diversity responsive BFCI resource centres at the CU level
- Print and distribute user friendly BFCI tools and job aids for all gender, age, and diversity population groups

Output 2

Strengthened and scaled up Baby Friendly Hospital Initiative (BFHI) implementation

Activities

- Sensitize male and female CHMT/SCHMT representatives on BFHI
- Train male and female health care workers on BFHI and effectively mainstream gender in the implementation of BFHI initiatives
- Carry out health education on the ten steps to a successful breastfeeding to mothers and fathers at the antenatal clinic (ANC), maternal child health (MCH) maternity and post-natal clinic (PNC)

- Conduct continuous medical education (CMEs) on BFHI
- Conduct baseline assessment on BFHI
- Carry out continuous monitoring of the ten steps to successful breastfeeding in the health facilities offering maternity services
- Establish gender, age, and diversity inclusive BFHI committee at health facility level
- Carry out final external gender, age, and diversity integrated BFHI assessment
- Print and distribute BFHI tools and job aids

### Output 3
Strengthened quality delivery of MIYCN services

### Activities
- Sensitize C/SCHMT on MIYCN policies, guidelines, and strategies
- Train male and female health care workers on MIYCN hybrid course in areas where BFCI is not being implemented and effectively mainstream gender for improved MIYCN interventions.
- Sensitize male and female CHVs on MIYCN course
- Carry out home visits and sensitize male and female community members on MIYCN by the CHVs
- Conduct gender integrated CMEs on MIYCN in health facilities
- Conduct mentorship/on job training on MIYCN to male and female HCWs across different cadres
- Sensitize community members on consumption of diverse food groups using effective communication channels

### Output 4
Enhanced adherence to policies and legislations protecting, promoting, and supporting breastfeeding and lactation stations/spaces at the workplace and among the general population

### Activities
- Sensitize male and female C/SCHMT representatives on the implementation framework for securing a breastfeeding friendly environment at workplace
- Sensitize male and female health care workers on the implementation framework for securing a breastfeeding friendly environment at workplace
- Sensitize other stakeholders (formal and informal) both in private and public sectors on the implementation framework for securing a breastfeeding friendly environment at workplace
- Establish lactation stations in selected health facilities and offices

### Output 5
Strengthened implementation of breastmilk (regulations and control) Act, 2012 in Bomet County

### Activities
- Sensitize C/SCHMT on BMS Act, 2012
- Carry out CMEs to male and female health care workers on BMS Act, 2012
- Train male and female PHOs, nutritionists and other health care workers on BMS monitoring and enforcement

• Train male and female HCWs on BMS implementation framework
• Carry out monitoring and enforcement of BMS Act within the County and report violations appropriately

### Output 6
Strengthened Growth Monitoring and Promotion (GMP) and Micronutrient supplementation at all levels

### Activities
• Sensitize male and female C/SCHMT representatives on WHO growth standards
• Train male and female HCWs on WHO growth standards
• Conduct CMEs on WHO growth standards and the use of anthropometric equipment
• Carry out gender integrated nutrition assessment of children 0-59 months,
• Provide health and nutrition counselling to mothers/caregivers and spouses of children aged 0-59months
• Train male and female HCWs on MNPs
• Train male and female HCWs on VAS
• Train male and female HCWs on IFAS
• Sensitize CHVs on Micronutrients (MNPS, VAS and IFAS)
• Train male and female HCWs on strategies for anaemia prevention
• Carry out Vitamin A supplementation to children 6-59 months
• Carry out deworming of children 12-59 months
• Carry out Micronutrient and powder supplementation to children 6-23 months
• Carry out IFA Supplementation to pregnant women
• Carry out Zinc Supplementation of Diarrhoeal cases
• Procure and distribute anthropometric tools to health facilities
• Advocate for procurement and distribution of VAS, MNPS, IFAS, dewormers and Zinc for health facilities

### Output 7
Enhanced monitoring and evaluation systems for MIYCN services

### Activities
• Carry out support supervision for gender responsive MIYCN services by C/SHMT
• Procure, print, and distribute MIYCN data capture and reporting tools
• Conduct quarterly data quality audits for MIYCN services
• Carry out gender sensitive data quarterly review meetings for MIYCN services
• Carry out gender integrated monthly report writing for MIYCN services
• Conduct quarterly support supervision and mentorship on micronutrient supplementation at health facilities

### Output 8
Strengthened consumption and compliance of fortified foods

### Activities
• Train male and female nutrition officers and PHOs on food fortification including on market level surveillance on adherence to food fortification
• Sensitize male and female CHVs on food fortification

• Conduct community sensitization sessions on consumption of fortified and diverse foods
• Carry out market level surveillance on fortified food commodities to monitor compliance and report violations appropriately
• Conduct annual salt iodization testing through identified channel such as schools and/or households
• Sensitize male and female C/SCHMT on food fortification

### 3.3.2 KRA 2: Nutrition of older children, adolescents, adults and older persons promoted

Expected outcome
Increased nutrition awareness and uptake of nutrition services for improved nutritional status of older children (5-9 years) and adolescents especially the girls (10-19 years)

Output 1
Improved policy environment at County level for older children (5-9 years), adolescents (10-19 years), Adults and older persons

Activities
• Sensitize CHMT/SCHMT on nutrition policies, guidelines, and strategies for older children (5-9 years), adolescents (10-19 years), adults and older persons
• Sensitize male and female HCWs on National guidelines for healthy diets and physical activity
• Identify and sensitize male and female key influencers, role models, and nutrition champions on nutrition for older children and adolescents.
• Engage male and female key influencers, role models, and nutrition champions in nutrition activities to create awareness on nutrition for older children and adolescents

Output 2
Weekly iron folic supplementation for adolescent girls promoted

Activities
• Train male and female HCWs and other stakeholders on adolescent Nutrition and health
• Conduct WIFA supplementation to adolescent girls aged (10-19years)
• Sensitize male and female school stakeholders on WIFAS
• Sensitize male and female HCWs on WIFAS
• Sensitize adolescent girls in schools on WIFAS
• Procure and distribute WIFAS to schools

Output 3
Increased awareness on healthy diets among caregivers, social influencers, older children, and adolescents themselves

Activities
• Sensitize male and female C/SCHMT representatives on healthy diets and physical activity for older children, adolescents, adults, and older persons
• Train male and female HCWs and key stakeholders on healthy diets and physical activity using the life course approach

• Train male and female key stakeholders on healthy diets and physical activity for older children, adolescents, adults, and older persons
• Sensitize male and female older children, adolescents and communities on healthy diets and physical activity using context-specific communication on channels in both rural and urban setups

### Output 4
Reduction of marketing of unhealthy foods among older children and adolescents

### Activities
• Sensitize male and female school stakeholders on marketing and promotions of healthy foods in the school and at the community as well as enough safe and nutritious foods in school
• Implement the regulation on control marketing of unhealthy foods for older children and adolescents
• Collaborate with the local media to pass messages on healthy foods in schools and at the community level for older children, adolescents, adults, and older persons

### Output 5
Enhanced linkages and collaboration with relevant sectors to promote the health and nutrition of the older child and adolescents

### Activities
• Promote collaboration with other health sector interventions to promote good nutrition of older child and adolescent (MoE, MOALF&C, MoH, Industry, Finance, Gender, Sports, and social protection) and the private sector

### Output 6
Access to quality, timely, affordable health care and nutrition support to adults and older persons promoted

### Activities
• Sensitize male and female C/SCHMT representatives on geriatric nutrition policy guidelines
• Train/Sensitize male and female health care worker on optimal nutrition for adults and elderly persons to provide quality health care and nutrition support for older people
• Sensitize male and female CHVs on optimal nutrition for adults and elderly persons to provide quality health care and nutrition support for older people
• Disseminate/pass health and nutrition messages to men and women across of different ages and diversities including the elderly utilizing existing social support groups and other community forums
• Disseminate user friendly and context specific communication materials on health, nutrition, and physical activities of adults across different gender, age and diversity and older persons

### Output 7
Advocacy, communication, and social mobilization of nutrition of adults and older persons strengthened and promoted.

Activities

• Advocate for participation and inclusion of nutrition for male and female older persons across different diversities in development programmes
• Develop, print, and distribute user friendly and context specific communication materials on health, nutrition and physical activities of men and women across different ages and diversities including older persons in local dialect
• Advocate for financial resources allocation for adults and older persons

### 3.3.3 KRA 03: Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled-up

Expected outcome

Prevention, management, and control of DRNCD non-communicable diseases improved.

Output 1

Improved policy and legal environment for nutrition in DRNCDs

Activities

• Sensitize male and female CHMT/SCHMT representatives on existing standards and regulations on healthy diets, DRNCDs and physical activity
• Promote multi-sectoral collaboration and joint planning on gender, age and diversity responsive healthy diets and physical activity in prevention, control, and management of DRNCDs
• Disseminate policies and guidelines on DRNCDs to CHMT/SCHMT
• Sensitize male and female CHMT/SCHMT representatives on legislations on advertising, packaging, labelling, and marketing of foods and beverages

Output 2

Strengthened County capacity to accelerate nutrition response for prevention, control, and management of DRNCDs

Activities

• Train male and female HCWs on prevention, control, and management of DRNCDs
• Conduct CMEs in health facilities on prevention, control, and management of DRNCDs
• Sensitize male and female CHVs on prevention, control, and management of DRNCDs
• Conduct screening and nutrition counselling of the public for early detection, control, management, and treatment of DRNCDs through community outreaches, medical camps, health action days, national health days e.g. World Diabetes Day, World Cancer day.
• Conduct gender, age and diversity sensitive nutrition assessment and counselling to clients of all gender and diversities with DRNCDs at health facility level
• Form DRNCDs gender inclusive support groups and provide nutrition education on prevention, control, and management of DRNCDs

Output 3

Behaviour change communication strategies developed and implemented to promote primary and secondary prevention of diet-related risk factors for DRNCDs

Activities
• Conduct mass media sensitization e.g. radio talk shows on nutrition specific related topics on prevention, control, and management of DRNCDs
• Identify and utilize DRNCDs male and female champions for community sensitization
• Participate in commemoration of world diabetes day and world cancer day
• Develop/adapt and distribute DRNCDs IEC/BCC materials equitably targeting men and women across all age and diversities.
• Develop key messages, advocacy tool kits and sensitize media and journalists on DRNCDs
• Advocate through key stakeholders on establishment of gender responsive workplace wellness centres
• Establish workplace wellness centres

Output 4
Improved monitoring and evaluation for diet related DRNCDs

Activities
• Conduct quarterly integrated support supervision/monitoring and evaluation for DRNCDs
• Hold bi-annual performance review meetings for DRNCDs

### 3.3.4 KRA 04: Integrated Management of Acute Malnutrition (IMAM) strengthened

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

Output 1
Policy, standards, and guidelines for the IMAM program implemented at County level

Activities
• Sensitize male and female CHMT, HMT and SCHMT on IMAM guidelines, SOPs, and treatment protocols

Output 2
IMAM programme performance monitored, and capacity enhanced for improved quality of IMAM services

Activities
• Train male and female health care workers on IMAM package
• Train male and female HCWs as trainer of trainees (TOT) on IMAM
• Carry out continuous medical education (CME) and mentorship on IMAM in health facilities
• Sensitize male and female CHVs on IMAM package.
• Carry out gender, age and diversity sensitive nutritional assessment, counselling, and support to all IMAM clients.
• Monitor adherence to IMAM program SOPs, guidelines and protocols by health and nutrition workforce
• Conduct IMAM program performance reviews - cure, defaulter, death, coverage (linkage with M&E)

### Output 3
Advocacy, communication, social mobilization, and resource mobilization for IMAM programme scaled up:

### Activities
• Advocate for increased resource allocation for IMAM implementation including commodities, equipment, and HR.
• Advocate for institutionalization of community health volunteer (CHV) motivation within County strategic document to key County decision makers in collaboration with community strategy department.
• Advocate for IMAM operational level research within the County to CHMT and SCHMT
• Advocate for integrated treatment and prevention of malnutrition and strengthen nutritional care and support of affected individuals
• Promote improved linkage with programmes on behavioural change awareness creation or for prevention strategies at community and household level including MIYCN, social protection and livelihood support strategies

### Output 4
Enhanced early case identification of Acute Malnutrition through community mobilization and referrals

### Activities
• Conduct nutrition screening/assessment for all cohorts and genders at community and facility level.
• Conduct follow-up for IMAM clients through CHVs
• Sensitize male and female CHVs on IMAM referral system
• Carry out gender, age, and diversity inclusive IMAM referrals from community to facility and facility to community
• Link IMAM Clients with other programs at community level such as livelihoods, social protection, food security, MIYCN and WASH.

### Output 5
Improved utilization of IMAM gender sensitive data for informed decision making

### Activities
• Carry out appropriate documentation on IMAM related research, best practices, and learning.
• Share best practices and learning on IMAM with stakeholders
• Carry out quarterly DQA for IMAM program
• Carry out quarterly data review meetings for IMAM program
• Adopt key actions/recommendations from gender integrated research, assessments/surveys, lessons learnt, routine data, programme review meetings and feedback from field experiences

### Output 6
Strengthened IMAM supply chain

Activities
• Procure therapeutic and supplementary feeds for management of severe acute malnutrition (SAM) and moderate acute malnutrition (MAM)
• Procure and distribute anthropometric tools for IMAM program
• Procure, print, and distribute IMAM reporting tools to implementing health facilities

### 3.3.5 KRA 05: Clinical nutrition and dietetics in disease management including HIV and TB

Expected outcome:
Improved and scaled-up services and practices related to clinical nutrition and dietetics

Output 1
Nutrition screening, assessment and triage to all individuals seeking health care promoted.

Activities
• Carry out nutrition screening and assessment in the triage areas/stations in the outpatient and inpatient services

Output 2
Improved referral services between facility to facility, community to facility and vice versa

Activities
• Conduct sensitization meetings to male and female health care workers on the use of standard facility-community referral tool, inter-facility referral tool for clinical nutrition and dietetics

Output 3
Improved advocacy for nutrition and dietetics

Activities
• Advocate for increased resource allocation for clinical nutrition and dietetics to County decision makers.
• Advocate for integration of gender, age and diversity responsive nutrition and dietetics services at all levels of health care system to County health decision makers
• Adapt and utilize IEC materials for nutrition management in diseases and conditions

Output 4
Nutrition and dietetics guidelines, standards, screening, and assessment tools integrating gender equality considerations developed and implemented

Activities
• Adopt and utilize SOPs for nutrition and dietetics
• Establish/activate gender, age and diversity inclusive inpatient feeding committees in health facilities offering in-patient care
• Sensitize male and female health care workers on safety package for clinical nutrition and dietetics
• Disseminate guidelines, strategies and policies on clinical nutrition and dietetics: guidelines for nutritional management of patients in disease and illness; home-based care guidelines for nutrition; guidelines on therapeutic food production units to C/SCHMT

### Output 5
Improved quality of clinical nutrition and dietetics care in management of diseases

### Activities
- Train male and female health care workers on clinical nutrition and dietetics care package in disease management
- sponsor male and female nutritionist for clinical nutrition short courses
- Sponsor male and female nutritionists for specialities in clinical nutrition such as oncology, renal, paediatrics etc.
- Carry out continuous CME on clinical nutrition and dietetics in health facilities
- Carry out nutrition assessment, counselling, and support to male and female patients in both outpatient and inpatient care

### Output 6
- Improved food procurement, supply, hygiene, and safety in health care institutions

### Activities
- Conduct supportive supervision to access quality of gender transformative nutrition care in health facilities
- Carry out bi-annual data review meetings for clinical nutrition and dietetics
- Procure nutrition commodities for feeding and management of special medical conditions based on inpatient feeding protocols
- Establish gender inclusive food safety inspection committees
- Procure and distribute clinical nutrition equipment and reporting tools

### Expected outcome 2: HIV/TB
Reduce impact of HIV related co-morbidities among PLHIV and TB through targeted nutrition therapy and counselling

### Output 1
Increased coverage for nutrition screening and referral of PLHIV and TB patients

### Activities
- Carry out nutritional assessment in all comprehensive PLVIH and TB care centres
- Train male and female health care workers to provide patient-focused nutrition therapy for paediatric patients and adolescents infected with HIV/TB
- Sensitize male and female health care workers and CHVs on information related to nutrition screening and comprehensive nutritional assessment for HIV/TB patients.
- Carry out quarterly supply chain monitoring, including electronic logistics management information system (LMIS) to minimize stock outs, avoid expiries and over and/under stocking of HIV/TB commodities.
- Carry out comprehensive nutritional assessment in all HIV, TB, service points to reduce missed opportunities and improve service uptake and retention into care
- Carry out County /Sub County level forecasting, quantification, and supply planning through integrated, operationalized County level commodity security committees.
- Conduct bi-annual surveillance on quality of nutrition commodities used in management of HIV/TB patients

### Output 2
Strengthened integration of nutrition interventions for home-based care at community level for PLHIVs towards the 90.90.90

### Activities
- Sensitize male and female CHVs and other community resource persons to promote healthy and sustainable lifestyles at household levels
- Develop/adopt a series of small doable actions that enhance dietary diversity and physical exercises at household level for HIV and TB patients
- Carry out health education on context-specific nutrition messages that promote positive lifestyles and behaviour for HIV and TB patients
- Conduct outreaches, referrals, and linkage to involve all community actors and optimize identification and linkage of PLHIV and TB patients with nutrition care and management.

### Output 3
Improved routine screening for nutrition related problems and referral for all PLHIV and TB patients

### Activities
- Train male and female health care workers through on-line and in-person continuous professional development on integrated nutrition therapy for TB/HIV nutrition
- Train male and female HCWs as TOTs on Nutrition in HIV and TB management
- Sensitize male and female CHMT, SCHMT, facility in-charges on new guidelines and policies on HIV/TB management.
- Adapt and utilize context-specific job aids for patient-focused nutrition therapy and interpersonal counselling.
- Carry nutrition assessment, counselling, and support to HIV/TB clients.

### Output 4
Enhanced use of implementation research to generate evidence for cost-effective nutrition TB and HIV programming

### Activities
- Carry out routine participatory progress, monitoring platforms at all levels (Sub-County, health facility, community) through scheduled data review meetings
- Adapt and implement nutrition gender sensitive assessment counselling and support (NACS) validated guidelines and tools including capacity building at sub County, facility, and community
- Conduct standard annual gender integrated NACS data and service audit including partner mapping at Sub-County level.
- Adapt use of County level score card for gender sensitive nutrition indicators including NACS
- Generate and utilize NACS gender sensitive analysed data
- Review and optimize integration of data systems from various nutrition service delivery points for HIV, TB clients across the NACS continuum of care
- Carry out quarterly data review meetings for nutrition in HIV/TB program
- Implement regular data quality assessments using work improvement teams' activities at all levels

• Adapt and use m-Health systems to identify and follow up patients at community level.
• Conduct annual bottleneck gender integrated assessment specific to key program areas in NACS to identify questions for implementation research.
• Develop an online inventory of bottlenecks related to specific NACS program areas to inform investments and programming
• Participate in regional learning meetings for NACS knowledge management and transfer on best practices.

Output 5
• Strengthened supply chain for nutrition commodities in HIV/TB

Activities
• Procure and distribute fortified blended flour (FBF) for health facilities with CCC /TB clinic
• Procure and distribute reporting tools for HIV/TB for health facilities with CCC /TB clinic
• Procure and distribute anthropometric tools for HIV and TB clinics.

### 3.3.6 KRA 06: Nutrition in emergencies strengthened

Expected outcome
Improved multi-level, multisectoral and gender responsive capacity for risk preparedness, reduction, and mitigation against impact of disasters

Output 1
Strengthened coordination and partnerships for integrated preparedness and response initiatives

Activities
• Map nutrition partners in preparedness and emergency risk reduction
• Nutrition personnel to participate in County emergency preparedness and risk reduction committee meetings and integrate nutrition activities
• Establish and functionalize nutrition emergency preparedness and risk reduction committee/task force

Output 2
Strengthened preparedness capacity for the nutrition sector

Activities
• Adapt and implement IMAM surge kit
• Review and update nutrition disaster preparedness and response plan
• Include a nutrition contingency plan into the existing County nutrition supply chain
• Conduct joint resource mobilization activities with other sectors on integrated preparedness and risk reduction
• Optimize gender responsive nutrition service delivery approaches including outreach services in hard-to-reach areas and affected urban areas
• Hold joint planning and implementation meetings with other sectors on integrated preparedness and risk reduction
• Train male and female stakeholders on gender, age, and diversity integrated needs assessment during emergencies, conduct the needs assessment and disseminate findings to stakeholders for decision making and appropriate response

• Adopt SOPs for emergency response and on linkage of nutrition with livelihood programmes

Output 3
Strengthened implementation of recovery interventions to enhance 'build back better' approaches

Activities
• Actively engage in the development of and social protection programmes to enhance integration of nutrition
• Nutrition personnel to participate in policy discussions related to post-disaster reviews to influence gender, age, and diversity responsive nutrition considerations
• Nutrition personnel to participate in community-level dialogue and recovery initiatives targeting men and women across different ages and diversities while ensuring their equal and meaningful participation.

Output 4
• Improved access to timely multi-sectoral high-impact interventions to populations affected by emergencies to prevent deterioration of nutritional status and avert excess morbidity and mortality

Activities
• Activate emergency coordination for gender integrated nutrition response monitoring
• Conduct gender integrated nutrition needs assessment during emergencies to adapt response to the context and address specific gender, age and diversity needs.
• Optimize gender, age and diversity responsive nutrition service delivery approaches including outreach services in hard-to-reach areas, affected urban areas
• Promote equitable access to high-impact nutrition interventions in emergencies by all targeted beneficiaries across different gender, age, and diversities.

### 3.3.7 KRA 07: Nutrition in education, agriculture, Water, Sanitation & Hygiene (WASH) and social protection

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

Output 1
Strengthened sustainable, gender responsive and all-inclusive food systems that are diverse, productive, and profitable for improved nutrition

Activities
• Advocate and participate in joint strategic planning with MoH, MoALF&C, MoW, MoE, department of gender and social services and other stakeholders for nutrition-sensitive agricultural production.
• Train/sensitize male and female CHMT, SCHMT and health care workers on early warning systems.

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

### Activities

• Hold coordination and collaborative meetings with public and private sector actors separately–in addressing access to nutritious and safe foods
• Sensitize male and female CHVs, extension officers and communities on food processing, preservation and storage technologies using effective communication strategies.

### Output 3

Consumption of safe, diverse, and nutritious foods promoted for specific groups: children, adolescent girls, boys, pregnant women, lactating women

### Activities

• Sensitize male and female CHVs and communities on diversified food production using effective communication strategies
• Sensitize male and female HCWs, CHVs and communities equally targeting men and women across different ages and diversities on use of food composition tables and recipes for decision making at household level
• Disseminate agri-nutrition resource manual and dialogue cards and other related materials to CHMT, SCHMT and health care workers
• Adopt Social Behaviour Change and Communication (SBCC) for increased consumption of nutritious foods and improved dietary diversity (including fortified foods)
• Adopt and dissemination of food safety regulations and enforcement mechanisms to stakeholders
• Advocate and support flour blending initiatives-regulations and standards to relevant County decision makers and other stakeholders
• Sensitize male and female Agriculture department staffs on gender responsive diversified food production.

### Output 4

Strengthened food-based capacities and coordination at County and sub-County levels

### Activities

• Advocate for nutrition sensitive -agriculture coordination mechanisms at County and sub County level and between private and public sectors
• Advocate for food-based capacity development and integration initiatives
• Nutrition personnel to participate in the nutrition sensitive-agriculture coordination working groups
• Support gender responsive food-based capacity development initiatives

## Expected outcome 2: WASH

Nutrition integrated into WASH policies, strategies, plans and programmes.

### Output 1

Collaboration with relevant stakeholders on WASH strengthened

### Activities

• Advocate and support the development of mechanisms that strengthen coordination, linking nutrition to WASH
• Disseminate policies and strategies to ensure universal access to adequate hygiene and sanitation to C/SHMT
• Promote joint resource mobilization for integrated WASH and nutrition activities

### Output 2
Optimal WASH practices promoted at all levels

### Activities
• Advocate for functional systems for WASH service provision in health facilities, institutions, and household level
• Sensitize community (equally targeting men and women across different age and diversities) on safe and hygienic practices during food preparation and storage using effective communication strategy
• Integrate hand washing and hygiene message during nutrition education sessions including preventive messages against COVID 19 targeting all men and women across different ages and diversities.
• Promote environmental hygiene and sanitation standards at household level targeting both men and women of different ages and diversities within the household.
• Disseminate Information Education Communication (IEC) materials and messaging on hand washing, community and institutions led total sanitation and food hygiene to CHMT, SCHMT, HMT, CHVs and community members using appropriate and effective communication strategy

### Expected outcome 3: Social Protection
Integration of nutrition in social protection programmes strengthened

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

### Activities
• Sensitize male and female HCWs and CHVs on the targeting criteria for nutrition in social protection programmes, cash transfers, hunger safety nets, and others.
• Sensitize stakeholders in social protection programmes on good and gender transformative nutrition practices
• Advocate for scale up of evidence based social safety nets in times of crises, with special positive discriminative measures or programs benefiting to women, informed by a gender integrated nutrition analysis.
• Support stakeholders mapping of various actors in social protection
• Advocate for inclusion of gender sensitive nutrition indicators in the M&E of social protection interventions
• Initiate participation of nutrition stakeholders in social protection coordination mechanisms
• Conduct a gender integrated baseline survey/situation analysis on status of nutrition and health for the vulnerable groups, including women and girls
• Conduct stakeholders mapping of various actors in social protection interventions
• Enhance participation of nutrition stakeholders in social protection coordination mechanisms

### Output 2
Resources for nutrition in social protection programmes mobilized

### Activities
• Advocate for deployment in nutrition human resource in social protection programmes

• Mobilize financial resources for gender transformative nutrition interventions in social protection programmes

### Output 3
Strengthened advocacy, communication, and social mobilization for nutrition's inclusive social protection

### Activities
• Advocate for harmonization of all-inclusive gender, age and diversity responsive nutrition and social protection services for vulnerable groups (people living with disabilities, orphans and vulnerable children and the elderly)
• Advocate for governance and accountability for nutrition and social protection for vulnerable groups (people living with disabilities, orphans and vulnerable children and the elderly)
• Advocate for high-level consultations for promotion of gender transformative health and nutrition for vulnerable groups (people living with disabilities, orphans and vulnerable children and the elderly) at County and sub-County levels.
• Sensitize the public and the management of institutions of vulnerable persons and correction facilities on gender, age and diversity responsive health and nutrition.
• Promote benchmarking/learning visits for policy makers and implementers in counties with best practices on gender transformative health and nutrition for vulnerable groups

## Expected outcome 4: Education
Nutrition mainstreamed in education sector policies, strategies, and action plans

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

### Activities
• Disseminate and support Implementation of School meals and Nutrition Strategy, Home Grown School Meal Implementation Guidelines, School Meals menu guide, School Health Policy, School Health Implementation Guidelines, food and nutrition reference manual to school and health stakeholders.
• Seek technical support from MoALF&C to schools on establishment and improvement of existing school demonstration gardens, small animals and revive 4Kclubs.
• Advocate for all-inclusive nutrition and physical activity themes in co-curricular school activities (drama, music, talent shows, contests, symposia) targeting boys and girls across different age cohorts.
• Document and implement best practices and information sharing on integrated food-based activities
• Assess the implementation of nutrition and physical activity education and promotion in early childhood development education ECDE centres
• Support Implementation of food, nutrition and, health content in curriculum and co-curriculum activities in ECDE centres.

### Output 2
Promote capacity for nutrition services in schools and other learning institutions

Activities

• Sensitize male and female teachers on school health programme such as nutrition assessments in schools
• Advocate for procurement of nutrition assessment equipment for schools.
• Disseminate tools and manuals for school health and nutrition assessment
• Conduct periodic nutritional status assessments in schools and other learning institutions
Advocate for establishment of a referral system for health and nutrition interventions for those assessed.
• Sensitize male and female stakeholders including, curriculum support officers, food service providers and handlers, Parent–Teacher Associations (PTA) on healthy and safe food environment.
• Promote improved, safe, and equitable access to safe and enough water, and adequate WASH services in schools and other learning institutions.
• Procure and distribute nutrition assessment equipment's to ECDE centres

### 3.3.8 KRA 08: Sectoral and multisectoral collaboration governance including co-ordination and legal/regulatory framework strengthened

Expected outcome

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

Output 1

Enhanced existing nutrition coordination and collaborating mechanisms and linkages between national and County governments

Activities

• Mapping nutrition partners and stakeholders at County level
• Hold quarterly County nutrition technical forum (CNTF) as per TORs
• Hold quarterly sub County nutrition technical forums (SCNTF) as per TORs
• Develop, cost, review, and update sector-specific coordination annual plans
• Participate in other sectoral co-ordination forums at County level
• Conduct County annual performance assessment reviews on coordination
• Conduct Sub County annual performance assessment reviews on coordination
• Hold gender integrated County nutrition annual learning forums.

Output 2

Enhanced coordination in development and implementation of nutrition-relevant regulatory frameworks

Activities

• Establish a task force mechanism to implement and follow up nutrition legal and regulatory frameworks at County level
• Participate in annual nutrition standards and regulation forums/summit with relevant actors

Output 3

Strengthened partnerships and collaboration for gender transformative nutrition programming and results.

Activities

• Adapt a strategy and framework for enhancing public–private partnerships for nutrition at County level
• Adapt nutrition sector/ multisectoral partnership framework to guide collaboration at County level

Output 4

Nutrition resource mobilization and accountability tracked

Activities

• Nutrition personnel to participate in County resource mobilization forums through County resource mobilization directorate
• Develop second generation gender responsive costed County Nutrition Action Plan (CNAP)
• Develop and implement nutrition resource mobilization and accountability strategy
• Conduct annual nutrition resource tracking at County level
• Support participation and representation of nutrition sector in all-inclusive citizen participation forums at all levels whole ensuring meaningful participation by men and women across all ages and diversities.

### 3.3.9 KRA 09: Sectoral and multisectoral nutrition information systems, learning and research strengthened

Expected outcome

Sectoral and multisectoral nutrition information systems, learning and research strengthened

Output 1

Nutrition sector plans progress reviewed

Activities

• Develop and conduct progress review of gender responsive nutrition annual work plans (AWPs) and other multi-year plans and policies
• Conduct annual, midterm and end term reviews/evaluations of AWPs and multi-year plans and policies for corrective action and way forward
• Generate and disseminate annual nutrition gender integrated reports to stakeholders

Output 2

Strengthened nutrition sector capacity in nutrition information system (NIS) and evidence-based decision-making

Activities

• Adopt and use a gender responsive nutrition multisectoral nutrition score card to monitor key CNAP indicators quarterly
• Conduct quarterly data review and feedback meetings with sub-counties
• Conduct M&E capacity needs assessment
• Train departmental M&E male and female champions on implementation and monitoring of gender sensitive nutrition indicators

Output 3

Improved access to and use of nutrition information to inform gender transformative program quality, adjustment, and learning

### Activities

- Conduct gender integrated nutrition situation analysis, generate information products, and disseminate to all levels for planning and response
- Upload gender integrated nutrition data and reports to KHIS to enable generation of information to be used for decision making
- Adopt gender, age, and diversity sensitive nutrition dashboards, scorecards, electronic data collection tools, etc.
- Systematically utilize gender integrated nutrition information to inform program quality improvement

### Output 4

Standardized and harmonized nutrition data collection methodologies, management, and reporting at all levels

### Activities

- Utilize KHIS reports through capacity building of male and female service providers
- Participate in the HMIS indicator manual review at the County level including integration of gender sensitive nutrition indicators.
- Print, distribute and disseminate gender responsive MoH nutrition M&E framework, tools, manuals, and guidelines
- Participate in the review of County indicator handbook ensuring that the indicators are gender sensitive and informed regularly

### Output 5

Quality nutrition gender sensitive data generated for evidence-based programming

### Activities

- Conduct nutrition data clinics to reflect on NIS processes, key emerging issues, lessons learnt from field implementation to improve NIS at County level
- Conduct data quality audits for DHIS, LMIS and sentinel surveillance
- Conduct gender integrated nutrition SMART surveys
- Conduct gender integrated MIYCN KAP survey
- Conduct gender, age and diversity inclusive coverage assessments using SQUEAC methodology
- Conduct nutrition capacity assessment
- Disseminate gender integrated nutrition survey and assessment findings to stakeholders for decision making

### Output 6

Enhanced multisectoral linkages result in improved nutrition information efficiencies and cost-effectiveness

### Activities

- Collaborate and link with other sectors and data producers and users for improved gender sensitive nutrition information system
- Advocate for a multisectoral Nutrition Information Platform (NIP) for improved gender integrated multisectoral data analysis, dissemination, and utilization

### Output 7

Improved decision making through research evidence

Activities

- Establish strategic partnerships and networks in addressing County research agenda with learning institutions and implementing partners
- Advocate for gender integrated nutrition research prioritization at County level
- Participate in County, national, and international forums for knowledge sharing such as symposiums and conferences, workshops, meetings
- Participate in County research technical working group
- Establish County nutrition research and ethics technical working group
- Hold forums for dissemination of gender integrated nutrition research findings and information sharing
- Advocate for systematic review of nutrition-sensitive and nutrition-specific research
- Promote knowledge sharing through publication of gender responsive nutrition information
- Establish a research repository for nutrition and dietetics at County level

### 3.3.10 KRA 10: Advocacy, Communication, and Social Mobilization (ACSM) strengthened

Expected outcome

Enhanced commitment and continued prioritization of nutrition in national and County agenda.

Output 1

Political commitment and prioritization of nutrition at County level enhanced

Activity

- Hold high level sensitization targeting policy makers on the value and impact of prioritizing gender transformative nutrition and advocate for increased financial allocation.
- Develop nutrition advocacy, communication, and social mobilization strategy for Bomet County
- Identify and engage male and female nutrition champions to advocate for prioritization of gender transformative nutrition at all levels of decision-making institutions
- Advocate for relevant sectors to support strengthening of multisectoral nutrition platforms
- Participate in County planning process ensuring nutrition representation and mainstreaming nutrition in the County plans

Output 2

Increased and strengthened human capital and capacity for gender transformative nutrition advocacy

Activity

- Conduct training sessions for male and female nutrition professionals and influencers on advocacy to promote improved nutrition status of the County population.
- Advocate for recruitment of male and female nutritionists for the County to address specific nutrition needs of the men and women across all ages and diversities in the County.

Output 3

Evidence-based and gender transformative nutrition advocacy and knowledge management promoted

### Activities

- Document and disseminate best practices, case studies, research findings and success stories on gender responsive nutrition programming
- Develop a gender responsive nutrition advocacy package at County level.
- Design, print and distribute gender transformative nutrition IEC/BCC materials for use during national health days or various occasions.

### Output 4

Effective engagements with media built and maintained

### Activities

- Adapt a gender responsive sensitization package on nutrition for journalists based on simplified messages and key information
- Sensitize media fraternity on gender transformative nutrition for better coverage.
- Support sensitization sessions of nutrition professionals and other relevant stakeholders on communication and writing skills to help them better package gender integrated nutrition information for media.
- Participate in mass media education programme on gender transformative nutrition.

### Output 5

Community engagement in nutrition strengthened

### Activities

- Observance of global and national nutrition-related days including Biannual Malezi Bora Week, World Breastfeeding Week, World Prematurity Day
- Support in promotion of community participation (equally targeting both men and women across different ages and diversities) in nutrition resilience building interventions and accountability mechanism.
- Establish a community feedback mechanism platform for nutrition interventions

# 4 MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL) FRAMEWORK

## 4.1 Introduction

This chapter provides guidance on the monitoring, evaluation, accountability and learning process, and how the monitoring process will measure and track the implementation of the County Nutrition Action Plan. The Bomet CNAP will evolve as the County assesses data gathered through monitoring.

Monitoring and evaluation will systematically track the progress of suggested interventions, and assesses the effectiveness, efficiency, relevance, and sustainability of these interventions. Monitoring will involve ongoing, routine collection of information about program's activity to measure progress toward results. The generated information will inform the implementers, decision makers and various stakeholders as to whether the nutrition program is on track, and when and where modifications may be needed. Regular monitoring will identify challenges and successes with an aim of evidence-driven decisions. A program may remain on course or change significantly based on the data obtained through monitoring. Monitoring and evaluation therefore forms the basis for modification of interventions and assessment of the quality of activities being conducted.

It will be critical to have a transparent system of joint periodic data and performance reviews that will involve key health stakeholders who use the information generated from it. Stakeholders will include donors, departments, staff, national government, and the community. Involvement of stakeholders contributes to better data quality because it reinforces their understanding of indicators, the data they expect to collect, and how that data will be collected. Stakeholders will be encouraged to align with the reporting tools and processes and avoid operating in silos. For ownership and accountability, the nutrition program will maintain an implementation tracking plan indicating planned activities for every year, which will keep track of review and evaluation recommendations and feedback. This implementation tracking plan will be used to develop the program specific annual work plans.

An assessment of the technical M&E capacity of the program within the County is key. This includes the data collection systems specifically utility of the Kenya Health Information System (KHIS) and the relevant source documents, and the level of skill of the staff in M&E. It is recommended that approximately 10% of a programs total resources should be slated for M&E, which may include the creation of data collection systems, data analysis software, information dissemination, and M&E coordination.

## 4.2 Background and context

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

## 4.3 Purpose of the MEAL plan

The Bomet CNAP MEAL Plan aims to provide strategic information needed for evidence-based decisions at County level through development of a Common results and Accountability Framework (CRAF). The CRAF will form the basis of one common results framework that integrates the information from the various sectors related to nutrition, and other non-state actors e.g. Private sector, CSOs, NGOs; and external actors e.g. Development partners, technical partners resulting in overall improved efficiency, transparency and accountability.

The current nutrition situation and strategic interventions have been defined in earlier chapters, while 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 delivery statistics
- Service coverage/Outcomes
- Client/Patient outcomes (behaviour change, morbidity)
- Clients access to services
- Quality of health services
- Impact of interventions
- Lessons learnt and best practices

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

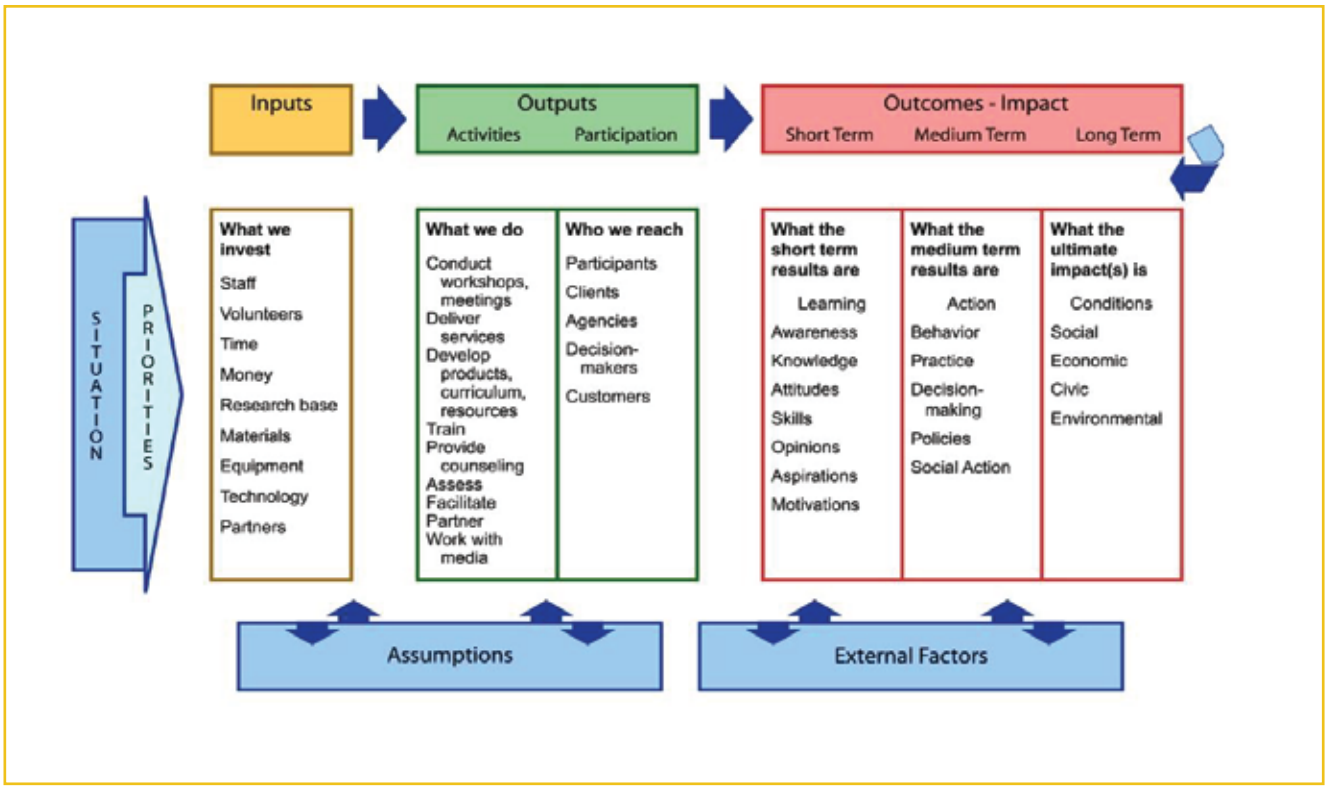
In an effort to ensure gender integration at all levels of the Bomet CNAP, all data collected, analysed, and reported on will be disaggregated by gender and age to provide information for analysis and address the impact of any gender issues and relations -including benefits- from the nutrition programming between men and women. Collection of sex, age and diversity disaggregated data and monitoring will 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 put in place to mainstream gender in the MEAL plan will include:
- Development / review M&E tools and methods to ensure they document gender differences.
- Ensuring that terms of reference for reviews and evaluations include gender-related results.
- Ensuring that M&E teams (e.g. data collectors, evaluators) include men and women as diversity can help in accessing different groups within a community.
- Reviewing existing data to identify gender roles, relations, and issues prior to design of nutrition programming to help set a baseline.
- Holding separate interviews and FGDs with women and men across different gender, age, and diversities including other socio-economic variations.

• Inclusion of verifiable indicators focused on the benefits of the nutrition programming for women and men.
• Integration of gender-sensitive indicators to point out gender-related changes leading to improved nutrition and related health outcomes over time.

## 4.4 Logic model

The logic model as outlined in Figure 5 looks at what it takes to achieve intended results, thus linking results expected, with the strategies, output and input, for shared understanding of the relationships between the results expected, activities conducted, and resources required.




*Source: (Taylor, Jones, & Henert, 2002)*

*Figure 5: Monitoring and evaluation logical framework*

**Situation/Priorities:** These capture the nutrition problem at hand that could needs to be addressed. In the current nutrition plan, the focus is on the triple burden of malnutrition: undernutrition, overnutrition and micronutrient deficiencies.

**Inputs:** These are the investments put into achievement of results. This includes the nutrition staff and volunteers, budgets set aside for nutrition, nutrition equipment and commodities.

**Outputs:** These will be the achievements after conducting a certain activity, and will range from the number of participants, both male and female trained on various aspects relating to nutrition; availability of commodities at facility and community level; coverage of various interventions for example Vitamin A, deworming, IFAS coverage; assessments conducted among others.

**Outcomes:** These are both intermediate and long term. It reflects a change in behaviour, attitude, and practice, because of given interventions. This would include breastfeeding coverage; minimum dietary diversification and intake; customer satisfaction; in the intermediate, while the long-term outcomes look at overall impact of nutrition on health in terms reduction of morbidity and mortality.

**Assumptions:** Assumptions are made on the inputs and outputs, where a certain activity or intervention is assumed to result in a change in behaviour, attitude, or practice.
External factors come into play on the outcomes, given that for an outcome to be achieved, a lot of external factors, including political support, climate changes, disasters etc., which could have a direct impact of achievement of set outcomes.

*Table 7: CNAP results framework*

<table>
<tr><td>IMPACT</td><td colspan="4">1. Reduce the number of children under-five who are stunted by 40% (WHA Target 2012) by 2025<br>2. Reduce and maintain childhood wasting to less than 5% (WHA 2021 Target) by 2025<br>3. No increase in childhood overweight (children under 5 years of age) (WHA 2021 Target) by 2025<br>4. Improved survival of children below the age of 5 by 25%<br>5. Reduction of deaths due to NCDs by 33%<br>6. Increase the rate of exclusive breastfeeding in the first six months to at least 50% by 2025 (WHA Target 2012)<br>7. Reduction by 25% of the proportion of the population who are overweight<br>8. Educational attainment of the female household population improved by 40%<br>9. Reduce anaemia in women of reproductive age (pregnant and non-pregnant) by 50% by 2025, WHA 2012 Targets</td></tr>
<tr><td>OUTCOMES</td><td>Outcome 1. Reduction in undernutrition:<br>- Improved proportion of children less than six months exclusively breastfed<br>- Reduce low birth weight by 30%<br>- Improved dietary diversity by 20%<br>- Improved nutrition among HIV patients<br>- Improved nutrition referrals</td><td>Outcome 2. Reduction of micronutrient deficiencies<br>- Improved Vitamin A coverage<br>- Improved deworming coverage<br>- Increase the proportion of pregnant women consuming iron and folate as per guidelines by 25%<br>- Improve dietary quality and micronutrient adequacy in both women and young children</td><td>Outcome 3. Reduction in overnutrition<br>- Reduced proportion of adults with overweight and obesity<br>- Reduced proportion of diet related NCDs</td><td>Outcome 4. Improved leadership, governance, and coordination<br>- Improved human resource for nutrition<br>- Monitoring and Evaluation improved<br>-Commodities/Logistics management enhanced<br>- Financing for nutrition secured<br>- Improved Access: Infrastructure</td></tr>
<tr><td>OUTPUTS</td><td colspan="4">1. Maternal, Infant, Young Child Nutrition (MIYCN) and prevention, control and management of micronutrient deficiencies scaled up<br>2. Nutrition of older children, adolescents, adults, and older persons promoted<br>3. Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled-up<br>4. Integrated management of acute malnutrition strengthened<br>5. Nutrition in emergencies strengthened<br>6. Clinical nutrition and dietetics in disease management including HIV and TB strengthened<br>7. Nutrition in Education, Agriculture, Water sanitation &Hygiene (WASH) and Social Protection scaled -up<br>8. Sectoral and multisectoral collaboration governance including co-ordination and legal/regulatory framework strengthened<br>9. Sectoral and multisectoral nutrition information systems, learning and research strengthened.<br>10. Advocacy, Communication and Social Mobilization (ACSM) strengthened</td></tr>
<tr><td rowspan="5">INPUTS</td><td colspan="2">1. Organization of service delivery for nutrition;</td><td colspan="2">6. Nutrition Financing;</td></tr>
<tr><td colspan="2">2. Human Resource for Nutrition;</td><td colspan="2">7. Nutrition research;</td></tr>
<tr><td colspan="2">3. Nutrition infrastructure;</td><td colspan="2">8. Nutrition leadership;</td></tr>
<tr><td colspan="2">4. Nutrition products and Technology including micronutrient supplements, anthropometric equipment, among others;</td><td colspan="2">9. Financial, human, physical, and social capital;</td></tr>
<tr><td colspan="4">5. Nutrition Information;</td></tr>
</table>

## 4.5 Monitoring process

To achieve a robust monitoring system, effective policies, tools, processes, and systems should be in place and disseminated. The collection, tracking and analysing of data thus making implementation effective to guide decision making. The critical elements to be monitored are: Resources (inputs); Service statistics; Service coverage/Outcomes; Client/Patient outcomes (behaviour change, morbidity); Investment outputs; Access to services; and impact assessment.

The key monitoring processes as outlined in figure 6 will involve:


*Figure 6: Monitoring processes*

### Data generation

- Various types of data will be collected from different sources to monitor the implementation progress. These data will be collected through routine methods, surveys, sentinel surveillance and periodic assessments, among others.
- Routine health facility data will be generated using the existing mechanisms and uploaded to the KHIS monthly. Other routine data, for example training activity reports, are stored in the nutrition program for reference and consolidation.
- Strong multi-sectoral collaboration with nutrition sensitive sectors will be encouraged.
- Data flow from the primary source through the levels of aggregation to the national level will be guided by reporting guidelines and SOPs and reach the MOH by agreed timelines for all levels.

### Data validation

- Data validation through regular data quality assessment to verify the reported progress from source to aggregated values to ensure that data is of the highest quality. Annual and quarterly data quality audits will 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.
- It requires a team with strong analytic skills to make sense out of the presented data.
- The analysis will be done during the quarterly and annual performance reviews, where achievements will be compared against set target in the CNAP. Trend analysis will also be conducted. The expected output will include quarterly nutrition bulletins and annual nutrition performance review reports.

### Information dissemination

- Information products for example the quarterly bulletins, annual performance review reports, nutrition fact sheets, developed will be routinely disseminated to key sector stakeholders and the public as part of the quarterly and annual reviews and feedback on the progress and plan provided.

## Stakeholder collaboration

• Effective engagement of other relevant Departments and Agencies and the wider private sector in the health sector M&E process is key.
• Each of these stakeholders generates and requires specific information related to their functions and responsibilities. This includes information from the various sectors that are relevant to nutrition.
• The information generated by all these stakeholders is collectively required for the overall assessment of sector performance.

## 4.6 Monitoring reports

The following are the monitoring reports and their periodicity:

*Table 8: Monitoring reports*

| Process/Report | Frequency | Responsible | Timeline |
|---|---|---|---|
| Annual Work Plans | Yearly | All departments | End of June |
| Surveillance Reports | Weekly | DSC and health facility in charge. | COB Friday |
| Health Data Reviews | Quarterly | All departments | End of each quarter |
| Monthly reports submissions | Monthly | Facilities, CUs | 5th of every month |
| Quarterly reports | Quarterly | All departments | After 21st of the preceding Month |
| Bi-annual Performance Reviews | Every six Months | All departments | End of January and end of July |
| Annual performance Reports and reviews | Yearly | All departments | Begins July and ends November |
| Expenditure returns | Monthly | All levels | 5th of every month |
| Surveys and assessments | As per need | Nutrition program | Periodic surveys |

## 4.7 Evaluation of the Bomet CNAP

Evaluation is intended to assess progress made towards achieving the results contained in the CNAP by tracking efforts and achievement across implementation period of Bomet 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 Bomet CNAP are met.

## Evaluation criteria

To carry out a comprehensive and in-depth evaluation of the Bomet CNAP, clear evaluation questions are to be in place. Evaluators will analyse relevance, efficiency, effectiveness, and sustainability for the Bomet CNAP. The proposed evaluation criterion is elaborated below.

**Relevance:** The extent to which the objectives of the Bomet CNAP correspond to the specific needs for men and women across different ages and diversities population needs including the vulnerable groups. It also includes an assessment of the responsiveness considering changes and shifts caused by external factors.
**Efficiency:** The extent to which the Bomet CNAP objectives have been achieved with the appropriate amount of resources
**Effectiveness:** The extent to which Bomet 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.

## 4.8 MEAL team

The County M&E units 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 inter-sectoral government M&E will be through the County M&E TWG. The nutrition program will ensure that it has male and female representatives at the overall County M&E TWG and whose capacity will continuously be built on effective gender integration in M&E. 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 national level. The County management teams will prepare the gender sensitive 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 will be promoted through collaboration with research institutions, international organizations, CSOs and NGOs specialized in data analytics 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 of 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 institutionalization of a functional team dedicated to this purpose.

## 4.9 Critical assumptions

i. Adequate resources and organizational systems will be available to implement the plan.
ii. Trainings offered during implementation will result in knowledge gain and behaviour change of the County nutrition personnel.
iii. Data and information used during development and implementation of the Bomet CNAP is credible, accurate, reliable, and timely.
iv. Information passed to members of the community and various stakeholders will result in actual change in behaviour and practices.
v. The various sectors will embrace this plan, monitor, and evaluate their specific action points outlined in this Bomet CNAP.

vi. Enhanced coordination with various stakeholders- other sectors, other programs in health and private sector, will impact positively to the outcomes.
vii. There will be a favourable prevailing evidence-based policy and political environment during the implementation of this Bomet CNAP.
viii. Investments as input, will result in desired outputs and outcomes, and eventually, achievement of overall results as outlined in the Bomet CNAP

## 4.10 Indicators and information sources

The Indicators that will guide monitoring of this Bomet CNAP are outlined in the table below.

## Expected Results

*Table 9: Impact and outcome nutrition indicators*

| IMPACT/OUTCOME | Indicator | Baseline | Baseline Data Source | Mid-term Target (2022) | End-Term target (2025) | Frequency of data collection |
|---|---|---|---|---|---|---|
| Reduce the number of children under-five who are stunted by 40% (WHA Target 2012) by 2025 | Percentage of stunted children under five years (low height for age) | 36<br>39 | KDHS 2014<br>GBD 2017<br>https://vizhub.healthdata.org/lbd/cgf | 28.8 | 21.6 | Every 2 years |
| Reduce and maintain childhood wasting to less than 5% (WHA 2021 Target) by 2025 | Percentage of wasted children under five years (low weight for height). | 1.8<br>2.8 | KDHS 2014<br>GBD 2017<br>https://vizhub.healthdata.org/lbd/cgf | 1.6 | 1.4 | Every 2 years |
| | Percentage of under-weight under five years (low weight for age) | 12<br>12.6 | KDHS 2014<br>GBD 2017<br>https://vizhub.healthdata.org/lbd/cgf | 9.6 | 7.2 | Every 2 years |
| No increase in childhood overweight (children under 5 years of age) (WHA 2021 Target) by 2025 | Percentage of overweight children less than 5 years (high weight for height->2SD) | 0.6 | KDHS 2014 | 0.6 | 0.6 | Every 5 years |
| Improved survival of children below the age of 5 by 25% | Neonatal mortality rate | 14.8 | GBD 2017<br>https://vizhub.healthdata.org/lbd/under5 | 13 | 11.1 | Every 3 years |
| | Infant mortality rate | 25.2 | GBD 2017<br>https://vizhub.healthdata.org/lbd/under5 | 22 | 18.9 | Every 3 years |
| | Under-5 mortality rate | 33.5 | GBD 2017<br>https://vizhub.healthdata.org/lbd/under5 | 29.3 | 25.1 | Every 3 years |
| Reduction of deaths due to DRNCDs by 33% | DRNCDs mortality rate (18-59 years) (per 100,000) | 161** | WHO NCD Progress Monitor, Kenya Vital Statistics Report | 135 | 108 | Every 3 years |
| Increase the rate of exclusive breastfeeding in the first six months to at least 50% by 2025 (WHA Target 2012) | Exclusive breastfeeding under 6 months prevalence estimates | 36.3 | GBD 2017<br>https://vizhub.healthdata.org/lbd/ebf | 60% | 75% | Every 3 years |
| Reduction by 25% of the proportion of the population who are overweight | Prevalence of overweight in the population (sex disaggregated and per age) | 0.14 | GBD 2017<br>https://vizhub.healthdata.org/lbd/dbm | 0.12 | 0.10 | Every 3 years |
| Educational attainment of the female household population improved by 40% | Percentage of women who have completed at least twelve years of schooling | 8.4*** | KDHS 2014 | 10.1 | 11.8 | Every 5 years |
| Reduce anaemia in women of reproductive age (pregnant women) by 50% by 2025, WHA 2012 Targets: | Prevalence of iron deficiency anaemia in pregnant women | 46.1%** | KMNS 2011 | 38% | 23% | Every 5 Years |
| Improved micronutrient consumption | Percentage of households consuming salt with any iodine | 100% | KDHS 2014 | 100% | 100% | Every 5 Years |
| | Percentage given vitamin A supplements in last 6 months among children aged between 6-59 months at population level | 69.9% | KDHS 2014 | 75% | 80% | Every 5 Years |
| | Prevalence of Zinc deficiency among preschool children aged below 59 months | 83** | KNMS 2017 | 70 | 60 | Every 5 Years |
| Human Resource for nutrition/Nutritionist density | Number of nutritionists per 100,000 population disaggregated by sex | 6 | County HR Data | 14 | 23 | Every 3 years |

** National Level Data for lack of disaggregated data

***Data for the greater Rift Valley region

## *Table 10: Indicators per nutrition objectives*

| Target | Indicator | Baseline | Baseline Year | Yr. 1 | Yr. 2 | Yr. 3 | Yr. 4 | Yr. 5 |
|---|---|---|---|---|---|---|---|---|
| **REDUCTION IN UNDERNUTRITION: WASTING, STUNTING, UNDERWEIGHT** | | | | | | | | |
| Improved proportion of children less than six months exclusively breastfed | Percentage of children 0-6 months visiting facilities exclusively breastfed. | 72.5% | KHIS 2019 | 75% | 77.5% | 80% | 82.5% | 85% |
| | Percentage of infants that were breastfed within one hour after delivery. | 92.7% | KHIS 2019 | 93% | 94% | 95% | 95% | 95% |
| Reduce low birth weight by 30% | Percentage of new-borns in the facilities, with low birth weight | 1.8% | KHIS 2019 | 1.7% | 1.6% | 1.5% | 1.4% | 1.26% |
| | Proportion of children under 5 attending CWC who are stunted | 0.48% | KHIS 2019 | 0.45% | 0.42% | 0.4% | 0.38% | 0.35% |
| | Proportion of children under 5 attending CWC who are underweight | 1.6% | KHIS 2019 | 1.5% | 1.4% | 1.3% | 1.2% | 1.1% |
| **REDUCTION OF MICRONUTRIENT DEFICIENCIES** | | | | | | | | |
| Improved Vitamin A coverage | Percentage of children (6-59 months) receiving Vitamin A Supplementation every six months (100,000 IU for children 6-12 months and 200,000 IU for children > 12 months). | 76.8% | KHIS 2019 | 77% | 78% | 79% | 80% | 80% |
| | Percentage of postnatal women receiving Vitamin A supplementation (200,000 IU) within 8 weeks after delivery. | 2% | KHIS 2019 | 10% | 20% | 30% | 40% | 50% |
| Improved deworming coverage | Percentage of children (12-59 months) receiving de-worming (Albendazole 1 to < 2 years 200 mg and > 2 years 400 mg or Mebendazole 1 to < 2 years 250 mg and > 2 years 500 mg) every six months. | 3.7% | KHIS 2019 | 10% | 20% | 30% | 40% | 50% |
| | Proportion of school-aged children (6-14 years) dewormed | 7.4% | KHIS 2019 | 15% | 25% | 35% | 45% | 55% |
| Improved Zinc supplementation | Percentage of children under five with diarrhoea treated with zinc & ORS | 85.6% | KHIS 2019 | 88% | 90% | 92% | 9% | 95% |
| Increase the proportion of pregnant women consuming iron and folate as per guidelines by 25% | Percentage of pregnant women attending ANC visits receiving Iron and folate supplementation | 73.9% | KHIS 2019 | 75% | 77% | 79% | 81% | 84% |
| Improve dietary quality and micronutrient adequacy in both women and young children | - Minimum dietary diversity among children 6-23 months<br>- Minimum dietary diversity among young children<br>- Minimum dietary diversity among women | 33.5*** | KDHS 2014 | 40% | 45% | 50% | 55% | 60% |
| **REDUCTION IN OVERNUTRITION AND DIET RELATED NON-COMMUNICABLE DISEASES** | | | | | | | | |
| Reduced proportion of adults with overweight and obesity by 25% | Prevalence of overweight among female adults | 16% | KDHS 2014 | 15.2% | 14.4% | 13.6% | 12.8% | 12% |
| | Prevalence of obesity among female adults | 4.4% | KDHS 2014 | 4.2% | 4.0% | 3.8% | 3.6% | 3.4% |
| | Proportion of adults aged 18-69 years who are overweight and obese | 28%** | STEPwise survey 2015 | 26% | 24% | 23% | 22% | 21% |
| Reduced proportion of diet related NCDs | Prevalence of Hypertension among women | 8.3*** | KDHS 2014 | 7.5% | 7.2% | 6.8% | 6.5% | 6.2% |
| **CROSS-CUTTING AREAS** | | | | | | | | |
| Improved human resource for nutrition | Percentage of key nutrition positions filled | 4% | Program data 2019 | 4% | 10% | 10% | 15% | 15% |
| Financing | Resources available for nutrition (absolute numbers, or a proportion of health budget) | 10M | 2020/2021 | 12M | 15M | 20M | 25M | 30M |
| Access: Infrastructure | Number of facilities offering nutrition services per100,000 people | 19 | KHIS, 2020 | 21 | 23 | 25 | 27 | 30 |

***Data for former Rift Valley Region

** National level data

*Table 11: KRA 01: Maternal, Infant, Young Child Nutrition (MIYCN) and prevention, control and management of micronutrient deficiencies scaled up*

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Scaled - up implementation of baby friendly community initiative (BFCI) | Number of CHMT/SCHMT and CHVs sensitized on BFCI disaggregated by both genders | 40 | 2019 | Program data | Every 3 Years | 0 | 365 | 300 | 300 | 300 |
| | Number of HCWs trained on BFCI disaggregated by both genders | 24 | 2019 | Program data | Bi-annual | 0 | 150 | 150 | 150 | 150 |
| | Number of gender sensitive CMSGs formed | 170 | 2019 | Program data | Every 5 Years | 0 | 30 | 30 | 30 | 30 |
| | Number of MTMSGs formed | 17 | 2019 | Program data | Every 5 Years | 0 | 90 | 90 | 90 | 90 |
| | Number of health facilities implementing BFCI visited for mentorships per quarter in the County | 0 | 2019 | Program data | Quarterly | 17 | 60 | 60 | 60 | 60 |
| | Number of community units implementing BFCI assessed by the C/SCHMT annually per CU | 0 | 2019 | Program data | Bi-annual | 34 | 60 | 60 | 60 | 60 |
| | Number of external assessments done | 0 | 2019 | Program data | Every 5 Years | 0 | 0 | 0 | 1 | 1 |
| Strengthened and scaled up of BFHI implementation | Number of C/SCHMT sensitized on BFHI disaggregated by gender | 0 | 2019 | Program data | Every 5 Years | 0 | 105 | 0 | 0 | 0 |
| | Number of HCWs trained on BFHI in the implementation of BFCI interventions disaggregated by both genders | 0 | 2019 | Program data | Every 5 Years | 0 | 60 | 60 | 60 | 0 |
| | Proportion of facilities offering health education on the steps of successful breastfeeding to mothers and fathers attending ANC, CWC, Maternity and PNC | No Data | 2019 | Supervision reports | Quarterly | 60% | 65% | 70% | 75% | 80% |
| | Number of gender integrated baseline assessments survey conducted | 0 | 2019 | Program data | Annually | 0 | 1 | 2 | 2 | 1 |
| | Number of facilities implementing gender transformative BFHI assessed by C/SCHMT | 0 | 2019 | Program data | Bi-annual | 0 | 2 | 4 | 4 | 2 |
| | Number of external assessments done | 0 | 2019 | Program data | Every 5 Years | 0 | 0 | 0 | 0 | 1 |
| Strengthened quality delivery of MIYCN services | Number of male and female CHVs sensitized on MIYCN | 0 | 2019 | Program data | Annually | 0 | 100 | 100 | 100 | 100 |
| | Number of HCWs trained on MIYCN and on effective provision of gender responsive MIYCN related services disaggregated by both genders | 0 | 2019 | Program data | Annually | 0 | 60 | 60 | 60 | 60 |
| | Number of men and women sensitized on MIYCN by CHVs per quarter | 0 | 2019 | Chv report | Quarterly | 0 | 50000 | 50000 | 50000 | 50000 |
| | Number of facilities visited for mentorships on MIYCN | 0 | 2019 | Program data | Quarterly | 0 | 15 | 15 | 15 | 15 |
| Enhanced adherence to policies and legislations protecting, promoting, and supporting breastfeeding at the workplace and among the general population | Number of facilities sensitized on the gender responsive implementation framework for securing a breastfeeding friendly environment at workplace | 0 | 2019 | Program data | Annually | 75 | 75 | 75 | 75 | 75 |
| | Number of other stakeholders sensitized on the gender responsive implementation framework for securing a breastfeeding friendly environment at workplace disaggregated by gender | 0 | 2019 | Program data | Annually | 0 | 30 | 30 | 30 | 30 |
| | Number of lactation stations established in selected areas | 0 | 2019 | Program data | Annually | 0 | 2 | 2 | 2 | 2 |
| Strengthened implementation of breastmilk (regulations and control) Act, 2012 in Bomet County | Number of Health facilities sensitized on BMS Act, 2012 | 0 | 2019 | Program data | Quarterly | 75 | 75 | 75 | 75 | 75 |
| | Number of PHOs, Nutritionists and other healthcare workers trained on BMS monitoring and enforcement disaggregated by gender | 0 | 2019 | Program data | Annually | 0 | 30 | 30 | 30 | 0 |
| | Number of HCWs trained on BMS implementation framework disaggregated by gender | 0 | 2019 | Program data | Annually | 0 | 30 | 30 | 30 | 30 |

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Strengthened Growth Monitoring and Promotion (GMP) at County level | Number of HCWs trained on WHO growth standards disaggregated by gender | 0 | 2019 | Program data | Annually | 0 | 30 | 30 | 30 | 30 |
| | Number of children attending GMP | | 2019 | Facility data (MOH 510) | Monthly | | | | | |
| | Proportion of caregivers of children at risk of malnutrition counselled | No data | 2019 | Facility data (MOH 510) | Monthly | | | | | |
| | Vitamin A coverage for children 6-11 months | 70.3 | 2019 | KHIS 2019 | Monthly | 75 | 80 | 85 | 90 | 95 |
| | Vitamin A coverage for children 12-59months | 43.9 | 2019 | KHIS 2019 | Monthly | 50 | 55 | 60 | 65 | 70 |
| | Proportion of children aged 12-59 months dewormed | 3.7 | 2019 | KHIS 2019 | Monthly | 10 | 15 | 20 | 25 | 30 |
| | Proportion of children of aged 6 -23 months receiving MNPs | 0 | 2019 | KHIS 2019 | Monthly | 0 | 5 | 10 | 15 | 20 |
| | Proportion of women attending ANC supplemented with IFA | 73.9 | 2019 | KHIS 2019 | Monthly | 75 | 77 | 78 | 79 | 80 |
| | Proportion of children under five with diarrhoea supplemented with Zinc | 85.6 | 2019 | KHIS 2019 | Monthly | 86 | 87 | 89 | 90 | 91 |
| Enhanced monitoring and evaluation systems for MIYCN services | Number of support supervisions done covering MIYCN | 4 | 2019 | Supervision reports | Quarterly | 20 | 20 | 20 | 20 | 20 |
| | Proportion of facilities experiencing no stock out of nutrition reporting tools | No data | 2019 | Supervision reports Facility assessment data | Annually | 60% | 70% | 80% | 85% | 90% |
| | Number of nutrition DQAs conducted | 4 | 2019 | Program data | Quarterly | 20 | 20 | 20 | 20 | 20 |
| | Number of nutrition data Reviews done | 4 | 2019 | Program data | Quarterly | 20 | 20 | 20 | 20 | 20 |

*Table 12: KRA 02: Nutrition of older children, adolescents, adults, and older persons promoted*

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Improved policy environment at County level for older children (5-9 years), adolescents (10-19 years), Adults and older persons<br>And Adolescent nutrition promoted | Number of HCWs trained on Healthy Diets and physical activity for the life course disaggregated by gender | 0 | 2019 | Program Data | Annually | 0 | 60 | 60 | 60 | 0 |
| | Number of HCWs trained on adolescent Nutrition disaggregated by gender | 0 | 2019 | Program Data | Annually | 0 | 60 | 60 | 60 | 0 |
| | Number of HCWs disaggregated by gender sensitized on nutrition guidelines for older children and adolescents | 0 | 2019 | Program Data | Annually | 0 | 11O | 110 | 120 | 0 |
| | Number of Key influencers, role models and nutrition champion disaggregated by gender, sensitized on nutrition for older children and adolescents | 0 | 2019 | Program Data | Quarterly | 0 | 20 | 20 | 20 | 20 |
| | Number of adolescents supplemented with WIFA disaggregated by gender | 0 | 2019 | Program Data | Monthly | 0 | 0 | 0 | 500 | 500 |
| Reduction of marketing of unhealthy foods among older children and adolescents | Number of assessment reports on regulation and control of marketing of unhealthy foods for older children and adolescents | 0 | 2019 | Program Data | Quarterly | 0 | 20 | 20 | 20 | 20 |
| Access to quality, timely, affordable health care and nutrition support to adults and older persons promoted | Number of healthcare workers sensitized on geriatric nutrition policy guidelines disaggregated by gender | 0 | 2019 | Program Data | Quarterly | 0 | 110 | 110 | 120 | 0 |
| | Number of CHVs sensitized on geriatric nutrition disaggregated by gender | 0 | 2019 | Program Data | Annually | 0 | 800 | 800 | 800 | 800 |

*Table 13: KRA 03: Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled-up*

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Improved policy and legal environment for nutrition in DRNCDs | Number of CHMT/SCHMT and HCWs disaggregated by gender, sensitized on legislations for advertising, packaging, labelling, and marketing of foods | 0 | 2019 | Program data | Annually | 280 | 200 | 200 | 0 | 0 |
| Strengthened County capacity to accelerate nutrition response for prevention and control of DRNCDs | Number of nutrition screening and counselling sessions conducted at community level | No Data | 2019 | Program data | Bi-annual | 60 | 60 | 60 | 60 | 60 |
| | Proportion of clients disaggregated by gender, age, and diversity with DRNCDs receiving nutrition assessment | 0 | 2019 | Program data | Monthly | 2 | 2 | 2 | 2 | 2 |
| | Number of support groups trained on DRNCDs | 0 | 2019 | Program data | Every 5 Years | 0 | 30 | 0 | 0 | 0 |
| Behaviour change communication strategies developed and implemented to promote primary and secondary prevention of diet-related risk factors for DRNCDs | Number of radio talk shows on gender, age, and diversity responsive DRNCDs conducted | 0 | 2019 | program data | Quarterly | 4 | 4 | 4 | 4 | 4 |
| | Number of champions identified disaggregated by gender | 0 | 2019 | Program data | Every 5 Years | 25 | 0 | 0 | 0 | 0 |
| | Number of DRNCDs related health days commemorated (World Diabetes and World Cancer Days) | 2 | 2019 | Program data | Annually | 2 | 2 | 2 | 2 | |
| | Number of male and female journalists sensitized on DRNCDs | No Data | 2019 | Program data | Every 2 Years | 5 | 0 | 5 | 0 | 5 |
| | Number of gender responsive workplace wellness centres established | No Data | 2019 | Program data | Every 5 Years | 0 | 0 | 1 | 0 | 0 |
| | Number of community sensitization sessions (equally targeting men and women across different ages and diversities) held on physical activity and healthy diet | No Data | 2019 | Program data | Quarterly | 60 | 60 | 60 | 60 | 60 |
| | Number of male and female HCWs trained on gender transformative prevention, control and management of DRNCDs | No Data | 2019 | Program data | Annually | 60 | 0 | 60 | 0 | 60 |

*Table 14: KRA 04: Integrated Management of Acute Malnutrition (IMAM) strengthened*

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Policy, standards, and guidelines for the IMAM program implemented at County level | Number of CHMT, HMT, SCHMT sensitized. | No data | 2019 | MOH | Annually | 130 | 130 | 130 | 130 | 130 |
| | Number of health facilities receiving disseminated SOPs guidelines and treatment protocols | No data | 2020 | MOH | Annually | 159 | 159 | 159 | 159 | 159 |
| IMAM programme performance monitored, and quality of services improved | Proportion of nutritionist and health workers adhering to IMAM program SOPs, guidelines, and protocols | No data | 2019 | Program data | Quarterly | 60% | 70% | 75% | 80% | 85% |
| | Number of IMAM performance and review meetings | No data | 2019 | Activity reports | Quarterly | 4 | 4 | 4 | 4 | 4 |
| Advocacy, communication, social mobilization, and resource mobilization for IMAM programme scaled up: | Number of advocacy meeting held at County and Sub County levels on increased allocation to IMAM | No data | 2019 | Program data | Annually | 6 | 6 | 6 | 6 | 6 |
| | Number of CHVs receiving monthly stipend from the County Government disaggregated by gender | 6 | 2019 | Community strategy records | Annually | 2470 | 2470 | 2470 | 2470 | 2470 |
| | Number of genders integrated operational level research done | 0 | 2019 | County research unit | Annually | 1 | 1 | 1 | 1 | 1 |
| | Percentage of individuals affected by malnutrition treated and supported disaggregated by gender | No data | 2019 | DHIS | Monthly | 60 | 75 | 85 | 95 | 95 |

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Enhanced early case identification through community mobilization and referrals | Number of nutrition screening and assessment sessions conducted at community and facility | No data | 2019 | Activity reports | Quarterly | 4 | 4 | 4 | 4 | 4 |
| | Proportion of IMAM clients followed up by CHVs | No data | 2019 | Program data | Monthly | 70 | 80 | 90 | 100 | 100 |
| | Number of CHVs sensitized on IMAM referral system | No data | 2019 | Activity reports | Quarterly | 620 | 620 | 620 | 620 | 620 |
| | Number of genders, age, and diversity inclusive IMAM referrals from community to facility and facility to community | No data | 2019 | CHAs report | Monthly | 70 | 80 | 90 | 100 | 100 |
| | Proportion of IMAM clients linked with programs on behaviour change for prevention at community level | No data | 2019 | CHAs report | Monthly | 60 | 75 | 85 | 100 | 100 |
| Improved utilization of gender, age and diversity sensitive IMAM data for informed decision making | Number of gender integrated research, best practices and learning documented | No data | 2019 | County research unit | Annually | 1 | 1 | 1 | 1 | 1 |
| | Number of stakeholders' fora held to share best practices and learning on gender responsive IMAM. | No data | 2019 | Activity reports | Annually | 1 | 1 | 1 | 1 | 1 |
| | Number of data quality review meetings for IMAM program | No data | 2019 | Activity reports | Quarterly | 4 | 4 | 4 | 4 | 4 |
| Capacity enhanced for IMAM Service delivery and programming | Number of male and female health care workers trained on IMAM package | No data | 2019 | Activity reports | Quarterly | 70 | 70 | 70 | 70 | 70 |
| | Number of male and female CHVs sensitized on IMAM package | No data | 2019 | Activity reports | Annually | 100 | 100 | 100 | 100 | 100 |
| | Proportion of male and female IMAM clients receiving nutritional assessment, counselling and support disaggregated by gender, age, and diversity. | No data | 2019 | Monthly reports | Monthly | 50 | 60 | 70 | 85 | 100 |
| Strengthen IMAM supply chain | Proportion of facilities with no stock outs of therapeutic and supplementary feeds for management of SAM and MAM | No data | 2019 | Supervisory reports | Quarterly | 60 | 75 | 85 | 100 | 100 |
| | Proportion of facilities with available anthropometric tools | No data | 2019 | Supervisory reports | Quarterly | 60 | 75 | 85 | 100 | 100 |

*Table 15: KRA 05: Clinical nutrition and dietetics in disease management including HIV and TB*

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Nutrition screening, assessment and triage to all individuals seeking health care promoted | Proportion of triage areas /stations carrying out nutrition screening and assessment for all clients disaggregated by gender, age, and diversity. | No data | 2019 | Supervisory reports | Quarterly | 50 | 60 | 75 | 85 | 100 |
| Improved referral services between facility to facility, community to facility and vice versa | Number of health care workers disaggregated by gender, sensitized on the facility-community referral tool | No data | 2019 | Activity reports | Quarterly | 200 | 200 | 200 | 200 | 200 |
| Improved advocacy for nutrition and dietetics | Proportion of health facilities integrating gender responsive nutrition services in other service areas | No data | 2019 | Monthly reports | Quarterly | 70 | 80 | 90 | 100 | 100 |
| | Number of hospitals and health centres with gender and diversity inclusive inpatient feeding committees | 1 | 2019 | Health facility data | Quarterly | 4 | 9 | 10 | 10 | 10 |
| | Number of health care workers sensitized on safety package for clinical nutrition and dietetics disaggregated by gender | No data | 2019 | Activity reports | Quarterly | 70 | 70 | 70 | 70 | 70 |
| Nutrition and dietetics guidelines, standards, screening, and assessment tools developed and implemented | Number of health care workers disaggregated by gender, trained on gender transformative clinical nutrition and dietetics in disease management | 0 | 2019 | Activity reports | Annually | 30 | 30 | 30 | 30 | 30 |
| | Number of nutritionists disaggregated by gender, sponsored for clinical nutrition short courses. | 0 | 2019 | Program data | Annually | 2 | 2 | 2 | 2 | 2 |
| | Number of nutritionists disaggregated by gender, sponsored for clinical nutrition specialised courses | 0 | 2019 | Program data | Every 2 Years | 0 | 1 | 0 | 1 | 0 |
| Improved quality of clinical nutrition and dietetics care in management of diseases | Number of supportive supervision sessions conducted for clinical nutrition and dietetics | 0 | 2019 | Activity reports | Quarterly | 4 | 4 | 4 | 4 | 4 |
| | Number of data review meetings for clinical nutrition and dietetics held | 0 | 2019 | Activity reports | Bi-annual | 1 | 2 | 2 | 2 | 2 |
| Improved food procurement, supply, hygiene, and safety in health care institutions | Proportions of admitting facilities with nutrition commodities for feeding and management of special conditions | No data | 2019 | Supervisory reports | Quarterly | 20 | 30 | 50 | 60 | 70 |
| | Number of Sub-Counties with food safety inspection committees | 0 | 2019 | Program data | Annually | 1 | 3 | 5 | 5 | 5 |
| | Proportion of health facilities with clinical nutrition reporting tools | No data | 2019 | Supervisory reports | Quarterly | 40 | 50 | 60 | 70 | 80 |
| Increased coverage for nutrition screening and referral of PLHIV and TB patients | Proportion of comprehensive care centres offering nutritional assessment | No data | 2019 | Supervisory reports | Quarterly | 50 | 60 | 70 | 80 | 90 |
| | Number of health care workers disaggregated by gender trained to provide patient focused nutrition therapy for paediatric patients and adolescents infected with HIV/TB | No data | 2019 | Activity reports | Quarterly | 20 | 20 | 20 | 20 | 20 |
| | Number of health care workers and CHVs disaggregated by gender sensitized on information related nutrition screening and comprehensive nutritional assessment | No data | 2019 | Activity reports | Quarterly | 30 | 30 | 30 | 30 | 30 |
| | Proportion of HIV, TB and MNCH service points carrying out comprehensive nutritional assessment | No data | 2019 | Activity reports | Quarterly | 50 | 60 | 70 | 80 | 90 |
| | Number of quality surveillance meetings done for nutrition commodities used in management of HIV/TB | 1 | 2019 | Activity reports | Bi-annual | 2 | 2 | 2 | 2 | 2 |
| Strengthened integration of nutrition interventions for home-based care at community level for PLHIVs towards the 90.90.90 | Number of outreaches, referrals and linkage done for nutritional care and management on PLHIV and TB patients | No data | 2019 | Outreach registers | Quarterly | 164 | 328 | 328 | 328 | 328 |

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Improved routine screening for nutrition related problems and referral for all PLHIV and TB patients | Number of health care workers (by gender) trained through on-line and in-person continuous professional development on responsive nutrition therapy for TB/HIV | No data | 2019 | Activity reports | Annually | 70 | 70 | 70 | 70 | 70 |
| | Proportion of health facilities utilizing context-specific job aids for patient focused nutrition therapy and interpersonal counselling | No data | 2019 | Supervisory reports | Quarterly | 50 | 60 | 70 | 80 | 90 |
| | Proportion of PLHIV and TB patients disaggregated by gender, age and diversity receiving nutritional assessment, counselling, and support | No data | 2019 | Activity reports | Monthly | 60 | 70 | 80 | 90 | 100 |
| Enhanced use of implementation research to generate evidence for cost-effective nutrition TB and HIV programming | Number of NACS data service audit sessions done | No data | 2019 | Activity reports | Quarterly | 12 | 24 | 24 | 24 | 24 |
| | Proportions of facilities using m-health to identify and follow-up patients at community level. | No data | 2019 | Supervisory reports | Annually | 40 | 50 | 60 | 70 | 80 |
| | Number of bottleneck assessments conducted specific to key program areas in NACS to identify questions for implementation research | No data | 2019 | Activity reports | Annually | 0 | 1 | 1 | 1 | 1 |

*Table 16: KRA 06: Nutrition in emergencies strengthened*

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Strengthened coordination and partnerships for integrated preparedness and response initiatives | Number of IMAM surge kits adapted | No Data | 2019 | Activity Report | Every 2 Years | 1 | 0 | 1 | 0 | 1 |
| | Number of disaster preparedness and response plan reviewed | No Data | 2019 | Activity Report | Annually | 1 | 1 | 1 | 1 | 1 |
| Strengthened implementation of recovery interventions to enhance 'build back better' approaches | Number of nutrition sessions conducted in livelihood and social protection programmes | No data | 2019 | Activity Report | Annually | 1 | 1 | 1 | 1 | 1 |
| | Number of post disaster review meetings held to influence age, gender, and diversity responsive nutrition considerations | No data | 2019 | Activity Report | Annually | 1 | 1 | 1 | 1 | 1 |
| | Number of community level dialogue and recovery initiatives conducted incorporating meaningful participation of men and women across different ages and diversities. | No data | 2019 | Activity Report | Annually | 1 | 1 | 1 | 1 | 1 |

*Table 17: KRA 07: Nutrition in education, agriculture, Water, Sanitation & Hygiene (WASH) and social protection*

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Strengthened sustainable and inclusive food systems that are diverse, productive, and profitable for improved nutrition | Number of people disaggregated by gender, sensitized on early warning systems per Ward. | 0 | 2019 | Sector reports | Annually | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 |
| Improved access to nutritious and safe foods along the food value chain | Number of public and private sector actors sensitized on gender responsive food value chain pathways at the County level disaggregated by gender | 0 | 2019 | Agriculture sector report | Annually | 30 | 30 | 30 | 30 | 30 |
| | Proportion of male and female farmers using appropriate processing, preservation and storage technologies per ward disaggregated by gender | No data | 2019 | Field reports | Annually | 30 | 40 | 50 | 60 | 70 |
| | Proportion of reduction of Post-harvest losses | 30 | 2019 | Agriculture sector report | Annually | 25 | 25 | 20 | 20 | 20 |
| Consumption of safe, diverse, and nutritious foods promoted | Proportion of households utilizing food composition tables and recipes | No data | 2018 | Agriculture sector report | Annually | 20 | 25 | 30 | 35 | 40 |
| | Number of agri- nutrition resource manuals and dialogue cards disseminated at the sub-County level | No data | 2019 | Agriculture sector report | Annually | 15 | 20 | 25 | 30 | 35 |
| | Number of food safety regulations and enforcement mechanisms disseminated per ward. | No data | 2019 | Agriculture sector report | Annually | 1 | 2 | 2 | 2 | 2 |
| | Number of regulation and standards developed in the County. | No data | 2019 | Agriculture sector report | Annually | 1 | 2 | 3 | 3 | 3 |
| | Number of male and female sub-County Agriculture staff disaggregated by gender, sensitized on gender responsive diversified food production | No data | 2019 | Agriculture sector report | Annually | 10 | 15 | 20 | 20 | 20 |
| Strengthened food-based capacities and coordination at County and sub-County levels | Number of sub-County staff disaggregated by gender sensitized on gender responsive Agri- nutrition capacity and coordination | No data | 2019 | Agriculture sector report | Annually | 20 | 25 | 30 | 35 | 35 |
| | Number of stakeholders sensitized on gender responsive Agri-nutrition capacity integration in the County | No data | 2019 | Agriculture sector report | Annually | 5 | 8 | 10 | 10 | 15 |
| Collaboration with relevant stakeholders on WASH strengthened | Number of Public health staff sensitized on mechanisms to strengthened linkages of nutrition to WASH at sub-County level | No data | 2019 | Public health sector report | Annually | 20 | 30 | 40 | 40 | 50 |
| Optimal WASH practices promoted | Number of functional systems adopted for WASH service provision per ward. | No data | 2019 | Public health sector report | Annually | 2 | 2 | 2 | 2 | 2 |
| | Number of sensitization meetings held on safe and hygiene during food preparation at household level targeting men and women across different ages, diversity, and level of influence. | No data | 2019 | Public health sector report | Annually | 2 | 3 | 3 | 4 | 5 |
| | Number of functional systems adopted for WASH service provision per ward. | No data | 2019 | Public health sector report | Annually | 2 | 2 | 2 | 2 | |
| | Number of TOTs conducted on Community led sanitation to promote integrated WASH nutrition practices per ward. | No data | 2019 | Public health sector report | Annually | 3 | 5 | 5 | 5 | 5 |
| Nutrition promoted and linkages enhanced in social protection programmes including in crisis | Number of safety nets at the sub-County level | No data | 2017 | Field reports/Sector reports | Annually | 3 | 5 | 5 | 5 | 5 |

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Strengthened advocacy, communication, and social mobilization for social protection | Number of nutrition human resource deployed in Social protection programs at sub-County level | No data | 2019 | Field reports/'sector reports | Annually | 2 | 5 | 5 | 5 | 5 |
| | Budgetary allocation for nutrition in social protection | No data | 2019 | Field reports/ sector reports | Annually | Yes | Yes | Yes | Yes | Yes |
| Strengthened advocacy, communication, and social mobilization for social protection | Number of sensitization meetings held on the management of institution of vulnerable persons and correction facilities on health and nutrition. | No data | 2019 | Field reports/Sector reports | Annually | 2 | 3 | 6 | 9 | 10 |
| | Number of learning visits for policy makers and implementers in counties with the best practices on gender transformative health and nutrition for vulnerable groups. | No data | 2019 | Field reports/sector reports | Annually | 1 | 1 | 1 | 1 | 1 |
| Promote capacity for nutrition services in schools and other learning institutions | Number of schools implementing school meals guidelines and feeding programme | No data | 2019 | ECD Data/ Assessment reports | Annually | 264 | 500 | 1000 | 1500 | 2000 |
| | Number of benchmarking /learning visits for policy makers and implementors in Counties with best feeding practices for ECD children, primary and secondary schools. | No data | 2019 | ECD Data/ Assessment reports | Annually | 1 | 1 | 1 | 1 | 1 |
| | Number of teachers sensitized on feeding manual disaggregated by gender | No data | 2019 | ECD Data/ Assessment reports | Annually | 500 | 1000 | 1500 | 2000 | 2500 |
| | Number of schools with active demonstration gardens, green house, small animals and revived 4K Clubs | No data | 2019 | ECD Data/ Assessment reports | Annually | 264 | 300 | 350 | 400 | 450 |
| | Proportion of co-curricular activity themes touching on nutrition and physical activity in schools. | No data | 2019 | ECD Data/ Assessment reports | Annually | 15% | 20% | 25% | 25% | 30% |
| Enhanced capacity for nutrition assessment in schools and other learning institutions | Number of gender and aged integrated nutrition assessment sessions conducted in schools. | No data | 2019 | ECD data/ Assessment reports | Annually | 500 | 500 | 500 | 500 | 500 |
| | Proportion of assessed children disaggregated by gender and age requiring nutrition review, referred | No data | 2019 | ECD Data/ Assessment reports | Annually | 60% | 70% | 75% | 80% | 85% |
| Healthy and safe food environment promoted in schools and other learning institutions. | Number of stakeholders including curriculum support officers, Sub-County and ward coordinators, teachers, food service providers and handlers, PTAs sensitized on healthy safe food environment in schools, disaggregated by gender. | No data | 2019 | ECD Data/ Assessment reports | Annually | 50 | 100 | 200 | 300 | 400 |

*Table 18: KRA 08: Sectoral and multisectoral collaboration governance including co-ordination and legal/regulatory framework strengthened*

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Enhanced existing nutrition coordination and collaborating mechanisms and linkages between national and County governments | Number of County and sub-County Nutrition Technical forums held as per ToR | 2 | 2019 | Nutrition activity report | Quarterly | 24 | 24 | 24 | 24 | 24 |
| | Number of nutrition sensitive sectors prioritizing gender responsive nutrition in their annual work plans. | ND | 2019 | Sector specific workplans | Annually | 4 | 4 | 4 | 4 | 4 |
| | Number of other sectoral coordination forums with nutrition programme representation | ND | 2019 | Nutrition programme report | Quarterly | 16 | 16 | 16 | 16 | 16 |
| | Number of County and sub-County annual gender integrated nutrition performance assessment reviews conducted | ND | 2019 | Nutrition activity report | Annually | 6 | 6 | 6 | 6 | 6 |
| | Number of nutrition learning forums held/stakeholder done | ND | 2019 | Nutrition activity report | Annually | 1 | 1 | 1 | 1 | 1 |
| Enhanced coordination in development and implementation of nutrition-relevant regulatory frameworks | Number of annual nutrition regulation forums with relevant actors held | ND | 2018 | Nutrition activity report | Annually | 1 | 1 | 1 | 1 | 1 |
| Nutrition resource mobilization and accountability tracked | Second generation costed County gender responsive Nutrition Action Plan (CNAP) developed | 0 | 2019 | Nutrition activity report | Every 5 Years | 0 | 0 | 0 | 0 | 1 |
| | Nutrition resource mobilization and accountability strategy developed | 0 | 2019 | Nutrition activity report | Annually | Yes | Yes | Yes | Yes | Yes |
| | Nutrition resource tracking conducted | 0 | 2019 | Nutrition activity report | Annually | Yes | Yes | Yes | Yes | Yes |
| | Number of public participations attended by Nutrition section | ND | 2019 | Nutrition activity report | Annually | 1 | 1 | 1 | 1 | 1 |

*Table 19: KRA 09: Sectoral and multisectoral Nutrition Information Systems, learning and research strengthened*

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Nutrition sector plans progress reviewed | Gender responsive nutrition AWPs developed from the CNAP | No data | 2019 | Nutrition activity report | Annually | Yes | Yes | Yes | Yes | Yes |
| | Number of gender responsive Annual, performance reviews conducted | 1 | 2019 | Nutrition activity report | Annually | 1 | 1 | 1 | 1 | 1 |
| Strengthened nutrition sector capacity in nutrition information system (NIS) and evidence-based decision-making | Number of quarterly data review and feedback meetings held | 0 | 2019 | Nutrition activity report | Quarterly | 4 | 4 | 4 | 4 | 4 |
| | M&E capacity needs assessments conducted | 0 | 2019 | Nutrition activity report | Annually | Yes | No | No | Yes | No |
| | Number of gender integrated nutrition data and reports uploaded to DHIS to enable generation of information to be used for decision making | ND | 2019 | Nutrition activity report | Monthly | 12 | 12 | 12 | 12 | 12 |
| Improved access to and use of nutrition information to inform program quality, adjustment, and learning | Number of Data Quality Audits for DHIS, LMIS and sentinel surveillance conducted | ND | 2018 | Nutrition activity report | Annually | 1 | 1 | 1 | 1 | 1 |
| | Gender integrated SMART Nutrition surveys conducted | ND | 2019 | Nutrition activity report | Every 2 Years | 1 | 0 | 0 | 1 | 0 |
| Standardized and harmonized nutrition data collection methodologies, management, and reporting at all levels | Number of collaboration and linkages with other sectors on nutrition to strengthened information system | ND | 2019 | Nutrition activity report | Quarterly | 4 | 4 | 4 | 4 | 4 |
| Improved decision making through research evidence | Number of gender integrated Nutrition research prioritized at the County level | ND | 2019 | Nutrition activity report | Annually | 1 | 1 | 1 | 1 | 1 |

*Table 20: KRA 10: Advocacy, communication, and social mobilization (ACSM) strengthened*

| Expected Outputs | Key Performance Indicators | Baseline Data | Year | Source of Data | Periodicity | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Nutrition sector plans progress reviewed | Gender responsive nutrition AWPs developed from the CNAP | No data | 2019 | Nutrition activity report | Annually | Yes | Yes | Yes | Yes | Yes |
| | Number of gender responsive Annual, performance reviews conducted | 1 | 2019 | Nutrition activity report | Annually | 1 | 1 | 1 | 1 | 1 |
| Strengthened nutrition sector capacity in nutrition information system (NIS) and evidence-based decision-making | Number of quarterly data review and feedback meetings held | 0 | 2019 | Nutrition activity report | Quarterly | 4 | 4 | 4 | 4 | 4 |
| | M&E capacity needs assessments conducted | 0 | 2019 | Nutrition activity report | Annually | Yes | No | No | Yes | No |
| | Number of gender integrated nutrition data and reports uploaded to DHIS to enable generation of information to be used for decision making | ND | 2019 | Nutrition activity report | Monthly | 12 | 12 | 12 | 12 | 12 |
| Improved access to and use of nutrition information to inform program quality, adjustment, and learning | Number of Data Quality Audits for DHIS, LMIS and sentinel surveillance conducted | ND | 2018 | Nutrition activity report | Annually | 1 | 1 | 1 | 1 | 1 |
| | Gender integrated SMART Nutrition surveys conducted | ND | 2019 | Nutrition activity report | Every 2 Years | 1 | 0 | 0 | 1 | 0 |
| Standardized and harmonized nutrition data collection methodologies, management, and reporting at all levels | Number of collaboration and linkages with other sectors on nutrition to strengthened information system | ND | 2019 | Nutrition activity report | Quarterly | 4 | 4 | 4 | 4 | 4 |
| Improved decision making through research evidence | Number of gender integrated Nutrition research prioritized at the County level | ND | 2019 | Nutrition activity report | Annually | 1 | 1 | 1 | 1 | 1 |

## 4.11 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 Bomet CNAP.

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

a) Developing gender responsive standard operating procedures (SOPs) for management of data, monitoring, evaluation and learning among all stakeholders.
b) Improving performance monitoring and review processes
c) Enhancing sharing of gender integrated data and use of information for evidence-based decision making

*Table 21: Roles and responsibilities of different actors in the implementation of Bomet CNAP*

| Actors | Roles and responsibilities |
|---|---|
| **Nutrition M&E Staff Members** | • Ensuring overall design of the MEAL plan is technically sound<br>• Working with stakeholders to develop and refine appropriate outputs, outcomes, indicators, and targets<br>• Providing technical assistance to create data collection instruments<br>• Helping program staff with data collection (including selection of appropriate methods, sources, enforcement of ethical standards)<br>• Ensuring data quality systems are established<br>• Analysing data and writing up the findings<br>• Aiding program staff to interpret their output and outcome data<br>• Promoting use of M&E data to improve program design and implementation<br>• Conducting evaluations or special studies |
| **Management at program level** | • Determining what resources, human and financial, should be committed to M&E activities<br>• Ensuring content of the M&E plan aligns with the overall vision and direction of the County<br>• Assuring data collected meet the information needs of stakeholders<br>• Tracking progress to confirm staff carry out activities in the M&E plan<br>• Improving project design and implementation based on M&E data<br>• Deciding how results will be used and shared<br>• Identifying who needs to see and use the data<br>• Deciding where to focus evaluation efforts<br>• Interpreting and framing results for different audiences |
| **County Department of health services** | • Providing technical services and coordinating gender sensitive M&E activities<br>• Establishing and equipping robust M&E units aligned to their respective departmental organograms<br>• Providing dedicated staff team comprised of the entire mix of M&E professionals needed to implement this scope (M&E, officers, HRIOs, Statisticians, planners, economics, epidemiologists<br>• Coordinating and supervising the implementation of all gender integrated M&E activities at the County and sub-County and facility levels |
| **Nutrition Sensitive Sectors** | • Monitoring and reporting on progress towards implementation of key activities that fall within their mandates in line with jointly agreed indicators<br>• Participating in high level M&E activities at the County<br>• Supporting surveys and evaluations needed to assess shared impact of joint interventions |

| Actors | Roles and responsibilities |
|---|---|
| **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<br>• Routine monitoring and evaluating their activities<br>• Using existing systems/developing M&E sub systems that utilize existing structures at all levels of the health information system<br>• Utilizing the data collected for decision making within the institution |
| **Development Partners** | • Providing substantive technical and financial support to ensure that the systems are functional.<br>• Ensuring that their reporting requirements and formats are in line with the indicators outlined in the M&E framework.<br>• Synchronizing efforts with existing development partners and stakeholder efforts based on an agreed upon one County-level M&E system.<br>• Utilizing reports generated in decision making, advocacy and engaging with other partners for resource mobilization. |
| **Health Facilities** | • Ensuring that data collected, and reports generated are disseminated and used by the implementors to monitor trends in supply of basic inputs, routine activities, and progress made.<br>• Using this data in making decisions on priority activities to improve access and quality of service delivery. |
| **Community Health Units** | • Identifying and notifying the health authority of all health and demographic events including M&E that occurs in the community<br>• Generating reports through community main actors e.g. the CHWs, teachers and religious leaders through a well-developed reporting guideline Community Health Information System (CHIS) |

## 4.13 Calendar of key M&E Activities

The County will adhere to the health sector accountability cycle as illustrated in the figure below. This will ensure the alignment of resources and activities to meet the needs of different actors in the health sector.

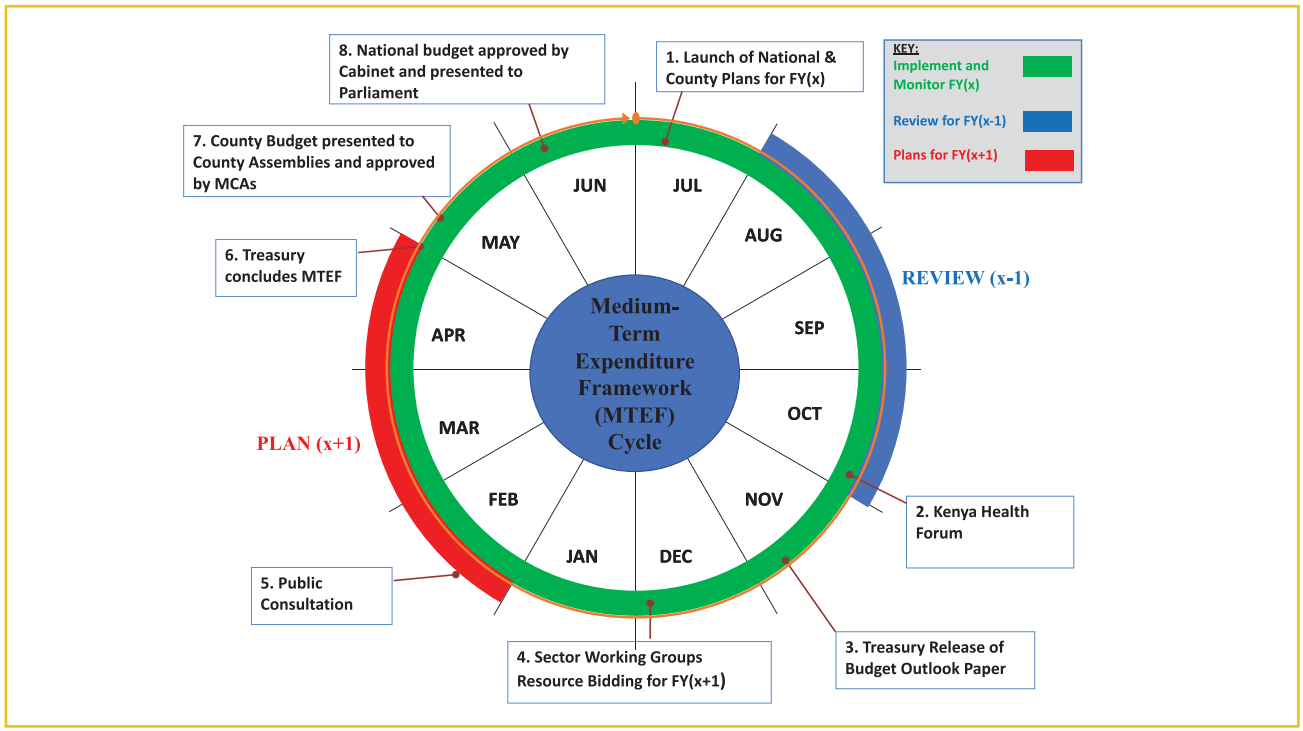



*Figure 7: Health sector accountability cycle*

### 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.

## 4.14 Implementation of the Bomet CNAP

In order to implement this CNAP effectively, the nutrition department and all stakeholders will continue to address structural bottlenecks and enhance capacity building within itself, engage all the stakeholders for their contribution and promote innovativeness, creativity and professionalism towards realization of the action plan.

# 5 RESOURCE REQUIREMENTS

## 5.1 Introduction

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

Costing is a process of determining in monetary terms, the value of inputs that are required to generate an 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 up to arrive at the **Output Cost,** the **Objective Cost,** and **eventually the budget.**

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

## 5.3 Total resource requirements (2020/21 – 2024/25)

The CNAP 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 2020/21 – 2024/25. The cost over time for all the Key Result Areas provides important details that will initiate debate and allow County health management and development partners to discuss priorities and decide on effective resource allocation.

The KRAs provided targets to be achieved within the plan period and the corresponding inputs to support attainment of the targets. Based on the targets and unit costs for the inputs, the costs for the strategic plan were computed. According to the Activity Based Costing, to fully actualize the strategic plan, KSh. 1.8 billion is required as shown in the figure below. Further annual breakdown of cost requirement (s) is also presented.

## 5.4 Resource requirements

According to the costing estimates, the County department of health requires an investment worth KSh.1.8 billion for nutrition over the plan period. This further has been disaggregated by KRAs as shown in the table below.

*Table 22: Summary cost by KRA*

| Key Result Areas | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|---|---|
| KRA 01: Maternal Infant and Young Child Nutrition (MIYCN) scaled up | 15,238,550 | 54,044,400 | 52,818,100 | 53,049,700 | 50,658,800 | 225,809,550 |
| KRA 02: Nutrition of older children, adolescents, adults, and older persons promoted | 2,722,500 | 8,716,250 | 10,814,750 | 10,277,250 | 5,186,000 | 37,716,750 |
| KRA 03: Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled-up | 8,704,500 | 11,735,300 | 11,117,600 | 8,529,100 | 8,964,100 | 49,050,600 |
| KRA 04: Integrated Management of Acute malnutrition (IMAM) strengthened | 110,700,000 | 111,919,600 | 110,700,000 | 111,919,600 | 110,700,000 | 555,939,200 |
| KRA 05: Clinical nutrition and dietetics in disease management including HIV and TB | 76,676,750 | 77,817,350 | 76,597,750 | 77,817,350 | 76,597,750 | 385,506,950 |
| KRA 06: Nutrition in Emergencies Strengthened | 6,332,500 | 5,292,500 | 6,132,500 | 5,292,500 | 6,132,500 | 29,182,500 |
| KRA 07: Nutrition in Education, Agriculture, Water, Sanitation & Hygiene (WASH) and Social Protection | 53,336,100 | 53,728,400 | 70,532,400 | 33,194,400 | 54,664,600 | 265,455,900 |
| KRA 08: Sectoral and multisectoral collaboration governance including co-ordination and legal/regulatory framework strengthened | 6,428,400 | 6,428,400 | 6,428,400 | 6,428,400 | 6,428,400 | 32,142,000 |
| KRA 09: Sectoral and multisectoral nutrition information systems, learning and research strengthened. | 31,367,300 | 29,102,300 | 29,638,300 | 32,146,300 | 29,638,300 | 151,892,500 |
| KRA 10: Advocacy, communication, and social mobilization (ACSM) strengthened | 18,229,500 | 16,972,300 | 18,565,800 | 17,133,300 | 18,565,800 | 89,466,700 |
| **Grand Total** | **329,736,100** | **375,756,800** | **393,345,600** | **355,787,900** | **367,536,250** | **1,822,162,650** |

Further annual breakdown of cost requirement (s) is also presented.

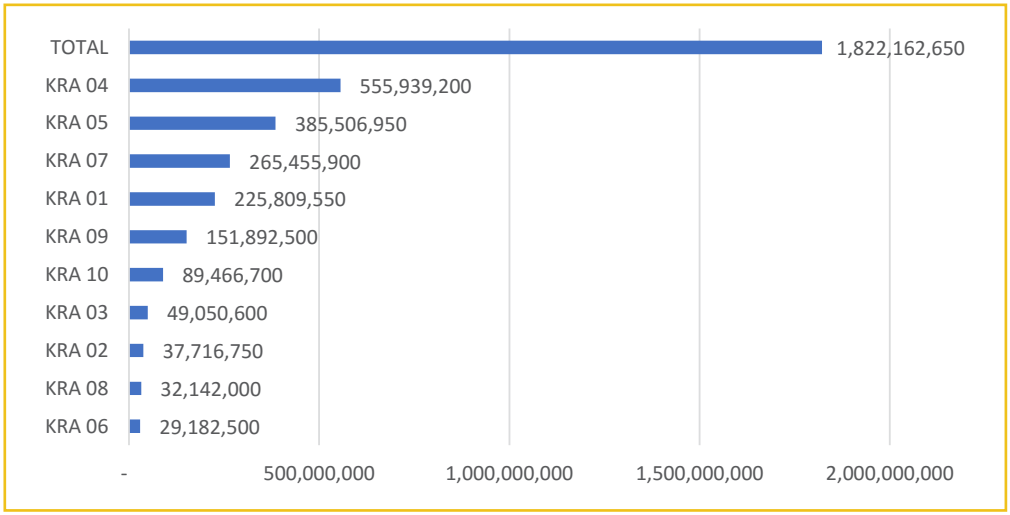



*Figure 8: Total cost requirements (2020/21 – 2024/25)*

Analysis of the cost requirements shows that 31% of the funds will be required to cater for KRA on integrated Management of Acute malnutrition (IMAM) strengthened; KRA on Clinical nutrition and dietetics in disease management including HIV and TB will require 21 % while KRA on Nutrition in Education, Agriculture, Water, Sanitation & Hygiene (WASH) and Social Protection will require 15 %.

## 5.5 Strategies to ensure available resources are sustained

### 5.5.1Strategies 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 stakeholders 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

### 5.5.2 Strategies to ensure efficiency in resource utilization

- Thorough 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.

# 6 REFERENCES


CIDP. (2018). Bomet County Integrated Development Plan (CIDP 2018-2022). Bomet, Kenya: County Government of Bomet.

FAO. (1996). The State of Food and Agriculture. Rome, Italy: FAO, UN.

GOB. (June 2011). Country Investment Plan. Dhaka, India: FPMU, Ministry of Food and Disaster Management.

IFAD. (2014). International Fund for Agricultural Development Annual Report 2014. Rome, Italy.

KDHS. (2014). Kenya Demographic and Health Survey. Nairobi, Kenya: KNBS.

KDHS. (March, 2018). Kenya Mortality Survey. Nairobi, Kenya: Ministry of Health.

KIHBS. (March 2018). Kenya Integrated Household Budget Survey 2015/2016. Nairobi, Kenya: KNBS.

KNMS. (2011). The Kenya National Micronutrient Survey. Nairobi, Kenya: Ministry of Health. Lancet. (2016). The Lancent Series Maternal and Child Nutrition. Nairobi,Kenya.

MOH. (December 2018). The Kenya National Action Plan 2018-2022. Nairobi, Kenya: Ministry of Health. Retrieved from https://scalingupnutrition.org/wp-content/uploads/2020/10/Kenya-National-Nutrition-Action-Plan-2018-22.pdf

Ndiku, M., Jaceldo-Siegl, K., Singh, P., & Sabaté, J. (2010, September). Gender inequality in food intake and nutritional status of children under 5 years old in rural Eastern Kenya. European journal of clinical nutrition, 65, 26-31. doi:10.1038/ejcn.2010.197

Oniang'o, R., & Komokoti, A. (1999). Food Habits in Kenya. doi:10.1006/appe.1998.0201

Ruth, O., & Edith, M. (2002). Nutrition and Gender. Geneva, Switzerland.

STEPwise. (2015). Kenya STEPwise Survey for Non Communicable Diseases Risk Factors 2015 Report. Nairobi, Kenya: Ministry of Health.

Taylor, P., Jones, & Henert. (2002). Enhancing Program Performance with Logic Models. 23. Madison, United States of America. Retrieved from http://www.uwex.edu/ces/lmcourse/#

UNICEF. (June 2015). UNICEF's Approach to Scaling Up Nutrition for Mothers and their Children. Nutrition Section, Programme Division, New York, United States of America.

WORLD BANK. (April 2016). Investing in Nutrition; The Foundation for Development. Retrieved from https://www.worldbank.org/en/topic/nutrition/publication/investing-in-nutrition-the-foundation-for-development

# 7 APPENDICES

| Key Result Areas | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|---|---|
| **KRA 01: Maternal Infant and Young Child Nutrition (MIYCN)scaled up** | **15,238,550** | **54,044,400** | **52,818,100** | **53,049,700** | **50,658,800** | **225,809,550** |
| Training of healthcare workers on BFHI | - | 1,609,200 | 1,609,200 | 1,609,200 | - | 4,827,600 |
| Carry out support supervision for MIYCN services | - | - | - | - | - | - |
| Carry out bi-monthly BFCI meetings | - | - | - | - | - | - |
| Carry out CMEs to healthcare workers on BMS Act, 2012 | - | - | - | - | - | - |
| Carry out continuous BFHI assessment | - | 276,000 | 276,000 | 276,000 | 276,000 | 1,104,000 |
| Carry out continuous mentorship to HCWs in the implementing CUs | - | 180,000 | 180,000 | 180,000 | 180,000 | 720,000 |
| Carry out data quarterly review meetings for MIYCN services | 840,000 | 840,000 | 840,000 | 840,000 | 840,000 | 4,200,000 |
| Carry out deworming of children 12-59 months | 1,500,000 | 1,500,000 | 1,500,000 | 1,500,000 | 1,500,000 | 7,500,000 |
| Carry out final external BFHI assessment | - | - | - | - | 135,000 | 135,000 |
| Carry out health education on the ten steps to a successful breastfeeding to mothers and fathers at the ANC, MCH maternity and PNC | - | - | - | - | - | - |
| Carry out home visits and sensitize male and female community members on MIYCN by the CHVs | - | - | - | - | - | - |
| Carry out IFA Supplementation to pregnant women | 1,857,000 | 1,857,000 | 1,857,000 | 1,857,000 | 1,857,000 | 9,285,000 |
| Carry out Micronutrient and powder supplementation to children 6-23 months | 75,000 | 1,075,000 | 1,075,000 | 1,075,000 | 1,075,000 | 4,375,000 |
| Carry out monitoring and enforcement of BMS Act within the county | - | - | - | - | - | - |
| Carry out monthly report writing for MIYCN services | - | - | - | - | - | - |
| Carry out Nutritional assessment and counselling of children 0-59 months | - | - | - | - | - | - |
| Carry out Vitamin A supplementation to children 6-59 months | 5,442,000 | 5,442,000 | 5,442,000 | 5,442,000 | 5,442,000 | 27,210,000 |
| Carry out Zinc supplementation of Diarrheal cases | - | - | - | - | - | - |
| Conduct baseline assessment on BFHI | - | 138,000 | 138,000 | 138,000 | 138,000 | 552,000 |
| Conduct BFCI baseline assessment at the community level | - | 630,000 | 630,000 | 630,000 | 630,000 | 2,520,000 |
| Conduct CMEs on MIYCN in high volume facilities | - | - | - | - | - | - |
| Conduct CMEs on WHO growth standards and the use of anthropometric equipment | - | - | - | - | - | - |
| Conduct community household mapping within the CUs and establish MTMSGs | - | 90,000 | 90,000 | 90,000 | 90,000 | 360,000 |
| Conduct continuous CMEs on BFHI | - | - | - | - | - | - |
| Conduct final external BFCI assessment | - | - | - | 231,600 | 231,600 | 463,200 |
| Conduct mentorship on MIYCN to HCWs | 28,750 | 28,750 | 28,750 | 28,750 | 28,750 | 143,750 |
| Conduct monthly meetings with MTMSGs and targeted home visits by the CHVs | - | - | - | - | - | - |
| Conduct quarterly data quality audits for MIYCN services | 270,000 | 270,000 | 270,000 | 270,000 | 270,000 | 1,350,000 |
| Continuous assessment of BFCI activities by C/SCHMT | - | 780,000 | 780,000 | 780,000 | 780,000 | 3,120,000 |
| Establish BFCI Committees in every CU implementing BFCI activities | - | - | - | - | - | - |
| Establish BFCI resource centers at the CU level | - | 75,000 | 75,000 | 75,000 | 75,000 | 300,000 |
| Establish BFHI committee at health facility level | - | - | - | - | - | - |
| Establish lactation stations in selected health facilities and offices | - | 150,000 | 150,000 | 150,000 | 150,000 | 600,000 |
| Form community mother support Groups (CMSGs) | - | - | - | - | - | - |
| Printing and distributing BFCI tools and job aids | - | 4,679,500 | 4,679,500 | 4,679,500 | 4,679,500 | 18,718,000 |
| Printing and distributing BFHI tools and job aids | - | 222,500 | 222,500 | 222,500 | - | 667,500 |
| Procure, print, and distributing of data capture and reporting tools | - | 1,775,000 | 1,775,000 | 1,775,000 | 1,775,000 | 7,100,000 |
| Procure and distribute anthropometric tools | 2,320,000 | 2,395,000 | 2,395,000 | 2,395,000 | 2,395,000 | 11,900,000 |
| Sensitization of CHMT/SCHMT on BFCI | - | 135,000 | - | - | - | 135,000 |
| Sensitization of CHMT/SCHMT on BFHI | - | 176,300 | - | - | - | 176,300 |
| Sensitize C/SCHMT on BMS Act, 2012 in Bomet County | - | 462,000 | - | - | 462,000 | 924,000 |
| Sensitize C/SCHMT on MIYCN policies, guidelines, and strategies | - | - | - | - | - | - |
| Sensitize C/SCHMT on the implementation framework for securing a breastfeeding friendly environment at workplace | - | - | - | - | - | - |
| Sensitize C/SCHMT on WHO growth standards | - | 453,000 | - | - | 453,000 | 906,000 |
| Sensitize health care workers on the implementation framework for securing a breastfeeding friendly environment at workplace | - | - | - | - | - | - |
| Sensitize male and female CHVs on MIYCN | 60,000 | 60,000 | 60,000 | 60,000 | 60,000 | 300,000 |

| Key Result Areas | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|---|---|
| **KRA 01: Maternal Infant and Young Child Nutrition (MIYCN)scaled up** | **15,238,550** | **54,044,400** | **52,818,100** | **53,049,700** | **50,658,800** | **225,809,550** |
| Sensitize other stakeholders (formal and informal) on the implementation framework for securing a breastfeeding friendly environment at workplace | - | 56,000 | 56,000 | 56,000 | 56,000 | 224,000 |
| Sensitize facility health committees on BFCI | - | - | - | - | - | - |
| Train HCWs on BMS implementation framework | - | 1,422,900 | 1,422,900 | 1,422,900 | 1,422,900 | 5,691,600 |
| Train HCWs on WHO growth standards | 1,422,900 | 1,422,900 | 1,422,900 | 1,422,900 | 1,422,900 | 7,114,500 |
| Train Health care workers on MIYCN | - | 4,668,400 | 4,668,400 | 4,668,400 | 3,059,200 | 17,064,400 |
| Train PHOs, nutritionists and other health care workers on BMS monitoring and enforcement | 1,422,900 | 1,422,900 | 1,422,900 | 1,422,900 | 1,422,900 | 7,114,500 |
| Training of HCWS on BFCI | - | 2,851,600 | 2,851,600 | 2,851,600 | 2,851,600 | 11,406,400 |
| Training of male and female CHVS in C-BFCI | - | 1,466,000 | 1,466,000 | 1,466,000 | 1,466,000 | 5,864,000 |
| Carry out training of HCWs on strategies for anaemia prevention | - | 4,750,000 | 4,750,000 | 4,750,000 | 4,750,000 | 19,000,000 |
| Carry out sensitization meetings with the community members on consumption of diverse food groups through community forums | | 535,000 | 535,000 | 535,000 | 535,000 | 2,140,000 |
| Carry out sensitization meeting with the C/SCHMT on food fortification | | 951,200 | 951,200 | 951,200 | 951,200 | 3,804,800 |
| Carry out training of HCWs on MNPs | | 1,963,000 | 1,963,000 | 1,963,000 | 1,963,000 | 7,852,000 |
| Carry out training of HCWs on VAS | | 1,963,000 | 1,963,000 | 1,963,000 | 1,963,000 | 7,852,000 |
| Carry out training of HCWs on IFAS | | 1,963,000 | 1,963,000 | 1,963,000 | 1,963,000 | 7,852,000 |
| Carry out sensitization of CHVs on Micronutrients | | 240,000 | 240,000 | 240,000 | 240,000 | 960,000 |
| Carry out training of Nutrition officers and PHOs on food fortification | | 1,963,000 | 1,963,000 | 1,963,000 | 1,963,000 | 7,852,000 |
| Carry out sensitization of CHVs on food fortification | | 240,000 | 240,000 | 240,000 | 240,000 | 960,000 |
| Conduct community sensitization sessions on consumption of fortified and diverse foods | | 535,000 | 535,000 | 535,000 | 535,000 | 2,140,000 |
| Carry out market level surveillance | | 45,000 | 45,000 | 45,000 | 45,000 | 180,000 |
| Conduct salt sampling sessions | | 191,000 | 191,000 | 191,000 | 191,000 | 764,000 |
| Conduct support supervisions and mentorship on micronutrient supplementation at health facilities | | 95,250 | 95,250 | 95,250 | 95,250 | 381,000 |
| **KRA 02: Nutrition of older children, adolescents, adults, and older persons promoted** | **2,722,500** | **8,716,250** | **10,814,750** | **10,277,250** | **5,186,000** | **37,716,750** |
| Advocate for participation and inclusion of nutrition for older persons in implementation of strategic programmes | - | 185,500 | 185,500 | 185,500 | - | 556,500 |
| Implement the regulation on control marketing of unhealthy foods for older children and adolescents | - | - | - | - | - | - |
| Sensitization of the C/SCHMT on healthy diets and physical activity for older children, adolescents, adults, and older persons | - | 190,500 | - | - | - | 190,500 |
| Sensitize C/SCHMT on geriatric nutrition policy guidelines | - | - | 190,500 | - | - | 190,500 |
| Sensitize CHMT/SCHMT on nutrition guidelines for life course | - | 190,500 | - | - | - | 190,500 |
| Sensitize male and female key influencers, role models, and nutrition champions on nutrition for older children and adolescents. | - | 54,000 | 54,000 | 54,000 | 54,000 | 216,000 |
| Sensitize SCHMT on geriatric nutrition policy guidelines | - | 260,000 | 1,140,000 | 1,140,000 | 880,000 | 3,420,000 |
| Sensitize stakeholders on marketing and promotions of healthy foods in the community | - | - | 238,000 | 238,000 | 238,000 | 714,000 |
| Supplement WIFA to adolescents aged (10-19) | - | - | - | 287,500 | 287,500 | 575,000 |
| Train key stakeholders on healthy diets and physical activity for older children, adolescents, adults, and older persons | - | - | 1,131,000 | - | - | 1,131,000 |
| Training of HCWs and other stakeholders on adolescent Nutrition and health | - | 1,281,000 | 1,281,000 | 1,281,000 | - | 3,843,000 |
| Training of HCWs and stakeholders on Healthy diets and physical activity for the life course | - | 3,066,000 | 3,066,000 | 3,066,000 | - | 9,198,000 |
| sensitize HCWs on National guidelines for healthy diets and physical activity | - | 260,000 | 260,000 | 260,000 | - | 780,000 |
| Engage male and female key influencers, role models, and nutrition champion to create awareness on nutrition for older children and adolescents | - | 200,000 | 200,000 | 200,000 | 200,000 | 800,000 |
| Sensitization of school stakeholders on WIFAS | - | - | - | 536,500 | 536,500 | 1,073,000 |
| Sensitization of HCWs on WIFAS | 440,000 | 440,000 | 440,000 | 440,000 | 440,000 | 2,200,000 |
| Sensitization of adolescent girls on WIFAs | 1,187,500 | 1,187,500 | 1,187,500 | 1,187,500 | 1,187,500 | 5,937,500 |
| Procurement and distribution of WIFAs | 1,095,000 | 1,095,000 | 1,095,000 | 1,095,000 | 1,095,000 | 5,475,000 |

| Key Result Areas | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|---|---|
| **KRA 02: Nutrition of older children, adolescents, adults, and older persons promoted** | **2,722,500** | **8,716,250** | **10,814,750** | **10,277,250** | **5,186,000** | **37,716,750** |
| Sensitize older children, adolescents, and communities (targeting boys and girls, men, and women) on healthy diets and physical activity using context-specific communicate on channels in both rural and urban setups | - | 133,750 | 173,750 | 133,750 | 133,750 | 575,000 |
| Promote collaboration with other health sector interventions to promote good nutrition of older child and adolescent (MoE, MOALF&I, MoH, Industry, Finance, Gender, Sports, and Social protection) and the private sector | - | 133,750 | 133,750 | 133,750 | 133,750 | 535,000 |
| Utilize existing social support groups (from both genders) to pass health and Nutrition messages to adults and the elderly | - | - | - | - | - | - |
| Disseminate communication materials on health, nutrition, and physical activities of adults and older persons | - | - | - | - | - | - |
| Develop in local dialect, print, and distribute gender transformative IEC materials for older children, adolescents, adults, and older persons | - | 38,750 | 38,750 | 38,750 | - | 116,250 |
| Train/Sensitize male and female health care workers on optimal nutrition for adults and elderly persons to provide quality health care and nutrition support for older people | | | | | | - |
| Sensitize male and female CHVs on optimal nutrition for adults and elderly persons to provide quality health care and nutrition support for older people | | | | | | - |
| **KRA 03: Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled-up** | **8,704,500** | **11,735,300** | **11,117,600** | **8,529,100** | **8,964,100** | **49,050,600** |
| Sensitize CHMT/SCHMT on existing standards and regulations on healthy diets, NCDs and physical activity | - | - | 535,000 | - | 535,000 | 1,070,000 |
| Identify and utilize male and female DRNCDs champions for community sensitization | 100,000 | - | - | 100,000 | - | 200,000 |
| Adapt and sensitize 680 CHMT/SCHMT and targeted HCWs on legislations for advertising, packaging, labelling, and marketing of foods and beverages | 1,375,000 | 1,375,000 | 1,375,000 | 1,375,000 | 1,375,000 | 6,875,000 |
| Conduct CMEs in 30 high volume health facilities on prevention, control, and management of DRNCDs in all health facilities | 600,000 | 600,000 | 600,000 | 600,000 | 600,000 | 3,000,000 |
| Conduct nutrition assessment and counselling to all clients with DRNCDs at health facility level | 7,500 | 7,500 | 7,500 | 7,500 | 7,500 | 37,500 |
| Develop gender responsive key messages, advocacy tool kits and sensitize media and journalist on NCDs | - | 495,600 | - | - | - | 495,600 |
| Develop/adapt and distribute nutrition related DRNCDs IEC materials | 135,000 | 495,600 | 135,000 | 135,000 | 135,000 | 1,035,600 |
| Disseminate policies and guidelines on nutrition related NCDs to CHMT/SCHMT | 375,000 | 375,000 | 375,000 | 375,000 | 375,000 | 1,875,000 |
| Form 30 gender inclusive DRNCDs support groups and provide nutrition education prevention, control, and management of DRNCDs | - | 210,000 | - | - | - | 210,000 |
| Promote collaboration and joint planning on healthy diets and physical activity in prevention, control, and management of DRNCDs | 562,500 | 562,500 | 562,500 | 562,500 | 562,500 | 2,812,500 |
| Sensitize male and female CHVs on prevention and control of DRNCDs | 2,240,000 | 2,240,000 | - | - | - | 4,480,000 |
| Training of male and female healthcare workers on DRNCDS | | 2,064,600 | 2,064,600 | 2,064,600 | 2,064,600 | 8,258,400 |
| Conduct screening and nutrition counselling of the public for early detection, control, management, and treatment of DRNCDs through gender integrated community outreaches, medical camps, health action days, national health days e.g., World Diabetes Day, World Cancer day. | 352,500 | 352,500 | 352,500 | 352,500 | 352,500 | 1,762,500 |
| Conduct mass media sensitization e.g., radio talk shows on nutrition related topics on prevention, control, and management of DRNCDs | 92,000 | 92,000 | 92,000 | 92,000 | 92,000 | 460,000 |
| Participate in commemoration of world diabetes day and world cancer day | 885,000 | 885,000 | 885,000 | 885,000 | 885,000 | 4,425,000 |
| Support establishment of workplace wellness centers | - | - | 153,500 | - | - | 153,500 |
| Conduct quarterly integrated support supervision/monitoring and evaluation for DRNCDs | 930,000 | 930,000 | 930,000 | 930,000 | 930,000 | 4,650,000 |
| Hold bi-annual performance review meetings for DRNCDs | 1,050,000 | 1,050,000 | 1,050,000 | 1,050,000 | 1,050,000 | 5,250,000 |
| Establish workplace wellness centers | | | 2,000,000 | | | 2,000,000 |

| Key Result Areas | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|---|---|
| **KRA 04: Integrated Management of Acute malnutrition (IMAM) strengthened** | **110,700,000** | **111,919,600** | **110,700,000** | **111,919,600** | **110,700,000** | **555,939,200** |
| Carry out appropriate documentation on IMAM related research, best practices, and learning. | 370,000 | 370,000 | 370,000 | 370,000 | 370,000 | 1,850,000 |
| Conduct follow-up for IMAM clients through CHVs | 6,000,000 | 6,000,000 | 6,000,000 | 6,000,000 | 6,000,000 | 30,000,000 |
| Conduct nutrition screening/assessment for all cohorts at community and facility level. | 1,300,000 | 1,300,000 | 1,300,000 | 1,300,000 | 1,300,000 | 6,500,000 |
| Advocate for IMAM operational level research | 252,500 | 252,500 | 252,500 | 252,500 | 252,500 | 1,262,500 |
| Carry out nutritional assessment, counselling, and support to all IMAM clients. | 531,000 | 531,000 | 531,000 | 531,000 | 531,000 | 2,655,000 |
| Conduct IMAM program performance reviews - cure, defaulter, death, coverage (linkage with M&E) | 3,810,000 | 3,810,000 | 3,810,000 | 3,810,000 | 3,810,000 | 19,050,000 |
| Procure and distribute anthropometric tools for IMAM program | 430,750 | 430,750 | 430,750 | 430,750 | 430,750 | 2,153,750 |
| Procure therapeutic and supplementary feeds for management of SAM and MAM | 69,000,000 | 69,000,000 | 69,000,000 | 69,000,000 | 69,000,000 | 345,000,000 |
| Sensitize male and female CHVs on IMAM | 745,000 | 745,000 | 745,000 | 745,000 | 745,000 | 3,725,000 |
| Sensitize male and female CHVs on IMAM referral system | 720,000 | 720,000 | 720,000 | 720,000 | 720,000 | 3,600,000 |
| Share best practices and learning on IMAM with stakeholders | 600,000 | 600,000 | 600,000 | 600,000 | 600,000 | 3,000,000 |
| Train health care workers on IMAM | 3,130,000 | 3,130,000 | 3,130,000 | 3,130,000 | 3,130,000 | 15,650,000 |
| Sensitize CHMT, HMT and SCHMT on IMAM guidelines, SOPs, and treatment protocols | 4,560,000 | 4,560,000 | 4,560,000 | 4,560,000 | 4,560,000 | 22,800,000 |
| Monitor adherence to IMAM program SOPs, guidelines and protocols by health and nutrition workforce | 6,275,000 | 6,275,000 | 6,275,000 | 6,275,000 | 6,275,000 | 31,375,000 |
| Advocate for increased resource allocation for IMAM implementation including commodities, equipment, and HR. | 340,000 | 340,000 | 340,000 | 340,000 | 340,000 | 1,700,000 |
| Advocate for institutionalization of community health volunteer (CHV) motivation within County strategic document in collaboration with community strategy department. | 370,000 | 370,000 | 370,000 | 370,000 | 370,000 | 1,850,000 |
| Advocate for integrated treatment and prevention of malnutrition and strengthen nutritional care and support of affected individuals. | 452,500 | 452,500 | 452,500 | 452,500 | 452,500 | 2,262,500 |
| Train male and female HCWS as IMAM TOTS | | 1,219,600 | | 1,219,600 | | 2,439,200 |
| Carry out IMAM referrals from community to facility and facility to community such as livelihoods, social protection, food security and WASH. | 6,000,000 | 6,000,000 | 6,000,000 | 6,000,000 | 6,000,000 | 30,000,000 |
| Link IMAM clients with programs on behavioural change or for prevention at community level | 600,000 | 600,000 | 600,000 | 600,000 | 600,000 | 3,000,000 |
| Carry out quarterly DQA for IMAM program | 263,000 | 263,000 | 263,000 | 263,000 | 263,000 | 1,315,000 |
| Carry out quarterly Data Review meetings for IMAM program | 1,480,000 | 1,480,000 | 1,480,000 | 1,480,000 | 1,480,000 | 7,400,000 |
| Carry out continuous training (CME) and mentorship on IMAM | 1,260,000 | 1,260,000 | 1,260,000 | 1,260,000 | 1,260,000 | 6,300,000 |
| Procure, print, and distribute IMAM reporting tools | 2,210,250 | 2,210,250 | 2,210,250 | 2,210,250 | 2,210,250 | 11,051,250 |
| **KRA 05: Clinical nutrition and dietetics in disease management including HIV and TB** | **76,676,750** | **77,817,350** | **76,597,750** | **77,817,350** | **76,597,750** | **385,506,950** |
| Advocate for increased resource allocation for clinical nutrition and dietetics. | 415,000 | 415,000 | 415,000 | 415,000 | 415,000 | 2,075,000 |
| Advocate for integration of nutrition and dietetics services at all levels of health care system | 297,000 | 297,000 | 297,000 | 297,000 | 297,000 | 1,485,000 |
| Carry out comprehensive nutritional assessment in all HIV, TB, MNCH service points to reduce missed opportunities and improve service uptake and retention into care | 297,000 | 297,000 | 297,000 | 297,000 | 297,000 | 1,485,000 |
| Carry out County /Sub county level forecasting, quantification, and supply planning through integrated, operationalized County level commodity security committees. | 844,000 | 844,000 | 844,000 | 844,000 | 844,000 | 4,220,000 |
| Adapt and implement NACS validated guidelines and tools including capacity building at sub county, facility, and community | 1,345,000 | 1,345,000 | 1,345,000 | 1,345,000 | 1,345,000 | 6,725,000 |
| Adapt and use m-Health systems to identify and follow up patients at community level. | 79,000 | - | - | - | - | 79,000 |
| Adapt and utilize context-specific job aids for patient-focused nutrition therapy and interpersonal counselling. | 271,000 | 271,000 | 271,000 | 271,000 | 271,000 | 1,355,000 |
| Adapt and utilize IEC materials for nutrition management in diseases and conditions | 60,250 | 60,250 | 60,250 | 60,250 | 60,250 | 301,250 |
| Adapt use of County level score card for nutrition indicators including NACs | 415,000 | 415,000 | 415,000 | 415,000 | 415,000 | 2,075,000 |
| Adopt and utilize SOPs for nutrition and dietetics | 60,250 | 60,250 | 60,250 | 60,250 | 60,250 | 301,250 |

| Key Result Areas | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|---|---|
| **KRA 05: Clinical nutrition and dietetics in disease management including HIV and TB** | **76,676,750** | **77,817,350** | **76,597,750** | **77,817,350** | **76,597,750** | **385,506,950** |
| Adopt guidelines, strategies and policies on clinical nutrition and dietetics | 625,000 | 625,000 | 625,000 | 625,000 | 625,000 | 3,125,000 |
| Carry out nutrition screening and assessment in the triage areas/stations and data disaggregated by age and sex | 297,000 | 297,000 | 297,000 | 297,000 | 297,000 | 1,485,000 |
| Carry out bi-annual data review meetings for clinical nutrition and dietetics | 839,000 | 839,000 | 839,000 | 839,000 | 839,000 | 4,195,000 |
| Carry out nutrition assessment, counselling, and support to HIV/TB clients. | 645,000 | 645,000 | 645,000 | 645,000 | 645,000 | 3,225,000 |
| Carry out routine participatory progress, monitoring platforms at all levels (Subcounty, health facility, community) through scheduled data review meetings | 4,191,000 | 4,191,000 | 4,191,000 | 4,191,000 | 4,191,000 | 20,955,000 |
| Conduct bi-annual surveillance on quality of nutrition commodities used in management of HIV/TB patients | 135,500 | 135,500 | 135,500 | 135,500 | 135,500 | 677,500 |
| Conduct outreaches, referrals, and linkage to involve all community actors and optimize identification and linkage of PLHIV and TB patients with nutrition care and management. | 1,800,000 | 1,800,000 | 1,800,000 | 1,800,000 | 1,800,000 | 9,000,000 |
| Conduct regional learning meetings for NACS knowledge management and transfer on best practices. | 911,000 | 911,000 | 911,000 | 911,000 | 911,000 | 4,555,000 |
| Conduct standard annual NACS data and service audit including partner mapping at Sub county level. | 67,750 | 67,750 | 67,750 | 67,750 | 67,750 | 338,750 |
| Conduct supportive supervision to assess quality of nutrition care in health facilities | 297,000 | 297,000 | 297,000 | 297,000 | 297,000 | 1,485,000 |
| Develop an online inventory of bottlenecks related to specific NACS program areas to inform investments and programming | 57,500 | 57,500 | 57,500 | 57,500 | 57,500 | 287,500 |
| Establish food safety inspection committees | 1,242,500 | 1,242,500 | 1,242,500 | 1,242,500 | 1,242,500 | 6,212,500 |
| Establish/activate inpatient feeding committees | 567,500 | 567,500 | 567,500 | 567,500 | 567,500 | 2,837,500 |
| Procure and distribute clinical nutrition equipment and reporting tools | - | - | - | - | - | - |
| Procure nutrition commodities for feeding and management of special medical conditions based on inpatient feeding protocols | 29,300,000 | 29,300,000 | 29,300,000 | 29,300,000 | 29,300,000 | 146,500,000 |
| Sensitize CHMT, SCHMT, facility in-charges on new guidelines and policies on HIV/TB management. | 3,182,500 | 3,182,500 | 3,182,500 | 3,182,500 | 3,182,500 | 15,912,500 |
| Sensitize health care workers and CHVs on information related to nutrition screening and comprehensive nutritional assessment for HIV/TB patients. | 419,500 | 419,500 | 419,500 | 419,500 | 419,500 | 2,097,500 |
| Sensitize health care workers on safety package for clinical nutrition and dietetics | 879,500 | 879,500 | 879,500 | 879,500 | 879,500 | 4,397,500 |
| Sponsor nutritionist for clinical nutrition short courses | 1,320,000 | 1,320,000 | 1,320,000 | 1,320,000 | 1,320,000 | 6,600,000 |
| Train health care workers on clinical nutrition and dietetics care package in disease management | 7,690,000 | 7,690,000 | 7,690,000 | 7,690,000 | 7,690,000 | 38,450,000 |
| Conduct sensitization meetings to health care workers on the use of standard facility-community referral tool, inter-facility referral tool. | 2,640,000 | 2,640,000 | 2,640,000 | 2,640,000 | 2,640,000 | 13,200,000 |
| Sponsor nutritionists for specialties in clinical nutrition | 1,524,000 | 1,524,000 | 1,524,000 | 1,524,000 | 1,524,000 | 7,620,000 |
| Carry out continues CME on clinical nutrition and dietetics | 1,380,000 | 1,380,000 | 1,380,000 | 1,380,000 | 1,380,000 | 6,900,000 |
| Carry out nutritional assessment in all comprehensive care centers | 297,000 | 297,000 | 297,000 | 297,000 | 297,000 | 1,485,000 |
| Train health care workers to provide patient-focused nutrition therapy for paediatrics patients and adolescents infected with HIV/TB. | 807,500 | 807,500 | 807,500 | 807,500 | 807,500 | 4,037,500 |
| Carry out quarterly supply chain monitoring, including electronic logistics management information system (LMIS) to minimize stockouts, avoid expiries and over and/understocking of HIV/TB commodities. | 271,000 | 271,000 | 271,000 | 271,000 | 271,000 | 1,355,000 |
| Sensitize CHVs and other community resource persons of both genders to promote healthy and sustainable lifestyles at household levels. | 482,500 | 482,500 | 482,500 | 482,500 | 482,500 | 2,412,500 |
| Carry out health education on context-specific nutrition messages that promote positive lifestyles and behaviour for HIV and TB patients | 1,000,000 | 1,000,000 | 1,000,000 | 1,000,000 | 1,000,000 | 5,000,000 |
| Training of male and female TOTs on Nutrition in HIV and TB | | 1,219,600 | | 1,219,600 | | 2,439,200 |
| Train health care workers through on-line and in-person continues professional development on integrated nutrition therapy for TB/HIV nutrition | 1,375,000 | 1,375,000 | 1,375,000 | 1,375,000 | 1,375,000 | 6,875,000 |

| Key Result Areas | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|---|---|
| **KRA 05: Clinical nutrition and dietetics in disease management including HIV and TB** | **76,676,750** | **77,817,350** | **76,597,750** | **77,817,350** | **76,597,750** | **385,506,950** |
| Review and optimize integration of data systems from various nutrition service delivery points for HIV, TB clients across the NACS continuum of care | 645,000 | 645,000 | 645,000 | 645,000 | 645,000 | 3,225,000 |
| Carry out quarterly data review meetings for nutrition in HIV/TB program | 7,640,000 | 7,640,000 | 7,640,000 | 7,640,000 | 7,640,000 | 38,200,000 |
| Conduct annual bottleneck assessment specific to key program areas in NACS to identify questions for implementation research. | 64,000 | 64,000 | 64,000 | 64,000 | 64,000 | 320,000 |
| Implement regular data quality assessments using work improvement teams' activities at all levels | | | | | | - |
| **KRA 06: Nutrition in Emergencies Strengthened** | **6,332,500** | **5,292,500** | **6,132,500** | **5,292,500** | **6,132,500** | **29,182,500** |
| Adapt and implement IMAM surge kit | 315,000 | - | 315,000 | - | 315,000 | 945,000 |
| Conduct joint resource mobilization activities with other sectors on integrated preparedness and risk reduction | 525,000 | - | 525,000 | - | 525,000 | 1,575,000 |
| Conduct nutrition sessions in livelihood and social protection programmes. | 300,000 | 300,000 | 300,000 | 300,000 | 300,000 | 1,500,000 |
| Inclusion of the nutrition contingency plan in the existing supply chain | 400,000 | 400,000 | 400,000 | 400,000 | 400,000 | 2,000,000 |
| Map partners in preparedness and emergency risk reduction | 525,000 | 525,000 | 525,000 | 525,000 | 525,000 | 2,625,000 |
| Optimize nutrition service delivery approaches including outreach services in hard-to-reach areas and affected urban area | 1,755,000 | 1,755,000 | 1,755,000 | 1,755,000 | 1,755,000 | 8,775,000 |
| Participate in community-level dialogue and recovery initiatives | 175,000 | 175,000 | 175,000 | 175,000 | 175,000 | 875,000 |
| Participate in post-disaster review meetings to influence nutrition considerations | 300,000 | 300,000 | 300,000 | 300,000 | 300,000 | 1,500,000 |
| Review disaster preparedness and response plan | 525,000 | 525,000 | 525,000 | 525,000 | 525,000 | 2,625,000 |
| integrate nutrition activities during the county emergency preparedness and risk reduction committee meetings | 262,500 | 262,500 | 262,500 | 262,500 | 262,500 | 1,312,500 |
| Conduct needs assessment for nutrition stakeholders | 1,050,000 | 1,050,000 | 1,050,000 | 1,050,000 | 1,050,000 | 5,250,000 |
| Emergency coordination for nutrition response monitoring activated | 200,000 | | | | | 200,000 |
| Nutrition needs assessment during emergencies to adapt response to the context conducted | | | | | | - |
| Nutrition service delivery approaches including outreach services in hard-to-reach areas, affected urban areas activated | | | | | | - |
| Promote access to high-impact nutrition interventions in emergencies | | | | | | - |
| Hold joint planning and implementation within me other sectors on integrated preparedness and risk reduction | | | | | | - |
| **KRA 07: Nutrition in Education, Agriculture, Water, Sanitation & Hygiene (WASH) and Social Protection** | **53,336,100** | **53,728,400** | **70,532,400** | **33,194,400** | **54,664,600** | **265,455,900** |
| Sensitize Sub-Counties on diversified food production targeting men and women across different ages and diversities | 10,918,800 | - | 10,918,800 | - | 10,918,800 | 32,756,400 |
| Advocate for Agri-nutrition capacity development and integration initiatives | - | 240,000 | - | 240,000 | - | 480,000 |
| Advocate for Agri-nutrition coordination mechanisms at county and sub county level and between private and public sectors | 684,000 | 684,000 | - | 684,000 | - | 2,052,000 |
| Advocate for deployment in nutrition human resource in social protection programmes | - | 322,500 | - | - | - | 322,500 |
| Advocate for establishment of a referral system for health and nutrition interventions for those assessed | - | 1,341,600 | - | 1,341,600 | - | 2,683,200 |
| Advocate for governance and accountability for nutrition and social protection for vulnerable groups | - | - | 138,000 | - | - | 138,000 |
| Advocate for harmonization of nutrition and social protection services for vulnerable groups | - | - | 48,000 | - | - | 48,000 |
| Advocate for high-level consultations for promotion of health and nutrition for vulnerable groups at County and Sub County levels. | - | 327,000 | 327,000 | 654,000 | - | 1,308,000 |
| Advocate for integration of school feeding policy at the county level. | - | - | 162,000 | - | - | 162,000 |
| Advocate for nutrition and physical activity themes in co-curricular school activities (drama, music, talent shows, contests, symposia) | - | 36,000 | 981,000 | 981,000 | 981,000 | 2,979,000 |
| Advocate for procurement of nutrition assessment equipment for schools. | 272,000 | - | - | - | - | 272,000 |
| Advocate for scale up social safety nets in times of crises | 401,000 | 57,000 | 344,000 | - | - | 802,000 |
| Assessment of implementation of nutrition and physical activity education and promotion in schools | 6,000 | 172,000 | 172,000 | - | 166,000 | 516,000 |

| Key Result Areas | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|---|---|
| **KRA 07: Nutrition in Education, Agriculture, Water, Sanitation & Hygiene (WASH) and Social Protection** | **53,336,100** | **53,728,400** | **70,532,400** | **33,194,400** | **54,664,600** | **265,455,900** |
| Conduct a baseline survey/situation analysis on status of nutrition and health for the vulnerable groups | 219,500 | 219,500 | - | - | - | 439,000 |
| Conduct periodic nutritional status assessments in schools and other learning institutions and disaggregate data by sex | - | 248,000 | 100,000 | 212,000 | 248,000 | 808,000 |
| Conduct sensitization on safe and hygienic practices during food preparation and storage | 720,000 | 540,000 | 180,000 | - | 720,000 | 2,160,000 |
| Create awareness on intake of locally available and nutritious food among the school children in their communities. | 540,000 | 3,420,000 | 3,420,000 | - | 3,420,000 | 10,800,000 |
| Disseminate teachers' nutrition feeding manual. | 810,000 | 810,000 | - | 810,000 | - | 2,430,000 |
| Disseminate tools and manuals for school health and nutrition assessment | - | 448,000 | - | - | 448,000 | 896,000 |
| Dissemination of Information Education Communication (IEC) materials and messaging on hand washing, community and institutions led total sanitation and food hygiene. | - | - | - | - | - | - |
| Documentation and implementation of best practices and information sharing | - | 1,920,000 | 1,920,000 | 60,000 | 1,800,000 | 5,700,000 |
| Enhance mechanisms that strengthen coordination, linking nutrition to WASH | 5,269,000 | 5,269,000 | 4,675,000 | 5,269,000 | 4,675,000 | 25,157,000 |
| Gender inclusive Sensitization on targeting criteria for nutrition in social protection programmes; cash transfers, hunger safety nets, and others | 615,000 | 624,000 | 75,000 | - | 540,000 | 1,854,000 |
| Generate and disseminate annual feeding program reports. | 810,000 | 810,000 | - | 810,000 | - | 2,430,000 |
| Initiate participation of nutrition stakeholders in social protection coordination mechanisms | 161,000 | 161,000 | - | - | - | 322,000 |
| Integrate handwashing message and hygiene during nutrition sessions | 360,000 | 360,000 | - | 360,000 | - | 1,080,000 |
| Lobby for adequate and reliable funding for the feeding programme | - | - | 8,000 | - | - | 8,000 |
| Mobilize financial resources for nutrition interventions in social protection programmes | - | 1,650,000 | 1,650,000 | 1,650,000 | - | 4,950,000 |
| Promote benchmarking/learning visits for policy makers and implementers in counties with best practices on health and nutrition for vulnerable groups | - | 270,000 | 270,000 | - | - | 540,000 |
| Promote environmental hygiene at household level | - | - | - | - | - | - |
| Promote joint resource mobilization for integrated WASH and nutrition activities | 684,000 | 684,000 | - | 684,000 | - | 2,052,000 |
| Promote uptake of food processing, preservation, and storage technologies. | 10,513,800 | - | 10,513,800 | - | 10,513,800 | 31,541,400 |
| Sensitize teachers on school health programmes and nutrition in schools | - | 1,170,000 | 1,278,000 | 108,000 | 1,278,000 | 3,834,000 |
| Sensitize the public and the management of institutions of vulnerable persons and correction facilities on health and nutrition. | - | - | 37,000 | - | - | 37,000 |
| Sensitize Agriculture department staffs on diversified food production | 297,000 | 297,000 | - | - | 297,000 | 891,000 |
| Sensitize stakeholders in social protection programmes on good nutrition practices | 104,000 | 104,000 | 104,000 | - | - | 312,000 |
| Sensitize the County Government, Civil Society, and the community on the importance of investing in school feeding programme | - | 436,000 | - | 436,000 | - | 872,000 |
| Strengthen coordination and collaboration with public and private sector actors – through capacity assessment of private sector | 2,648,000 | 1,150,000 | 2,572,000 | 1,150,000 | 2,572,000 | 10,092,000 |
| Support adoption of functional systems for WASH service provision at institution and household level | 1,000,000 | 1,160,000 | 1,000,000 | 1,160,000 | 1,000,000 | 5,320,000 |
| Support County sensitization on early warning systems. | 1,362,000 | 480,000 | 882,000 | - | 882,000 | 3,606,000 |
| Support disseminate policies and strategies to ensure universal access to adequate sanitation | 6,460,000 | 960,000 | 1,500,000 | 3,060,000 | 3,400,000 | 15,380,000 |
| Support dissemination of food safety regulations and enforcement mechanisms | - | - | - | - | - | - |
| Support dissemination of the Agri-nutrition resource manual and dialogue cards and other related materials | 324,000 | 10,783,800 | 11,107,800 | 10,783,800 | 324,000 | 33,323,400 |
| Support flour blending initiatives-regulations and standards development. | - | 304,000 | - | 304,000 | - | 608,000 |
| Support Implementation of food, nutrition and, health content in curriculum and co-curriculum activities in schools. | 66,000 | 1,170,000 | 1,278,000 | 108,000 | 1,278,000 | 3,900,000 |

| Key Result Areas | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|---|---|
| **KRA 07: Nutrition in Education, Agriculture, Water, Sanitation & Hygiene (WASH) and Social Protection** | **53,336,100** | **53,728,400** | **70,532,400** | **33,194,400** | **54,664,600** | **265,455,900** |
| Support Implementation of school meals guidelines and feeding programme | - | - | 6,645,000 | - | - | 6,645,000 |
| Support joint strategic planning with MoH, MoALF&C, MoW, MoE and other stakeholders for nutrition-sensitive agricultural production. | 760,000 | - | 720,000 | - | 720,000 | 2,200,000 |
| Support stakeholder mapping of various players in social protection | 54,000 | 57,000 | - | 57,000 | - | 168,000 |
| Support uptake and use of food composition tables and recipes for decision making at household level | 188,000 | - | - | - | 88,000 | 276,000 |
| Promote Social Behaviour Change and Communication (SBCC) for increased consumption of nutritious foods and improved dietary diversity (including fortified foods) | - | - | - | - | - | - |
| Advocate for inclusion of nutrition indicators in the M&E of social protection interventions | 30,000 | 30,000 | - | - | - | 60,000 |
| Benchmarking/ learning visits for policy makers and implementors in Counties with the best feeding practices for ECD children, primary and secondary schools. | - | 6,858,000 | 6,858,000 | - | - | 13,716,000 |
| Seek technical support from MoALF&C to schools on establishment and improvement of existing school demonstration gardens, greenhouse small animals and revive 4Kclubs. | 648,000 | - | 648,000 | - | 648,000 | 1,944,000 |
| Involve management boards, male and female parents and other stakeholders in school gardening, green houses, poultry as a source of food. | 5,106,000 | 4,842,000 | - | 264,000 | 4,842,000 | 15,054,000 |
| Advocate for the use of locally available and nutritious foods | 1,305,000 | 1,305,000 | - | - | 1,305,000 | 3,915,000 |
| Sensitize stakeholders including, Curriculum Support Officers, Sub County and Ward Education Coordinators, teachers, food service providers and handlers, Parent–Teacher Associations (PTA) on healthy and safe food environment. | - | 2,008,000 | - | 2,008,000 | 1,600,000 | 5,616,000 |
| Nutrition personnel to participate in the nutrition sensitive-agriculture coordination working groups | | | | | | - |
| **KRA 08: sectoral and multisectoral collaboration governance including co-ordination and legal/regulatory framework strengthened** | **6,428,400** | **6,428,400** | **6,428,400** | **6,428,400** | **6,428,400** | **32,142,000** |
| Develop, cost, review, and update sector-specific coordination annual plans | 1,293,000 | 1,293,000 | 1,293,000 | 1,293,000 | 1,293,000 | 6,465,000 |
| Participate in annual nutrition regulation forums with relevant actors | 74,000 | 74,000 | 74,000 | 74,000 | 74,000 | 370,000 |
| Conduct annual nutrition resource tracking at county level | 224,000 | 224,000 | 224,000 | 224,000 | 224,000 | 1,120,000 |
| Conduct county annual performance assessment reviews on coordination | 203,000 | 203,000 | 203,000 | 203,000 | 203,000 | 1,015,000 |
| Conduct Sub county annual performance assessment reviews on coordination | 83,000 | 83,000 | 83,000 | 83,000 | 83,000 | 415,000 |
| Develop and update nutrition sector/ multisectoral partnership framework to guide collaboration at county level | 120,500 | 120,500 | 120,500 | 120,500 | 120,500 | 602,500 |
| Develop annual nutrition resource mobilization and accountability strategy | 99,000 | 99,000 | 99,000 | 99,000 | 99,000 | 495,000 |
| Develop second generation costed County Nutrition Action Plan (CNAP) | 2,422,000 | 2,422,000 | 2,422,000 | 2,422,000 | 2,422,000 | 12,110,000 |
| Domesticate national strategy and framework for enhancing public–private partnerships at county level | 1,130,000 | 1,130,000 | 1,130,000 | 1,130,000 | 1,130,000 | 5,650,000 |
| Hold gender integrated County nutrition annual learning forums. | 95,300 | 95,300 | 95,300 | 95,300 | 95,300 | 476,500 |
| Hold quarterly county Nutrition Technical Forums county as per TORs | 159,600 | 159,600 | 159,600 | 159,600 | 159,600 | 798,000 |
| Hold quarterly sub county Nutrition Technical Forums county as per TORs | 104,000 | 104,000 | 104,000 | 104,000 | 104,000 | 520,000 |
| Map nutrition partners and stakeholders | 104,000 | 104,000 | 104,000 | 104,000 | 104,000 | 520,000 |
| Participate in county resource mobilization forums through county resource mobilization directorate | 125,000 | 125,000 | 125,000 | 125,000 | 125,000 | 625,000 |
| Participate in other sectoral co-ordination forums at county level | 63,000 | 63,000 | 63,000 | 63,000 | 63,000 | 315,000 |
| Support participation and representation of nutrition sector in citizen-participation forums at all levels. | 25,000 | 25,000 | 25,000 | 25,000 | 25,000 | 125,000 |
| Establish a Task force mechanism for engagement in nutrition legal and regulatory process at county level | 104,000 | 104,000 | 104,000 | 104,000 | 104,000 | 520,000 |

| Key Result Areas | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|---|---|
| **KRA 09: Sectoral and multisectoral nutrition information systems, learning and research strengthened.** | **31,367,300** | **29,102,300** | **29,638,300** | **32,146,300** | **29,638,300** | **151,892,500** |
| Develop and progress review of AWPs and other multi-year plans and policies | 3,240,000 | 3,240,000 | 3,240,000 | 3,240,000 | 3,240,000 | 16,200,000 |
| Utilize DHIS reports through capacity building of service providers | 10,384,000 | 10,384,000 | 10,384,000 | 10,384,000 | 10,384,000 | 51,920,000 |
| Adopt and use a nutrition multisectoral nutrition score card to monitor key CNAP indicators quarterly | 95,000 | 95,000 | 95,000 | 95,000 | 95,000 | 475,000 |
| Advocate for nutrition research prioritization at county level | 104,000 | 104,000 | 104,000 | 104,000 | 104,000 | 520,000 |
| Conduct annual, midterm and end term reviews/evaluations of AWPs and multiyear plans and policies for corrective action and way forward | 95,000 | 95,000 | 95,000 | 95,000 | 95,000 | 475,000 |
| Conduct Data Quality Audits for DHIS, LMIS and sentinel surveillance | 432,000 | 432,000 | 432,000 | 432,000 | 432,000 | 2,160,000 |
| Conduct M&E capacity needs assessment and action plan for findings | 2,638,400 | 2,638,400 | 2,638,400 | 2,638,400 | 2,638,400 | 13,192,000 |
| Conduct nutrition situation analysis, generate information products, and disseminate to all levels for planning and response | 2,095,000 | 2,095,000 | 2,095,000 | 2,095,000 | 2,095,000 | 10,475,000 |
| Conduct nutrition SMART Surveys | 2,000,000 | 2,000,000 | 2,000,000 | 2,000,000 | 2,000,000 | 10,000,000 |
| Conduct quarterly Data review and feedback meetings with sub counties | 185,000 | 185,000 | 185,000 | 185,000 | 185,000 | 925,000 |
| Establish strategic partnerships and networks in addressing county research agenda with learning institutions and implementing partners | 104,000 | 104,000 | 104,000 | 104,000 | 104,000 | 520,000 |
| Generate and disseminate annual Nutrition reports. | 280,000 | 280,000 | 280,000 | 280,000 | 280,000 | 1,400,000 |
| Participate in the HMIS indicator manual review | 90,000 | 90,000 | 90,000 | 90,000 | 90,000 | 450,000 |
| Participate in the review of county indicator handbook | 565,500 | 565,500 | 565,500 | 565,500 | 565,500 | 2,827,500 |
| Print, distribute and disseminate MoH Nutrition M&E framework, tools, manuals, and guidelines | 1,500,000 | 1,500,000 | 1,500,000 | 1,500,000 | 1,500,000 | 7,500,000 |
| Systematic utilization of nutrition information to inform program quality improvement | 95,000 | 95,000 | 95,000 | 95,000 | 95,000 | 475,000 |
| Train departmental M&E champions on Nutrition indicators | 2,336,400 | 2,336,400 | 2,336,400 | 2,336,400 | 2,336,400 | 11,682,000 |
| Upload nutrition data and reports to DHIS to enable generation of information to be used for decision making | 655,000 | 655,000 | 655,000 | 655,000 | 655,000 | 3,275,000 |
| Adopt nutrition dashboards, scorecards, electronic data collection tools, etc. | 615,000 | 615,000 | 615,000 | 615,000 | 615,000 | 3,075,000 |
| Conduct nutrition data clinics to reflect on NIS processes, key emerging issues, lessons learnt from field implementation to improve NIS | 104,000 | 104,000 | 104,000 | 104,000 | 104,000 | 520,000 |
| Disseminate nutrition survey findings | | 304,000 | | 304,000 | - | 608,000 |
| Strengthen collaboration and linkages with other sectors on nutrition information system | 104,000 | 104,000 | 104,000 | 104,000 | 104,000 | 520,000 |
| Participate in county, national, and international forum for knowledge sharing forums such as symposiums and conferences, workshops, meetings | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 750,000 |
| Establish and strengthen County Research and Ethics Technical Working | - | 123,000 | 123,000 | 123,000 | 123,000 | 492,000 |
| Participate in county research technical working group | - | 176,000 | 176,000 | 176,000 | 176,000 | 704,000 |
| Advocate for systematic review of nutrition-sensitive and nutrition-specific research | - | 176,000 | 176,000 | 176,000 | 176,000 | 704,000 |
| Promote knowledge sharing through publication | - | - | 1,296,000 | - | 1,296,000 | 2,592,000 |
| Establish a research repository for nutrition and dietetics at county level | - | 456,000 | - | - | - | 456,000 |
| Conduct gender integrated MIYCN KAP survey | - | - | - | - | - | - |
| Conduct gender, age and diversity inclusive coverage assessments using SQUEAC methodology | 1,500,000 | - | - | 1,500,000 | - | 3,000,000 |
| Conduct nutrition capacity assessment | 2,000,000 | - | - | 2,000,000 | - | 4,000,000 |
| Advocate for a multisectoral Nutrition Information Platform (NIP) for improved gender integrated multi-sectoral data analysis, dissemination, and utilization | - | - | - | - | - | - |

| Key Result Areas | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | Total |
|---|---|---|---|---|---|---|
| **KRA 10: Advocacy, communication, and social mobilization (ACSM) strengthened** | **18,229,500** | **16,972,300** | **18,565,800** | **17,133,300** | **18,565,800** | **89,466,700** |
| Adapt a gender responsive sensitization package on nutrition for journalists based on simplified messages and key information | 337,500 | - | 337,500 | - | 337,500 | 1,012,500 |
| Advocate for relevant sectors to support strengthening of multisectoral nutrition platforms | 1,050,000 | 1,050,000 | 1,050,000 | 1,050,000 | 1,050,000 | 5,250,000 |
| Conduct training sessions for nutrition professionals and influencers on advocacy | 1,294,500 | 405,000 | 1,035,000 | 405,000 | 1,035,000 | 4,174,500 |
| Design, print and distribute gender transformative IEC materials for use during national health days | 180,000 | - | 180,000 | - | 180,000 | 540,000 |
| Develop advocacy, communication, and social mobilization strategy for Bomet County | - | 210,000 | - | 210,000 | - | 420,000 |
| Development of a gender inclusive nutrition advocacy package at county level. | 255,000 | - | - | - | - | 255,000 |
| Document and disseminate best practices, case studies, research findings and success stories | 32,500 | 32,500 | 32,500 | 32,500 | 32,500 | 162,500 |
| Establish a community feedback mechanism platform. | 262,500 | 262,500 | 262,500 | 262,500 | 262,500 | 1,312,500 |
| Hold high level sensitization targeting policy makers on the value and impact of prioritizing nutrition and advocate for increased financial allocation. | 495,000 | - | 495,000 | - | 495,000 | 1,485,000 |
| Identify and engage male and female nutrition champions to advocate for prioritization of nutrition at all levels in Bomet County. | 215,000 | - | - | - | - | 215,000 |
| Participate in county planning process ensuring nutrition representation and mainstreaming nutrition in the county plans | 300,000 | 300,000 | 300,000 | 300,000 | 300,000 | 1,500,000 |
| Participate in mass media education programme on nutrition | 5,070,000 | 5,070,000 | 5,070,000 | 5,070,000 | 5,070,000 | 25,350,000 |
| Sensitize media fraternity on nutrition for better coverage | - | - | - | - | - | - |
| Support in promotion of community participation in nutrition resilience building interventions and accountability mechanism. | 4,500,000 | 4,500,000 | 4,500,000 | 4,500,000 | 4,500,000 | 22,500,000 |
| Support sensitization sessions of nutrition professionals and other relevant stakeholders on communication and writing skills to help them better package information for media | 4,237,500 | 4,237,500 | 4,237,500 | 4,237,500 | 4,237,500 | 21,187,500 |
| Advocate for recruitment of male and female nutritionists for the county to address specific nutrition needs of the men and women across all ages and diversities in the county | | | | | | - |
| Support sensitization sessions of nutrition professionals and other relevant stakeholders on communication and writing skills to help them better package gender integrated nutrition information for media | - | - | 161,000 | 161,000 | 161,000 | 483,000 |
| Observance of global and national nutrition-related days including Biannual Malezi Bora Week, World Breastfeeding Week, World Prematurity Day | - | 904,800 | 904,800 | 904,800 | 904,800 | 3,619,200 |
| Grand Total | **329,736,100** | **375,756,800** | **393,345,600** | **355,787,900** | **367,536,250** | **1,822,162,650** |

*Note: Activities that seem NOT to have been costed have their costs taken care of in other costed activities.*

## Appendix B: List of key contributors

| NAME | GENDER | TITLE | ORGANIZATION |
|---|---|---|---|
| Alex Mutai | Male | County Health Records and Information Officer | County Government of Bomet |
| Andrew Wanyonyi | Male | County Programme Coordinator | Nutrition International |
| Beatrice Kaptich | Female | County Reproductive Health Coordinator | County Government of Bomet |
| Chelangat Gladys | Female | County Coordinator WASH | County Government of Bomet |
| Chirchir Wesley | Male | Gender & Social Services | County Government of Bomet |
| David K. Soi | Male | CHS | County Government of Bomet |
| Elizabeth Nyagoha | Female | Project Officer – Livelihoods & Resilience | World Vision |
| Eric Boinnet | Male | Director - Agriculture | County Government of Bomet |
| Fancy Kirui | Female | County Nutrition Coordinator | County Government of Bomet |
| Faridah Mutai | Female | Sub-County Nutrition Officer | County Government of Bomet |
| Dr. Joseph K. Sitonik | Male | County Executive Committee Member - Health | County Government of Bomet |
| Josephine Mutai | Female | Nursing Services Coordinator | County Government of Bomet |
| Dr. Joyce Tonui | Female | Chief Officer – Medical Services | County Government of Bomet |
| Kiptoo Bett | Male | Heath Accountant | County Government of Bomet |
| Linus Ng'eno | Male | Director – Economic Planning & Budgeting | County Government of Bomet |
| Mercy Chepng'enoh | Female | Sub-County Nutrition Officer | County Government of Bomet |
| Micah Koech | Male | Director – Public Health | County Government of Bomet |
| Monica Okwanyi | Female | Nutritionist | Kenya Red Cross Society |
| Salina Kimwa | Female | Asst. County Director Nutrition Services | County Government of Bomet |
| Sarah Koech | Female | CHFP | County Government of Bomet |
| Sigei Mathew | Male | Nutrition Officer – In charge LCRH | County Government of Bomet |
| Stephen Mwangi | Male | Senior Program Officer | Nutrition International |
| Victolyne Korir | Female | Director - Education | County Government of Bomet |
| Vivian Keter | Female | Social Development Officer | County Government of Bomet |
| Zaddy Chepkorir | Male | Chief Officer - Public Health | County Government of Bomet |