EMBU COUNTY NUTRITION

ACTION PLAN (CNAP) 2020/21 – 2024/25

EMBU COUNTY NUTRITION ACTION PLAN 2020/21–2024/25

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS AND ABBREVIATIONS

ABC	Activity Based Costing
ACSM	Advocacy, Communication and Social Mobilization
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ASAL	Arid and Semi-Arid Land
AWP	Annual Work Plan
BCC	Behaviour Change Communication
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
BMI	Body Mass Index
BMS	Breast Milk Substitute
C-BFCI	CHV Baby Friendly Community Initiatives
CCC	Comprehensive Care Centre
CDRRs	Facility Consumption Data Report and Request
CHA	Community Health Assistant
CHMT	County Health Management Team
CHU	Community Health Unit
CHVs	Community Health Volunteers
CIDP	County Integrated Development Plan
CMAM	Community-based Management of Acute Malnutrition
CME	Continuous Medical Education
CMSGs	Community Mother Support Groups
CNAP	County Nutrition Action Plan
CNC	County Nutrition Coordinator
CRAF	Common Results and Accountability Framework
CS-CDRR	Central Site Consumption Data Report and Request
CSO	Civil Society Organization
CUs	Community Units
CWC	Child Welfare Clinic
DALYs	Disability-Adjusted Life Years
DARS	Data Access Request Service
DARs	Daily Activity Registers
DCS	Department of Children Services
DD	Diarrhoea Disease
DQA	Data Quality Assessment
DRNCDs	Diet Related Non-Communicable Diseases

SDSP	State Department for Social Protection
ECNAP	Embu County Nutrition Action Plan
ECD	Early Childhood Development
ECDE	Early Childhood Development Education
EWASCO	Embu Water and Sewerage Company
FAO	Food and Agriculture Organization
FBF	Fortified Blended Flour
FBO	Faith Based Organization
F-CDRRs	Facility Consumption Data Report and Requests
FPE	Free Primary Education
FGD	Focus Group Discussion
GBV	Gender Based Violence
GDP	Gross Domestic Product
GMP	Growth Monitoring and Promotion
HB	Haemoglobin
HCWs	Health Care Workers
HINI	High Impact Nutrition Interventions
HMIS	Health Management Information System
HMT	Health Management Team
HR	Human Resource
ICCM	Integrated Community Case Management
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
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitude and Practices
KHIS	Kenya Health Information System
KHMFL	Kenya Health Master Facility List
KHSSP	Kenya Health Sector Strategic Plan
KM	Kilometre
KNAP	Kenya Nutrition Action Plan
KNBS	Kenya National Bureau of Statistics
KRA	Key Result Area
LMIS	Logistic Management Information System
MAD	Minimum Acceptable Diet

MAM	Moderate Acute Malnutrition
M&E	Monitoring and Evaluation
MCH	Maternal Child Health
MDG	Millennium Development Goal
MEAL	Monitoring Evaluation Accountability and Learning
MIYCN	Maternal, Infant, Young Child Nutrition
MIYCN-E	Maternal, Infant, Young Child Nutrition Emergency
MNCHN	Maternal, New-born and Child Health Nutrition
MNPs	Micronutrient Powders
MOALF&C	Ministry of Agriculture, Livestock, Fisheries and Cooperatives
MOE	Ministry of Education
MOH	Ministry of Health
MOPC	Medical Outpatient Clinic
MTEF	Medium Term Expenditure Framework
MTMSGs	Mother to Mother Support Groups
MTP	Medium Term Plan
MUAC	Mid Upper Arm Circumference
NACS	Nutrition Assessment Counselling and Support
NASRs	Nutrition Adult Service Registers
NCPB	National Cereals and Produce Board
NCSRs	Nutrition Child Service Registers
NDMA	National Drought Management Authority
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
OPCT	Older Persons Cash Transfer
ORS	Oral Rehydration Solution
OVC	Orphans and Vulnerable Children
PD HEARTH	Positive Deviance Hearth
PHOs	Public Health Officers
PLHIV	People Living with HIV
PNC	Post-Natal Care

PPP	Public-Private Partnership
PTA	Parents Teachers Association
PWDs	People with Disabilities
PWSD	People with Severe Disability
SAM	Severe Acute Malnutrition
SBCC	Social Behaviour Change Communication
SCHMT	Sub-County Health Management Team
SCNCs	Sub-County Nutrition Coordinators
SDG	Sustainable Developmental Goal
SFP	Supplementary Feeding Programmes
SMART	Standardized Monitoring and Assessment in Relief and Transition
SNI	Special Needs Institution
SOPs	Standard Operating Procedures
SWOT	Strengths, Weaknesses, Opportunities and Threats
TAN	Technical Assistance for Nutrition
TB	Tuberculosis
TOC	Theory of Change
TOR	Terms of Reference
TWG	Technical Working Group
UHC	Universal Health Coverage
UK	United Kingdom
UN	United Nations
USD	United States Dollar
VAS	Vitamin A Supplementation
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

A healthy population is a global priority as per the Sustainable Development Goals (SDGs). SDG two and three provide for zero hunger, good health, and well-being, respectively.
The Constitution of Kenya, 2010, Article 43 (1) (a) and (c) states that every person has a right to the highest attainable standard of health, which includes the right to healthcare services including reproductive health care as well as freedom from hunger and to have adequate food of acceptable quality. The Government of Kenya is committed to creating an enabling environment for citizens to realize these rights as evidenced in the Vision 2030, Kenya Health Policy (2014–2030) and the National Food and Nutrition Security Policy, 2012.

Embu County's nutrition vision promotes positive nutrition practices through evidence-based programming, policies and research to enable access to nutritious and safe food; encouraging prudent use of resources and; fosters food secure communities where men, women, boys and girls across all ages and diversities are provided with equal opportunities and enabling environment to meaningfully contribute to, and equally benefit from the nutrition development agenda, as an essential ingredient to social economic development. The prevalence of stunting, wasting and underweight in Embu County is 26.8%, 3% and 11.1% respectively (KDHS, 2014). Stunting hinders optimal child growth and development which may lead to non-attainment of full potential in various spheres of life. Furthermore, early exposure to adverse conditions such as illness, inappropriate & poor diets and feeding practices are the immediate causes of malnutrition while other underlying issues such as the socio-cultural, political, and economic factors contribute to malnutrition. This calls for concerted efforts by all stakeholders to achieve highest attainable standards of health. The UNICEF conceptual framework of malnutrition stipulates the causes of malnutrition to be multifaceted hence need for a multi-sectoral approach in addressing malnutrition.

The Embu County Nutrition Action Plan (CNAP) 2020/21-2024/25, is cognizant of lessons learnt in the planning and implementation of health and nutrition interventions in the country and therefore is anchored on the Kenya National Nutrition Action Plan (KNAP) 2018-2022. The main objective of the Embu CNAP is to accelerate and scale-up efforts towards the elimination of malnutrition which is a significant public health problem. The CNAP focuses on three areas of intervention, namely: Nutrition-Specific; Nutrition-Sensitive and Enabling environment, putting emphasis on the need for strengthening multisectoral collaboration in addressing malnutrition. This plan will assist the County attain its vision on developmental agenda as well as contribute to the national goal of a healthy nation.
I thereby call upon the County Government, stakeholders, and partners to actively support implementation of the Embu CNAP for optimal nutrition, growth, and development of our County.

H.E David Kariuki
Deputy Governor
Ag.County Executive Committee Member-Health
County Government of Embu

PREFACE

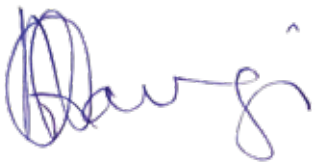
Good nutrition is a vital building block in the foundation of human health and development. There is a direct relationship between nutrition and child survival, physical & mental development, learning capacity, adult productivity, and overall social and economic development.

Nearly one in three people around the world have at least one form of malnutrition. Despite continuous improvements in health outcomes and economic development, rates of malnutrition remain unacceptably high.

According to the KDHS, December 2014, Kenya is experiencing triple burden of malnutrition, where undernutrition (underweight, stunting and wasting), overweight and obesity and micronutrient deficiencies are on the increase in addition to the burden of Non-Communicable Diseases (NCDs). Progress towards reducing the burden is too slow and part of the reason for this is that nutrition has not been systematically prioritized and integrated across sectors, particularly in health systems. The main objective of Embu County Nutrition Action Plan (ECNAP) is therefore to accelerate and scale-up efforts towards the elimination of malnutrition as a problem of public health significance.

Embu County Nutrition Action Plan 2020/21-2024/25 is the first of its kind in the County. The format is adopted to follow the second Kenya Nutrition Action Plan 2018/22 whose approach applies a multisectoral approach and promotes cross sectoral collaboration to address the social determinants of malnutrition. The purpose of the document is to provide a road map of how to address nutrition challenges identified and prioritized to be addressed in a period of five years. The development of Embu CNAP was driven by County Department of Health, under the leadership of the Nutrition Section in the entire process. It involved a series of dedicated consultative multisectoral meetings during the entire development process. The process brought together a broad range of national and County departments that included Agriculture, Livestock, Fisheries and Irrigation, Education, Social Services, Gender and Youth. Technical support was provided by Nutrition International (NI), consultants and the Division of Nutrition and Dietetics.

The Embu CNAP will provide a critical catalyst for enhancing accountability, multi-sectoral collaboration, coordination, and tracking progress of the results. Key priorities to be implemented during the five years period have been identified. It is my expectation that in working together, the overall objective of Embu CNAP will be achieved.



Rosaline Kaugi
Ag.Chief Officer Health
County Government of Embu

ACKNOWLEDGEMENT

The process for development of this document (Embu County Nutrition Action Plan 2020/21-2024/25) was highly participatory with a multisectoral approach. The Department of Health would like to thank everyone who participated in the development of the Embu County Nutrition Action Plan.

The Embu CNAP could not have been finalized without the valuable contributions and full commitment of the technical committee members of different government departments and partners.

The support of the County Government of Embu is highly appreciated. This CNAP was developed with support from Nutrition International under the Technical Assistance for Nutrition (TAN) project, funded by UK aid from the UK Government. We express our sincere gratitude and indebtedness to Nutrition International (NI) staff led by Martha Nyagaya; Joy Kiruntimi, Sarah Kihianyu, technical experts from NI Headquarters, Mary Kihara and Joan Irungu for their immense technical leadership in the entire development process of the Embu CNAP 2020/21-2024/25.

We acknowledge the Division of Nutrition and Dietetics which has played a critical role in the development by providing technical guidance of linking CNAP to an umbrella framework and guidance for nutrition in Kenya, specifically Caroline Kathiari for her support during the process.

The contributions of the following ministries and Departments in providing leadership and technical inputs to the ECNAP are also appreciated: National Government Ministries of Labour and Social Protection, Education and National Drought Management Authority (NDMA); Embu County Departments of Health, Education (ECDE), Agriculture, Finance and Economic Planning, Gender and Social Services.

Lastly, we greatly appreciate the consulting team led by Dr. Daniel Mwai (Health financing and strategic planning expert), David Njuguna (Policy, Costing, Financial Tracking and Resource Mobilization), Clementina Ngina (Nutrition expert), Dr. Wangia Elizabeth (M&E and Accountability Plan), Tabitha Kinyanjui & Agatha Muthoni (Gender experts) and Edna Muthoni (Program Assistant) for providing immense technical support throughout the whole CNAP development process.

John Njagi
Ag.Director Public Health
County Government of Embu

1 INTRODUCTION

1.1 Background information

1.1.1 Location and size

Embu County is one of the nine counties in Eastern region of the Republic of Kenya located approximately 120 Km North East of Nairobi towards Mt. Kenya. The administrative capital of the County is Embu town which was formerly the Eastern Province headquarters. Embu County borders Tharaka-Nithi County to the North, Kitui County to the East, Machakos County to the South, Murang'a County to the South-West and Kirinyaga County to the West. The County is comprised of four Sub-counties: Runyenjes, Manyatta, Mbeere South and Mbeere North. It covers an area of approximately 2,818 square kilometres with an estimated population of 622,993 (Male 309,628; Female 313,365) according to 2020 projection from the Kenya National Bureau of Statistics (KNBS 2019 Census). Below is a map of the County with the administrative units.

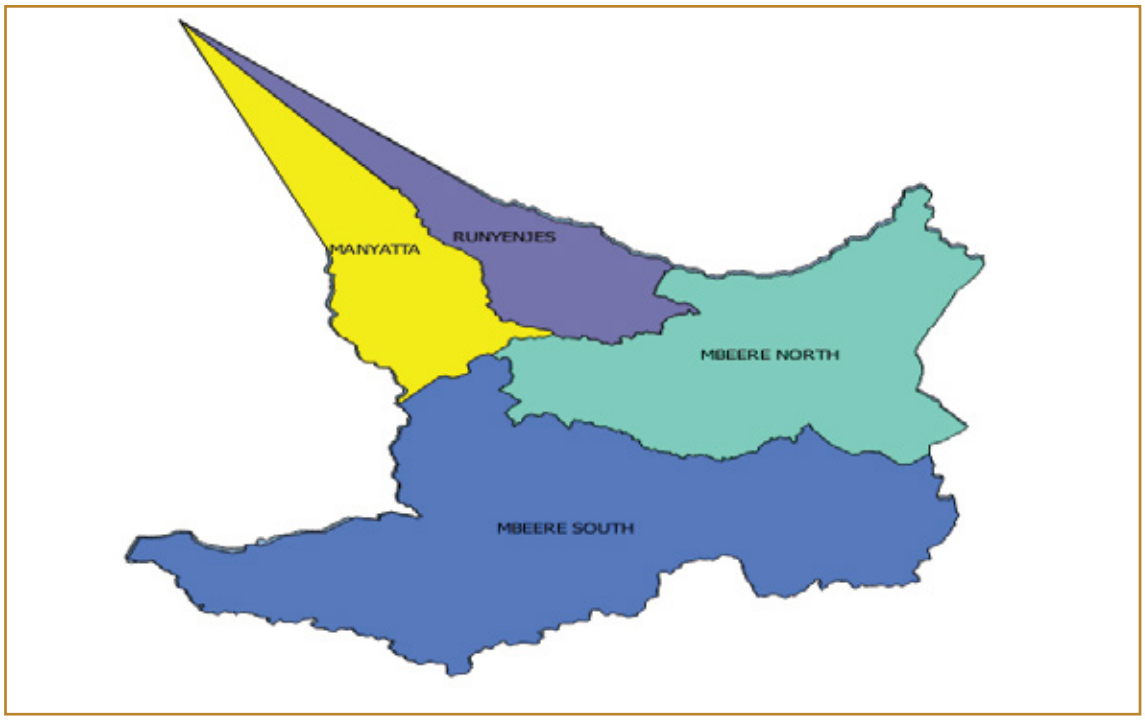


Figure 1: Map for Embu with administrative units

1.2 Demographic profile

Demographic characteristics are important in development planning as they provide a basis for sharing the limited resources. They also help to identify, address, and deliver services responsive to the different nutrition and health related needs and concerns of men, women, boy and girls across different ages and diversities. The table below shows the demographic profile by description, estimated proportion in percentage and the estimated population in 2020 for Embu health care system.

Table 1: Demographic profile

Description	Estimated Proportion %	Projected Population 2020
Total Population		622,993
Total Number of Households		187,958
Children under 1 year (12 months)	2.4	14,656
Children under 5 years (60 months)	10.1	63,007
Under 15-year population	31.3	194,899
Women of childbearing age (15 – 49 Years)	25.6	159,579
Total number of adolescent (15-24)	19.1	119,064
Total number of adults (25-59)	40.9	254,829
Total number of elderly (60+)	8.7	54,201

Source: (KNBS, 2019)

1.3 Population description per Sub-County and Ward

There are four sub-counties in Embu County, namely, Manyatta, Runyenjes, Mbeere North and Mbeere South. These are further subdivided into 20 electoral wards. Manyatta and Runyenjes have 6 electoral wards each while Mbeere North has 3 and Mbeere South 5. The table below gives the population distribution per Sub-County for Embu County according to the Kenya National Bureau of Statistics (KNBS, 2019).

Table 2: Population description per Sub-County

Sub-County	Male	Female	Intersex	Total
Runyenjes	64,571	64,991	2	129,564
Manyatta	39,665	39,888	3	79,556
Mbeere South	83,311	80,159	6	163,476
Mbeere North	53,517	55,360	4	108,881
Embu	63,125	63,966	9	127,100
Mt Kenya Forest***[1]**	19	3	0	22
TOTAL	**304,208**	**304,367**	**24**	**608,599**

Source: (KNBS, 2019)

1.3.1 Facility distribution by Sub-County

Embu County is endowed with 209 health facilities that offer health services at varying levels of care, from primary health care to specialized healthcare. 40% of the facilities are distributed in Manyatta, 26% in Mbeere South, 18% in Runyenjes and 16% in Mbeere North sub-counties.

Table 3: Health facilities by ownership per Sub-County

	Ownership Category	Dispensary	Health Centre	Hospital	TOTAL	Grand Total
Runyenjes	**GOK**	20	4	1	25	**37**
	FBO	1	0	1	2	
	Private	7	3	0	10	
Manyatta	**GOK**	18	5	1	24	**84**
	FBO	14	1	0	15	
	Private	36	7	1	44	
	NGO	1	0	0	1	
Mbeere North	**GOK**	16	0	2	18	**33**
	FBO	2	0	0	2	
	Private	11	2	0	13	
Mbeere South	**GOK**	28	3	0	31	**55**
	FBO	7	0	0	7	
	Private	11	6	0	17	
County Totals	**GOK**	82	12	4	98	**209**
	FBO	24	1	1	26	
	Private	65	18	1	84	
	NGO	1	0	0	1	

Source: (KHMFL, 2020)

1.4 National and County nutrition situation

1.4.1 Trends in nutrition and health situation in Kenya

Various forms of malnutrition can co-exist 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 micro-nutrient deficiencies like of iron, iodine, zinc, or folic acid. In Kenya, the situation of under nutrition is very similar to the global one: Of the 7.22 million children under five years in Kenya, 1.9 million are stunted (26%); 290,000 are wasted (4%); 794,200 (11%) are underweight.

According to the 2018 Global Nutrition Report, Kenya is clustered among 41 countries (29 %) of countries experiencing the triple burden of malnutrition (Development Initiatives Poverty Research Ltd, 2018). This is characterized by the co-existence of under nutrition as manifested by stunting, wasting, underweight, micronutrient deficiencies and over nutrition through overweight and obesity including diet related non-communicable diseases.

Over the past years, Kenya has witnessed an improvement in the nutritional status of children: stunting declined from 35% in 2008-9 to 26% in 2014, wasting from 7% to 4% and underweight from 16% to 11% (KDHS, December 2014). Despite the reduced child under nutrition, there are regional disparities where some counties with lowest stunting are at 15% while those with highest are at 45%. Out of the 47 counties, 11 (23%) have stunting prevalence of above 30%, a level categorized as "severe" in public health significance. Consistent with other low-income countries, stunting is highest in the 19-23-month age group (36%); with boys having slightly higher stunting prevalence (30%) as compared to girls (22%) and rural areas having higher rates (29%) than urban areas with 20%. Stunting decreases with level of the education of the mother with women who have not completed primary school having children who are twice as likely to suffer from stunting (34%) than mothers with secondary or higher education (17%).

Although the KDHS showed the nutrition status of women of reproductive age (WRA) being a triple burden, the trend indicated reduction of under nutrition while overweight and obesity increased. Comparing data in 2008-09 and 2014 KDHS, the proportion of thin women (BMI) declined from 12% to 9%. A total of 28% of adults aged 18 to 69 years are either overweight or obese, with the prevalence in women being 38.5% and men 17.5%. Similar trends are seen when comparing the 2008 to 2014 KDHS. The proportion of women who were overweight or obese increased from 25% to 33% and those who were obese increased from 7% to 10%.

In terms of micronutrient deficiencies, Zinc deficiency had the highest prevalence, according to Kenya National Micronutrient Survey 2011. Anaemia prevalence was highest in pregnant women 41.6% and among children 28.3% while among school going children, it was 16.5% (MOH, 2011). The 2011 National Micronutrient Survey established that pre-school children had the highest prevalence of Zinc deficiency (83.3%) among all the population subgroups. This was 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 (MOH, 2011).

Nationally, 61% of mothers exclusively breastfeed for the first six months and 62% of infants are initiated to the breast within one hour after birth. Only 22 % of children aged 6 to 23 months are fed according to the Minimum Acceptable Diet (MAD). According to the 2015 Step-wise Survey conducted in Kenya, 95% of adults aged 18 to 69 years did not consume the WHO daily recommended five servings of fruits and/or vegetables; fruits were consumed on average about 2.4 days in a week, and vegetables were consumed five days in a week. Approximately 20% of adults in this group add salt or salty sauce to their food before eating; 3.7% consume processed foods high in salt; 83.5% often add sugar when cooking or preparing beverages at home; and 28% always add sugar to beverages (MOH, 2015).

1.4.2 Trends in health and nutrition situation in Embu County

1.4.2.1 Under-nutrition trends

The wellness of any population is gauged by the nutritional status of children under-five years since they are the most vulnerable subset of the population of any community. Nearly half of all deaths in children under five years of age are attributable to under nutrition (UNICEF/WHO/World Bank Joint Child Malnutrition Estimates, March 2020 edition).

Under-nutrition puts children at greater risk of dying from common infections, increases the frequency and severity of infections and delays recovery. The interaction between under-nutrition and infection can create a potentially lethal cycle of worsening illness and deteriorating nutritional status. Poor nutrition in the first 1,000 days of a child's life can also lead to stunted growth, which is associated with impaired cognitive ability and reduced school and work performance.

Embu County is one of the regions substantially contributing to the worrying national malnutrition indicators. The County stunting level stands at 26.8 %, wasting at 3 % and underweight at 11.1 % (KDHS, December 2014). The following figure shows the stunting, underweight and wasting levels of Embu County as compared to the national levels as per KDHS, 2014.

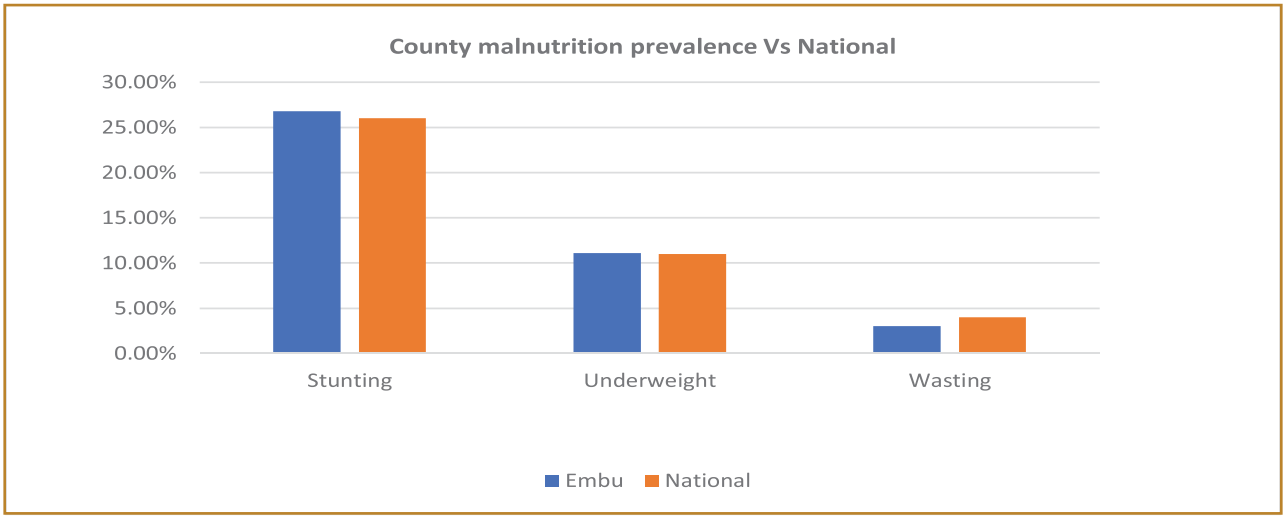


Figure 2: County vs national malnutrition prevalence

Source: (KDHS, December 2014)

1.4.2.2 Infant and young child feeding practices

Adequate nutrition is critical to children's growth and development. The period from birth to age 2 years is especially important for optimal physical, mental, and cognitive growth, health, and development. Early initiation of breastfeeding within the first hour after birth lays the foundation for exclusive breastfeeding for infants, for the first six months, which is critical in promoting survival and health. In Embu County, 87.2% of new-borns are breastfed within 1 hour of birth while the proportion of infants exclusively breastfed for the first six months of life is at 86.4 % (KHIS 2019). There still exists a gap in infant feeding practices that need to be addressed. According to an MNCHN baseline assessment conducted in January 2020 the findings indicates that 36.5% of children receive minimum acceptable diet while 54.6% receive minimum dietary diversity. The same report indicates that only 33.2% of mothers received counselling for improved IYCF practices while 21.6% had knowledge on the age-appropriate feeding for children 6 to 23 months. This knowledge gap could be linked to the sub-optimal nutrition practices leading to high malnutrition status in the County thus, increasing the need to expedite the global strategy on maternal infant and young child nutrition.

Furthermore, it is paramount to address socio- cultural and economic vulnerabilities among women and girls that contribute to poor utilization of health care services. Unequal social systems and deep-rooted gender inequalities that have a wide range influence on unequal access to, ownership of and control over benefits from productive resources and decision making disproportionately affecting women and girls in the County, has a great impact on maternal and infant and young children care and feeding practices. Further cultural norms, beliefs and practices affects maternal, infant, and young children optimal dietary diversity through locally available and affordable nutritious foods. Levels of knowledge on nutrition among men and women across different ages and diversities, further greatly determines the level of support especially by men and other key influencers within communities, which is key in prompting increased uptake of optimal nutrition and health care and practices by women and children in the County.

MDD- Percentage of children 6–23 months of age who receive foods from five or more food groups.

MAD- Proportion of children 6–23 months of age who received a minimum acceptable diet (apart from breast milk). The MAD indicator is a composite indicator composed of the Minimum Dietary Diversity (MDD) and Minimum Meal Frequency.

1.4.2.3 Micronutrient deficiencies

Deficiencies of micronutrients are a major global health problem. More than 2 billion people in the world today are estimated to be deficient in key vitamins and minerals, particularly Vitamin A, Iodine, Iron and Zinc. There exists no County-specific data to show the burden of micronutrient deficiencies in the County. However, available routine data extracted from KHIS 2019 shows that the proportion of pregnant women attending ANC with Anaemia (Hb<11g/dl) is 16%. The County coverage of iron folic acid supplementation (IFAS) among pregnant women attending antenatal clinic stood at 78.5% (KHIS 2019). This indicates that a sizeable proportion of pregnant women do not receive and consume the IFAS as recommended.

In the prevention of Vitamin, A deficiency, among children under 5 years, 61.3% of the children aged 6 to 59 months received at least the 2 recommended doses of vitamin A in the year (KHIS, 2019). This coverage is below the 80% national program target for any public health impact intervention.

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 by 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.

1.4.3 Morbidity trends

Estimates of the burden of disease at County level could inform targeted interventions, while evidence of risk factors could guide prioritization of interventions. Intestinal worms, pneumonia and diarrhoea are particularly noteworthy given their major direct impact on under-nutrition and micronutrient deficiencies which require a multidisciplinary approach.

Table 4: Top ten causes of morbidity in the County

S/NO	Diseases	Number of cases	Proportion
1	Respiratory Tract Infections	374,559	47.5
2	Disease of the skin	92,413	11.7
3	Intestinal worms	82,462	10.5
4	Arthritis, Joint pains	51,096	6.5
5	Urinary Tract Infection	45,108	5.7
6	Hypertension	40,157	5.1
7	Diarrhoea	31,726	4
8	Pneumonia	30,356	3.8
9	Other injuries	23,094	2.9
10	Eye Infections	18,127	2.3

Source: (KHIS, 2019)

1.5 Integration of nutrition in food security & agriculture, gender & social protection, education, and WASH

1.5.1 Food security & agriculture

Food security exists ***'when all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active and healthy life' (World summit,1996)*** This includes both physical and economic access to food that meets people's dietary needs as well as their food preferences.

Food security remains a priority objective for Embu County. Access to quality, nutritious food is critical to human existence. Secure access to food can produce wide ranging positive impacts, including: Economic growth and job creation. Poverty reduction, among others. In Embu, there are initiatives that have been undertaken by the National and County Governments with support from development partners which will go a long way in attainment of food self-sufficiency and mitigation of recurrence of food shortages occasioned by droughts and climate change.

The County government guided by the Ministry of Agriculture, Livestock and Fisheries (MOAL&F) has come up with strategies/approaches within the CNAP to address food security and agriculture in collaboration with the nutrition department, they include:

1. Promotion of kitchen gardens at household level
2. Value addition and processing of farm produce this ensures that the produce fetches better market prices when the market is not flooded like the times of seasonal availability
3. Bio-fortification of food crops
4. Nutrition education to the community through various community groups (e.g., farmer to farmer farm schools, mother to mother support groups)
5. Production and consumption of diverse, safe, and nutritious foods
6. Crop insurance: Access of certified seeds to the farming community at the beginning of every rainy season. The seeds are usually based on agro-ecological zones and in this way cater for farmers needs i.e., according to their requirements, these seeds include maize, beans, sorghum, green grams
7. GOK subsidized fertilizers: The government through the National Cereals and Produce Board (NCPB) has made fertilizers available for the small-scale farmers at a subsidized price
8. Support and train 4K club members, young farmers club and out of school youth to ensure that they continue practicing on agricultural projects that interest them for continuity in agriculture engagement leading to a new generation to take over from the elderly farmers; and
9. Active involvement and empowerment of women in all agricultural interventions at the County level

1.5.2 Social protection

Social protection policies and programmes hold immense potential for improving the nutrition situation of vulnerable populations. To ensure that these policies holistically combat malnutrition, a nutrition-sensitive approach needs to be employed in their design and implementation. Nutrition and social protection are linked by their relevance for building resilience and linking emergency and development approaches. Adopting a multisectoral and multi-stakeholder approach, which is sensitive to the specific needs and roles of both women and men, is necessary for nutrition and social protection programmes.

The main objective of the State Department for Social Protection is to mobilize and empower individuals, families, groups, and communities to facilitate the process of social change for growth and improved livelihoods. In Kenya, the social assistance programs target individual and households with the lowest incomes, those that are socially and economically marginalized and whose livelihood is greatly diminished which unfortunately are at the greatest risk of suffering malnutrition.

The State Department for Social Protection is implementing three cash transfer programs: cash transfers to old persons (OPCT), persons with severe disabilities (PWSD-CT) and to orphans and vulnerable children (CT-OVC) in Embu County. These measures will enhance the capacity and opportunities of working together with the nutrition department to improve the nutrition status of the vulnerable population in the County.

1.5.3 Early childhood development

Malnutrition among school age children is due to inadequacies in one or more of the three preconditions for good nutrition: food, care, and health. The health of children has great influence on the growth, development, and learning ability. Recent research has shown that poor health and nutrition among children reduces their time in school and their learning during that time. This implies that programs or policies that increase children's health status could also improve their education outcome.

With this realization the education department through the ECDE teacher Diploma and Certificate training curriculum has unit is in health and nutrition that equips the teacher trainees with knowledge and skills to promote good health and nutrition. The preschool curriculum has topics in heath practices that reinforce and promote nutrition and hygiene that include hand washing, care for nose and teeth, toileting, and foods/feeding, (types of food for healthy living, table manners etc.

School Feeding Programme (SFP) is a targeted safety net program designed to provide educational and health benefits to vulnerable children. Embu County school feeding Programme is at an advanced stage. The department is currently funding and implementing a food Programme pilot in ECDE centers of Runyenjes central ward. (Schools are provided with maize, rice, green grams, beans, porridge flour, cooking fat, sugar, and salt).
Embu County Department of Education looks forward to collaborating with the nutrition sector in ensuring nutrition is mainstreamed within the County policies and programs as envisioned within the CNAP.

MOE efforts in promoting learners' health:

- Introduction of Free Primary Education (FPE) and Free Day Secondary Education (FDSE) to cushion parents from the burden of feeding their children.
- Introduction of low-cost boarding primary schools to support children from needy back grounds.
- Introduction and funding of school feeding programmes in arid and semi –arid land (ASAL) areas - Mbeere North & South to help meet nutritional needs of children.
- Nutrition awareness integrated into school curriculum; and
- Collaboration and partnerships with:
    - o County governments- e.g., water tanks, milk programmes for pre-primary; and
    - o MOH - school health programme (policy), vaccination

1.5.4 Water Sanitation and Hygiene (WASH)

The World Health Organization (WHO) estimates that 50% of malnutrition is associated with repeated diarrhoea or intestinal worm infections because of unsafe water, inadequate sanitation, or insufficient hygiene. Sustainable development goal (SDG) 6 aims at achieving universal and equitable access to safe and affordable drinking water for all and to end open defecation by 2030 as well as paying special attention to the needs of women and girls and those in vulnerable situations. It also seeks to protect and restore water-related ecosystems, including mountains, forests, wetlands, rivers, aquifers, and lakes.

In response to SDG 6, the public health department will collaborate with the nutrition department to identify, recognize, and disseminate the efforts of County governments to understand, test and improve the coherence of WASH and nutrition linkages. Recognition that women and girls bear the greatest responsibility for acquiring and using water, the nutrition department together with the public health department will advocate for active involvement and empowerment of women and girls in the implementation of WASH services. The public health department has agreed to collaborate, focusing on three thematic areas, namely joint advocacy and promote good WASH practices. There is recognition that building collective knowledge is key to ensuring learning which can be shared to guide better implementation and advocacy efforts as well as to inform stronger research in future.

1.6 Gender mainstreaming in CNAP

Addressing gender issues in nutrition is critical to effective nutrition programming. Gender inequalities are a cause as well as an effect of malnutrition and hunger (FAO, 2012). Higher levels of gender inequality are associated with higher levels of undernutrition, both acute and chronic undernutrition. Studies examining the relationship between gender inequality, nutrition and health have consistently shown that gender-related factors influence nutrition and health related outcomes (UNICEF, 2011).

The domains of gender equality such as gender roles and responsibilities leading to overburdening maternal roles and responsibilities among women and girls, limited opportunities to engage in competitive and skilled productive work especially among women and youth; beliefs, attitudes and norms pertaining to the way women and men relate to each other within the household or community; lack of autonomy in decision-making, power and idea sharing; unequal access to, use and control over productive economic resources, services and opportunities by women and girls and attitudes about or experience of gender-based violence disproportionately affecting women, girls and children have been observed to have an far-reaching influence on nutrition and health related outcomes (Nutrition International, 2018).

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.

This CNAP aligns itself with the Embu County Integrated Development Plan 2018 – 2022 which calls for gender mainstreaming across all policies and programmes implemented in the County. It seeks to promote gender transformation by targeting both men and women across different ages and diversities throughout its development, implementation, monitoring and evaluation process.

Specifically, the CNAP seeks to ensure that nutrition programmes are consistently informed by context-based gender analysis, defining the gender issues and relations relating to the specific nutrition needs and priorities of men and women of different ages and diversities across the County.

This further includes prioritization of strategies/interventions to help identify and address socio-cultural and economic vulnerabilities, technology, and political barriers, promote equal participation of men and women in key decision processes pertaining to their nutrition and wellbeing as well as equal access to, use and control over and benefit from productive resources, for improved and sustainable nutrition and health related results. Using gender transformative IEC materials together with implementation of SBCC strategies, this CNAP pursues to transform gender-based community attitudes towards nutrition related roles and responsibilities. The common result and accountability framework have intentionally included gender sensitive indicators to help monitor and evaluate gender transformative nutrition interventions for improved and sustainable nutrition and health related outcomes.

1.7 Human resource for nutrition

Embu County current nutrition staffing levels are too far below the required officers based on the existing human resources for health norms and standards guidelines for the health sector. Currently, the County Department of Health has 31 nutrition and dietetics personnel in government health facilities against the standard norm of 461 thus translating to a deficit of 430 nutrition staff. Additionally, there is need for clinical nutrition specialties training to offer specialized nutrition care to support such areas as oncology, renal etc. as well as community nutrition specialties. The County Government has put up short terms measures to combat the wanting nutrition staffing levels by engaging nutrition and dietetics interns on contractual basis to work in the nutrition department across the various health facilities.

Gender equality and good nutrition are mutually reinforcing. However, despite the increasing awareness and call on the significance of integrating gender equality and women empowerment 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 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.

1.8 Constraints

An analysis with various County stakeholders revealed various constraints limiting optimal nutrition services. Addressing these gaps is critical to the realization of the goals of this CNAP as well as national and global targets. Areas of constraints include:

1. Inadequate staffing as evidenced by the lean number of the nutrition personnel

2. Limited nutrition knowledge and skills gap among health care providers including Commu nity Health Volunteers.
3. Inadequate capacity among nutrition and health related staff on the nexus between gender equality, socio-economic, cultural factors and nutrition including effective gender integra tion and implementation of gender responsive nutrition –health related policies, crucial for realization of sustainable and transformative nutrition and health results.
4. Knowledge gap on sound nutrition practices among caregivers and the general population.
5. Inadequate IEC/BCC materials and various job aids for optimal delivery of nutrition and dietetics services.
6. Access to integrated management of acute malnutrition program is low for its only 27/209 facilities that are served by the food by prescription program.
7. Low utilization of growth monitoring services which is a platform to offer health and nutri tion preventive and promotive care among children under-five years of age and their care givers.
8. Retrogressive myths and misconception about DRNCDs among the population
9. Erratic supply of nutrition commodities
10. Inadequate nutrition equipment's within the health facilities
11. Inadequate gender integration in nutrition assessments, surveys/research to identify social and non-medical factors; and inconsistent collection and use of sex-age disaggregated nutrition data leads to lack of evidence-based decision making for enhanced transformative nutrition programming.
12. Lack of County specific nutrition surveys and surveillance mechanisms for timely and informed decision making and action planning

2 COUNTY NUTRITION ACTION PLAN (CNAP) FRAMEWORK

2.1 Introduction

Malnutrition is caused by factors which are broadly categorized as immediate, underlying, and basic. Immediate causes of malnutrition include disease and inadequate food intake. This means that disease can affect nutrient intake and absorption, leading to malnutrition, while not taking enough and the right quality of food can also lead to malnutrition.
The underlying causes of malnutrition include food insecurity (availability, economic access and use of food); feeding and care practices (at maternal, household and community level); and environment and access to and use of health services (WORLD BANK, 2016). Household food insecurity implies that there is lack of access to sufficient, safe, nutritious food to support a healthy and active life. The level of nutrition awareness among mothers or caregivers and other influencers affects the child feeding and care practices, consequently impacting on their nutritional status. Similarly, poor access to and utilization of health services as well as environmental contaminants brought about by inadequate water, poor sanitation, and hygiene practices, influence the nutrition of households.

Beyond poor diets and morbidity which are the immediate causes of malnutrition, there are underlying socio-cultural, political, and economic factors. These include but not limited to household food insecurity; inadequate care of vulnerable household members including cultural norms and practices influencing food sharing and uptake; poor access to clean water, hygiene and sanitation; inadequate health services; poor health seeking behaviour and care practices among men and women across all ages and diversities; low community and male support in relieving women of overburdening maternal workload; inadequate and inequitable access to nutrition and health education, unequal access, use and control of benefits from productive assets disproportionately affecting women and girls including their discrimination in decision making on issues pertaining their nutrition and wellbeing, which must be addressed as part of effective and sustainable ways in addressing malnutrition.

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

Nutrition is neither a sector nor a domain of one ministry or discipline but a multi-sectoral and multi-disciplinary issue that has many ramifications from the individual, household, community national to global levels.
Addressing all forms of malnutrition at all three levels of causation (immediate, underlying, and basic) requires Triple-duty actions that have the potential to improve nutrition outcomes across the spectrum of malnutrition, through integrated initiatives, policies, and programmes. The potential for triple-duty actions emerges from the shared drivers behind different forms of malnutrition, and from shared platforms that can be used to address these various forms. Examples of shared platforms for delivering triple-duty actions include health systems, agriculture and food security systems, education systems, social protection systems, WASH systems and nutrition sensitive policies, strategies, and programs. Strategies for integration of nutrition specific interventions and sensitive interventions have been tested and proven to work.

2.2 Vision, mission, and guiding principles

2.2.1 CNAP vision

A County free from malnutrition

2.2.2 CNAP mission

To provide effective nutrition leadership and participate in provision of high-quality health care services, that are equitable, responsive, accessible, and accountable to Embu community and its neighbourhood.

2.3 Rationale

There is overwhelming evidence that improving nutrition contributes to economic productivity and development and poverty reduction by improving physical work capacity, mental capacity, and school performance.

Improving nutrition has tremendous value for money as it reduces the costs related to lost productivity and health care expenditures. Globally, it is estimated that each dollar spent on nutrition delivers between USD 8 and USD 138, which is a cost–benefit ratio of around 1:17, like that of infrastructure development like roads, railways, and electricity. Table 5 shows the cost–benefit ratios of different nutrition intervention programs (WORLD BANK, 2016).

Table 5: Cost benefit ratios of different nutrition intervention programs

NUTRITION INTERVENTION PROGRAMS	COST-BENEFIT (USD$)	COST-BENEFIT RATIO
Breastfeeding promotion in health facilities	5 – 67	1:13
Integrated childcare programs	9 – 16	1:1.8
Iodine supplementation (women)	15 – 520	1:35
Vitamin A supplementation (children <6 years)	4 – 43	1:11
Iron fortification (per capita)	176 – 200	1:1.4
Iron supplementation (per pregnant woman)	6 – 14	1:2.3

Source: (World Bank, April 2016)

Cost–benefit analysis conducted in Kenya in 2016 by UNICEF, the World Bank and Ministry of Health reported that every USD1 invested in scaling up high-impact nutrition interventions has the potential return of USD22, higher than the global estimates of USD16–18 (WORLD BANK, 2016).

The study was done to help guide the selection of the most cost-effective interventions as well as strategies for scaling up a package of interventions tailored to County specific needs, as done in this CNAP. The study considered high-impact nutrition-specific interventions that rely on typical health sector delivery mechanisms.

It is estimated that the costs and benefits of implementing these 11 critical nutrition-specific interventions could avert more than 455,000 Disability Adjusted Life Years (DALYs) annually, save over 5,000 lives, and avert more than 700,000 cases of stunting among children under five.

The 11 High-Impact Nutrition Interventions (HINI) were: (i) Promotion of good infant and young child nutrition and hygiene practices, (ii) Vitamin A supplementation, (iii) Therapeutic Zinc supplementation with Oral Rehydration Salts (ORS), (iv) Multiple micronutrient powders for children, (v) Deworming, (vi) Iron-Folic Acid Supplementation during pregnancy, (vii) Iron fortification of staple foods, (viii) Salt iodization, (ix) Public provision of complementary food for the prevention of moderate acute malnutrition, (x) Management of moderate acute malnutrition and (xi) Treatment of severe acute malnutrition.

The implementation of Embu CNAP will help in improving the County nutrition more especially for children less than five years, pregnant and lactating women

2.4 National policy and legal framework for CNAP

The Constitution of Kenya gives every child the right to basic nutrition (Article 43 c); all individuals the right to free from hunger and food of acceptable quality (Article 53c) and provides for equal treatment, equal opportunities for both men and women and freedom from discrimination based on race, sex, marital status, age, disability among others (Article 27). The country has a huge responsibility of ensuring the communities have equitable access to good quality health care and live a healthy life. To achieve the aspirations of the Constitution and Vision 2030, Kenya has given legislative force to some key aspects of nutrition interventions including the mainstreaming of gender in all policies and programmes. The legislations below are aligned with the Kenya nutrition action plan which has laid out the direction to the development of CNAPs

These include legislation on the following:

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

Further, improved nutrition and gender equality are development priorities as reflected in several international, national, and County commitments including just to mention a few, the 1981 United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) of which Kenya is a signatory, including conventions the Convention of the Rights of the Child and the Universal Declaration of the Human Rights, SDGs 1, 2 and 5 that target poverty eradication, elimination of hunger and malnutrition together with promoting gender equality in all spheres, respectively.

When women and men across different ages and diversities are empowered to claim their rights, this will lead to improved health and nutrition for themselves and a better quality of life for their families and communities.

Empowering women as health care givers, as mothers, and/or community decision-makers, promoting positive male engagement that enable more equitable distribution of household nutrition, health decision-making, caregiving or professional health-related responsibilities will lead to increased gender equality, a key prerequisite in realization of improved nutrition in the short and long term. Thus, gender mainstreaming in nutrition programming will be strengthened as captured through multisectoral approaches defined in this CNAP.

2.5 County Nutrition Action Plan objective and expected result objectives

The objectives of Embu CNAP are to eradicate malnutrition in all its forms. This will be achieved through mainstreaming nutrition interventions in patient management, establishment and strengthening multi-sectoral nutrition platforms, mobilizing adequate financial resources for sustained quality nutrition services, participation in County planning process by ensuring nutrition representation and mainstreaming nutrition in County strategic plans and advocating for employment of adequate Nutrition and Dietetics personnel. The expected result or desired change is to achieve optimal nutrition for a healthier and better quality of life and improved productivity that will accelerate the social and economic growth of Embu County.

2.6 Target audience for Embu CNAP

The target audience for the Embu CNAP includes health care planners, policy makers at the County and National level, National and global decision makers, nutrition-sensitive sectors, nutrition officers, managers at all levels, donors, development partners, NGOs, civil society organizations, faith-based organizations, the private sector, academia, research institutions, the media, and the Embu residents 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.

2.7 Embu County Nutrition Action Plan (ECNAP) development process

The development of ECNAP was driven by the County Department of Health led by Nutrition and Dietetics section with involvement of other health sections as well as the line ministries (Agriculture, Education, Social Protection, Finance and Economic Planning, Gender and National Drought Management Authority). The process also ensured that the ECNAP is results-based and provides for a common results and accountability framework for performance-based M&E. Evidence was gathered through desk reviews of relevant documents, information from key sectors and overall guidance from the Kenya Nutrition Action Plan.

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

3.1 Introduction

The overall expected result or desired change for the CNAP is to achieve optimal nutrition for the entire Embu 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: Prioritized KRAs per focus area

CATEGORY OF KRAs BY FOCUS AREA	KEY RESULT AREAS (KRAs)
Nutrition specific interventions	1) Maternal, Infant, Young Child Nutrition (MIYCN) scaled up
	2) Nutrition of older children and adolescents promoted
	3) Prevention, control, and management of micronutrient Deficiencies scaled-up
	4) Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs)among all cohorts scaled-up
	5) Integrated management of Acute malnutrition and nutrition in emergencies strengthened
	6) Clinical nutrition and dietetics in disease management, nutrition in HIV/TB promoted
Nutrition sensitive interventions	7) Nutrition in Agriculture, ECDE, WASH and Social Protection and other relevant sectors promoted and scaled up
Enabling environment interventions	8) Sectoral and multi-sectoral nutrition governance, coordination, and legal/regulatory frameworks, strengthened
	9) Sectoral and multi-sectoral governance, coordination, legal/regulatory frameworks, leadership, and management 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 3), defines long-term goals in this case realizing an Embu County free from malnutrition and providing effective nutrition leadership and high-quality health care services. 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 Embu 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 the improved nutritional status of Embu residents.

The logic framework outlining the key elements and process used to integrate "ToC" in Embu CNAP development is captured in Figure 3. The expected outcome Output and priority activities in line with the process logic have been discussed in section 3.3.

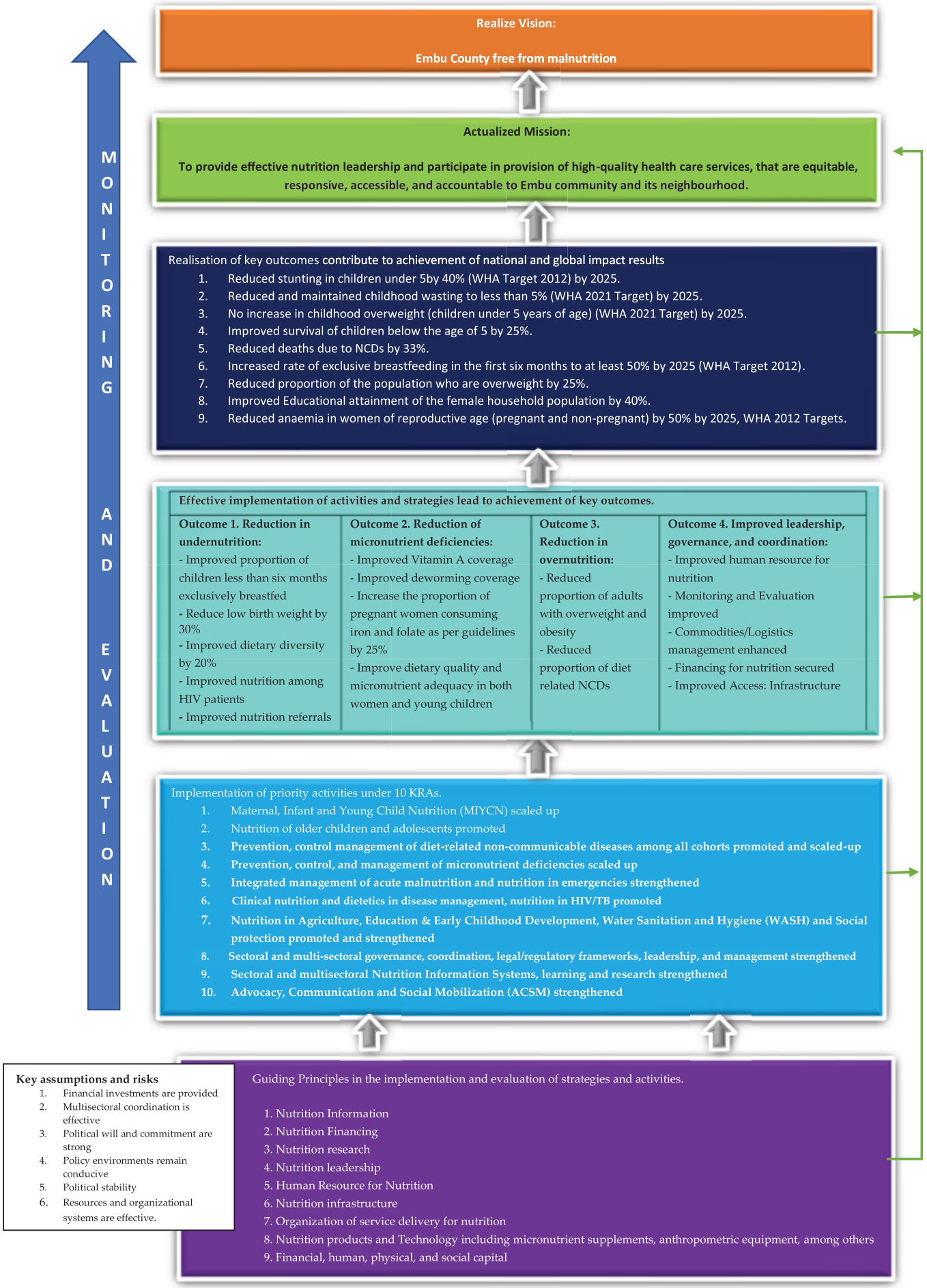


Figure 3: The Embu CNAP logic process

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

3.3.1 KRA 1: Maternal, Infant and Young Child Nutrition (MIYCN) scaled up

Expected outcome

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

Output 1

Scale-up Baby Friendly Community Initiative (BFCI) in selected community Units (CUs)

Activities

- Sensitize County health management team (CHMT), Sub-County health management team (SCHMT) targeting both male and female representatives and other implementing partners on BFCI
- Train male and female health care workers (HCWs) on BFCI and to effectively mainstream and implement gender transformative BFCI initiatives.
- Sensitize Community Health Committee, Primary Health Care Facility Committee, and other community leaders on BFCI targeting both male and female across different diversities.
- Establish Community Mother Support Groups incorporating mothers across different age categories and level of influence while promoting increased male support for sustainability.
- Train male and female CHVs and community mother support group (CMSG) on C-BFCI
- Map households within community units and establish gender sensitive CMSGs consisting of men and women of different ages and diversities and across various levels of influence both at the household and community levels.
- 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. Establish Mother-to-Mother (MTMSG) and father to father (FTFSG) support groups at community unit level
- Conduct gender integrated baseline BFCI assessment at CU level while ensuring collection and analysis of data disaggregated data by gender, age, and diversity.
- Conduct Continuous gender integrated BFCI assessment by CHMT and SCHMT
- Conduct gender integrated BFCI external assessment
- Conduct monthly CHVs meeting
- Conduct quarterly CHVs review meetings on BFCI

Output 2

Strengthened baby friendly hospital initiative (BFHI) implementation at high volume health facilities

Activities

- Sensitize CHMT, SCHMT, HMT and other implementing partners on BFHI
- Train HCWs on BFHI
- Select and establish facility BFHI Committee members of both genders
- Conduct BFHI baseline assessment in implementing health facilities
- Conduct quarterly assessment for BFHI by HMT and BFHI committee members
- Hold quarterly facility BFHI committee members meeting
- Carry out quarterly continuous medical education (CME) on BFHI in implementing health facilities

•Conduct bi-annual internal BFHI assessment by CHMT and SCHMT
•Conduct external BFHI assessment

Output 3
Strengthened growth monitoring and promotion (GMP) at County level

Activities
•Train male and female HCWs on World Health Organization (WHO) growth standards
•Train male and female HCWs on childcare and stimulation
•Procure anthropometric measurement equipment's
•Distribute anthropometric equipment's
•Sensitize male and female CHVs on childcare and stimulation
•Sensitize male and female CHVs on growth monitoring and promotion (MUAC)
•Train mothers and care givers on family MUAC
•Conduct quarterly CME on GMP and mother child handbook at facility level targeting HCWs
•Print and distribute data collection and reporting tools disaggregated by gender age and diversities for MNCHN

Output 4
Workplace support for breastfeeding mothers promoted

Activities
•Sensitize and disseminate the implementation framework for securing a user –friendly, gender and diversity responsive breastfeeding environment at workplace to CHMT, SCHMT, and HMT
•Establish gender and diversity responsive lactation stations at workplace in selected areas
•Sensitize other stakeholders on the implementation framework for securing a user-friendly, gender and diversity responsive breastfeeding environment at workplace
•Train male and female HCWs on workplace support for breastfeeding
•Form a gender, age, and diversity inclusive workplace breastfeeding support task force at County level
•Hold quarterly meetings for workplace support for breastfeeding mothers
•Form/Establish a gender, age, and diversity inclusive lactation station management team

Output 5
PD-HEARTH implementation in selected community units promoted

Activities
•Sensitize CHMT, SCHMT targeting both male and female representatives on PD-HEARTH model
•Train male and female HCWs on PD-HEARTH approach from facilities linked to the selected community units
•Sensitize male and female CHVs on PD-HEARTH approach in the selected community units
• Sensitize communities through MTMSGs and FTFSGs on PD-HEARTH approach and implement the model while promoting gender transformative MIYCN practices towards improved behaviour change
•Printing of data collecting and summarizing tools for MNCHN
•Distribution of data collection and analysis tools for MNCHN
•Strengthen the implementation of SBCC strategy on MIYCN.

Output 6
Optimal nutrition practices amongst children in day care centers promoted

Activities
- Sensitize CHMT, SCHMT and other stakeholders targeting both male and female representatives on optimal nutrition needs for children in day care centers
- Sensitize male and female care givers including other male and female key influencers on optimal nutrition needs for children in day care centers through user-friendly and easy to understand communication channels

Output 7
- Strengthened BMS Act, 2012 implementation at County level

Activities
- Sensitize and disseminate the BMS Act 2012, implementation framework to CHMT, SCHMT and other stakeholders
- Train HCWs on BMS Act 2012, implementation framework
- Form BMS Act 2012, implementation task force at County level
- Train PHOs, nutritionists and other stakeholders targeting both male and female representatives on BMS Act, 2012 monitoring and enforcement
- Conduct market level surveillance to monitor compliance of BMS Act, 2012 and report violations appropriately
- Carry out continuous CME on BMS Act, 2012 at health facility level

Output 8
Increased proportion of women of reproductive age (15–49 years) and caregivers who practice optimal behaviours for improved nutrition for children under five years

Activities
- Sensitize and disseminate CHMT, SCHMT, HMT and other stakeholders on all existing MIYCN policies
- Train male and female HCWs on MIYCN in areas where BFCI is not implemented including special clinics
- Sensitize selected communities targeting men and women of different ages, diversities, and levels of influence on gender transformative MIYCN practices through selected community units not implementing BFCI
- Carry out continuous MIYCN CME in health facilities

3.3.2 KRA 2: Nutrition of older children and adolescents promoted

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

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

Activities

- Sensitize stakeholders on nutrition policies, guidelines related to older children and adolescents (food-based dietary guidelines; tuck shop guidelines; menu guidelines; sports nutrition guidelines; school garden guidelines), training packages (healthy diet and physical activity).

Output 2

Increased awareness on healthy diets among key stakeholders, older children, and adolescents themselves

Activities

- Sensitize key stakeholders on healthy diets and physical activity for older children and adolescents
- Sensitize older children, adolescents and communities targeting both genders on healthy diets and physical activity using context-specific communication channels in both rural and urban setups
- Integrate messaging on healthy diets and physical activity in the school health programme
- Collaborate with MoALF&C on establishment of diverse gender and age inclusive food production (crops, livestock, edible insects, and fisheries)

Output 3

Reduction of marketing of unhealthy foods among older children and adolescents

Activities

- Sensitize stakeholders on marketing and promotions within the school: sufficient safe and nutritious foods in school
- Sensitize older children and adolescents in school and out of school targeting both genders on consumption and marketing of healthy/unhealthy foods
- Create awareness through the media on consumption of and marketing of healthy/unhealthy foods

3.3.3 KRA 3: Prevention, control management of diet-related non-communicable diseases among all cohorts promoted and scaled-up

Expected outcome

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

Output 1

Improved policy environment around prevention, control, and management of diet related NCDs

Activities

- Sensitize CHMT & SCHMT on guidelines and policies around diet related NCDs
- Sensitize male and female HCWs and CHAs on DRNCDs guidelines and policies

Output 2

Improved awareness among HCWs, CHAs and CHVs on the prevention, control, and management of diet related NCDs

Activities

- Train male and female HCWs on Healthy diets and physical activity
- Sensitize male and female CHVs/CHAs on Healthy diets and physical activity
- Sensitize male and female CHAs and CHVs on diabetes nutrition therapy management
- Train male and female HCWs on diabetes nutrition therapy management
- Sensitize male and female CHAs/CHVs on Diabetes management in children
- Train male and female HCWs on Diabetes management in children
- Carry out CME and OJT to male and female HCWs on DRNCDs at facility level

Output 3

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

Activities

- Develop and Customize key messages for nutrition management in DRNCDs.
- Sensitize community through gender, age, and diversity inclusive community groups on the customized user friendly, context specific and gender transformative messages for nutrition management in DRNCDs including physical activity and healthy diets for men and women across different ages and diversities.
- Adopt and customize various IEC materials in DRNCDs.
- Sensitize male and female journalists and editors of print, online and mass media on inclusion of gender transformative nutrition messages about DRNCDs.

Output 4

Timely and quality provision of nutrition therapy in the management of DRNCDs

Activities

- Carry out gender, age and diversity sensitive nutrition assessment counselling and support (NACS) to patients with DRNCDs
- Hold advocacy forums for the integration of gender, age, and diversity responsive nutrition services at all NCD clinics in hospitals.
- Procure nutrition supplies and equipment for DRNCD screening.
- Participate in gender, age, and diversity inclusive screening of the public for early detection, control management and treatment of DRNCDs during world thematic health days/celebrations

Output 5

Improved monitoring and evaluation of DRNCDs

Activities

- Submit gender, age, and diversity sensitive monthly reports for DRNCDs on KHIS.
- Advocate for inclusion of gender, age, and diversity sensitive monthly reporting for DRNCDs on KHIS to Level 3 facilities.
- Conduct support supervision and offer technical support/mentorship to health facilities on DRNCDs.
- Conduct quarterly review meetings to assess trends for both Nutrition specific and nutrition sensitive risk factors for DRNCDs.
- Advocate and conduct gender-integrated surveys and operational research of nutrition-related risk factors for DRNCDs

Output 6

Strengthened psychosocial support among clients with DRNCD by establishment of various NCD support groups

Activities

- Establish gender, age, and diversity sensitive DRNCD support groups in health facilities
- Carry out monthly meetings for gender, age, and diversity inclusive DRNCD support groups
- Conduct routine gender- transformative nutrition education during support group meetings

3.3.4 KRA 4: Prevention, control, and management of micronutrient deficiencies scaled up

Expected outcome

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

Output 1

Strengthened routine micronutrient supplementation (Vitamin A, Iron and Folate and Micronutrient Powders) for targeted groups

Activities

- Sensitize CHMT, SCHMT and HMT on existing micronutrient policies (VAS, MNP and IFAS)
- Train male and female HCWs on VAS
- Train male and female HCWs on MNPs
- Train male and female HCW on IFAS
- Procure and distribute micronutrients (MNP, IFAS) and dewormers
- Print and distribute micronutrient program reporting tools
- Carry out VAS for children aged 6-59 months
- Carry out MNPs supplementation for children aged 6-23 months
- Carry out IFAS for pregnant mothers
- Carry out deworming for children 12-59 months and pregnant mothers

Output 2

Increased dietary diversity and Bio-fortification of food

Activities

- Sensitize community on increased gender, age and diversity responsive production, preservation, and consumption of micronutrient-rich foods at household level through various communication channels targeting men and women, boys and girls of different ages and diversities.
- Sensitize care givers through MTMSGs and FTFSGs on food preparation methods that enhance bio availability of micronutrients in foods

Output 3

Strengthened production, consumption, and compliance of fortified foods.

Activities

- Sensitize teachers, PHOs and nutritionists on how to conduct testing for salt iodization

- Procure iodine test kits
- Carry out annual household salt iodization testing through schools
- Sensitize stakeholders and Millers (medium and small) on food fortification strategy and compliance
- Sensitize the community through gender, age and diversity inclusive community groups and other community forums on the fortified foods in the market (flours, salt, oils, and fats)
- Sensitize PHOs & nutritionists on market level surveillance on adherence to food fortification
- Conduct market level surveillance on fortified food commodities to monitor compliance and report violations appropriately

3.3.5 KRA 5: Integrated management of acute malnutrition (IMAM) and nutrition in emergencies strengthened

Expected outcome

Improved coverage, effectiveness, and efficiency in delivery of IMAM services

Output 1

Disseminate IMAM policies, standards, and guidelines

Activities

- Sensitize CHMTs and SCHMTs on IMAM policies, standards, and guidelines
- Adapt and disseminate gender responsive IMAM standard operating procedures (SOPs) in all facilities implementing IMAM services

Output 2

Scaled-up access to delivering IMAM services

Activities

- Identify health facilities for the scale up of IMAM sites
- Carry out gender, age and diversity inclusive nutrition screening in all service delivery points for early identification of malnutrition and refer for action appropriately

Expected outcome 3

IMAM programme performance monitored, and quality of services improved

Activities

- Monitor adherence to gender responsive IMAM programme SOPs, guidelines and protocols by health and nutrition workforce
- Conduct quarterly IMAM programme performance reviews meetings at County and Sub-County level

Output 4

Strengthened partnerships including public–private partnership (PPP) to improve access and coverage of IMAM services and linkages with other interventions

Activities

- Link IMAM Clients with other programmes within the community (WASH livelihood, MIYCN support groups, social protection, and food security).

- Advocate for Public Private Partnership in the implementation of IMAM services.

Output 5
Innovative approaches to improve IMAM quality and coverage implemented

Activities
- Monitor and report on IMAM services using the available tools (data capturing, analysis, reporting, dissemination, and surveillance)
- Effectively utilize IMAM surge.
- Advocate for gender integrated operational research on IMAM

Output 6
Enhanced early case identification through community mobilization and referral, including ICCM

Activities
- Conduct nutrition screening/assessment for all cohorts at community and facility level and disaggregate data by sex, age, and diversity.
- Carry out follow up and referral systems for IMAM across all levels

Output 7
Improved utilization of IMAM data for informed decision making

Activities
- Submit gender, age, and diversity sensitive IMAM monthly report
- Carry out documentation of related research, best practices and learning on IMAM services
- Adopt gender responsive key actions/recommendations from research, assessments/surveys, lessons learnt, routine gender, age and diversity disaggregated data, programme review meetings and feedback from field experiences
- Health workers On-Job Training (OJT) on IMAM service delivery

Output 8
Enhanced capacity for IMAM Service delivery and programming

Activities
- Train health workers on IMAM including affective identification, documentation and addressing underlying social cultural and economic factors contributing to malnutrition, affecting optimal adherence to IMAM services and relapse by MAM/SAM patients.
- Train/sensitize health care workers on IMAM surge model
- ETAT IMAM training for male and female health care workers
- Train health care workers on Emergency Triaging and Treatment
- Carry out quarterly support supervision in IMAM sites
- Sensitize/ carry out on-job training of male and female CHVs/CHAs on CMAM including affective identification, documentation and addressing underlying social cultural and economic factors contributing to malnutrition, affecting optimal adherence to IMAM services and relapse by MAM/SAM patients.
- Conduct continuous Medical Education, OJT, and mentorship for health care workers and CHVs/CHAs on IMAM and CMAM
- Train /sensitize health care workers on forecasting and quantification of IMAM commodities

- Procure and distribute IMAM commodities for management of MAM and SAM

Expected outcome 2: Nutrition in emergencies strengthened

Improved sectoral and multisectoral 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 specific and sensitive partners in preparedness and emergency risk reduction
- Participate in emergency preparedness and risk reduction committees

Output 2

Strengthened preparedness and response capacity for the nutrition department

Activities

- Participate in joint planning and implementation meetings with other sectors on gender, age and diversity responsive integrated preparedness, risk reduction, response, and assessments
- Conduct joint resource mobilization activities with other sectors on gender, age and diversity responsive integrated preparedness and risk reduction
- Upscale IMAM surge kit during disaster emergencies
- Conduct annual review of gender, age and diversity responsive disaster preparedness and response plans for nutrition
- Participate in stakeholder meeting/workshops on disaster risk reduction and climate change adaptation
- Develop nutrition supply chain contingency plans at County level
- Procure and distribute nutrition commodities during emergencies informed by a gender, age and diversity integrated rapid needs assessment.
- Conduct, report and disseminate nutrition early warning systems findings
- Train healthcare workers on gender transformative MIYCN-E
- Sensitize male and female CHAs and CHVs on MIYCN-E
- Conduct gender, age, and diversity integrated MIYCN-E assessment in selected emergency hotspots
- Disseminate gender, age, and diversity integrated MIYCN-E assessment findings to stakeholders
- Adapt and disseminate gender, age and diversity responsive SOPs for emergency response and guidelines on linkage of nutrition with livelihood programmes to CHMT, SCHMT and other stakeholders

Output 3

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 nutrition response Taskforce
- Carry out continuous sensitization of HINI to communities during nutrition emergencies

- Carry out nutrition service delivery approaches including outreach services in hard-to-reach areas, affected urban areas

Output 4

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

Activities

- Advocate for implementation of gender, age and diversity responsive and inclusive livelihood and social protection programmes to enhance integration of nutrition
- Disseminate post-disaster reviews on nutrition activities to stakeholders to inform decision making regarding nutrition considerations
- Participate in community-level dialogue and gender, age, and diversity responsive recovery initiatives

3.3.6 KRA 6: Clinical nutrition and dietetics in disease management, nutrition in HIV/TB promoted

Expected outcome

Improved and scaled-up services and practices related to clinical nutrition and dietetics in disease management

Output 1

Strengthened policy environment on clinical nutrition and dietetics in disease management

Activities

- Disseminate guidelines and policies on clinical nutrition to male and female CHMT/SCHMT and HCWs

Output 2

Improved quality of clinical nutrition and dietetics care in management of diseases

Activities

- Train male and female health care workers on National New-born Guidelines for hospitals
- Train male and female health care workers on kangaroo mother care
- Support male and female nutritionists to be trained on nutrition critical care.
- Support male and female nutritionists to be trained on oncology nutrition.
- Support male and female nutritionists to be trained on nephrology nutrition.
- Sensitize male and female healthcare workers through CME on nutrition care process.
- Carry out nutrition assessment, counselling, and support (NACS) to patients and refer appropriately.
- Prepare dietary regimes/feeding plans for inpatient clients.
- Prescribe and issue therapeutic, disease specific and supplemental feeds to both inpatients.
- Train healthcare workers on clinical nutrition and dietetics management.
- Sensitize HCW on basic essential clinical nutrition and dietetics care package
- Train male and female HCWs on patient safety package for clinical nutrition and dietetics.

Output 3
Nutrition and dietetics standards, guidelines, screening, and assessment tools developed and implemented

Activities
- Adopt and disseminate to HCWs clinical nutrition SOPs
- Conduct support supervision on SOPs implementation.
- Procure and distribute clinical nutrition tools, i.e., screening tools, inter-facility referral, patient feeding and monitoring, and service quality management tools.
- Disseminate basic training and patient safety package for clinical nutrition and dietetics.
- Sensitize male and female CHVs and CHAs on Home-based care guidelines on nutrition
- Conduct widespread NACS on the public during World Nutrition Day (every 28th of May)
- Sensitize male and female HCWs on Home-based care guidelines on nutrition

Output 4
Promote nutrition screening, assessment and triage of all individuals seeking health care promoted

Activities
- Integrate nutrition screening assessment and triage centers with their corresponding assessment tools in outpatient and inpatient services.
- Procure and distribute nutrition assessment tools

Output 5
Strengthened procurement system of therapeutic and supplementary feeds

Activities
- Carry out forecasting, quantification, and costing for the selected therapeutic and supplemental feeds (Enteral and Parenteral feeds).
- Establishment of food safety inspection committees in health facilities.
- Procurement and distribution of LMIS hard copy tools; DARs, NCSRs, NASRs, Nutrition F-CDRR, Nutrition CS-CDRR, Nutrition Prescription Booklets.
- Conduct support supervision to health facilities food safety committees.
- Procurement and distribution of therapeutic- disease specific/supplemental feeds for use in clinical areas

Output 6
Strengthened in-patient feeding in health facilities offering in-patient care

Activities
- Establish and strengthen gender, age, and diversity inclusive inpatient feeding committees.
- Participate in medicines and therapeutics committees.
- Review and implement hospital menus that are sensitive to patient needs

Output 7
Improved quality in provision of clinical nutrition and dietetic services

Activities

- Carry out Supportive supervision on clinical nutrition services.
- Conduct continuous medical education/mentorship on clinical nutrition for male and female HCWs and Community Health Assistants (CHAs)
- Conduct clinical on-job training on various service areas.
- Conduct quarterly clinical nutrition review meetings to monitor and evaluate performance/-service delivery

Expected outcome 2: HIV/TB

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

Output 1

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

Activities

- Sensitize the CHMT, SCHMT & facility in charges on nutrition guidelines in HIV & TB management.
- Train male and female health workers on integrated nutrition therapy (HIV in nutrition and Nutrition in TB)
- Sensitize male and female HCWs on nutrition counselling card for HIV patients for focused nutrition therapy and interpersonal counselling for HIV and TB
- Conduct nutrition assessment at comprehensive care clinics and TB clinics and disaggregate data by sex, age, and diversity.
- Procure nutrition assessment tools for CCC and TB clinics
- Carry out continuous medical education/OJT to male and female health workers on nutrition management of HIV and TB
- Carry out forecasting quantification for nutrition commodities in HIV&TB clinics.
- Train health workers on supply chain including electronic LMIS in TB/ HIV nutrition commodities
- Conduct quarterly supply chain monitoring including electronic LMIS in TB/ HIV nutrition commodities
- Procure and distribute nutrition commodities for HIV and TB Management

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 CHAs/ CHVs on gender, age, and diversity sensitive nutrition management for TB/HIV clients
- Sensitize the community via gender, age and diversity inclusive community groups key context specific messages that promote positive lifestyles and behaviour for TB/ HIV patients
- Link malnourished male and female HIV/TB clients to community-based livelihood and social programs.

Output 3
Strengthened utilization of Nutrition HIV /TB strategic information for monitoring and evaluation and learning using NACs

Activities
- Participate in County, Sub-County, facility scheduled data review meetings for gender responsive and transformative HIV/TB program.
- Use County NACS data disaggregated by sex, age and diversity for surveillance and decision-making in CCC & TB clinics.
- Adopt and use County level scorecard for nutrition indicators disaggregated by sex, age and diversities including NACS in TB and HIV.
- Participate in supportive supervision by CHMT and SCHMT teams for TB and HIV clinics.
- CHMT and SCHMT Participate in bi-annual Joint Commodity support supervisions.
- Procurement of LMIS hard copy tools; DARs, NCSRs, NASRs, Nutrition F-CDRR, Nutrition CS-CDRR, nutrition prescription booklets

3.3.7 KRA 7: Nutrition in agriculture, education & early childhood development, Water Sanitation and Hygiene (WASH) and social protection promoted and strengthened

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

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

Activities
- Hold joint planning meeting with agriculture department.
- Participate in agriculture coordination forums
- Sensitize stakeholders on gender, age and diversity responsive food and nutrition security policies
- Sensitize stakeholders on agri-nutrition manual

Output 2
Promote increased access to nutritious and safe food along the food value chain pathways

Activities
- Sensitize male and female County agricultural extension and health staff on food processing, preservation, and storage technologies.
- Sensitize male and female community members on food processing, preservation, and storage technologies

Output 3
Improved access and utilization of nutritious and safe foods along the food value chain

Activities
- Sensitize male and female County agricultural extension and health staff on gender, age, and diversity inclusive and diversified food production strategies

- Sensitize communities on diversified food production strategies such as kitchen gardens, rearing of small animals targeting both genders across different ages and diversities
- Sensitize communities on utilization and nutritional value of variety of locally available foods targeting men and women across different ages and diversities
- Sensitize the community on energy saving technologies targeting both men and women
- Sensitize the community on meal planning targeting both men and women
- Establish kitchen garden demonstration sites at selected health facilities /Community units in every Sub-County
- Procurement of demonstration materials

Output 4
Strengthened monitoring and evaluation of Agri-nutrition activities

Activities
- Conduct joint quarterly support supervision of all Agri-nutrition activities
- Submission of quarterly reports

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

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

Activities
- Hold joint planning meeting with Education and ECDE department.
- Participate in Education and ECDE coordination forums
- Sensitize stakeholders on school health and nutrition related policies and guidelines e.g., School meals guidelines, school health policy, National pre-primary policy and service standard guidelines, teacher reference manual etc.

Output 2
Nutrition assessments, Vitamin A supplementation, deworming, and referrals in ECDES conducted.

Activities
- Sensitize management committees in ECDE on nutrition assessment, Vitamin A supplementation and deworming
- Sensitize ECDE teachers on VAS, deworming, assessment, and documentation
- Procure ECDE VAS registers
- Conduct joint bimonthly nutrition assessment for ECDE
- Conduct biannual Vitamin A supplementation and deworming activities
- Refer sick and malnourished children to the link health facilities

Output 3
Nutrition and physical activity in curricular and co-curricular frameworks integrated

Activities

- Promote inclusion of nutrition and physical activity themes in co-curricular school activities (drama, music, talent shows, contests)
- Advocate for technical support from MoALF&C to schools on establishment and improvement of existing school demonstration gardens, small animals and revive 4Kclubs

Output 4

Strengthened monitoring and evaluation of integrated nutrition activities in schools and ECDE Centers

Activities

- Document and share best practices in the implementation of nutrition activities in schools
- Develop assessment tools for the implementation of nutrition and physical activity education and promotion in schools and ECDE centers
- Conduct assessment of implementation of nutrition and physical activity education and promotion in ECDE centers
- Carry out joint support supervision
- Prepare quarterly progress reports

Output 5

Healthy and safe food environment promoted in schools and other learning institutions

Activities

- Sensitize stakeholders including, curriculum support officers, food service providers and handlers, Parent–Teacher Associations (PTA) on Healthy and safe food environment
- Promote improved equitable, safe, and easy access to safe and sufficient water, and adequate WASH services in schools and ECDE Centers

Expected outcome 3: WASH

Nutrition integrated into WASH policies, strategies, plans and programmes

Output 1

Improved access to safe and adequate WASH services.

Activities

- Sensitize the community on the use of potable drinking water and safe water storage within households, health facilities, schools and ECDE centers in collaboration with Public Health Officers.
- Advocate for protection of water sources and regular water treatment quality checks in collaboration with Public Health Officers and water department.
- Sensitize the community through gender, age, and diversity inclusive community groups on water treatment technologies

Output 2

Collaboration with relevant stakeholders on WASH strengthened

Activities

- Hold joint planning meetings with WASH sector

- Participate in stakeholders' partnerships design, development and dissemination of IEC materials and messaging on hand washing, community and institutions led total sanitation and food Hygiene
- Participate in the WASH coordination forums
- Promote joint resource mobilization for integrated gender transformative WASH and nutrition activities

Output 3
Optimal water hygiene and sanitation (WASH) practices promoted

Activities
- Conduct sensitization to community members targeting men and women across different ages, diversities, and level of influence on safe and hygienic practices during food preparation and storage
- Integrate hand washing message and hygiene during nutrition sessions
- Promote environmental hygiene at household level
- Sensitize the community through gender, age and diversity inclusive community forums on proper latrine use, proper disposal of baby diapers and menstrual hygiene management.
- Sensitize the community through gender, age, and diversity inclusive community forums on proper waste management

Output 4
Improved monitoring and evaluation of WASH practices integrated in nutrition services

Activities
- Document and share best practices in the implementation of integrated and gender transformative nutrition WASH activities
- Carry out joint support supervision
- Submit quarterly progress reports

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

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

Activities
- Hold joint planning meetings with social protection sector
- Participate in social protection coordination forums
- Sensitize stakeholders on the importance of gender, age, and diversity inclusive targeting criteria for nutrition in social protection programmes, cash transfers, hunger safety nets, and others
- Conduct stakeholder mapping of various players in social protection programmes in collaboration with social protection sector
- Train stakeholders in social protection programmes on good and transformative nutrition practices
- Conduct a gender integrated baseline survey/situation analysis on status of nutrition and health for the vulnerable groups in collaboration with the social protection sector

Output 2
Resources for nutrition in social protection programmes mobilized

Activities
- Advocate for participation of nutrition human resource in social protection programmes
- Mobilize financial resources for nutrition interventions in social protection programmes
- Sensitize the public and management of institutions of vulnerable persons and correction Facilities on health and nutrition.
- Promote benchmarking/learning visits for policy makers and implementers in counties with best practices on health and nutrition for vulnerable groups

3.3.8 KRA 8: Sectoral and multi-sectoral governance, coordination, legal/regulatory frameworks, leadership, and management strengthened

Expected outcome
Efficient and effective nutrition governance, coordination, and legal frameworks in place at County level

Output 1
Enhanced existing nutrition coordination and collaborating mechanisms and linkages between National and County governments

Activities
- Map nutrition specific and sensitive partners and stakeholders
- Hold bi-annual nutrition stakeholder meetings
- Hold quarterly Nutrition Technical Forums at County and Sub-County levels as per TORs
- Enhance representation of nutrition at other sectoral forums at County

Output 2
Enhanced coordination in development and implementation of nutrition-relevant regulatory frameworks

Activities
- Establish a Taskforce for engagement in nutrition legal and regulatory process
- Hold annual nutrition standards and regulation meeting with relevant actors
- Participate in development of gender responsive County strategic plans e.g., CIDP, AWP etc.

Output 3
Strengthened partnerships and collaboration for nutrition

Activities
- Develop a County nutrition strategy and framework for enhancing public–private partnerships
- Sensitize private partners on County strategy and framework for enhancing public private partnerships

Output 4
Nutrition resource mobilization and accountability tracked

Activities

- Develop annual gender responsive County nutrition resource mobilization strategy
- Develop nutrition resource tracking and accountability tool at County level
- Conduct annual nutrition resource tracking and accountability
- Participate in relevant citizen-participation forums while ensuring equal and meaningful participation by men and women across different ages, diversities and levels of influence including representation by women and youth-based organizations to create nutrition awareness

3.3.9 KRA 9: Sectoral and multisectoral Nutrition Information Systems, learning and research strengthened

Expected outcome

Strengthened sectoral and multisectoral nutrition information systems (NIS), learning and research

Output 1

Nutrition sector plans progress reviewed at the County level

Activities

- Ensure adherence to gender sensitive Nutrition M&E framework within CNAP
- Develop and review gender responsive nutrition annual work plans (AWPs)
- Conduct annual, midterm and end term reviews/evaluation of gender transformative nutrition interventions in the County.
- Generate and disseminate annual gender sensitive nutrition reports.
- Develop second generation gender responsive costed CNAP

Output 2

Strengthened nutrition sector capacity in NIS and evidence-based decision-making

Activities

- Adapt and train on use of nutrition score card to monitor key nutrition indicators annually
- Adapt and report on nutrition score card to monitor key CNAP indicators quarterly
- Conduct gender integrated SMART survey and disaggregate data by sex
- Conduct gender integrated MIYCN-KAP survey.
- Conduct nutrition capacity assessment
- Hold forums to disseminate gender integrated findings from SMART, MIYCN KAP and nutrition capacity assessment
- Conduct quarterly data review and feedback meetings for gender transformative nutrition activities with sub-counties and health facilities for decision making
- Conduct quarterly gender sensitive data Quality Audits for KHIS, LMIS and sentinel surveillance for nutrition activities

Output 3

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

Activities

- Monthly submission of gender sensitive nutrition reports
- Integrate, capture, and upload gender transformative nutrition activities in the County website
- Sensitize male and female nutritionists on data protection sharing guidelines
- Print and distribute nutrition M&E tools to health facilities
- Procurement of data bundles for uploading reports (nutritionists and HRIO)
- Procure 5 laptops for CNC and SCNC and 6 desktops for high level facilities

Output 4

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

Activities

- Sensitize and disseminate Nutrition Coverage Guideline; Data Quality Audit (DQA) Guideline for gender sensitive nutrition indicators; Sentinel Sites DQA Guidelines; MIYCN KAP to CHMTs, SCHMT and other health care workers
- Sensitize male and female nutritionists and other health care workers on nutrition related health management and information system (HMIS) indicators

Output 5

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

Activities

- Hold quarterly multisectoral nutrition collaboration TWG meetings for gender sensitive nutrition M&E sharing
- Establish and maintain linkages between national information technical working group (NITWG)

Output 6

Improved decision making through research evidence

Activities

- Advocate for gender integrated nutrition-sensitive and nutrition-specific research at County level
- Train male and female nutritionists in gender sensitive research methodologies, knowledge translation and systematic review processes

  Hold forums to disseminate any nutrition related research findings and information sharing
- Establish gender integrated research repository for nutrition and dietetics at County level
- Update and maintain gender integrated 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 national and County level enhanced

Activities
- Hold high level nutrition advocacy meetings targeting the County assembly on prioritizing and financing of gender transformative nutrition interventions.
- Identify Male and female County nutrition champion and engage them in promotion of gender transformative nutrition activities

Output 2
Increased and strengthened human capital and capacity for nutrition advocacy

Activities
- Train nutritionist workforce and other health care workers on gender transformative nutrition advocacy, communication and writing skills to help them better package information for media
- Sensitize male and female nutrition champion and influencers on advocacy for gender transformative Nutrition

Output 3
Effective engagements with media built and maintained

Activities
- Sensitize media fraternity on gender responsive nutrition advocacy for better coverage
- Adapt training package on nutrition for journalists based on simplified messages and key information
- Participate in mass media education programme on nutrition

Output 4
Community engagement in nutrition strengthened

Activities
- Sensitize communities targeting both men and women across different ages, diversities, and levels of influence through community groups to participate in nutrition resilience building interventions and accountability mechanism
- Participate in community dialogue and action days

Output 5
Evidence-based nutrition advocacy and knowledge management promoted

Activities
- Documentation of best practices and success stories on nutrition
- Share best practices and success stories in County, national and international forums
- Print, disseminate and distribute nutrition gender transformative BCC materials for nutrition messages
- Participate in launch and celebration of international and national thematic days (world breastfeeding week, Malezi bora weeks, etc.)

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 Embu 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 a programs 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, form 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 which will keep track of review and evaluation recommendations and feedback.

An assessment of the technical and institutional M&E capacity of the program within the County is key. This includes the data collection systems that may already exist and the level of skill of the staff in M&E. It is recommended that approximately 10% of a programs total resources should be slated for M&E, which may include the creation of data collection systems, data analysis software, information dissemination, and M&E coordination.

4.2 Background and context

The Embu 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 Embu 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
- Service outcomes
- Client/Patient outcomes (behaviour change, improvement in nutrition status, morbidity)
- Clients access to services
- Quality of nutrition 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 Embu CNAP, all data collected, analysed, and reported on will be disaggregated by gender and age to provide information and address the impact of any gender issues and relations including benefits from the nutrition programming between men and women.

Sex disaggregated data and monitoring 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 4 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.

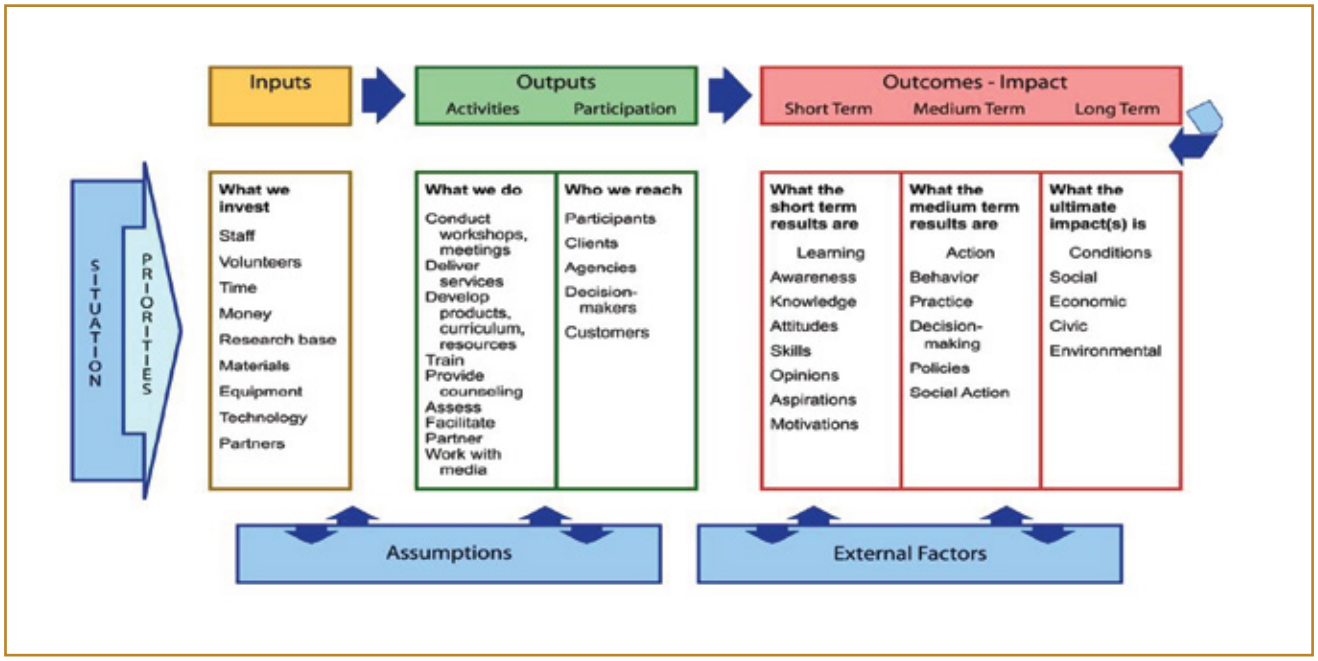


Figure 4: Monitoring and evaluation logical framework

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

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, as a result 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: The 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
2. Reduce and maintain childhood wasting to less than 5% (WHA 2021 Target) by 2025
3. No increase in childhood overweight (children under 5 years of age) (WHA 2021 Target) by 2025
4. Improved survival of children below the age of 5 by 25%
5. Reduction of deaths due to NCDs by 33%
6. Increase the rate of exclusive breastfeeding in the first six months to at least 50% by 2025 (WHA Target 2012)
7. Reduction by 25% of the proportion of the population who are overweight
8. Educational attainment of the female household population improved by 40%
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:
- Improved proportion of children less than six months exclusively breastfed
- Reduce low birth weight by 30%
- Improved dietary diversity by 20%
- Improved nutrition among HIV patients
- Improved nutrition referrals</td><td>Outcome 2. Reduction of micronutrient deficiencies
- Improved Vitamin A coverage
- Improved deworming coverage
- Increase the proportion of pregnant women consuming iron and folate as per guidelines by 25%
- Improve dietary quality and micronutrient adequacy in both women and young children</td><td>Outcome 3. Reduction in overnutrition
- Reduced proportion of adults with overweight and obesity
- Reduced proportion of diet related NCDs</td><td>Outcome 4. Improved leadership, governance, and coordination
- Improved human resource for nutrition
- Monitoring and Evaluation improved
- Commodities/Logistics management enhanced
- Financing for nutrition secured
- Improved Access: Infrastructure</td></tr>
<tr><td>OUTPUTS</td><td colspan="4">1. Maternal, Infant and Young Child Nutrition (MIYCN) scaled up
2. Nutrition of older children and adolescents promoted
3. Prevention, control management of diet-related non-communicable diseases among all cohorts promoted and scaled-up
4. Prevention, control, and management of micronutrient deficiencies scaled up
5. Integrated management of acute malnutrition and nutrition in emergencies strengthened
6. Clinical nutrition and dietetics in disease management, nutrition in HIV/TB promoted
7. Nutrition in Agriculture, Education & Early Childhood Development, Water Sanitation and Hygiene (WASH) and Social Protection promoted and strengthened
8. Sectoral and multi-sectoral governance, coordination, legal/regulatory frameworks, leadership, and management strengthened
9. Sectoral and multisectoral Nutrition Information Systems, learning and research strengthened
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 5 will involve:

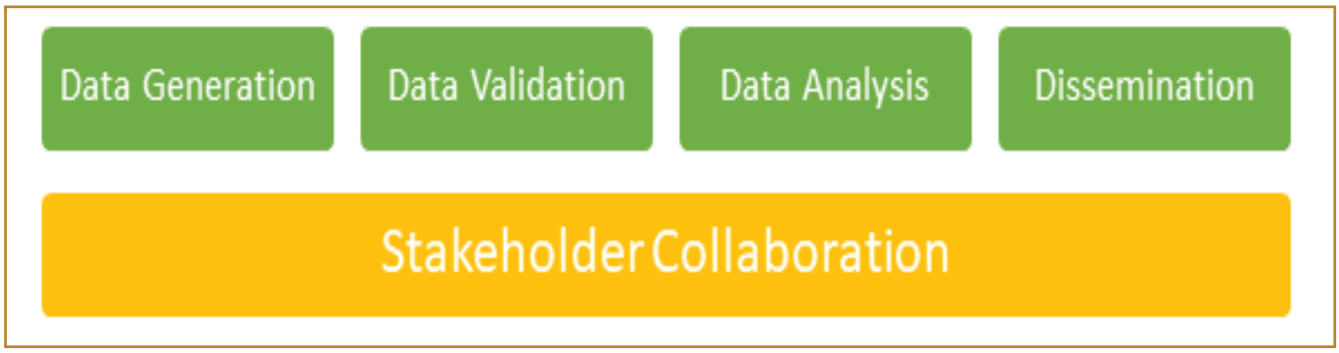


Figure 5: Monitoring processes

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 in the generation of data 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 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 Embu 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 Embu 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 in 2022/23 and an end evaluation in 2025/26 will be undertaken to determine the extent to which the objectives of this Embu CNAP are met.

Evaluation criteria

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

Relevance: The extent to which the objectives of the Embu CNAP correspond to 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 Embu CNAP objectives have been achieved with the appropriate amount of resources

Effectiveness: The extent to which Embu 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. 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 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 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.
iii. Data and information used during development and implementation of the Embu 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 Embu 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 Embu CNAP.
viii. Investments as input, will result in desired outputs and outcomes, and eventually, achievement of overall results as outlined in the Embu CNAP

4.10 Indicators and information sources

The Indicators that will guide monitoring of this Embu 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)	33% 26.8% 30%	KIHBS 2016 KDHS 2014 GBD 2017 https://vizhub.healthdata.org/lbd/cgf	26.4	19.8%	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).	3.5% 3.0% 2.9%	KIHBS 2016 KDHS 2014 GBD 2017 https://vizhub.healthdata.org/lbd/cgf	3%	2.5%	Every 2 years
	Percentage of under-weight under five years (low weight for age)	16.8% 11.1% 9.3%	KIHBS 2016 KDHS 2014 GBD 2017 https://vizhub.healthdata.org/lbd/cgf	14%	12%	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)	3.6%	KDHS 2014	3.4%	3.2%	Every 5 years
Increased intake of micronutrient through dietary diversification	Minimum Dietary Diversification (MDD) Score**	41%	KDHS 2014	60%	70%	Every 5 years
Improved survival of children below the age of 5 by 25%	Infant mortality rate	33.2 deaths per 1,000 live births	GBD 2017 https://vizhub.healthdata.org/lbd/under5	29.1	24.9	Every 3 years
	Under-5 mortality rate	28.8 deaths per 1,000 live births	GBD 2017 https://vizhub.healthdata.org/lbd/under5	25.2	21.6	Every 3 years
Reduction of deaths due to NCDs by 33%	NCD 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 (population based)	63.9%	GBD 2017 https://vizhub.healthdata.org/lbd/ebf	71.9%	79.9%	Every 3 years
Reduction by 25% of the proportion of the population who are overweight	Prevalence of overweight in the population	12.6%	GBD 2017 https://vizhub.healthdata.org/lbd/dbm	11%	9.5%	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	6.9%***	KDHS 2014	12%	18%	Every 5 years
Reduce anaemia in women of reproductive age (pregnant and non-pregnant) by 50% by 2025, WHA 2012 Targets	Estimates of anaemia prevalence 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	78.5%	KDHS 2014	82%	85%	Every 5 Years
	Prevalence of ZINC deficiency among preschool children aged below 59 months	83**	KNMS 2017	70	60	Every 5 Years

IMPACT/OUTCOME	Indicator	Baseline	Baseline Data Source	Mid-term Target (2022)	End-Term target (2025)	Frequency of data collection
Enhanced political commitment to nutrition	County budget allocation to nutrition	100,000	Approved budget Estimates FY2020/2021	1,000,000	3,000,000	Every Year
Human Resource for nutrition/Nutritionist's density	Number of nutritionist available per level of care as per HRH staffing norms	31	HR staff returns	41	61	Every two years
Social protection	Proportion of women (and adolescent girls, where appropriate) reached through social protection measures which include a nutrition component (i.e., explicit nutrition objectives and actions to be monitored	10%	County DCS & DSP Annual Reports	30%	80%	Every two years
Water and sanitation	Proportion of population using a safely managed drinking water service	40%	EWASCO	70%	100%	Every 2 years
	Proportion of population using a safely managed sanitation service	40%	EWASCO	70%	100%	Every 2 years

** National Level Data for lack of disaggregated data

***Data for the greater Eastern 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.	86.7%	KHIS 2019	87%	87.5%	88%	88.5%	89%
	Percentage of infants that were breastfed within one hour after delivery	87.2%	KHIS 2019	88.5%	89%	89.5%	90%	90%
Reduce low birth weight by 30%	Percentage of new-borns in the facilities, with low birth weight	3.9%	KHIS 2019	3.7%	3.4%	3.2%	2.9%	2.7%
	Proportion of children under 5 attending CWC who are stunted	2.7%	KHIS 2019	2.5%	2.4%	2.3%	2.1%	2%
	Percentage of clients with NCDs that receive nutrition assessment	4%	MOPC and DCC data	4.1%	4.2%	4.3%	4.4%	4,5%
	Percentage of inpatients that receive nutrition assessment	No data	No data	25%	35%	45%	55%	65%
	Percentage of low births in facilities conducting deliveries	3.9%	KHIS 2019	3.8%	3.7%	3.6%	3.5%	3.4%
	Percentage of preterm babies in facilities conducting deliveries	1.7%	1.6%	1.5%	1.4%	1.3%	1.2%	1.1%
Improved dietary diversity by 20%	Proportion of children receiving minimum acceptable diet	36.5%	MNCHN Baseline Assessment 2020	38%	39.5%	41%	42.5%	44%
	Proportion of children receiving minimum dietary diversity	54.6%	MNCHN Baseline Assessment 2020	56.8%	59%	61.2%	63.5%	65.7%
Improved nutrition among HIV patients	Proportion of health facilities offering therapeutic and supplementary foods to PLHIV	8%	KHIS 2019	10%	12%	14%	16%	18%
	Proportion of undernutrition among PLHIV	3%	KDHS 2014	3%	3%	3%	3%	3%
	Proportion of undernourished PLHIV provided with therapeutic or supplementary food	1.5%	KHIS data 2019	2%	2.5%	3%	3.5%	4%
Improved nutrition referrals	Proportion of under 5s with severe and moderate malnutrition referred for management	No data	No data	5%	10%	15%	20%	25%
REDUCTION OF MICRONUTRIENT DEFICIENCIES								
Improved Vitamin A coverage	Percentage of children (6-59 months) receiving Vitamin A Supplementation twice a year (100,000 IU for children 6-12 months and 200,000 IU for children > 12 months).	67.3%	KHIS 2019	70%	72%	74%	76%	78%
Improved deworming coverage	Percentage of children (12-59 months) receiving de-worming twice a year.	44.7%	KHIS 2019	50%	55%	60%	65%	70%
	Proportion of school-aged children (6-14 years) dewormed	37.4%	KHIS 2019	40%	45%	50%	55%	60%
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	78.5%	KHIS 2019	80%%	82%	84%	86%	88%
Improve dietary quality and micronutrient adequacy in both women and young children	Minimum dietary diversity among children 6-23 months	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	Prevalence of overweight among adults	21.6%***	KDHS 2014	20%	19%	18%	17%	16%
	Prevalence of obesity among adults	8.4%***	KDHS 2014	8%	7.7%	7.5%	7.3%	7%
Reduced proportion of diet related NCDs	Prevalence of Hypertension	8.1%***	KDHS 2014	7.8%	7.6%	7.4%	7.2%	7.0%

Target	Indicator	Baseline	Baseline Year	Yr. 1	Yr. 2	Yr. 3	Yr. 4	Yr. 5
CROSS-CUTTING AREAS								
Improved human resource for nutrition	Percentage of key nutrition positions filled	6.7%	2020 Section staff establishment	10%	15%	20%	25%	30%
Monitoring and Evaluation improved	Proportion of facilities systematically using information to monitor performance	49.3%	County HIS report	54%	59%	64%	69%	75%
	Proportion of facilities submitting routine information in a timely manner	95%	Program data 2019	96%	97%	98%	100%	100%
Commodities/Logistics management enhanced	Percentage of facilities that experience a stock out at any point during a given period	No Data	Program data 2019	50%	30%	15%	5%	0%
	Percentage difference between consumption forecasts and actual consumption	No Data	Forecasting yet to be carried out.	50%	30%	15%	5%	0%
	Percentage difference between the quantity of products ordered and the quantity actually received	No Data	Program data 2019	50%	30%	15%	5%	0%
	Percentage of health facilities with no stock of Iron-Folic Acid (IFA) and Vitamin A.	No Data	Program data 2019	15%	7%	0%	0%	0%
Financing for nutrition secured	Resources available for nutrition (absolute numbers, or a proportion of health budget)	No budget	No budget	100,000	500,000	1,000,000	2,000,000	Financing
Improved Access: Infrastructure	Number of facilities with nutritionists offering nutrition services per 100,000 people	17	Section 2020 staff returns Report	22	27	32	37	Access: Infrastructure

****Data for former Eastern Region*

Coverage/Process Indicators

KRA 1. Maternal, Infant and Young Child Nutrition (MIYCN) scaled up

Expected Outputs	Performance Indicator	Baseline Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Scaled-up Baby Friendly Community Initiative (BFCI) in selected community units (CUs)	Number of male and female HCWs trained on BFCI	30	2019	Activity report	Annually	30	0	30	0	30
	Number of male and female community health committees' members, primary health care facility committees' members and other community leaders sensitized on BFCI targeting both gender	30	2019	Activity report	Annually	60	60	60	60	60
	Number of community mother support groups established including both gender	2	2019	Activity report	Annually	7	7	7	7	7
	Number of male and female CHVs and CMSG members trained on c- BFCI	89	2019	Activity report	Annually	100	0	100	0	100
	Number of MTMSGs and FTFSGs formed	4	2019	Activity report	Annually	0	10	10	10	10
	Number of continuous BFCI assessments done	0	2019	Activity report	Bi-annual	0	4	10	4	10
	Number of BFCI external assessments done	0	2019	Activity report	Every 2 Years	0	2	5	0	7

Expected Outputs	Performance Indicator	Baseline Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened baby friendly hospital initiative (BFHI) implementation at high volume health facilities	Number of male and female HCWs trained on BFHI	0	2019	Activity report	Annually	0	120	90	60	60
	Number of baselines BFHI assessments done	0	2019	Activity report	Bi-annual	0	15	10	5	5
	Number of BFHI assessments conducted by HMT and BFHI committee members	0	2019	Activity report	Bi-annual	0	10	5	5	5
	Number of biannual internal BFHI assessments done by CHMT and SCHMT	0	2019	Activity report	Bi-annual	0	30	15	15	15
	Number of external assessments done on BFHI	0	2019	Activity report	Every 2 Years		10	5	5	5
Strengthened growth monitoring and promotion (GMP) at County level	Number of male and female HCWs trained on WHO growth standards trainings	0	2019	Activity report	Bi-annual	60	60	60	60	60
	Number of childcare and stimulation trainings held targeting male and female HCWs	0	2019	Activity report	Bi-annual	60	60	60	60	60
	Number of male and female CHVs sensitized on childcare and stimulation	0	2019	Activity report	Bi-annual	100	100	100	100	100
	Number of mothers and caregivers trained on family MUAC	0	2019	Activity report	Annually	1200	3600	2400	1200	1200
Workplace support for breastfeeding mothers promoted	Number of lactation stations at workplace established	1	2019	Activity report	Annually	0	2	3	2	2
PD-HEARTH implementation in selected community units promoted	Number of male and female HCWs from selected facilities trained on PD-HEARTH approach	0	2019	Activity report	Annually	60	60	60	60	30
	Number of male and female CHVs from selected CUs trained on PD-HEARTH approach	0	2019	Activity report	Annually	90	90	90	90	60
	Number of PD-HEARTH and MIYCN practices sensitization meetings held targeting MTMSGs and FTFSGs in the community	0	2019	Activity report	Monthly	3	3	2	2	1
Optimal nutrition practices amongst children in day care centers promoted	Number of male and female day care centres care givers sensitized on optimal nutrition needs	0	2019	Activity report	Annually	100	200	160	120	80
Strengthened BMS Act, 2012 implementation at County level	Number of male and female HCWs trained on BMS Act 2012, implementation framework	0	2019	Activity report	Annually	80	80	60	40	40
	Number of PHOs, Nutritionists and other stakeholders trained on monitoring and enforcement of the BMS Act 2012.	0	2019	Activity report	Annually	0	40	0	0	0
	Number of market level surveillance for monitoring BMS Act 2012 conducted	0	2019	Activity report	Bi-annual	2	2	2	2	2
Increased proportion of women of reproductive age (15–49 years) and caregivers who practice optimal behaviours for improved nutrition for children under five years	Number of male and female HCWs in areas not implementing BFHI including special clinics, trained on MIYCN	0	2019	Activity report	Annually	120	100	80	60	30
	Number of male and female communities not implementing BFCI sensitized on MIYCN practices	0	2019	Activity report	Annually	200	200	200	200	200

KRA 2. Nutrition of older children and adolescents 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) and adolescents (10-19 years).	Number of male and female stakeholders sensitized on nutrition policies, guidelines related to older children and adolescents (food-based dietary guidelines; tuck shop guidelines; menu guidelines; sports nutrition guidelines; school garden guidelines), training packages (healthy diet and physical activity).	0	2019	Reports	Annually	1000	1000	1000	1000	1000
Increased awareness on healthy diets among key stakeholders, older children, and adolescents themselves	Number of male and female key stakeholders trained on healthy diets and physical activity for older children and adolescents	0	2019	Reports	Every 2 years	0	30	0	30	0
	Number of sensitization forums on nutrition for older children and adolescents; and on healthy diets and physical activity using context-specific communication channels in both rural and urban setups	0	2019	Reports	Quarterly	200	500	500	500	0
	Messaging on healthy diets and physical activity integrated in the school health programme	0	2019	Reports	Annual	1	1	1	1	1
	Number of Collaboration meetings with MoALF&C on establishment of diverse food production (crops, livestock, edible insects, and fisheries)	0	2019	Reports	Annually	1	1	1	1	1
Reduction of marketing of unhealthy foods among older children and adolescents	Number of male and female stakeholders sensitized on marketing and promotion within the school of healthy foods; and availability of sufficient safe and nutritious foods in school	0	2019	Reports	Quarterly	320	320	320	320	320
	Number of male and female older children and adolescents in school sensitized on consumption and marketing of healthy/unhealthy foods	0	2019	Reports	Quarterly	0	320	320	360	400
	Number of talk shows on the media on consumption of and marketing of healthy/unhealthy foods	0	2019	Reports	Bi-annual	2	4	4	4	4

KRA 3. Prevention, control management of diet-related non-communicable diseases among all cohorts promoted and 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 environment around prevention, control, and management of diet related NCDs	Number of male and female CHMT/SCHMT members sensitized on guidelines and policies around diet related NCDs.	0	2019	Activity reports	Annually	30	0	0	30	30
	Number of male and female HCWs and CHAs sensitized on guidelines and policies on DRNCDs	0	2019	Activity reports	Annually	0	60	0	60	60

Expected Outputs	Key Performance Indicators	Baseline Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Improved awareness among HCWs, CHAs and CHVs on the prevention, control, and management of diet related NCDs	Number of male and female HCWs trained on Guidelines on Healthy diets and physical activity.	0	2019	Activity reports	Annually	0	60	0	60	60
	Number of male and female CHVs/CHAs sensitized on Guidelines on Healthy diets and physical activity, and diabetes nutrition therapy management.	0	2019	Activity reports	Annually	0	30	0	30	30
	Number of male and female HCWs trained on diabetes nutrition therapy management.	0	2019	Activity reports	Annually	0	60	0	60	60
Behaviour change communication strategies developed and implemented to promote primary and secondary prevention of diet-related risk factors for NCDs	Number of gender-integrated community groups sensitized on physical activity and healthy diets.	0	2019	Activity reports	Annually	0	4	4	4	4
	Number of male and female journalists and editors of print, online and mass media sensitized on nutrition messages with regard to DRNCDs.	0	2019	Activity reports	Annually	0	10	0	10	10
Timely and quality provision of nutrition therapy in the management of DRNCDs	Proportion of male and female patients with DRNCDs assessed and counselled.	0	2019	Facility assessment	Every 2 Years	50%	60%	60%	80%	80%
	Proportion of NCD clinics with integrated nutrition services.	No data	2019	Supervision checklists	Quarterly	0	70%	80%	90%	100%
	Proportion of health facilities with nutrition supplies and equipment for NCD screening.	No data	2019	Supervision checklists	Quarterly	0	70%	80%	90%	100%
	Number (out of 12) of world thematic health days / celebrations in which nutrition department participates in the gender-integrated screening of the public.	No data	2019	Activity reports	Monthly	0	8	10	11	12
Improved monitoring and evaluation of DRNCDs	Reporting rates for DRNCDs in KHIS.	84.7%	2019	KHIS Reporting rate - MOH 740	Annually	95%	100%	100%	100%	100%
	Proportion of Level 3 facilities that are reporting for DRNCDs in KHIS.	0	2019	KHIS Reporting rate - MOH 740	Annually	0	75	95	100	100
	Quarterly review meetings held to assess trends for Nutrition-related risk factors for DRNCDs.	0	2019	Activity reports	Quarterly	0	4	4	4	4
	Gender-integrated surveys and operational research of nutrition-related risk factors for DRNCDs conducted.	0	2019	Activity reports	Every 2 Years	0	1	0	1	0
Strengthened psychosocial support among clients with DRNCD by establishment of various NCD support groups	Gender-integrated DRNCD support groups established.	0	2019	Activity reports	Annually	0	8	10	12	12
	Monthly meetings for gender integrated DRNCD support groups carried out.	0	2019	Activity reports	Annually	0	96	120	144	144
	Routine nutrition education during gender-integrated support group meetings conducted.	No data	2019	Activity reports	Annually	Yes	Yes	Yes	Yes	Yes

KRA 4. 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
Strengthened routine micronutrient supplementation (vitamin A, iron and folate and micronutrient powders) for targeted groups	Number of male and female HCWs trained on VAS	30	2019	Activity report	Annually	150	120	90	60	60
	Number of male and female HCWs trained on MNPs	0	2019	Activity report	Annually	150	120	90	60	60
	Number of male and female HCWs trained on IFAS	0	2019	Activity report	Annually	150	120	90	60	60
	Number of male and female children aged 6-59 months supplemented with VAS	2	2019	Activity report	Bi-annual	56,126	61,793	67,973	74,840	82,399
	Number of male and female children aged 6-23 months supplemented with MNPs	0	2019	Activity report	Monthly	17,825	18,324	18,837	19,364	19,906
Increased dietary diversity and Bio-fortification of food	Number of male and female community members sensitized on production, preservation, and consumption of micronutrient rich foods at household	0	2019	Activity report	Bi-annual	1,000	1,000	1,000	1,000	1,000
	Number of male and female community members sensitized on food preparation methods that enhance bio availability of nutrients in food	0	2019	Activity report	Monthly	50	150	100	100	100
Strengthened production, consumption, and compliance of fortified foods.	Number of male and female teachers, PHOs and Nutritionists sensitized on how to conduct testing for salt iodization	0	2019	Activity report	Annually	300	300	300	300	300
	Number of salt iodization testing in schools done	1	2019	Activity report	Annually	16	16	16	16	16
	Proportion of millers fortifying the flours	No Data	2019	Supervision reports	Annually	20%	25%	30%	40%	50%
	Number of male and female community members sensitized on the fortified foods in the market through community groups and other forums.	0	2019	Activity report	Bi-annual	200	150	100	100	100

KRA 4. 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
Disseminated IMAM policies, standards, and guidelines	Number of male and female CHMTs and SCHMTs sensitized on IMAM program policy, standards, and guidelines	0	2019	Activity reports	Every 2 Years	0	60	0	60	0
	Proportion of health facilities utilizing surge model	No data	2019	Nutrition program reports	Bi-annual	8%	10%	12%	14%	16%
	Proportion of health facilities conducting comprehensive nutrition screening	20	2019	Supervision reports	Quarterly	30%	40%	50%	60%	70%
Scaled-up access to delivering IMAM services	Proportion of facilities implementing IMAM services with SOPs	No data	2019	Supervision reports	Quarterly	40%	50%	60%	70%	75%
	Proportion of health workers in level 3, 4 and 5 facilities adhering to IMAM SOPs, guidelines, and protocols	50	2019	Supervision reports	Quarterly	60%	70%	80%	90%	100%

Expected Outputs	Key Performance Indicators	Baseline Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened partnerships including public–private partnership (PPP) to improve access and coverage of IMAM services and linkages with other interventions	Proportion of IMAM clients linked to other health and livelihood programmes	No Data	2019	Programme reports	Annually	20%	30%	40%	50%	60%
	Number of Private partners collaborating with MOH in implementing IMAM services	0	2019	Nutrition program reports	Annually	2	3	4	5	6
Innovative approaches used to improve quality and coverage of IMAM services.	Number of forums for advocating operational IMAM research held	No data		Activity reports	Annually	1	1	1	1	0
	Number of reports on best practices for IMAM program	0	2019	Activity reports	Annually	4	4	4	4	4
	Proportion of health facilities adopting recommendations best practices, and lessons learnt from research, assessments, and surveys	No Data	2019	Activity Reports	Annually	20%	30%	40%	50%	60%
	Proportion of male and female clients screened at facility and community level	40%	2019	Programme reports	Bi-annual	45%	50%	55%	65%	70%
Enhanced early case identification through community mobilization and referral, including ICCM	Number of male and female health care workers trained on IMAM	30	2019	Nutrition training inventory	Annually	40	40	40	40	40
	Number of male and female CHAs and CHVs trained on CMAM	0	2019	Nutrition training inventory	Annually	40	40	40	40	40
	Number of health male and female care workers trained on IMAM surge	0	2019	Nutrition training inventory	Annually	40	40	40	40	40
	Number of male and female health care workers trained on ETAT IMAM	0	2019	Nutrition training inventory	Annually	20	20	20	20	20
	Number of partners in emergency risk reduction enlisted	3	2020	Nutrition programme reports	Annually	5	5	5	5	5
Strengthened coordination and partnerships for integrated preparedness and response initiatives	Number of emergency preparedness and risk reduction committees held	0	2019	Nutrition programme reports	Quarterly	4	4	4	4	4
	The proportion of population at risk reached during disaster emergencies	No Data	2019	Assessment reports	Bi-annual	25%	35%	45%	55%	65%
Strengthened preparedness and response capacity for the nutrition department	Number of male and female health care workers trained on MIYCN-E	0	2019	Nutrition reports	Annually	40	40	40	40	40
	Number of male and female CHAs and CHVs trained on MIYCN-E	0	2019	Nutrition reports	Annually	100	100	100	100	100
	Number of MIYCN-E assessments conducted in the hotspots	0	2019	Nutrition reports	Bi-annual	2	2	2	2	2
	Number of nutrition advocacy meetings on implementation of livelihood and social protection programmes held	0	2019	Activity reports	Bi-annual	2		2	2	2
Strengthened implementation of recovery interventions to enhance 'build back better' approaches	Number of post disaster review meetings held	0	2019	Activity reports	Bi-annual	2	2	2	2	2
	Number of community level dialogue and recovery initiatives meetings held	0	2019	Activity reports	Bi-annual	2	2	2	2	2

KRA 6. Clinical nutrition and dietetics in disease management, nutrition in HIV/TB/promoted/strengthened

Expected Outputs	Key Performance Indicators	Baseline Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened policy environment on clinical nutrition.	Number of male and female CHMT/SCHMT members, HCWs sensitized on guidelines and policies around clinical nutrition.	No data	2019	Activity Reports	Annually	60	60	60	60	60
Improved quality of clinical nutrition and dietetics care in management of diseases	Number of male and female nutritionists trained on critical care nutrition.	0	2019	Activity Reports	Every 2 Years	0	30	30	30	30
	Number of male and female nutritionists trained on oncology nutrition.	0	2019	Activity Reports	Every 2 Years	0	30	30	30	30
	Number of male and female Nutritionists trained on nephrology nutrition.	0	2019	Activity Reports	Every 2 Years	0	30	30	30	30
	Number of male and female healthcare workers trained on nutrition care process.	0	2019	Activity Reports	Annually	0	30	30	30	30
	Proportion of in-patient files with dietary regimes/feeding plans for male and female clients prepared.	0	2019	Facility assessment	Bi-annual	0	60%	80%	100%	100%
	Number of male and female healthcare workers trained on clinical nutrition and dietetics management.	0	2019	Activity Reports	Every 2 Years	0	30	0	30	0
	Number of male and female HCWs sensitized on Basic Essential Clinical Nutrition and Dietetics care package.	0	2019	Activity Reports	Every 2 Years	0	30	0	30	0
Nutrition and dietetics standards, guidelines, screening, and assessment tools developed and implemented	Proportion of health facilities with clinical nutrition tools, i.e., screening tools, inter-facility referral, patient feeding and monitoring, and service quality management tools in use.	No data	2019	Supervision checklists	Annually	0	50%	60%	80%	100%
	Number of male and female HCWs taken through basic training and patient safety package for clinical nutrition and dietetics.	No data	2019	Activity Reports	Annually	0	30	30	30	30
	Number of male and female CHVs, CHAs and HCWs sensitized on Home-based care guidelines on nutrition	No data	2019	Activity Reports	Annually	0	120	120	120	120
	Number of male and female individuals assessed, counselled, and supported during World Nutrition Day.	No data	2019	Activity Reports	Annually	100	200	300	400	500
Nutrition screening, assessment and triage of all individuals seeking health care conducted	Proportion of facilities with their OPDs and inpatient units using nutrition screening assessment and triage with their corresponding assessment tools.	No data	2019	Supervision checklists	Bi-annual	0	50%	60%	80%	100%
	Proportion of health facilities with functional nutrition assessment tools	No data	2019	Supervision checklists	Bi-annual	0	50%	60%	80%	100%
Strengthened procurement system for therapeutic and supplementary feeds.	Proportion of facilities with no stock outs of selected therapeutic and supplemental feeds.	No Data	2019	Supervision checklists and Monthly reports	Bi-annual	0	50%	60%	80%	100%
	Number of food safety and inspection committees in place at various health facilities.	No data	2019	Supervision checklists	Bi-annual	0	10	10	10	10
	Proportion of facilities with LMIS hard-copy nutrition tools in use.	No data	2019	Supervision checklists	Bi-annual	0	50%	70%	85%	100%

Expected Outputs	Key Performance Indicators	Baseline Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened in-patient feeding in health facilities offering in-patient care	Number of inpatient feeding committees established.	No data	2019	Supervision checklists	Bi-annual	0	10	10	10	10
	Number of meetings held to review patient menus.	No data	2019	Minutes	Annually	0	10	10	10	10
Strengthened quality in provision of clinical nutrition services	Number of supportive supervision visits on clinical nutrition services carried out.	No data	2019	Supervision checklists	Bi-annual	0	14	14	14	14
	Quarterly clinical review meetings to monitor and evaluate performance/service delivery conducted.	No data	2019	Activity and performance reports	Quarterly	0	28	28	28	28
Improved routine screening for nutrition related conditions and referral for all PLHIV and TB patients	Number of male and female health workers trained on integrated nutrition therapy (HIV in nutrition and Nutrition in TB)	No data	2019	Activity Reports	Annually	0	30	30	30	30
	Number of male and female HCWs sensitized on nutrition counselling card for focused nutrition therapy and interpersonal counselling in HIV and TB.	No data	2019	Activity Reports	Annually	30	30	30	30	30
	Proportion of HIV/TB clinics conducting gender disaggregated HIV/ TB nutrition screening	No data	2019	Supervision checklists	Bi-annual	50%	50%	65%	95%	100%
	Proportion of HIV/TB clinics using nutrition assessment tools	No data	2019	Supervision checklists	Bi-annual	0	50%	65%	95%	100%
	Proportion of HIV/TB facilities reporting no stock outs of nutrition commodities.	No data	2019	Supervision checklists and Monthly reports	Bi-annual	0	50%	60%	80%	100%
	Number of male and female health workers trained on supply chain and electronic LMIS in HIV/TB nutrition commodities.	No data	2019	Activity Reports	Bi-annual	0	30	30	30	30
Strengthened integration of nutrition interventions for home-based care at community level for PLHIVs towards the 90.90.90	Number of male and female CHAs/ CHVs sensitized on nutrition management for TB/HIV clients	No data	2019	Activity Reports	Annually	0	90	90	90	90
	Number of gender integrated community groups sensitized on key context specific messages that promote positive lifestyles and behaviour for TB/ HIV patients	No data	2019	Activity Reports	Annually	0	8	8	8	8
	Proportion of Malnourished male and female HIV/TB clients linked to community-based livelihood and social programs.	No data	2019	Activity Reports	Bi-annual	50%	60%	70%	80%	80%
Strengthened utilization of Nutrition HIV /TB strategic information for monitoring and evaluation and learning through the use of NACs	Number of HIV/TB program data review meetings with nutritionists participating at County and Sub-County,	No data	2019	Activity Reports	Bi-annual	2	2	2	2	2
	Scorecard for nutrition indicators disaggregated by sex including NACS Adopted	No data	2019	Activity Reports	Annually	No	Yes	Yes	Yes	Yes

KRA 7. Nutrition in agriculture, education & early childhood development, Water Sanitation and Hygiene (WASH) and social protection promoted and strengthened

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 joint planning meetings held	0	2019	Activity reports	Annually	1	1	1	1	1
	Proportion of agricultural forums attended by nutrition staff	No data	2019	Agriculture activity reports	Quarterly	75%	75%	80%	80%	85%
	Number of male and female stakeholders sensitized on food and nutrition security policies	No data	2019	Activity reports	Annually	30	60	60	60	60
Increased access to nutritious and safe food along the food value chain pathways.	Number of male and female County agricultural extension and health staff sensitized on food processing, preservation, and storage technologies	No data	2019	Activity reports	Annually	20	20	15	15	15
	Number of male and female community members sensitized on food processing, preservation, and storage technologies.	No data	2019	Activity reports	Annually	0	100	100	0	0
Increased consumption of safe, diverse, nutritious foods.	Number of male and female County agricultural extension and health staff sensitized on diversified food production strategies	No data	2019	Activity reports	Bi-annual	0	30	30	0	0
	Number of male and female communities' members sensitized on diversified food production strategies such as kitchen gardens, rearing of small animals	No data	2019	Activity reports	Quarterly	100	200	200	200	200
	Number of male and female community members sensitised on utilisation and nutritional value of variety of locally available foods	No data	2019	Activity reports	Quarterly	100	200	300	400	500
	Number of male and female community members sensitised on energy saving technologies	No data	2019	Activity reports	Quarterly	100	100	100	100	100
	Number of male and female community members sensitised on meal planning	No data	2019	Activity reports	Quarterly	100	100	100	100	100
	Number of kitchen garden demonstration sites established at selected health facilities /Community units in every Sub-County	No data	2019	Activity reports	Bi-annual	8	8	8	8	8
Strengthened monitoring and evaluation of agri-nutrition activities	Number of Joint quarterly support supervision of all agri-nutrition activities conducted	No data	2019	Activity reports	Quarterly	4	4	4	4	4
Policies, strategies, standards and guidelines on nutrition and physical activity in schools and other learning institutions developed and promoted	Number of Education and ECDE coordination forums attended by nutrition staff.	No data	2019	Activity reports	Quarterly	4	4	4	4	4
	Number of male and female stakeholders sensitised on school health and nutrition related policies and guidelines	No data	2019	Activity reports	Annually	0	100	0	100	0
Nutrition assessments, Vitamin A supplementation, deworming, and referrals in ECDES conducted.	Number of ECDE centres management committees sensitized on nutrition assessment, Vitamin A supplementation and deworming.	397 ECDE Centres	2019	Activity reports	Annually	100	100	100	100	100
	Number of joint nutrition assessment for ECDE conducted	397 ECDE Centres	2019	Activity reports	Annually	397	397	397	397	397
	Proportion of sick and malnourished children referred to link health facilities	No data	2019	MoH reporting tools	Monthly	40%	50%	60%	70%	80%

Expected Outputs	Key Performance Indicators	Baseline Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Nutrition and physical activity integrated in curricular and co-curricular frameworks	Proportion of physical and co-curricular activities with nutrition themes in school promoted (drama, music, talent shows, contests)	0	2019	ECDE Quarterly reports	Quarterly	20%	30%	40%	55%	60%
	Proportion of school with demonstration gardens establishment and improvement of existing, small animals reared and revive 4Kclubs	0	2019	School reports	Quarterly	10%	15%	20%	25%	40%
Strengthened monitoring and evaluation of integrated nutrition activities in schools and ECDE Centres	Number of assessments conducted on implementation of nutrition and physical activity education and promotion in ECDE centres	0	2019	MoH and MoE tools	Quarterly	4	4	4	4	4
	Number of joint support supervision carried out	0	2019	Reports	Annually	1	1	1	1	1
Healthy and safe food environment promoted in schools and other learning institutions	Number of male and female stakeholders sensitised on healthy and safe food environment	0	2019	Reports	Annually	30	30	30	30	30
	Proportions of schools and ECDE Centres with improved access to safe and sufficient water, and adequate WASH services	No Data	2019	Reports	Quarterly	50%	60%	70%	80%	85%
Improved access to safe and adequate WASH services	Number of male and female community members sensitised on the use of potable drinking water and safe water storage within households, health facilities, schools and ECDE centres in collaboration with Public Health Officers	No Data	2019	Reports	Quarterly	500	500	500	500	500
	Number of community groups sensitised on water treatment technologies	No Data	2019	Reports	Quarterly	160	160	160	160	160
Collaboration with relevant stakeholders on WASH strengthened	Number of joint planning meetings held with WASH staff	No Data	2019	Minutes	Annually	1	1	1	1	1
	Number of WASH coordination forums held	No Data	2019	Reports	Quarterly	8	8	8	8	8
Adequate WASH in households and institutions	Number of male and female community members sensitised on safe and hygienic practices during food preparation and storage	No Data	2019	Reports	Quarterly	500	500	500	500	500
	Number of households reached with environmental hygiene messages/information	No Data	2019	Reports	Monthly	1000	1000	1000	1000	1000
Community sensitized through community forums on proper waste management	Number of male and female community members sensitised through community forums on proper latrine use, proper disposal of baby diapers and menstrual hygiene management.	No Data	2019	Reports	Monthly	1000	1000	1000	1000	1000
	Number of male and female community members sensitised through community forums on proper waste management	0	2019	Reports	Monthly	1000	1000	1000	1000	1000
Improved monitoring and evaluation of WASH practices integrated in nutrition services	Number of Best practices in the implementation of integrated nutrition WASH activities documented and shared	0	2019	Reports	Bi-annual	10	15	10	20	20
	Number of joint supports supervision carried out	0	2019	Reports	Bi-annual	2	2	2	2	2
	Number of quarterly reports submitted	0	2019	Reports	Quarterly	4	4	4	4	4

Expected Outputs	Key Performance Indicators	Baseline Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Nutrition promoted and linkages enhanced in social protection programmes including in crisis	Number of social protection coordination forums attended by male and female nutrition staff.	0	2019	Reports	Bi-annual	2	2	2	2	2
	Number of male and female stakeholders sensitised on targeting criteria for nutrition in social protection programmes; cash transfers, hunger safety nets, and others	0	2019	Reports	Annually	120	120	120	120	120
	Mapping of stakeholders in social protection programmes in collaboration with social protection staff done	No	2019	Reports	Every 3 Years	Yes	No	No	Yes	No
	Baseline survey/situation analysis conducted on the status of nutrition and health for the vulnerable groups in collaboration with the social protection sector	No	2019	Baseline survey reports	Annually	No	Yes	No	No	No
Resources for nutrition in social protection programmes mobilized	Number of institutions of vulnerable groups and correction facilities sensitised on nutrition	0	2019	Report	Annually	10	20	15	15	10
	Number of benchmarking/learning visits for policy makers and implementers in counties with best practices on health and nutrition for vulnerable groups promoted	0	2019	Activity reports	Every 2 Years	0	1	1	1	1

KRA 8. Sectoral and multi-sectoral governance, coordination, legal/regulatory frameworks, leadership, and management 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	Mapping of nutrition partners and stakeholders done	No	2019	Nutrition programme report	Annually	Yes	Yes	Yes	Yes	Yes
	Number of nutrition stakeholder meetings held	0	2019	Activity report	Bi-annual	2	2	2	2	2
	Number of County and Sub-County nutrition technical forums held	2	2019	Quarterly nutrition reports	Quarterly	3	4	4	4	4
Strengthened partnerships and collaboration for nutrition	Nutrition representation in development of key strategic plans in Health and relevant sectors	No	2019	Sector report	Annually	Yes	Yes	Yes	Yes	Yes
Nutrition resource mobilization and accountability tracked	County nutrition resource mobilization strategies developed	No	2019	County nutrition resource mobilization strategy report	Every 5 Years	No	Yes	No	No	No
	Nutrition resource tracking and accountability tools developed	No	2019	Nutrition resource tracking and accountability tool	Every 5 Years	No	Yes	No	No	No
	Nutrition resource tracking and accountability exercises conducted	No	2019	Activity report	Annually	Yes	Yes	Yes	Yes	Yes

KRA 9. Sectoral and multisectoral Nutrition Information Systems, learning and research strengthened

Expected Outputs	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Nutrition sector plans progress reviewed at the County level	Nutrition department AWPs developed	Yes	2019	AWP document	Annually	Yes	Yes	Yes	Yes	Yes
	Annual nutrition reports generated	1	2020	Nutrition programme reports	Annually	1	1	1	1	1
	CNAP developed	Yes	2020	Second generation CNAP	Every 5 Years	No	No	No	No	Yes
Strengthened nutrition sector capacity in NIS and evidence-based decision-making	SMART surveys conducted and data disaggregated by sex	No	2019	SMART Survey report	Every 2 Years	No	Yes	No	Yes	No
	MIYCN surveys conducted targeting both genders	No	2019	MIYCN survey report	Every 2 Years	No	No	Yes	No	No
	Capacity assessment conducted on healthcare workers	No	2019	Activity reports	Annually	No	Yes	No	No	Yes
	Number of quarterly data review meetings for nutrition activities held	2	2019	Activity reports	Quarterly	3	4	4	4	4
	Number of nutrition data quality audits conducted	2	2019	Data quality audit reports	Quarterly	3	4	4	4	4
	Number of nutrition reports submitted	12	2019	Nutrition reports	Monthly	12	12	12	12	
Improved access to and use of nutrition information to inform program quality, adjustment, and learning	Number of nutritionists sensitized on nutrition related HMIS indicators	No data	2019	Activity reports	Annually	35	45	55	65	75
	Number of multisectoral nutrition collaboration TWG meetings held	0	2019	Activity	Quarterly	3	4	4	4	4
Improved decision making through research evidence	Number of nutritionists trained on research	0	2019	Activity reports	Annually	35	45	55	65	75
	Research repositories established	No	2019	Research repository	Every 5 Years	No	Yes	Yes	Yes	Yes
	No. of nutrition research papers prepared	0	2019	Research paper	Annually	1	2	2	2	2
	Research repositories updated and maintained	No	2019	Research repository maintenance reports	Annually	No	Yes	Yes	Yes	Yes

KRA 10. Advocacy, Communication and Social Mobilization (ACSM) strengthened

Expected Outputs	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Political commitment and prioritization of nutrition at national and County level enhanced	Number of high-level advocacy meetings targeting the County assembly on prioritizing and financing of nutrition interventions held	0	2019	Activity report	Annually	1	1	1	1	1
	Number of male and female nutrition champions identified and engaged for promoting nutrition activities	0	2019	Activity report	Annually	1	1	1	1	1
Increased and strengthened human capital and capacity for nutrition	Number of male and female nutritionists trained on nutrition advocacy, communication writing skills to help them package information for media targeting nutritionist workforce, health workers	0	2019	Activity report	Annually	5	5	5	5	5
	Number of sensitization meetings on gender responsive nutrition advocacy targeting key influencers and the nutrition champion	0	2019	Activity report	Annually	1	1	1	1	1

Expected Outputs	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Effective engagements with media built and	Number of male and female media fraternity sensitized on gender responsive nutrition advocacy targeting	0	2019	Activity report	Annually	10	10	10	10	10
	Number of media education programmes on nutrition done	0	2019	Activity report	Bi-annual	3	2	2	2	2
Community engagement in nutrition strengthened	Number of sensitization meetings on nutrition resilience building interventions and accountability mechanisms targeting communities through community groups	0	2019	Activity report	Every 2 Years	4	4	0	4	0
	Number of community dialogue and action days done	0	2019	Activity report	Quarterly	16	16	16	16	16
	Number of international and national thematic days celebrated.	1	2019	Activity report	Bi-annual	1	2	2	2	2

4.11 Implementation plan

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

a) Developing 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 data and use of information for evidence-based decision making
d) Enhancing data availability through support of surveys, and assessments, and strengthening the capacity of nutrition staff to analyse and use the data.
e) Joint nutrition monitoring and evaluation, including the other sectors.

4.12 Roles and responsibilities of different actors in the implementation of Embu CNAP

Table 11: Roles and responsibilities of different actors in the implementation of Embu CNAP

Actors	Roles and responsibilities
Nutrition M&E Staff Members	• Ensuring overall design of the MEAL plan is technically sound • Working with stakeholders to develop and refine appropriate outputs, outcomes, indicators, and targets • Providing technical assistance to create data collection instruments • Helping program staff with data collection (including selection of appropriate methods, sources, enforcement of ethical standards) • Ensuring data quality systems are established • Analysing data and writing up the findings • Aiding program staff to interpret their output and outcome data • Promoting use of M&E data to improve program design and implementation • Conducting evaluations or special studies
Management at program level	• Determining what resources, human and financial, should be committed to M&E activities • Ensuring content of the M&E plan aligns with the overall vision and direction of the County • Assuring data collected meet the information needs of stakeholders • Tracking progress to confirm staff carry out activities in the M&E plan • Improving project design and implementation based on M&E data • Deciding how results will be used and shared • Identifying who needs to see and use the data • Deciding where to focus evaluation efforts • Interpreting and framing results for different audiences
County Department of health services	• Providing technical services and coordinating gender sensitive M&E activities • Establishing and equipping robust M&E units aligned to their respective departmental organograms • 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 • Coordinating and supervising the implementation of all gender integrated M&E activities at the County and Sub-County and facility levels

Actors	Roles and responsibilities
Nutrition Sensitive Sectors	• Monitoring and reporting on progress towards implementation of key activities that fall within their mandates in line with jointly agreed indicators • Participating in high level M&E activities at the County • Supporting surveys and evaluations needed to assess shared impact of joint interventions
Implementing partners and agencies	• Aligning all their M&E activities to realize the goals of this plan as well as the institutional M&E goals articulated in sectoral, programmatic, and County specific M&E Plans • Routine monitoring and evaluating their activities • Using existing systems/developing M&E sub systems that utilize existing structures at all levels of the health information system • 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. • Ensuring that their reporting requirements and formats are in line with the indicators outlined in the M&E framework. • Synchronizing efforts with existing development partners and stakeholder efforts based on an agreed upon one County-level M&E system. • 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. • 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 • 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.

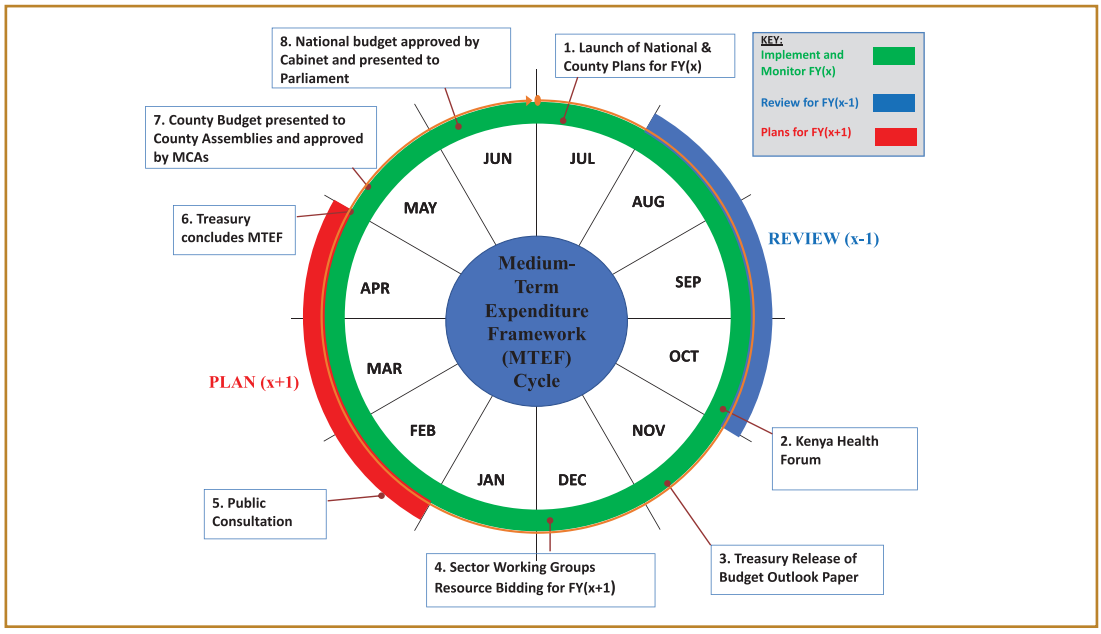


Figure 6: Health sector accountability cycle

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 Embu 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 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. 1.5 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.1.5 billion for nutrition over the plan period. This further has been disaggregated by KRAs as shown in the table below.

Table 12: Resource requirements

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	83,418,430	88,691,180	85,328,055	85,807,055	85,356,180	428,600,900
KRA 02. Nutrition of older children and adolescents promoted	516,500	1,698,000	570,500	1,698,000	570,500	5,053,500
KRA 03. Prevention, control management of diet-related non-communicable diseases among all cohorts promoted and scaled-up.	15,000	27,174,000	17,466,000	27,369,000	22,369,000	94,393,000
KRA 04. Prevention, control, and management of micronutrient deficiencies Scaled up	14,919,300	14,555,700	14,192,100	13,683,060	13,610,340	70,960,500
KRA 05. Integrated management of acute malnutrition and nutrition in emergencies strengthened	90,558,220	92,884,420	90,558,220	92,884,420	90,558,220	457,443,500
KRA 06. Clinical nutrition and dietetics in disease management, nutrition in HIV/TB/promoted/strengthened	4,515,000	65,732,540	66,827,540	66,002,540	67,057,540	270,135,160
KRA 07. Nutrition in agriculture, education & early Childhood Development, Water Sanitation and Hygiene (WASH) and Social protection promoted and strengthened	9,758,550	10,249,300	10,145,800	8,293,800	9,728,300	48,175,750
KRA 08. Sectoral and multi-sectoral governance, coordination, legal/regulatory frameworks, leadership, and management strengthened	717,500	1,639,500	3,959,500	1,334,500	1,309,500	8,960,500
KRA 09. Sectoral and multisectoral Nutrition Information Systems, learning and research strengthened	14,727,200	17,113,100	16,814,500	19,693,600	16,814,500	85,162,900
KRA 10. Advocacy, Communication and Social Mobilization (ACSM) strengthened	7,467,132	7,467,132	6,843,012	6,843,012	6,843,012	35,463,300
Grand Total	**226,612,832**	**327,204,872**	**312,705,227**	**323,608,987**	**314,217,092**	**1,504,349,010**

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

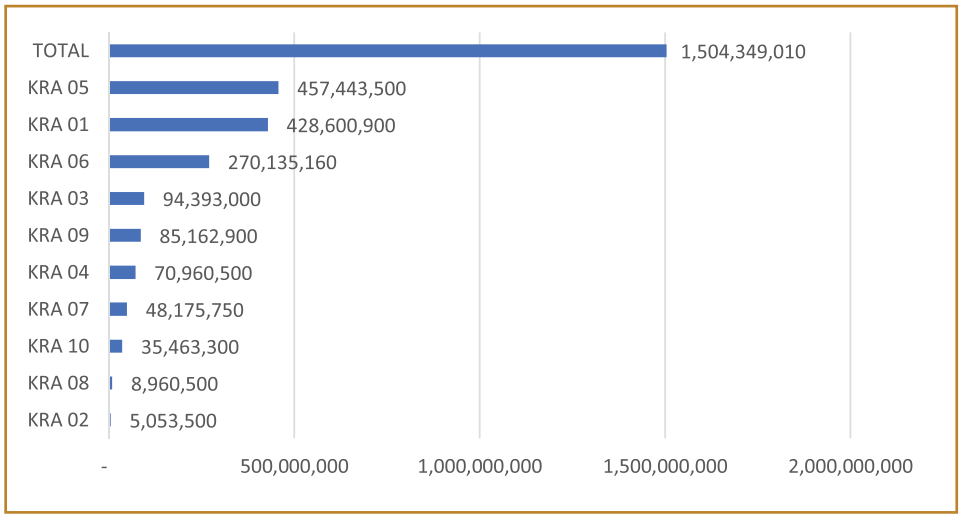


Figure 7: Total cost requirements (2020/21 – 2024/25)

Analysis of the cost requirements shows that 31% of the funds will be required to cater for KRA on Integrated management of acute malnutrition and nutrition in Emergencies strengthened; KRA on Maternal, Infant and Young Child Nutrition (MIYCN) scaled up will require 29% while KRA on Clinical nutrition and dietetics in disease management, nutrition in HIV/TB/promoted/strengthened will require 18%.

5.5 Strategies to ensure available resources are sustained

5.5.1 Strategies to mobilize resources from new sources

- Lobbying for a legislative framework in the County assembly for resource mobilization and allocation
- Identification of potential donors both bilateral and multi-lateral
- Conducting stakeholder mapping for identification of areas of support
- Conduct resource mobilization engagement and advocacy meetings.
- Identification, appointment, and accreditation of eminent persons in the community as resource mobilization good will ambassadors

5.1.2 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.

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7 APPENDICES

Appendix A: Summary table of resource needs for KRAs and activities

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	**83,418,430**	**88,691,180**	**85,328,055**	**85,807,055**	**85,356,180**	**428,600,900**
Sensitize County health management team (CHMT), Sub-County health management team (SCHMT) targeting both male and female representatives and other implementing partners on BFCI	225,000	225,000	225,000	225,000	225,000	1,125,000
Train male and female health care workers (HCWs) on BFCI and to effectively mainstream and implement gender transformative BFCI initiatives	3,888,000	3,888,000	3,888,000	3,888,000	3,888,000	19,440,000
Sensitize Community Health Committee, Primary Health Care Facility Committee, and other community leaders on BFCI targeting both male and female across different diversities	252,000	252,000	252,000	252,000	252,000	1,260,000
Establish Community Mother Support Groups incorporating mothers across different age categories and level of influence while promoting increased male support for sustainability	458,900	458,900	458,900	458,900	458,900	2,294,500
Training of male and female CHVs and community mother support group (CMSG) on c- BFCI	3,856,800	3,856,800	3,856,800	3,856,800	3,856,800	19,284,000
Map households within community units and establish gender sensitive CMSGs consisting of men and women of different ages and diversities and across various levels of influence both at the household and community levels	3,410,000	3,410,000	3,410,000	3,410,000	3,410,000	17,050,000
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 Establish Mother-to-Mother (MTMSG) and father to father (FTFSG) support groups at community unit level	1,926,000	1,926,000	1,926,000	1,926,000	1,926,000	9,630,000
Conduct gender integrated baseline BFCI assessment at CU level while ensuring collection and analysis of data disaggregated data by gender, age, and diversity	1,082,000	1,082,000	1,082,000	1,082,000	1,082,000	5,410,000
Conduct Continuous gender integrated BFCI assessment by CHMT and SCHMT	2,420,000	2,420,000	2,420,000	2,420,000	2,420,000	12,100,000
Conduct gender integrated BFCI external assessment	-	-	770,000	-	770,000	1,540,000
Conduct monthly CHVs meeting	2,844,000	2,844,000	2,844,000	2,844,000	2,844,000	14,220,000
Conduct quarterly review meetings on BFCI for male and female CHVs	948,000	948,000	948,000	948,000	948,000	4,740,000
Sensitize CHMT, SCHMT, HMT and other implementing partners on BFHI	202,500	202,500	202,500	202,500	202,500	1,012,500
Train male and female HCWs on BFHI	3,087,600	3,087,600	3,087,600	3,087,600	3,087,600	15,438,000
Select and establish facility BFHI Committee members of both genders	80,000	80,000	80,000	80,000	80,000	400,000
Conduct BFHI baseline assessment in implementing health facilities	2,192,000	2,192,000	2,192,000	2,192,000	2,192,000	10,960,000
Conduct quarterly assessment for BFHI by HMT and BFHI committee members	84,000	84,000	84,000	84,000	84,000	420,000
Hold quarterly facility BFHI committee members meeting	44,000	44,000	44,000	44,000	44,000	220,000
Conduct quarterly CMEs on BFHI	20,000	20,000	20,000	20,000	20,000	100,000
CHMT, SCHMT to conduct biannual internal BFHI assessment	520,000	520,000	520,000	520,000	520,000	2,600,000
Hold quarterly facility BFHI committee members meeting	240,000	240,000	240,000	240,000	240,000	1,200,000
quarterly CMEs on BFHI	208,000	208,000	208,000	208,000	208,000	1,040,000
CHMT, SCHMT to conduct biannual internal BFHI assessment	432,000	432,000	432,000	432,000	432,000	2,160,000
Hold quarterly facility BFHI committee members meeting	80,000	80,000	80,000	80,000	80,000	400,000
quarterly CMEs on BFHI	168,750	112,500	84,375	84,375	112,500	562,500
CHMT, SCHMT to conduct biannual internal BFHI assessment	1,312,000	1,312,000	1,312,000	1,312,000	1,312,000	6,560,000
Conduct external BFHI assessment	2,824,200	2,824,200	2,824,200	2,824,200	2,824,200	14,121,000
Train male and female HCWs on World Health Organization (WHO) growth standards	3,888,000	5,928,000	4,500,000	4,500,000	4,500,000	23,316,000
Train male and female HCWs on childcare and stimulation	3,888,000	5,928,000	4,500,000	4,500,000	4,500,000	23,316,000
Procure anthropometric measurement equipment	6,937,180	8,993,380	6,937,180	8,993,380	6,937,180	38,798,300
Distribute anthropometric equipment	18,000	18,000	18,000	18,000	18,000	90,000

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	**83,418,430**	**88,691,180**	**85,328,055**	**85,807,055**	**85,356,180**	**428,600,900**
Sensitize male and female CHVs on childcare and stimulation	4,497,600	4,497,600	4,497,600	4,497,600	4,497,600	22,488,000
Sensitize male and female CHVs on growth monitoring and promotion (MUAC)	4,497,600	4,497,600	4,497,600	4,497,600	4,497,600	22,488,000
Conduct training to mothers and male and female caregivers on family MUAC	13,230,000	13,230,000	13,230,000	13,230,000	13,230,000	66,150,000
Conduct quarterly CMEs on GMP and mother child handbook at facility level targeting male and female HCWs	1,344,000	1,344,000	1,344,000	1,344,000	1,344,000	6,720,000
Print and distribute data collection and reporting tools disaggregated by gender age and diversities for MNCHN	4,018,000	4,018,000	4,018,000	4,018,000	4,018,000	20,090,000
Sensitize and disseminate the implementation framework for securing a user -friendly, gender and diversity responsive breastfeeding environment at workplace to CHMT, SCHMT, and HMT	157,500	157,500	157,500	157,500	157,500	787,500
Establish gender and diversity responsive lactation stations at workplace in selected areas	169,500	169,500	169,500	169,500	169,500	847,500
Sensitize other stakeholders on the implementation framework for securing a user-friendly, gender and diversity responsive breastfeeding environment at workplace	9,900	9,900	9,900	9,900	9,900	49,500
Train male and female HCWs on workplace support for breastfeeding	158,500	158,500	158,500	158,500	158,500	792,500
Form a gender, age, and diversity inclusive workplace breastfeeding support task force at County level	62,500	62,500	62,500	62,500	62,500	312,500
Hold quarterly meetings for workplace support for breastfeeding mothers	7,500	7,500	7,500	7,500	7,500	37,500
Form/Establish a gender, age, and diversity inclusive lactation station management team	63,000	63,000	63,000	63,000	63,000	315,000
Sensitize CHMT, SCHMT targeting both male and female representatives on PD-HEARTH model	165,900	165,900	165,900	165,900	165,900	829,500
Train male and female HCWs on PD-HEARTH approach from facilities linked to the selected community units	623,100	623,100	623,100	623,100	623,100	3,115,500
Sensitize male and female CHVs on PD-HEARTH approach in the selected CUs	225,000	225,000	225,000	225,000	225,000	1,125,000
Sensitize communities through MTMSGs and FTFSGs on PD-HEARTH approach and implement the model while promoting gender transformative MIYCN practices towards improved behaviour change	57,900	57,900	57,900	57,900	57,900	289,500
Printing of data collecting and summarizing tools for MNCHN	-	-	-	-	-	-
Distribution of data collection and analysis tools for MNCHN	28,000	28,000	28,000	28,000	28,000	140,000
Strengthen the implementation of SBCC strategy on MIYCN	807,200		807,200		807,200	2,421,600
Sensitize CHMT, SCHMT and other stakeholders targeting both male and female representatives on optimal nutrition needs for children in day care centers	96,500	96,500	96,500	96,500	96,500	482,500
Sensitize male and female care givers including other male and female key influencers on optimal nutrition needs for children in day care centers through user-friendly and easy to understand communication channels	96,500	96,500	96,500	96,500	96,500	482,500
Sensitize and disseminate the BMS Act, implementation framework to CHMT, SCHMT and other stakeholders	157,500	157,500	157,500	157,500	157,500	787,500
Train male and female HCWs on BMS Act, implementation framework	1,838,400	1,838,400	1,838,400	1,838,400	1,838,400	9,192,000
Form BMS Act, implementation task force at County level	15,000	15,000	15,000	15,000	15,000	75,000
Train PHOs, nutritionists and other stakeholders targeting both male and female representatives on BMS Act, monitoring and enforcement	1,838,400	1,838,400	1,838,400	1,838,400	1,838,400	9,192,000
Conduct market level surveillance to monitor compliance of BMS Act and report violations appropriately	55,000	55,000	55,000	55,000	55,000	275,000
Carry out continuous CME on BMS Act, at health facility level	60,000	60,000	60,000	60,000	60,000	300,000
Sensitize and disseminate CHMT, SCHMT, HMT and other stakeholders on all existing MIYCN policies	157,500	157,500	157,500	157,500	157,500	787,500
Train male and female HCWs on MIYCN in areas where BFCI is not implemented including special clinics	1,381,500	1,381,500	1,381,500	1,381,500	1,381,500	6,907,500
Sensitize selected communities targeting men and women of different ages, diversities, and levels of influence on gender transformative MIYCN practices through selected community units not implementing BFCI	32,500	32,500	32,500	32,500	32,500	162,500
Carry out continuous MIYCN CME in health facilities	30,000	30,000	30,000	30,000	30,000	150,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 02: Nutrition of Older Children and Adolescents Promoted	**516,500**	**1,698,000**	**570,500**	**1,698,000**	**570,500**	**5,053,500**
Production of the sensitization materials	356,000	356,000	356,000	356,000	356,000	1,780,000
Sensitize stakeholders on nutrition policies, guidelines related to older children and adolescents (food-based dietary guidelines; tuck shop guidelines; menu guidelines; sports nutrition guidelines; school garden guidelines), training packages (healthy diet and physical activity)	2,000	2,000	2,000	2,000	2,000	10,000
Sensitization key stakeholders on healthy diets and physical activity for older children and adolescents	500	308,000	500	308,000	500	617,500
Sensitize older children, adolescents and communities targeting both genders on healthy diets and physical activity using context-specific communication channels in both rural and urban setups	40,000	40,000	40,000	40,000	40,000	200,000
Integrate messaging on healthy diets and physical activity in the school health programme	100,000	100,000	100,000	100,000	100,000	500,000
Collaborate with MoALF&C on establishment of diverse gender and age inclusive food production (crops, livestock, edible insects, and fisheries)	-	-	-	-	-	-
Sensitize stakeholders on marketing and promotions within the school; sufficient safe and nutritious foods in school	-	820,000	-	820,000	-	1,640,000
Sensitize older children and adolescents in school and out of school targeting both genders on consumption and marketing of healthy/unhealthy foods	-	-	-	-	-	-
Create awareness through the media on consumption of and marketing of healthy/unhealthy foods	18,000	72,000	72,000	72,000	72,000	306,000
KRA 03: Prevention, control management of diet-related non-communicable diseases among all cohorts promoted and scaled-up	**15,000**	**27,174,000**	**17,466,000**	**27,369,000**	**22,369,000**	**94,393,000**
Sensitize CHMT & SCHMT on guidelines and policies around diet related NCDs	-	-	-	165,000	165,000	330,000
Sensitize male and female HCWs and CHAs on DRNCDs guidelines and policies	-	395,000	-	395,000	395,000	1,185,000
Train male and female HCWs on Healthy diets and physical activity	-	680,000	-	680,000	680,000	2,040,000
Sensitize male and female CHVs/CHAs on Healthy diets and physical activity	-	577,000	-	577,000	577,000	1,731,000
Sensitize male and female CHAs and CHVs on diabetes nutrition therapy management	-	577,000	-	577,000	577,000	1,731,000
Train male and female HCWs on diabetes nutrition therapy management	-	1,932,000	-	1,932,000	1,932,000	5,796,000
Sensitize male and female CHAs/CHVs on Diabetes management in children	-	577,000	-	577,000	577,000	1,731,000
Train male and female HCWs on Diabetes management in children	-	1,355,000	1,355,000	1,355,000	1,355,000	5,420,000
Carry out CME and OJT to male and female HCWs on DRNCDs at facility level	15,000	15,000	15,000	15,000	15,000	75,000
Develop and customize key messages for nutrition management in DRNCDs	-	-	30,000	30,000	30,000	90,000
Sensitize community through gender, age, and diversity inclusive community groups on the customized user friendly, context specific and gender transformative messages for nutrition management in DRNCDs including physical activity and healthy diets for men and women across different ages and diversities	-	30,000	30,000	30,000	30,000	120,000
Adopt and customize various IEC materials in DRNCDs	-	30,000	30,000	30,000	30,000	120,000
Sensitize male and female journalists and editors of print, online and mass media on inclusion of gender transformative nutrition messages about DRNCDs	-	30,000	30,000	30,000	30,000	120,000
Carry out gender, age and diversity sensitive nutrition assessment counselling and support (NACS) to patients with DRNCDs	-	-	-	-	-	-
Hold advocacy forums for the integration of gender, age, and diversity responsive nutrition services at all NCD clinics in hospitals	-	150,000	150,000	150,000	150,000	600,000
Procure nutrition supplies and equipment for DRNCD screening	-	16,460,000	11,460,000	16,460,000	11,460,000	55,840,000
Participate in gender, age, and diversity inclusive screening of the public for early detection, control management and treatment of DRNCDs during world thematic health days/celebrations	-	-	-	-	-	-

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 03: Prevention, control management of diet-related non-communicable diseases among all cohorts promoted and scaled-up	**15,000**	**27,174,000**	**17,466,000**	**27,369,000**	**22,369,000**	**94,393,000**
Submit gender, age, and diversity sensitive monthly reports for DRNCDs on KHIS	-	-	-	-	-	-
Advocate for inclusion of gender, age, and diversity sensitive monthly reporting for DRNCDs on KHIS to Level facilities	-	220,000	220,000	220,000	220,000	880,000
Conduct support supervision and offer technical support/mentorship to health facilities on DRNCDs	-	196,000	196,000	196,000	196,000	784,000
Conduct quarterly review meetings to assess trends for both Nutrition specific and nutrition sensitive risk factors for DRNCDs	-	150,000	150,000	150,000	150,000	600,000
Advocate and conduct gender-integrated surveys and operational research of nutrition-related risk factors for DRNCDs	-	3,200,000	3,200,000	3,200,000	3,200,000	12,800,000
Establish gender, age, and diversity sensitive DRNCD support groups in health facilities	-	120,000	120,000	120,000	120,000	480,000
Carry out monthly meetings for gender, age, and diversity inclusive DRNCD support groups	-	480,000	480,000	480,000	480,000	1,920,000
Conduct routine gender- transformative nutrition education during support group meetings	-	-	-	-	-	-
KRA 04: Prevention, control, and management of micronutrient deficiencies Scaled up	**14,919,300**	**14,555,700**	**14,192,100**	**13,683,060**	**13,610,340**	**70,960,500**
Sensitize CHMT, SCHMT and HMT on existing micronutrient policies (VAS, MNP and IFAS)	2,025,000	2,025,000	2,025,000	2,025,000	2,025,000	10,125,000
Train male and female HCWs on VAS	727,200	606,000	484,800	315,120	290,880	2,424,000
Train male and female HCWs on MNPs	727,200	606,000	484,800	315,120	290,880	2,424,000
Train male and female HCWs on IFAS	727,200	606,000	484,800	315,120	290,880	2,424,000
Procure and distribute micronutrients (MNP, IFAS) and dewormers	1,478,000	1,478,000	1,478,000	1,478,000	1,478,000	7,390,000
Print and distribute micronutrient program reporting tools	910,000	910,000	910,000	910,000	910,000	4,550,000
Carry out VAS for children aged - months	4,985,500	4,985,500	4,985,500	4,985,500	4,985,500	24,927,500
Carry out MNPs supplementation for children aged - months	650,000	650,000	650,000	650,000	650,000	3,250,000
Carry out IFAS for pregnant mothers	480,000	480,000	480,000	480,000	480,000	2,400,000
Carry out deworming for children - months and pregnant mothers	-	-	-	-	-	-
Sensitize community on increased gender, age and diversity responsive production, preservation, and consumption of micronutrient-rich foods at household level through various communication channels targeting men and women, boys and girls of different ages and diversities	282,000	282,000	282,000	282,000	282,000	1,410,000
Sensitize care givers through MTMSGs and FTFSGs on food preparation methods that enhance bio availability of micronutrients in foods	32,000	32,000	32,000	32,000	32,000	160,000
Sensitize teachers, PHOs and nutritionists on how to conduct testing for salt iodization	144,000	144,000	144,000	144,000	144,000	720,000
Carry out annual household salt iodization testing through schools	8,800	8,800	8,800	8,800	8,800	44,000
Procure iodine test kits	152,400	152,400	152,400	152,400	152,400	762,000
Sensitize stakeholders and Millers (medium and small) on food fortification strategy and compliance	172,500	172,500	172,500	172,500	172,500	862,500
Sensitize the community through gender, age and diversity inclusive community groups and other community forums on the fortified foods in the market (flours, salt, oils, and fats)	1,130,000	1,130,000	1,130,000	1,130,000	1,130,000	5,650,000
Sensitize PHOs & nutritionists on market level surveillance on adherence to food fortification	287,500	287,500	287,500	287,500	287,500	1,437,500
Conduct market level surveillance on fortified food commodities to monitor compliance and report violations appropriately						

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 05: Integrated management of acute malnutrition and nutrition in emergencies strengthened	**90,558,220**	**92,884,420**	**90,558,220**	**92,884,420**	**90,558,220**	**457,443,500**
Identify health facilities for the scale up of IMAM sites	175,000	175,000	175,000	175,000	175,000	875,000
Link IMAM clients with other programmes within the community (WASH, livelihood, MIYCN support groups, social protection, and food security)	90,000	90,000	90,000	90,000	90,000	450,000
Advocate for Public Private Partnership in the implementation of IMAM services	90,000	90,000	90,000	90,000	90,000	450,000
Monitor and report on IMAM services using the available tools (data capturing, analysis, reporting, dissemination, and surveillance)	1,020,000	1,020,000	1,020,000	1,020,000	1,020,000	5,100,000
Effectively utilize IMAM surge	177,600	177,600	177,600	177,600	177,600	888,000
ETAT IMAM training for male and female health care workers	137,700	137,700	137,700	137,700	137,700	688,500
Carry out follow up and referral systems for IMAM across all levels	-	-	-	-	-	-
Carry out documentation of related research, best practices and learning on IMAM services	90,000	90,000	90,000	90,000	90,000	450,000
Health workers On-Job Training (OJT) on IMAM service delivery	238,400	238,400	238,400	238,400	238,400	1,192,000
Carry out quarterly support supervision in IMAM sites	238,400	238,400	238,400	238,400	238,400	1,192,000
Participate in emergency preparedness and risk reduction committees	540,000	540,000	540,000	540,000	540,000	2,700,000
Upscale IMAM surge kit during disaster emergencies	57,600	57,600	57,600	57,600	57,600	288,000
Develop nutrition supply chain contingency plans at County level	69,681,840	69,681,840	69,681,840	69,681,840	69,681,840	348,409,200
Conduct, report and disseminate nutrition early warning systems findings	180,000	180,000	180,000	180,000	180,000	900,000
Activate emergency coordination for nutrition response Taskforce	135,000	135,000	135,000	135,000	135,000	675,000
Carry out continuous sensitization of HINI to communities during nutrition emergencies	270,000	270,000	270,000	270,000	270,000	1,350,000
Carry out nutrition service delivery approaches including outreach services in hard-to-reach areas, affected urban areas	297,600	297,600	297,600	297,600	297,600	1,488,000
Sensitize CHMTs and SCHMTs on IMAM policies standards and guidelines	-	270,000	-	270,000	-	540,000
Adapt and disseminate gender responsive IMAM standard operating procedures (SOPs) in all facilities implementing IMAM services	700,000	700,000	700,000	700,000	700,000	3,500,000
Carry out gender, age and diversity inclusive nutrition screening in all service delivery points for early identification of malnutrition and refer for action appropriately	7,529,180	9,585,380	7,529,180	9,585,380	7,529,180	41,758,300
Monitor adherence to gender responsive IMAM programme SOPs, guidelines and protocols by health and nutrition workforce	592,000	592,000	592,000	592,000	592,000	2,960,000
Conduct quarterly IMAM programme performance reviews meetings at County and Sub-County level	1,260,000	1,260,000	1,260,000	1,260,000	1,260,000	6,300,000
Advocate for gender integrated operational research on IMAM	90,000	90,000	90,000	90,000	90,000	450,000
Conduct nutrition screening/assessment for all cohorts at community and facility level and disaggregate data by sex, age, and diversity	259,200	259,200	259,200	259,200	259,200	1,296,000
Train health workers on IMAM including affective identification, documentation and addressing underlying social cultural and economic factors contributing to malnutrition, affecting optimal adherence to IMAM services and relapse by MAM/SAM patients	1,830,900	1,830,900	1,830,900	1,830,900	1,830,900	9,154,500
Train health care workers on Emergency Triaging and Treatment	649,500	649,500	649,500	649,500	649,500	3,247,500
Train/sensitize health care workers on IMAM surge model	1,857,900	1,857,900	1,857,900	1,857,900	1,857,900	9,289,500
Adopt gender responsive key actions/recommendations from research, assessments/surveys, lessons learnt, routine gender, age and diversity disaggregated data, programme review meetings and feedback from field experiences	90,000	90,000	90,000	90,000	90,000	450,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 05: Integrated management of acute malnutrition and nutrition in emergencies strengthened	**90,558,220**	**92,884,420**	**90,558,220**	**92,884,420**	**90,558,220**	**457,443,500**
Sensitize/ carry out on-job training of male and female CHVs/CHAs on CMAM including affective identification, documentation and addressing underlying social cultural and economic factors contributing to malnutrition, affecting optimal adherence to IMAM services and relapse by MAM/SAM patients	86,400	86,400	86,400	86,400	86,400	432,000
Conduct continuous Medical Education, OJT, and mentorship for health care workers and CHVs/CHAs on IMAM and CMAM	58,400	58,400	58,400	58,400	58,400	292,000
Map nutrition specific and sensitive partners in preparedness and emergency risk reduction	-	-	-	-	-	-
Participate in joint planning and implementation meetings with other sectors on gender, age and diversity responsive integrated preparedness, risk reduction, response, and assessments	135,000	135,000	135,000	135,000	135,000	675,000
Conduct joint resource mobilization activities with other sectors on gender, age and diversity responsive integrated preparedness and risk reduction	135,000	135,000	135,000	135,000	135,000	675,000
Conduct annual review of gender, age and diversity responsive disaster preparedness and response plans for nutrition	180,000	180,000	180,000	180,000	180,000	900,000
Participate in stakeholder meeting/workshops on disaster risk reduction and climate change adaptation	-	-	-	-	-	-
Train healthcare workers on gender transformative MIYCN-E	204,500	204,500	204,500	204,500	204,500	1,022,500
Sensitize male and female CHAs and CHVs on MIYCN-E	119,500	119,500	119,500	119,500	119,500	597,500
Conduct gender, age, and diversity integrated MIYCN-E assessment in selected emergency hotspots	57,600	57,600	57,600	57,600	57,600	288,000
Disseminate gender, age, and diversity integrated MIYCN-E assessment findings to stakeholders	360,000	360,000	360,000	360,000	360,000	1,800,000
Adapt and disseminate gender, age and diversity responsive SOPs for emergency response and guidelines on linkage of nutrition with livelihood programmes to CHMT, SCHMT and other stakeholders	180,000	180,000	180,000	180,000	180,000	900,000
Advocate for implementation of gender, age and diversity responsive and inclusive livelihood and social protection programmes to enhance integration of nutrition	450,000	450,000	450,000	450,000	450,000	2,250,000
Disseminate post-disaster reviews on nutrition activities to stakeholders to inform decision making regarding nutrition considerations	270,000	270,000	270,000	270,000	270,000	1,350,000
Participate in community-level dialogue and gender, age, and diversity responsive recovery initiatives	44,000	44,000	44,000	44,000	44,000	220,000
KRA 06: Clinical nutrition and dietetics in disease management, nutrition in HIV/TB/promoted/strengthened	**4,515,000**	**65,732,540**	**66,827,540**	**66,002,540**	**67,057,540**	**270,135,160**
Disseminate guidelines and policies on clinical nutrition to male and female CHMT/SCHMT and HCWs	400,000	520,000	520,000	520,000	520,000	2,480,000
Support male and female nutritionists to be trained on oncology nutrition	-	1,575,800	1,575,800	1,575,800	1,575,800	6,303,200
Support male and female nutritionists to be trained on nephrology nutrition	-	1,575,800	1,575,800	1,575,800	1,575,800	6,303,200
Train male and female healthcare workers on clinical nutrition and dietetics management	-	1,475,000	1,475,000	1,475,000	1,475,000	5,900,000
Sensitize male and female healthcare workers through CMEs on nutrition care process	-	6,000	6,000	6,000	6,000	24,000
Train male and female Health care workers on National New-born Guidelines for Hospitals	-	1,575,800	1,575,800	1,575,800	1,575,800	6,303,200
Train male and female health care workers on kangaroo mother care	-	1,575,800	1,575,800	1,575,800	1,575,800	6,303,200
Support male and female nutritionists to be trained on nutrition critical care	-	1,575,800	1,575,800	1,575,800	1,575,800	6,303,200
Sensitize male and female HCWs on Basic Essential Clinical Nutrition and Dietetics care package	-	1,475,000	1,475,000	1,475,000	1,475,000	5,900,000
Sensitize male and female HCWs on Basic Essential Clinical Nutrition and Dietetics care package	-	1,475,000	1,475,000	1,475,000	1,475,000	5,900,000
Carry out nutrition assessment, counselling, and support (NACS) to patients and refer appropriately	-	-	-	-	-	-
Prepare dietary regimes/feeding plans for male and female inpatient clients	-	-	-	-	-	-
Prescribe and issue therapeutic, disease specific and supplemental feeds to both inpatients	-	-	-	-	-	-
Adopt and disseminate to HCWs clinical nutrition SOPs	285,000	285,000	285,000	285,000	285,000	1,425,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 06: Clinical nutrition and dietetics in disease management, nutrition in HIV/TB/promoted/strengthened	**4,515,000**	**65,732,540**	**66,827,540**	**66,002,540**	**67,057,540**	**270,135,160**
Conduct support supervision on SOPs implementation	200,000	200,000	200,000	200,000	200,000	1,000,000
Procure and distribute clinical nutrition tools, i.e., screening tools, inter-facility referral, patient feeding and monitoring, and service quality management tools	500,000	500,000	500,000	500,000	500,000	2,500,000
Disseminate basic training and patient safety package for clinical nutrition and dietetics	263,000	-	263,000	-	263,000	789,000
Sensitize male and female HCWs on Home-based care guidelines on nutrition	1,355,000	1,355,000	1,355,000	1,355,000	1,355,000	6,775,000
Sensitize male and female CHVs and CHAs on Home-based care guidelines on nutrition	-	2,250,000	2,250,000	2,250,000	2,250,000	9,000,000
Conduct widespread NACS on the public during World Nutrition Day (every 28th of May)	-	272,000	272,000	272,000	272,000	1,088,000
Integrate nutrition screening assessment and triage centers with their corresponding assessment tools in outpatient and inpatient services	-	-	270,000	270,000	270,000	810,000
Procure and distribute nutrition assessment tools	-	4,523,000	4,523,000	4,523,000	4,523,000	18,092,000
Carry out forecasting, quantification, and costing for selected therapeutic and supplemental feeds (Enteral and Parenteral)	-	230,000	-	230,000	230,000	690,000
Establishment of food safety inspection committees in health facilities	-	-	-	-	-	-
Procurement and distribution of LMIS hard copy tools; DARs, NCSRs, NASRs, Nutrition F-CDRR, Nutrition CS-CDRR, Nutrition Prescription Booklets	792,000	-	792,000	-	792,000	2,376,000
Conduct support supervision to health facilities food safety committees	240,000	240,000	240,000	240,000	240,000	1,200,000
Procurement and distribution of therapeutic- disease specific/supplemental feeds for use in clinical areas	-	4,000,000	4,000,000	4,000,000	4,000,000	16,000,000
Procured supplemental feeds rationally prescribed and issued	-	2,000,000	2,000,000	2,000,000	2,000,000	8,000,000
Establish and strengthen gender, age, and diversity inclusive inpatient feeding committees	-	-	-	-	-	-
Participate in medicines and therapeutics committees	-	-	-	-	-	-
Review and implement hospital menus that are sensitive to patient needs	-	-	-	-	-	-
Carry out supportive supervision on clinical nutrition services	-	240,000	240,000	240,000	240,000	960,000
Conduct continuous medical education/mentorship on clinical nutrition for male and female HCWs and Community Health Assistants (CHAs)	-	15,000	15,000	15,000	15,000	60,000
Conduct clinical on-job training on various service areas	-	528,000	528,000	528,000	528,000	2,112,000
Conduct quarterly clinical nutrition review meetings to monitor and evaluate performance/service delivery	-	395,000	395,000	395,000	395,000	1,580,000
Sensitize the male and female CHMT, SCHMT & facility in charges on nutrition guidelines in HIV & TB management	-	442,500	442,500	442,500	442,500	1,770,000
Train male and female health workers on integrated nutrition therapy (HIV in nutrition and Nutrition in TB)	-	1,355,000	1,355,000	1,355,000	1,355,000	5,420,000
Sensitize male and female HCWs on nutrition counselling card for HIV patients for focused nutrition therapy and interpersonal counselling for HIV and TB	-	500,000	500,000	500,000	500,000	2,000,000
Conduct nutrition assessment at comprehensive care clinics and TB clinics and disaggregate data by sex, age, and diversity	-	-	-	-	-	-
Procure nutrition assessment tools for CCC and TB clinics	-	3,469,000	3,469,000	3,469,000	3,469,000	13,876,000
Carry out continuous medical education/OJT to male and female health workers on nutrition management of HIV and TB	-	15,000	15,000	15,000	15,000	60,000
Carry out forecasting quantification for nutrition commodities in HIV&TB clinics	-	230,000	230,000	230,000	230,000	920,000
Train health workers on supply chain including electronic LMIS in TB/ HIV nutrition commodities	-	685,000	685,000	685,000	685,000	2,740,000
Conduct quarterly supply chain monitoring including electronic LMIS in TB/ HIV nutrition commodities	-	395,000	395,000	395,000	395,000	1,580,000
Procure and distribute nutrition commodities for HIV and TB Management	-	25,229,040	25,229,040	25,229,040	25,229,040	100,916,160
Sensitize male and female CHAs/ CHVs on gender, age, and diversity sensitive nutrition management for TB/HIV clients	-	2,925,000	2,925,000	2,925,000	2,925,000	11,700,000
Sensitize the community via gender, age and diversity inclusive community groups key context specific messages that promote positive lifestyles and behaviour for TB/ HIV patients	-	-	-	-	-	-

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 06: Clinical nutrition and dietetics in disease management, nutrition in HIV/TB/promoted/strengthened	**4,515,000**	**65,732,540**	**66,827,540**	**66,002,540**	**67,057,540**	**270,135,160**
Link malnourished male and female HIV/TB clients to community-based livelihood and social programs	-	-	-	-	-	-
Conduct frequent nutrition messages at the HIV/ TB gender age and diversity inclusive support groups forums	-	-	-	-	-	-
Participate in County, sub-County, facility scheduled data review meetings for gender responsive and transformative HIV/TB program	-	-	-	-	-	-
Use County NACS data disaggregated by sex, age and diversity for surveillance and decision-making in CCC & TB clinics	-	72,000	72,000	72,000	72,000	288,000
Adopt and use County level scorecard for nutrition indicators disaggregated by sex, age and diversities including NACS in TB and HIV	-	72,000	72,000	72,000	72,000	288,000
Participate in supportive supervision by CHMT and SCHMT teams for TB and HIV clinics	240,000	240,000	240,000	240,000	240,000	1,200,000
CHMT and SCHMT participate in bi-annual joint commodity support supervisions	240,000	240,000	240,000	240,000	240,000	1,200,000
KRA 07: Nutrition in Agriculture, Education & Early Childhood Development, Water Sanitation and Hygiene (WASH) and Social protection promoted and strengthened	**9,758,550**	**10,249,300**	**10,145,800**	**8,293,800**	**9,728,300**	**48,175,750**
Hold joint planning meeting with agriculture department	30,000	30,000	30,000	30,000	30,000	150,000
Participate in agriculture coordination forums	40,000	40,000	40,000	40,000	40,000	200,000
Conduct joint quarterly support supervision of all agri-nutrition activities	127,500	127,500	127,500	127,500	127,500	637,500
Hold joint planning meeting with Education and ECDE department	40,000	40,000	40,000	40,000	40,000	200,000
Participate in Education and ECDE coordination forums	40,000	40,000	40,000	40,000	40,000	200,000
Sensitize stakeholders on gender, age and diversity responsive food and nutrition security policies	146,500	293,000	293,000	293,000	293,000	1,318,500
Sensitize stakeholders on agri-nutrition manual	-	105,000	105,000	-	-	210,000
Sensitize male and female County agricultural extension and health staff on food processing, preservation, and storage technologies	-	85,000	-	85,000	-	170,000
Sensitize male and female community members on food processing, preservation, and storage technologies	-	312,500	312,500	-	-	625,000
Sensitize male and female County agricultural extension and health staff on gender, age, and diversity inclusive and diversified food production strategies	-	-	-	-	-	-
Sensitize communities on diversified food production strategies such as kitchen gardens, rearing of small animals targeting both genders across different ages and diversities	-	-	-	-	-	-
Sensitize communities on utilization and nutritional value of variety of locally available foods targeting men and women across different ages and diversities	400,000	400,000	400,000	400,000	400,000	2,000,000
Sensitize the community on energy saving technologies targeting both men and women	179,000	179,000	179,000	179,000	179,000	895,000
Sensitize the community on meal planning targeting both men and women	-	-	-	-	-	-
Establish kitchen garden demonstration sites at selected health facilities /Community units in every Sub County	1,250	2,500	2,500	2,500	2,500	11,250
Procurement of demonstration materials,	380,000	620,000	620,000	620,000	620,000	2,860,000
Submission of quarterly reports	-	-	-	-	-	-
Sensitize stakeholders on school health and nutrition related policies and guidelines e.g., School meals guidelines, school health policy, National pre-primary policy and service standard guidelines, teacher reference manual etc.	383,000	383,000	383,000	383,000	383,000	1,915,000
Sensitize management committees in ECDE on nutrition assessment, Vitamin A supplementation and deworming	169,500	169,500	169,500	169,500	169,500	847,500
Sensitize ECDE teachers on VAS, deworming, assessment, and documentation	1,519,500	-	1,519,500	-	1,519,500	4,558,500
Procure ECDE VAS registers	450,000	-	-	-	-	450,000
Refer sick and malnourished children to the link health facilities	-	-	-	-	-	-
Conduct joint bimonthly nutrition assessment for ECDE	2,259,000	2,259,000	2,259,000	2,259,000	2,259,000	11,295,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 07: Nutrition in Agriculture, Education & Early Childhood Development, Water Sanitation and Hygiene (WASH) and Social protection promoted and strengthened	**9,758,550**	**10,249,300**	**10,145,800**	**8,293,800**	**9,728,300**	**48,175,750**
Conduct biannual Vitamin A supplementation and deworming activities	1,716,000	1,716,000	1,716,000	1,716,000	1,716,000	8,580,000
Promote inclusion of nutrition and physical activity themes in co-curricular school activities (drama, music, talent shows, contests)	-	-	-	-	-	-
Advocate for technical support from MoALF&C to schools on establishment and improvement of existing school demonstration gardens, small animals and revive 4K clubs	96,000	96,000	96,000	96,000	96,000	480,000
Document and share best practices in the implementation of nutrition activities in schools	-	-	-	-	-	-
Develop assessment tools for the implementation of nutrition and physical activity education and promotion in schools and ECDE centers	-	-	-	-	-	-
Conduct assessment of implementation of nutrition and physical activity education and promotion in ECDE centers	300,000	300,000	300,000	300,000	300,000	1,500,000
Carry out joint support supervision	-	-	-	-	-	-
Prepare quarterly progress reports	-	-	-	-	-	-
Sensitize stakeholders including, curriculum support officers, food service providers and handlers, Parent–Teacher Associations (PTA) on Healthy and safe food environment	500	500	500	500	500	2,500
Sensitize stakeholders including, curriculum support officers, food service providers and handlers, Parent–Teacher Associations (PTA) on Healthy and safe food environment	73,000	73,000	73,000	73,000	73,000	365,000
Promote improved access to safe and sufficient water, and adequate WASH services in schools and ECDE Centers	370,500	370,500	370,500	370,500	370,500	1,852,500
Sensitize the community on the use of potable drinking water and safe water storage within households, health facilities, schools and ECDE centers in collaboration with Public Health Officers	60,000	60,000	60,000	60,000	60,000	300,000
Advocate for protection of water sources and regular water treatment quality checks in collaboration with Public Health Officers and water department	75,000	75,000	75,000	75,000	75,000	375,000
Sensitize the community through gender, age, and diversity inclusive community groups on water treatment technologies	-	-	-	-	-	-
Hold joint planning meetings with WASH sector	40,000	40,000	40,000	40,000	40,000	200,000
Participate in stakeholders' partnerships design, development and dissemination of IEC materials and messaging on hand washing, community and institutions led total sanitation and food hygiene	46,800	46,800	46,800	46,800	46,800	234,000
Participate in the WASH coordination forums	60,000	60,000	60,000	60,000	60,000	300,000
Sensitize the community through gender, age, and diversity inclusive community groups on water treatment technologies	60,000	60,000	60,000	60,000	60,000	300,000
Promote joint resource mobilization for integrated gender transformative WASH and nutrition activities	135,000	135,000	135,000	135,000	135,000	675,000
Conduct sensitization to community members targeting men and women across different ages, diversities, and level of influence on safe and hygienic practices during food preparation and storage	-	-	-	-	-	-
Integrate hand washing message and hygiene during nutrition sessions	-	-	-	-	-	-
Promote environmental hygiene at household level	-	-	-	-	-	-
Sensitize the community through gender, age and diversity inclusive community forums on proper latrine use, proper disposal of baby diapers and menstrual hygiene management	60,000	60,000	60,000	60,000	60,000	300,000
Sensitize the community through gender, age, and diversity inclusive community forums on proper waste management	-	-	-	-	-	-
Document and share best practices in the implementation of integrated and gender transformative nutrition WASH activities	-	-	-	-	-	-
Carry out joint support supervision	62,500	62,500	62,500	62,500	62,500	312,500
Submit quarterly progress reports	-	-	-	-	-	-

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 07: Nutrition in Agriculture, Education & Early Childhood Development, Water Sanitation and Hygiene (WASH) and Social protection promoted and strengthened	**9,758,550**	**10,249,300**	**10,145,800**	**8,293,800**	**9,728,300**	**48,175,750**
Hold joint planning meetings with social protection sector	20,000	20,000	20,000	20,000	20,000	100,000
Participate in social protection coordination forums	60,000	60,000	60,000	60,000	60,000	300,000
Sensitize stakeholders on the importance of gender, age, and diversity inclusive targeting criteria for nutrition in social protection programmes, cash transfers, hunger safety nets, and others	281,000	281,000	281,000	281,000	281,000	1,405,000
Conduct stakeholder mapping of various players in social protection programmes in collaboration with social protection	-	-	-	-	-	-
Train stakeholders in social protection programmes on good and transformative nutrition practices	-	-	-	-	-	-
Conduct a gender integrated baseline survey/situation analysis on status of nutrition and health for the vulnerable groups in collaboration with the social protection sector	-	288,000	-	-	-	288,000
Advocate for participation of nutrition human resource in social protection programmes	-	-	-	-	-	-
Mobilize financial resources for nutrition interventions in social protection programmes	45,000	45,000	45,000	45,000	45,000	225,000
Sensitize the public and management of institutions of vulnerable persons and correction Facilities on health and nutrition	32,000	64,000	64,000	64,000	64,000	288,000
Promote benchmarking/learning visits for policy makers and implementers in counties with best practices on health and nutrition for vulnerable groups	-	1,250,000	-	-	-	1,250,000
KRA 08: Sectoral and multi-sectoral governance, coordination, legal/regulatory frameworks, leadership, and management strengthened	**717,500**	**1,639,500**	**3,959,500**	**1,334,500**	**1,309,500**	**8,960,500**
Hold bi-annual nutrition stakeholder meetings	180,000	180,000	180,000	180,000	180,000	900,000
Hold quarterly Nutrition Technical Forums at County and Sub-County levels as per TORs	360,000	360,000	360,000	360,000	360,000	1,800,000
Enhance representation of nutrition at other sectoral forums at County	-	-	-	-	-	-
Hold annual nutrition standards and regulation meeting with relevant actors	112,500	112,500	112,500	112,500	112,500	562,500
Participate in development of County strategic plans e.g., CIDP, AWP etc.	45,000	45,000	45,000	45,000	45,000	225,000
Develop a County nutrition strategy and framework for enhancing public–private partnerships	-	305,000	100,000	-	-	405,000
Sensitize private partners on County strategy and framework for enhancing public private partnerships	-	-	135,000	-	-	135,000
Conduct annual nutrition resource tracking and accountability	-	592,000	592,000	592,000	592,000	2,368,000
Map nutrition specific and sensitive partners and stakeholders	-	-	-	-	-	-
Establish a Taskforce for engagement in nutrition legal and regulatory process	20,000	45,000	20,000	45,000	20,000	150,000
Develop annual gender responsive County nutrition resource mobilization strategy	-	-	1,252,500	-	-	1,252,500
Develop nutrition resource tracking and accountability tool at County level	-	-	1,162,500	-	-	1,162,500
Participate in relevant citizen-participation forums while ensuring equal and meaningful participation by men and women across different ages, diversities and levels of influence including representation by women and youth-based organizations to create nutrition awareness	-	-	-	-	-	-
KRA 09: Sectoral and multisectoral Nutrition Information Systems, learning and research strengthened	**14,727,200**	**17,113,100**	**16,814,500**	**19,693,600**	**16,814,500**	**85,162,900**
Conduct nutrition capacity assessment	86,400	86,400	86,400	86,400	86,400	432,000
Adapt and report on nutrition score card to monitor key CNAP indicators quarterly	-	-	-	270,000	-	270,000
Ensure adherence to gender sensitive Nutrition M&E framework within CNAP	422,400	422,400	422,400	422,400	422,400	2,112,000
Develop and review gender responsive nutrition annual work plans (AWPs)	90,000	90,000	90,000	90,000	90,000	450,000
Conduct annual, midterm and end term reviews/evaluation of gender transformative nutrition interventions in the County	45,000	45,000	45,000	45,000	45,000	225,000
Generate and disseminate annual gender sensitive nutrition reports	765,000	765,000	765,000	765,000	765,000	3,825,000
Develop second generation gender responsive costed CNAP	-	-	-	2,310,500	-	2,310,500
Adapt and train on use of nutrition score card to monitor key indicators	1,034,400	1,034,400	1,034,400	1,034,400	1,034,400	5,172,000

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	**14,727,200**	**17,113,100**	**16,814,500**	**19,693,600**	**16,814,500**	**85,162,900**
Conduct gender integrated SMART survey and disaggregate data by sex	-	2,385,900	-	2,385,900	-	4,771,800
Conduct gender integrated MIYCN-KAP survey	-	-	2,087,300	-	2,087,300	4,174,600
Hold forums to disseminate gender integrated findings from SMART, MIYCN KAP and nutrition capacity assessment	118,000	118,000	118,000	118,000	118,000	590,000
Conduct quarterly data review and feedback meetings for gender transformative nutrition activities with sub-counties and health facilities for decision making	960,000	960,000	960,000	960,000	960,000	4,800,000
Conduct quarterly gender sensitive data Quality Audits for KHIS, LMIS and sentinel surveillance for nutrition activities	3,438,000	3,438,000	3,438,000	3,438,000	3,438,000	17,190,000
Print and distribute nutrition M&E tools to health facilities	2,008,000	2,008,000	2,008,000	2,008,000	2,008,000	10,040,000
Procurement of data bundles for uploading reports (nutritionists and HRIO)	40,000	40,000	40,000	40,000	40,000	200,000
Monthly submission of gender sensitive nutrition reports						
Procure laptops for CNC and SCNC and desktops for high level facilities	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	5,500,000
Integrate, capture, and upload gender transformative nutrition activities in the County website	2,000	2,000	2,000	2,000	2,000	10,000
Sensitize male and female nutritionists on data protection sharing guidelines	112,500	112,500	112,500	112,500	112,500	562,500
Sensitize and disseminate Nutrition Coverage Guideline; Data Quality Audit (DQA) Guideline for gender sensitive nutrition indicators; Sentinel Sites DQA Guidelines; MIYCN KAP to CHMTs, SCHMT and other health care workers	180,000	180,000	180,000	180,000	180,000	900,000
Sensitize male and female nutritionists and other health care workers on nutrition related health management and information system (HMIS) indicators	607,500	607,500	607,500	607,500	607,500	3,037,500
Hold quarterly multisectoral nutrition collaboration TWG meetings for gender sensitive nutrition M&E sharing	225,000	225,000	225,000	225,000	225,000	1,125,000
Establish and maintain linkages between national information technical working group (NITWG)						
Advocate for gender integrated nutrition-sensitive and nutrition-specific research at County level	135,000	135,000	135,000	135,000	135,000	675,000
Train male and female nutritionists in gender sensitive research methodologies, knowledge translation and systematic review processes	3,240,000	3,240,000	3,240,000	3,240,000	3,240,000	16,200,000
Hold forums to disseminate any nutrition related research findings and information sharing	118,000	118,000	118,000	118,000	118,000	590,000
Establish gender integrated research repository for nutrition and dietetics at County level	-	-	-	-	-	-
Update and maintain gender integrated research repository for nutrition and dietetics at County level	-	-	-	-	-	-
KRA 10: Advocacy, Communication and Social Mobilization (ACSM) strengthened	**7,467,132**	**7,467,132**	**6,843,012**	**6,843,012**	**6,843,012**	**35,463,300**
Train nutritionists' workforce and other health care workers on nutrition advocacy, communication and writing skills to help them better package information for media	1,206,632	1,206,632	582,512	582,512	582,512	4,160,800
Adapt training package on nutrition for journalists based on simplified messages and key information	107,500	107,500	107,500	107,500	107,500	537,500
Participate in mass media education programme on nutrition	64,800	64,800	64,800	64,800	64,800	324,000
Documentation of best practices and success stories on nutrition	3,697,000	3,697,000	3,697,000	3,697,000	3,697,000	18,485,000
Share best practices and success stories in County, national and international forums	180,300	180,300	180,300	180,300	180,300	901,500
Participate in launch and celebration of international and national thematic days (world breastfeeding week, Malezi bora weeks, etc.)	723,000	723,000	723,000	723,000	723,000	3,615,000
Hold high level nutrition advocacy meetings targeting the County assembly on prioritizing and financing of gender transformative nutrition interventions	381,000	381,000	381,000	381,000	381,000	1,905,000
Identify male and female County nutrition champion and engage them in promotion of gender transformative nutrition activities	37,900	37,900	37,900	37,900	37,900	189,500
Sensitize male and female nutrition champion and influencers on advocacy for gender transformative Nutrition	94,000	94,000	94,000	94,000	94,000	470,000
Sensitize media fraternity on gender responsive nutrition advocacy for better coverage	112,500	112,500	112,500	112,500	112,500	562,500

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 10: Advocacy, Communication and Social Mobilization (ACSM) strengthened	**7,467,132**	**7,467,132**	**6,843,012**	**6,843,012**	**6,843,012**	**35,463,300**
Sensitize communities targeting both men and women across different ages, diversities, and levels of influence through community groups to participate in nutrition resilience building interventions and accountability mechanism	80,000	80,000	80,000	80,000	80,000	400,000
Participate in community dialogue and action days	70,000	70,000	70,000	70,000	70,000	350,000
Print, disseminate and distribute gender transformative BCC materials for nutrition messages	712,500	712,500	712,500	712,500	712,500	3,562,500
Grand Total	**226,612,832**	**327,204,872**	**312,705,227**	**323,608,987**	**314,217,092**	**1,504,349,010**

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

S/NO	NAME	GENDER	DESIGNATION	ORGANIZATION/DEPARTMENT
1.	H.E DAVID KARIUKI	MALE	Ag. COUNTY EXECUTIVE COMMITTEE MEMBER (CECM HEALTH)	HEALTH
2.	ROSALINE KAUGI	FEMALE	Ag. CHIEF OFFICER HEALTH	HEALTH
3.	JOHN NJAGI	MALE	Ag. DIRECTOR PUBLIC HEALTH	HEALTH
4.	ENG. PATRICK WAGANAGWA	MALE	FORMER CECM HEALTH	HEALTH
5.	JERVASIO MBOGO	MALE	CHIEF OFFICER AGRICULTURE & COOPERATIVES	AGRICULTURE
6.	GRACE MURITHI	FEMALE	CHIEF OFFICER GENDER, CHILDREN, CULTURE & SOCIAL SERVICESM	GENDER, CHILDREN, CULTURE & SOCIAL SERVICES
7.	MARY M. KIRINGA	FEMALE	SUB-COUNTY NUTRITION COORDINATOR-MBEERE NORTH	HEALTH
8.	DR. DANIEL NYAGA	MALE	COUNTY PHARMACIST	HEALTH
9.	BRENDA KAUMA	FEMALE	CLINICAL NUTRITIONIST-EMBU LEVEL 5 HOSPITAL	HEALTH
10.	JOHN NJAGI	MALE	COUNTY WASH COORDINATOR	HEALTH
11.	RITA NJIRU	FEMALE	COUNTY REPRODUCTIVE HEALTH COORDINATOR	HEALTH
12.	PAULINE WAITHIRA	FEMALE	COUNTY HEALTH RECORDS AND INFORMATION OFFICER	HEALTH
13.	MONICA KIRUGU	FEMALE	SUB-COUNTY NUTRITION COORDINATOR-MBEERE SOUTH	HEALTH
14.	EMMY NYAGA	FEMALE	SUB-COUNTY NUTRITION COORDINATOR-RUNYENJES	HEALTH
15.	JEREMIAH WANJAU	MALE	COUNTY DIRECTOR EARLY CHILD DEVELOPMENT EDUCATION	ECDE
16.	BEN KENYAGA	MALE	DEPUTY DIRECTOR EDUCATION	MOE
17.	JOSHUA MWANGI	MALE	STATISTICIAN	PLANNING
18.	JACKLINE MUTENDE	FEMALE	COUNTY HOME ECONOMICS	AGRICULTURE
19.	REHEMA IBRAHIM	FEMALE	COUNTY DIRECTOR YOUTH EMPOWERMENT	GENDER, CHILDREN, CULTURE & SOCIAL SERVICES
20.	DAVELYNE MUNDI	MALE	COUNTY COORDINATOR FOR CHILDREN SERVICES	STATE DEPARTMENT FOR SOCIAL PROTECTION
21.	ERICK OMANWA	MALE	ASSISTANT DIRECTOR DROUGHT INFORMATION	NATIONAL DROUGHT MANAGEMENT AUTHORITY-EMBU
22.	MARY KIHARA	FEMALE	SENIOR PROGRAMME OFFICER	NUTRITION INTERNATIONAL
23.	JOAN IRUNGU	FEMALE	COUNTY PROGRAM COORDINATOR	NUTRITION INTERNATIONAL
24.	MERCY W. KITHINJI	FEMALE	COUNTY NUTRITION COORDINATOR	HEALTH