KIAMBU COUNTY NUTRITION

ACTION PLAN (CNAP) 2020/2021-2024/2025

Championing Nutrition agenda towards a malnutrition free County

KIAMBU COUNTY NUTRITION ACTION PLAN (CNAP) 2020/2021-2024/2025

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LIST OF ABBREVIATIONS AND ACRONYMS

ABC	Activity Based Costing
ACSM	Advocacy, Communication and Social Mobilization
ANC	Antenatal Care
AWP	Annual Work Plan
BCC	Behaviour Change Communication
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
BMS	Breast Milk Substitute
CDOH	County Department of Health
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CHC	Community Health Committee
CHIS	Community Health Information System
CHMT	County Health Management Team
CHVs	Community Health Volunteers
CIDP	County Integrated Development Plan
CMEs	Continuous Medical Education
CNAP	County Nutrition Action Plan
CNTF	County Nutrition Technical Forum
CRAF	Common Results and Accountability Framework
CSO	Civil Society Organisation
CUs	Community Units
DQA	Data Quality Assessment
DRNCDs	Diet Related Non-Communicable Diseases
ECDE	Early Childhood Development Education
EMMS	Essential Medicines and Medical Supplies
FAO	Food and Agriculture Organization
FBO	Faith Based Organization
FGD	Focus Group Discussion
GMP	Growth Monitoring and Promotion
HA	Hectares
HACCP	Hazard Analysis Critical Control Point
HB	Haemoglobin
HCW	Health Care Worker
HFC	Health Facility Committee
HIS	Health Information System

HIV/AIDS	Human Immunodeficiency Virus / Acquired ImmunoDeficiency Syndrome
HMT	Health Management Team
HRIO	Health Records and Information Officer
ICCM	Integrated Comprehensive Care for Malnutrition
IDD	Iodine Deficiency Disorder
IEC	Information, Education and Communication
IFAS	Iron Folic Acid Supplementation
IHRIS	Integrated Human Resource Information System
IMAM	Integrated Management of Malnutrition
IMNCI	Integrated Management of Neonatal and Childhood Illness
KAP	Knowledge, Attitude and Practices
KCNAP	Kiambu County Nutrition Action Plan
KDHS	Kenya Demographic Health Survey
KEBS	Kenya Bureau of Standards
KEPH	Kenya Essential Package for Health
KHIS	Kenya Health Information System
KM	Kilometre
KNAP	Kenya Nutrition Action Plan
KNBS	Kenya National Bureau of Statistics
KPHC	Kenya Population and Housing Census
KRA	Key Result Area
LMIS	Logistics Management and Information System
M&E	Monitoring and Evaluation
MAD	Minimum Acceptable Diet
MAM	Moderate Acute Malnutrition
MCT	Mother to Child Transmission
MEAL	Monitoring, Evaluation, Accountability and Learning
MIYCN	Maternal Infant and Young Child Nutrition
MIYCN-E	Maternal Infant and Young Child Nutrition Emergency
MNCH	Maternal, New-born and Child Health
MNPs	Micro-Nutrient Powders
MOH	Ministry of Health
MTMSGs	Mother to Mother Support Groups
NARIG	National Agriculture and Rural Inclusive Growth
NCD	Non-Communicable Disease
NFNSP	National Food and Nutrition Security Policy
NFNSP-IF	National Food and Nutrition Security Policy Implementation Framework
NGO	Non-Governmental Organization
NIPN	National Information Platforms for Nutrition

NITWG	Nutrition Information Technical Working Group
OJT	On-Job Training
OPD	Out-Patient Department
PFM	Public Finance Management
PHO	Public Health Officers
PLHIV	People Living with HIV
PLW	Pregnant and Lactating Women
PPP	Public-Private Partnership
SAM	Severe Acute Malnutrition
SBCC	Social-Behaviour Communication Change
SCHMT	Sub County Health Management Team
SDG	Sustainable Development Goal
SGBV	Sexual Gender-Based Violence
SHEP-PLUS	Smallholder Horticulture Empowerment and Promotion Project for Local and Up-Scaling
SHEP-UP	Smallholder Horticulture Empowerment and Promotion Unit Project
SMART	Standardized Monitoring and Assessment in Relief and Transition
SOP	Standard Operating Plan
SUN	Scaling Up Nutrition
TB	Tuberculosis
TOC	Theory of Change
TOR	Terms of Reference
TWG	Technical Working Group
URTI	Upper Respiratory Tract Infection
USD	US Dollar
WASH	Water and Sanitation Hygiene
WBW	World Breastfeeding Week
WHA	World Health Assembly
WHO	World Health Organization
WIFAS	Weekly Iron Folic Acid Supplementation

FOREWORD

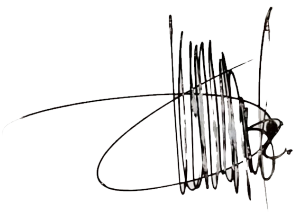
Nutrition is a vital building block in the foundation of human health and development. Good health and nutrition play an important role in boosting economic growth, poverty reduction and the realization of social goals in line with Kenyan Vision 2030.

Investing in good nutrition for all population groups across different ages and diversities is essential in achieving the overall developmental goals for Kiambu County.

Kiambu County Nutrition Action Plan (KCNAP) 2020/21–2024/25 was developed through a widely consultative forum involving all key nutrition stakeholders through a multisectoral process informed by result and evidence-based data. This CNAP is enveloped in line with the Kenya Nutrition Action Plan (KNAP) 2018-2022, anchored to the Kenya Vision 2030 and National Food and Nutrition Security Policy, 2012. Kiambu County recognizes the importance of preventing and reducing malnutrition which is anchored to the County policy documents that highlight the integral role that nutrition plays in ensuring a healthy population and productive workforce. Kiambu CNAP uses a life-course approach, that identifies key nutrition interventions for each age cohort through three areas of intervention, namely nutrition-specific; nutrition-sensitive; and enabling environment with key note on increasing cases of overweight, obesity and non-communicable diseases (NCDs) in the County.

The CNAP development will facilitate mainstreaming of the nutrition budgeting process into County development plans, and subsequently, allocation of resources to nutrition programs. Furthermore, it is anticipated that when fully implemented it will contribute to an improvement in nutritional status for the population of Kiambu.

My office commits to support every effort aimed at fighting all forms of malnutrition and I call upon like-minded partners and stakeholders to join us kick malnutrition out and ensure optimal health of men, women, boys and girls across different ages and diversities in Kiambu County.



H.E JAMES K. NYORO
KIAMBU COUNTY GOVERNOR

PREFACE

The Kenyan Constitution (2010) gives provision for basic nutrition and health of highest attainable standards to all children and adults as a fundamental, economic, social and human right under article 43 (1) (a) "attain highest standards of health including reproductive health", (c) "free from hunger" and (d) "clean and safe water in adequate quantities. Article 53 (c): "(1) every child has the right to: basic nutrition and healthcare'' and (e) ''social security''. Vision 2030 aims to transform Kenya into a globally competitive and prosperous nation with a high quality of life.

High levels of malnutrition remain a public health concern and a hindrance to achieving County development with under nutrition (underweight, stunting and wasting), overweight and obesity, micronutrient deficiencies and Non-Communicable Diseases (NCDs), contributing to increased economic burden which slows down the development of the County.

Kiambu County though reported in KHDS 2014 to have low levels of malnutrition with stunting at 15.7%, wasting at 2.3% and underweight at 5.1%. The County has pockets of malnutrition with rising numbers of informal settlements and increasing population over the years. Kiambu County with a population of 2.4 million has 21% being under 15 years, translates to high numbers of children with malnutrition despite the low percentages.

The Kiambu County Nutrition Action Plan (KCNAP) 2020/21–2024/25 is the first action plan in the County. This CNAP articulates clear roles and responsibilities of different sectors and seeks to address the triple burden of malnutrition. The KCNAP will be used as a document for financing nutrition interventions with a focus on domestic financing for sustainability of Nutrition programmes in the County.

The Department of Health in the County renews its commitment to provide leadership that creates an enabling environment and political goodwill that will facilitate the implementation of the Kiambu County Nutrition Action Plan 2020/21-2024/25.

DR. JOSEPH MUREGA
COUNTY EXECUTIVE MEMBER OF HEALTH

ACKNOWLEDGEMENT

The process for development of the Kiambu 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 this CNAP. The Kiambu 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 Kiambu 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, and Hannah Mburu for their immense technical leadership in the entire development process of the Kiambu 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, 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 KCNAP are also appreciated: National Government Ministry of Education (MOE), Ministry of Agriculture, Livestock and Irrigation, Ministry of Finance and Planning and Gender and Social Services and the support from the County government through the Ministry of Health.

The participation and contribution of the County Executive Committee Members (CECM), Chief Officers Medical and Public Health, the County Health Management Teams (CHMTs), other Health Programme coordinators and Sub-County Nutrition Coordinators (SCNCs), Nutrition Officers and the County Nutrition Coordinator, Rachael Wanjugu, for the overall leadership during the development and validation of the Kiambu CNAP.
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 immerse immense technical support throughout the whole CNAP development process.

Dr. Patrick Nyaga
CHIEF OFFICER OF HEALTH

1 INTRODUCTION

1.1 Background information

1.1.1 Location and size

Kiambu County is one of the 47 counties in the Republic of Kenya. It is in the Central Region and covers a total area of 2,543.5 Km2 with 476.3 Km2 under forest cover. The County is 40% rural and 60% urban owing to Nairobi's consistent growth. The County borders Nairobi and Kajiado counties to the South, Machakos to the East, Murang'a to the North and North East, Nyandarua to the North West, and Nakuru to the West. The County lies between latitudes 00 25'and 10 20'South of the Equator and longitude 360 31'and 370 15'East. Administratively, the county is subdivided into twelve sub counties (Figure 1) and sixty wards.

Figure 1: Map of Kiambu County showing the administrative wards

1.2 Population distribution

According to the 2019 Kenya Population and Housing Census, the total population in the county stood at 2,417,735 persons of which 1,187,146 are males, 1,230,454 females and 135 intersex persons with a growth rate of 1.6%. There are 796,241 household with an average household size of 3.0 persons per household and a population density 952 people per square Kilometre.

Table 1: Distribution of population by sex and Sub-County

KIAMBU	MALE	FEMALE	INTERSEX	TOTAL
Gatundu North	54,189	55,678	3	109,870
Gatundu South	60,384	61,714	5	122,103
Githunguri	82,037	83,187	8	165,232
Juja	148,446	152,480	22	300,948
Kabete	97,794	101,845	14	199,653
Kiambaa	115,690	120,695	15	236,400
Kiambu	69,661	76,225	17	145,903
Kikuyu	90,919	96,198	5	187,122
Lari	67,061	68,238	4	135,303
Limuru	79,632	79,682	-	159,314
Ruiru	180,947	190,144	20	371,111
Thika East	19,688	19,264	4	38,956
Thika West	120,698	125,104	18	245,820
TOTALS	**1,187,146**	**1,230,454**	**135**	**2,417,735**

Source: (KPHC, 2019)

1.2.1 Population segmentation in health

Segmentation is grouping the local population by what kind of care they need as well as how often they might need it. It divides populations into distinct groups with different characteristics, for which intervention programmes can be designed.

This can be used to help understand the specific needs and provide detailed insights of the population across different gender, age and diversities to inform design and delivery of services responsive to the specific nutrition and health needs for men and women across different age and diversities. Tailoring interventions to specific segments, is the best way of ensuring the most effective use of resources.

In Kiambu County, the proportion of the different population cohorts differ across different sub counties e.g. the urban sub counties have younger population compared to the rural sub counties. The categorization of the cohorts in the table below is very critical in planning for various health care services as different cohorts have different nutrition and health related needs.

Table 2: Population segments in Kiambu County

	Description	Population segment estimates	County projected population
1	Total population in the county		2,476,788
2	Number of households		495,358
3	Children under one year (12 months)	2.44%	60,397
4	Children under five years (60 months)	11.50%	284,810
5	Under fifteen-year population	31.1%	770,281
6	Women of childbearing age (15 – 49 years)	29.62%	733,738
7	Estimated number of pregnant women	2.7%	66,873
8	Estimated number of deliveries	2.60%	64,396
9	Estimated live births	2.50%	61,920
10	Number of adolescents (15-24)	20%	491,560
11	Adults (25-59)	38.3%	948,971
12	Elderly (60+)	5%	133,592

Source: (KPHC Vol III, 2019)

1.3 County health facilities

There is a total of 505 health facilities distributed across the county; 108 are public, 64 are faith based and 333 are private health facilities. The County health system is structured along five levels of care that are guided by the Kenya Essential Package for Health (KEPH).

These levels are Level 1 - Community Health Services; Level 2 –Dispensaries; Level 3 - Health Centre's; Level 4 – Primary Hospitals; and Level 5 – Secondary Hospitals (County Referral Hospitals).

The County Government owned facilities include 3 Level 5 hospitals, 11 Level 4 hospitals, 24 health centres and 70 dispensaries. Most of these facilities are accessible as the county is served by a fair road network and the average distance to the nearest health facilities from households is estimated to be 7kms. The recommended standard is 5kms. The County public facilities are served by a total 2,652 health care workers.

The distribution of health staff indicates that the sub-counties that host Level 5 hospitals – Thika Town, Kiambu Town and Gatundu South – account for most of the staff at 25%, 16% and 12% respectively. Thika Town sub-county has 86 facilities (17%), the highest, followed by Ruiru with 55 (11%), and Kiambu Town with 45 (9%). The sub-counties with the lowest number are Gatundu North and Gatundu South with 21 (4%) and 24(5%) respectively.

Table 2: Population segments in Kiambu County

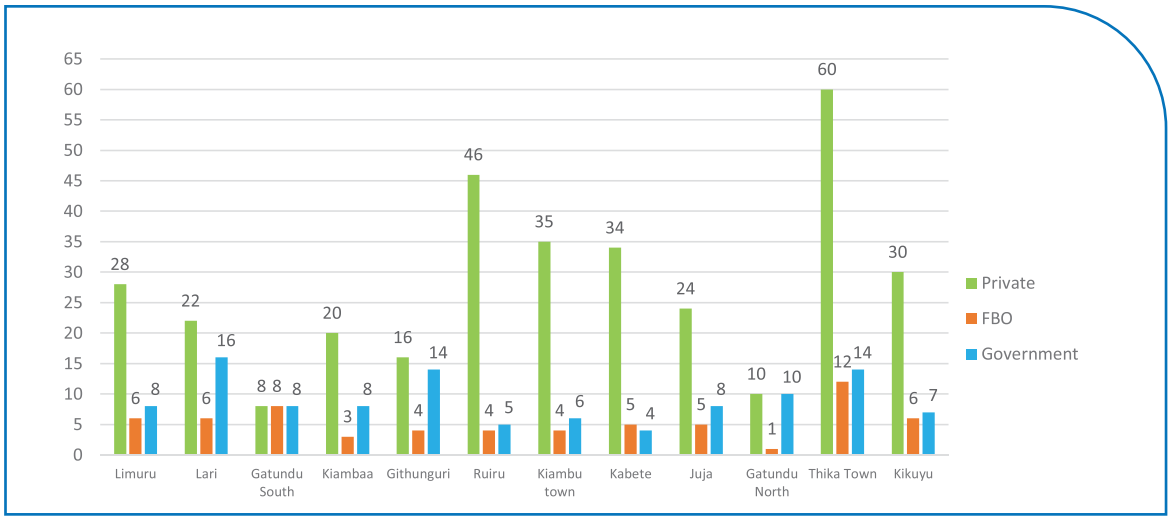


Figure 2: Distribution of Health facilities across the sub counties in Kiambu County

Source: Kiambu County CHSSP 2019-2023

1.4 Health care service utilization

Health care service utilization refers to the equitable access to and use of health care services by the population responsive to their specific age, gender, and diversity health needs. Individuals use health care for many reasons including preventing and curing health problems as well as promoting maintenance of health and well-being or obtaining information about their health status and prognosis.

It is worth noting that the sub-counties with level 5 and 4 health facilities recorded the highest utilization rates, with Thika town registering the highest utilization rate. The county had an average of 97% utilization rate.

Table 3: Health care service utilization in the County

	Sub-county/Constituency	Population at beginning of FY	Number of new outpatients (past twelve months)	Outpatient utilization per person
	(A)	(B)	(C)	(D = C/B X 100)
1	Gatundu North	109,870	107,247	97.6
2	Gatundu South	122,103	136,031	111.4
3	Githunguri	165,232	152,168	92.1
4	Juja	300,948	199,876	66.4
5	Kabete	199,653	124,818	62.5
6	Kiambaa	236,400	177,475	75.1
7	Kiambu	145,903	298,961	204.9
8	Kikuyu	187,122	93,506	50.0
9	Lari	135,303	127,627	94.3
10	Limuru	159,314	205,890	129.2
11	Ruiru	371,111	270,422	72.9
12	Thika Town	284,776	516,291	181.3
	COUNTY TOTALS	**2,417,735**	**2,410,312.00**	**99.7**

Source: Kiambu County Annual Development Plan (FY 2020-2021)

1.5 National nutrition situation

Kenya is on course to meet the global targets, but still experiencing malnutrition burden among its under-five population. It has witnessed an improvement in the nutritional status of children with stunting declining from 35% in 2008-9 to 26% in 2014, wasting from 7% to 4% and underweight from 16% to 11%. Despite the reduction in childhood under nutrition, there are regional disparities with some counties having lower levels of stunting at 15%, while others have higher levels of stunting at 45%.

Under micronutrient deficiencies, Zinc deficiency has been noted to be highest. Anaemia prevalence is also high, with the highest prevalence seen among pregnant women at 41.6% and children 28.3%. Nationally, infant, and young child practices indicated that, 61 percent of mothers exclusively breastfeed their babies for the first six months while 62 percent were able to initiate breastfeeding within one hour after birth. Only 22% of children aged 6-23 months were able to consume a Minimum Acceptable Diet (MAD) (KDHS, December 2014).

A total of 28% of adults aged 18–69 years are either overweight or obese, with the prevalence in women being 38.5% and men 17.5. The proportion of women who were overweight or obese increased from 25% to 33% and those who were obese increased from 7% to 10% as per (KDHS, December 2014). 95% of adults aged 18–69 years did not consume the WHO daily recommended five servings of fruits and/or vegetables; fruits were consumed on average about 2.4 days in a week, and vegetables were consumed five days in a week. Approximately 20% 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.

1.6 Nutrition status Kiambu County

Malnutrition remains a big challenge across the county with the three forms of malnutrition evident across the County including undernutrition (underweight, stunting and wasting), micronutrient deficiency, and overweight & obesity. over nutrition among the women of reproductive health in the County was reported at fifth in the country (KDHS, December 2014). The County is 40% rural and 60% urban. Urban expansions and related benefits are uneven, and as a result, children in marginalized urban settings confront daily challenges and deprivations of their rights. Both acute and chronic food insecurity and undernutrition amongst the urban poor, especially children under 5 years of age, is a consequence.

Gender roles and responsibilities between men and women resulting to overburdening maternal workload for women and girls, with limited community and male support lead to limited time for women and girls of reproductive age, especially Pregnant and Lactating Women (PLWs) to practice optimal care and feeding practices for themselves and their young children (FAO-UN, 2017).

There has been an increase in informal child day care centres for mothers working casual jobs in flower farms, industries, tea and coffee estates. These day-care centres usually operate within people's homes. They are crowded, have poor hygiene, and offer children very little stimulation. Facilities like this put children at risk of malnutrition, infections, child abuse and delayed development.

Research findings from a study conducted by the University of Nairobi (African Women's Studies Centre) in 2014, showed that 8.4 % of the households in Kiambu went all day without food, while 6% slept at night hungry because there was not enough food. On average, 7% were severely affected by hunger in the county. In terms of food access, the research findings showed that 15.9% of the households worried that they would not have enough food (African Women's Studies Centre & KNBS, 2014).

1.6.1 Under nutrition

Good nutrition is a prerequisite for the county development and for the well-being of individuals. Adequate nutrition is critical to children's growth and development, and its importance is articulated in the Constitution of Kenya (2010), recognizing adequate food and nutrition as a human right (Article 43), and that every child has the right to basic nutrition (Article 53). Kiambu County has 252,770 children under five years, with stunting level according to (KDHS, December 2014) at 15.7%, wasting at 2.3% and underweight at 5.1%, while the national stunting level is at 26%, wasting at 4%, and underweight is at 11%. The projected global 2025 targets are to reduce stunting by 40%, reduce and maintain childhood wasting to less than 5%, reduce low birth weight by 30% and to ensure that there is no increase in childhood overweight.

Although these levels are below the national average, the triple burden of malnutrition is still being felt, with variation among the urban, peri-urban, and rural populations of the county. The urban poor population was reported to be more vulnerable.

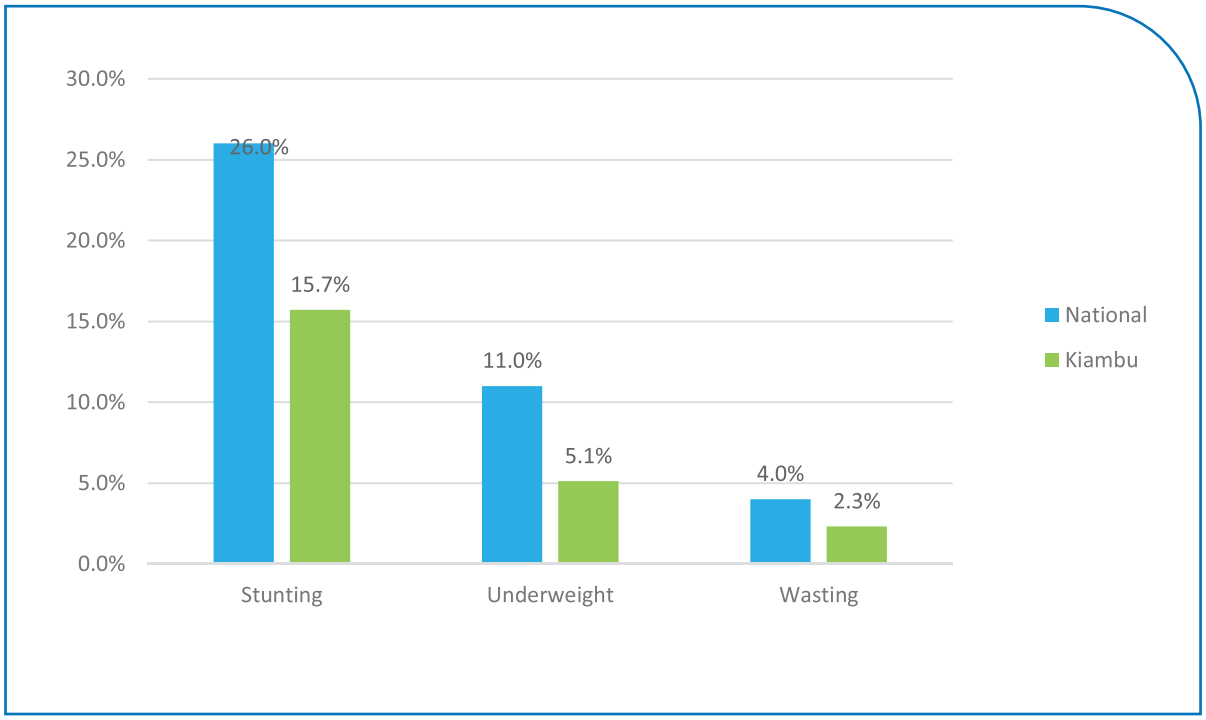


Figure 3: Nutrition status of the children

Source: (KDHS, December 2014)

1.6.2 Micronutrient deficiencies

In Kiambu, just like other counties in Kenya, malnutrition is one of the major causes of mortality and morbidity. Malnutrition resulting from micronutrient deficiencies (MNDs) such as Vitamin A, Zinc, Iron, and Iodine deficiencies are attributed to poor nutrition and health of the population.

Several measures have been put in place to address micronutrient deficiencies but still there is need to upscale the coverage. Routine vitamin A coverage for children under five years is at 91.5% (KHIS, 2020), while IFAS coverage among pregnant women is at 74.3% (KHIS, 2020). The proportion of women with low haemoglobin levels in pregnancy is at 21.3% (14,244) (KHIS, 2020). Low and late ANC attendance continue to cause a challenge in IFAS supplementation as well as inadequate knowledge on maternal nutrition.

Strategies to combat micronutrient deficiencies include micronutrient supplementation, nutrition education both at the health facilities and at the community level, food fortification and promotion of indigenous and diversified crops at household level. 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 have an 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, which in effect has a great impact on maternal and infant and young children care and feeding practices. Additionally, cultural norms, beliefs and practices affect maternal, infant, and young children feeding practices such as consumption of diversified foods through use of locally available and affordable nutritious foods for enhanced micronutrient intake. Different levels of knowledge on nutrition among men and women across different ages and diversities, further greatly determines the level of support given especially by men and other key influencers within communities on nutrition matters. This is key in prompting increased uptake of optimal nutrition and health care practices by women and children in the County. For example, men and other community influencers need to understand the importance of Iron and Folic acid supplementation among pregnant women so they can support early initiation of antenatal care. There is a need to bring the community leaders of both genders and other stakeholders on board as change agents through training, community participation and use of evidence-based approaches.

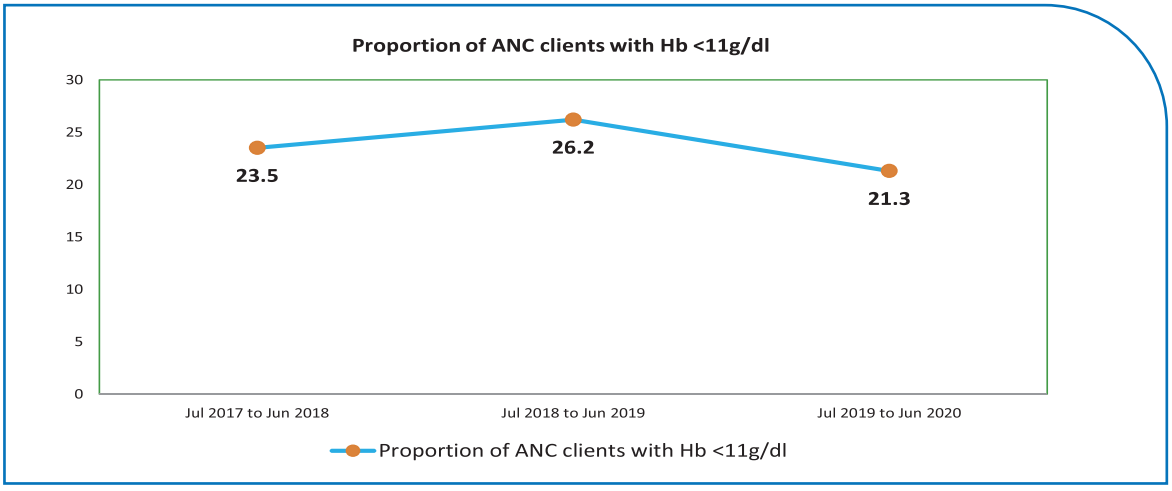


Figure 4: Proportion of ANC clients with HB <11g/dl

Source: (KHIS, 2020)

1.6.3 Deworming

Soil-transmitted helminth infections are widespread. Deworming is an important measure in controlling the parasite, in order to prevent anaemia. WHO recommends that children in developing countries exposed to poor sanitation and poor availability of clean safe water be dewormed once every 6 months. In order to reduce the effects of the worm and improve the overall nutrition and health status of the children, it is important to ensure that children are dewormed regularly.

However, there has been an erratic supply of the dewormers as well as reporting tool challenges. A coordinated approach of all stakeholders will be key in improving this indicator.

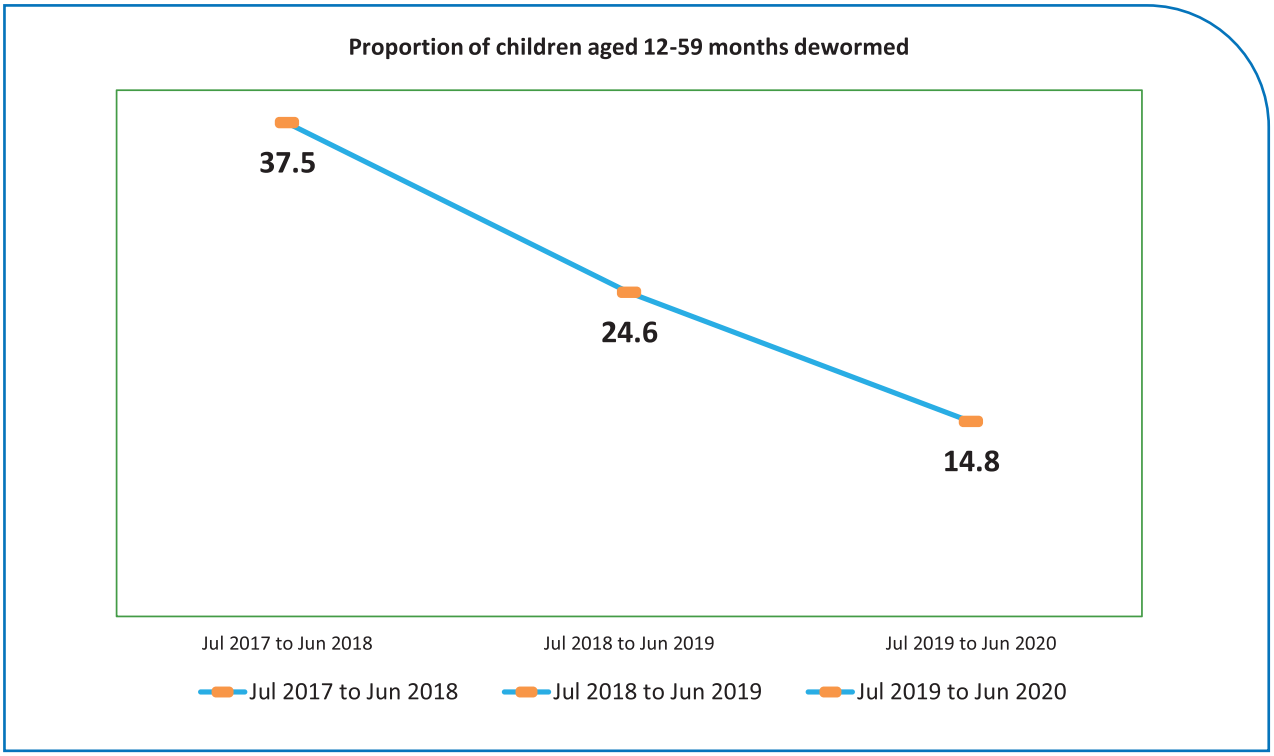


Figure 5: Proportion of children aged 12-59 months dewormed

Source: (KHIS, 2020)

1.7 Mortality and morbidity rates

The common illnesses affecting the residents of Kiambu County are communicable diseases, though the non-communicable diseases are on rise. This is contributed by the climatic change (communicable diseases) and lifestyle (non-communicable diseases).

URTIs are the commonest health conditions both in under and above five years old. Hypertension is the commonest non-communicable disease. Road Traffic Accidents contribute to 0.5 % of the OPD cases. Additionally, Gender-based violence (GBV) as a violation of human rights, not only have grievous consequences on people's health, emotional and mental wellbeing, but also largely affects women and girls in their productive and reproductive years, compromising their capacity to be productive workers, earners, caregivers, thus reinforcing the vicious cycle of poverty and jeopardizing food and nutrition security.

SGBV stands at 0.05 % in the county and continues to be rising to worrying levels raising concern among lawmakers and humanitarian organizations. Data compiled from national hotline 1195 shows that Kiambu has the third highest rates of SGBV incidences after Nairobi and Kisumu counties. Maternal deaths are still high at 78/10,000 live births as per KDHS, 2014. HIV/AIDs prevalence, especially Mother to Child transmission (MCT) is still high at 6.2 % as per Kenya AIDs Indicator Survey (KAIS), 2012.

1.8 Agriculture and food access

The Department of Agriculture promotes sustainable agriculture through capacity building on agricultural productivity, food and nutrition security, value addition, marketing, extension, and infrastructural development. Its functions include crop and animal husbandry, livestock sale yards, county abattoirs, plant and animal disease control and fisheries.

The average holding size of land in the county is approximately 0.36Ha. Therefore, crop and animal production are mostly small scale due to subdivision of land into small units such that most of the food produced is for immediate consumption and often inadequate. The main food crops are maize, beans, Irish potatoes, bananas, and vegetables, while milk and poultry products are main animal products. Notably, maize which is the staple food is mainly imported from other counties. The farmers also grow industrial crops for income such as coffee, tea, pyrethrum, macadamia nuts, major vegetables including French-beans, snow peas, kales, cabbage, garden peas, tomatoes, spinach, and carrot. Selected high value herbs and spices are also grown by some farmers for income generation. The main fruits grown are pineapples, mangoes, and avocadoes.

Despite the broad agricultural opportunities and ready market for agricultural produce, optimum productivity is challenged by several factors. These include limited availability of productive land as a major constraint to increased agricultural production with only about 21,447 Ha under food crops and 35,367.41 Ha under industrial crops. Although over 85% of farmers have land titles which may signify stability, there are pockets of landless people especially generation of families who have worked in the tea and coffee plantations who are prone to incidences of food insecurity.

Gender equality and women empowerment is an important and long overdue stimulus to a more inclusive human development and accelerated economic growth. In as much as women contribute close to 80% labour in crop production they lack ownership and control of productive assets such as land which impacts on their ability to influence and control nutrition and food security in the households (National Policy on Gender and Development, 2019), It should however be recognized that no meaningful and sustainable success in the fight against poverty in both urban and rural areas is achievable without appreciating the roles and contribution by both women and girls in the County. This CNAP therefore advocates for meaningful and adequate inclusion of women and girls in all agricultural development activities in the County. Youth currently constitute 29.1% of the total population (Kiambu County Annual Development Plan, 2019/20). Limited involvement of youth in gainful employment and economic participation as well as their exclusion and marginalization from decision making process and policies is a threat to the stability not only to the county but the entire nation.

Additionally, Kiambu County is dependent on rain for agriculture but with an irrigation potential of over 30,000Ha that has not been tapped. Notably, intensified irrigation can increase agricultural productivity fourfold and incomes can be multiplied.

This could improve food security below the recorded average level of food insecurity in the county of 6% (KNBS & UON, 2014). The county is relatively food secure but nutritional value seems not well considered leading to a manifestation of hidden hunger. This can be prevented and/or reduced through strategies to equally train and engage men and women across different ages and diversities on climate-smart sustainable gardening technologies, rearing of small livestock coupled with irrigation and or household used water treatment, enhancing their knowledge on the nutritional value of under-utilized traditional foods, recipes and preparation methods, including sustainable income-generating activities. This will go a long way in realizing increased food security and improved dietary diversity, as well as increased purchasing power of households, enhanced asset building mechanism, access to market and financial facilities.

The following ongoing projects could be a good avenue for implementation of gender responsive and transformative nutrition related activities

- SHEP-UP: horticulture
- SHEP-PLUS: horticulture
- FAO: Increased farm productivity
- Promotion of Enriched beans
- Irrigation Project
- NARIG (World Bank): Increased farm productivity
- Promotion of indigenous crops
- Promotion of local poultry
- General extension

However, due to unintegrated planning by both agriculture and nutrition sectors, the benefits may be limited. Effective collaboration and partnership through joint planning, implementation, monitoring, and evaluation is highly recommended to achieve common good as captured within the CNAP. Additionally, Covid-19 pandemic has limited the interaction between farmers and extension staff.

1.9 Education and nutrition

The County has a total population of 108,777 children falling within the age group of 3 to 5 years (Pre-school). The total number of ECDE teachers is 5,370 with public centre's having 1,200 ECDE teachers. The teacher to pupil ratio is 1:28. 33,287 pupils have been enrolled in public ECDE comprising 16, 940 males and 16,347 females while private ECDE centres have total enrolment of 75,490. The gross enrolment rate is 71.70% with completion rate retention and transition rate at 95%. There are 98 schools for pupils with special needs where 3,163 pupils have been enrolled.

There is good solid evidence that children who are hungry are not able to focus, so they have a low attention span, behavioural and discipline issues in the school. Having children who are well-fed makes a difference in their individual performance, and how much they are contributing to or disrupting the classroom situation. However, finding the most efficient and effective ways to help get children the nutrients they need involves parsing through complex and interconnected issues like poverty, accessibility, and nutrition.

Pre-school and school children face many health challenges, such as pneumonia, malaria, measles, micro and macronutrient deficiencies. These young children frequently suffer from one or several of these problems concurrently., Health and nutritional programmes focusing on this age group are necessary and requires to be implemented at scale. Many of these diseases and deficiencies are preventable among the pre-school and schoolchildren who bear the greatest burden and at the same time among the most vulnerable groups within the population.

School health and nutrition interventions have the potential to improve equity in education by helping girls and boys from low-income families to attain good (or at least some) education. Some of the interventions articulated within this document includes, Vitamin A supplementation, deworming, nutrition assessment and referrals to link health facilities as well as promotion of safe nutritious food within the school environments.

1.10 The National Treasury and Planning

Through the Strategy for Public Financial Management Reforms 2013-2018, implementation guidance on macro-economic management and resource mobilization in line with macro-economic and fiscal policies on strategic planning and resource allocation are provided. The strategy aims to ensure effective and equitable allocation of public funds in line with national and county government priorities including for food and nutrition security and universal health coverage. This CNAP document will be used as an advocacy tool for resource allocation to nutrition department.

1.11 Water, Sanitation and Hygiene & nutrition

Access to clean and safe water is foundational to the development of any community. Kiambu County is endowed with both surface and ground water resources. There is evidence which indicates that access to safe drinking-water, sanitation, and hygiene (WASH) services has an important positive impact on nutrition. The county has sixteen permanent rivers originating from the Aberdare Ranges, which is the main water tower for the County. The County enacted the Water and Sanitation Services Act, 2015 with one of the goals being to ensure availability of water for irrigation and other agricultural purposes.

The World Health Organization (WHO) estimates that 50% of malnutrition is associated with repeated diarrhoea or intestinal worm infections as a result of unsafe water, inadequate sanitation, or insufficient hygiene. Insufficient, unsafe water at household level has many indirect effects on child care and feeding practices especially for women and children, as a result of more time being spent covering long distances in search for water, coupled with traditional roles placing household hygiene and sanitation as a women's responsibility. Where safe water is available to purchase from vendors, a limited quantity leaves little for good hygiene practices. Further, the time wasted collecting water or suffering from water-related illnesses prevents young people, and particularly girls from getting an education, which has a significant impact on their health, well-being and economic status.

This CNAP has articulated how nutrition will be integrated into WASH activities and vice versa with an aim of reducing malnutrition to contribute to achieving global nutrition targets by 2025 as well as Vision 2030.

1.12 Social Service, Youth, Gender & nutrition

Pre-school and school children face many health challenges, such as pneumonia, malaria, measles, micro and macronutrient deficiencies. These young children frequently suffer from one or several of these problems concurrently., Health and nutritional programmes focusing on this age group are necessary and requires to be implemented at scale. Many of these diseases and deficiencies are preventable among the pre-school and schoolchildren who bear the greatest burden and at the same time among the most vulnerable groups within the population.

School health and nutrition interventions have the potential to improve equity in education by helping girls and boys from low-income families to attain good (or at least some) education. Some of the interventions articulated within this document includes, Vitamin A supplementation, deworming, nutrition assessment and referrals to link health facilities as well as promotion of safe nutritious food within the school environments.

1.13 Human resource for nutrition

Health and nutrition are one of the important components of human resource development. The relationship between health-nutrition and human resource development is reciprocal and takes a cyclical pattern. There has a been a progressive employment of nutritionists from 22 in 2014 to 55 in 2020. Despite this, there are currently inadequate nutrition staff deployed in hospital and community level. Additionally, there is need for training on clinical nutrition specialties to offer services in these units as well as public health nutrition services including community nutrition as per the human resource norms and standards for the Ministry of Health (IHRIS, 2019).

On a positive note 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.

1.14 Constraints within the nutrition department

Table 4: Constraints

Category	Constraints
Political	Inadequate allocation of funds
	Low budgetary allocation for nutrition
	Increased unemployment
	High poverty level in some areas within the county
	Reducing donor support
	Low level of education
Coordination	Poor coordination structures and referrals within another relevant department
	Inadequate community units
	Uncoordinated nutrition activates across various units in health
Harmful practices	Increased alcohol and drug abuse
	Increased gender-based violence affecting women and girls in their productive and reproductive years, compromising their capacity to be productive workers, earners, caregivers, thus reinforcing the vicious cycle of poverty and jeopardizing food and nutrition security.
Capacity	Inadequate capacity of staff in terms of knowledge & skills
	Inadequate space for nutrition activities within the health facilities
	Inadequate equipment's for nutrition assessment
	Inadequate capacity among nutrition and health related staff on the nexus between gender equality, socio-economic, cultural factors and nutrition including effective gender integration in nutrition –health related policies and implementation
	Inadequate advocacy, communication, social mobilization (ACSM) in the community
Disease burden	Upsurge of non-communicable diseases
	Increasing trend of malnutrition
KAP	Sedentary lifestyles behaviour among the population
	Poor eating habits among the population especially adolescents, under five years and lactating mothers among others
	Poor health seeking behaviour among most community members
	Ignorance and knowledge gap on nutrition
Gender	Inadequate gender integration in nutrition assessments, surveys/research to identify social and non-medical factors Inconsistent collection and use of sex-age disaggregated nutrition data leads to lack of evidence-based decision making for enhanced transformative nutrition programming.
Supply	Insufficient nutrition commodities
Human resource	Inadequate staffing as per the WHO staffing norms & standards

2 COUNTY NUTRITION ACTION PLAN (CNAP) FRAMEWORK

2.1 Introduction

The County Nutrition Action Plan is designed to accelerate and scale up efforts towards the elimination of malnutrition as a problem of public health significance in Kiambu county and in Kenya by 2030. The three basic rationales for the action plan are: (a) the health consequences – improved nutrition status leads to a healthier population and enhanced quality of life; (b) economic consequences – improved nutrition and health is the foundation for rapid economic growth; and (c) the ethical argument – optimal nutrition is a human right.

Child undernutrition remains a persistent threat to the lives of Kenyan children, particularly those under five years. Access to good nutrition plays a fundamental role in stimulating economic growth and development. Malnutrition in childhood and pregnancy has many adverse consequences for child survival and long-term well-being. A healthy population means a productive economy.

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. Childhood malnutrition increases the risk of infections, morbidity, and mortality in conjunction with cognitive development. This result in far-reaching consequences for human capital, labour productivity, and is a major obstacle in the attainment of the overall goal of economic development.

On the other hand, when women and men across different ages and diversities are empowered to claim their rights, it leads to improved health and nutrition for themselves and a better quality of life for their families and communities. When women are empowered as health care givers, as mothers, and/or community decision-makers, they are better able to share their first-hand knowledge, collectively discuss and act on existing nutritional barriers and engage in local health agendas.

Men on the other hand have many roles in society, as fathers, partners, brothers, teachers, health care providers and leaders. Promotion of 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, women's empowerment, and nutrition in the short and long term.

Improving nutrition is 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 USD8 and USD138, (WORLD BANK, April 2016) which is a cost–benefit ratio of around 1:1, similar to that of infrastructure development like roads, railways and electricity.
Success in elimination of child malnutrition in Kiambu will depend on successful partnership and strategic investments in nutrition actions by the national and county government, development partners, private sector, and other non-state actors. The partnerships should leverage on coordinated effort given the limited financial resources.

2.2 CNAP vision

Kiambu County free from malnutrition

2.3 CNAP mission

To reduce all forms of malnutrition in Kiambu county using well-coordinated multisectoral and community-centred approaches for optimal health of men, women, boys and girls across different ages and diversities and the county's economic growth.

2.4 Core values and guiding principles

In our commitment to provision of high-quality nutrition and dietetic care services; we are guided by the following set of values

- Integrity
- Professionalism
- Innovation and excellence
- Safety
- Accountability
- Partnership
- Teamwork and collaboration
- Ethics
- Gender transformative approach
- Efficiency and effectiveness
- Quality
- Risk management
- Sustainability and ownership

2.5 National policy and legal framework for Kiambu CNAP

The County has a huge responsibility of ensuring the communities have access to good quality health care and live a healthy life. To achieve the aspirations of the Constitution and Vision 2030, Kenya has given legislative force to some key aspects of nutrition interventions. These include prevention and control of Iodine Deficiency Disorders (IDD) through mandatory salt iodization, and control of other micronutrient deficiencies by mandatory food fortification of cooking fats and oils and cereal flours, through the Food Drugs and Chemical Substances Act.

The benefits of breastfeeding are protected through the Breast Milk Substitutes (Regulation and Control Act) 2012. The Food, Drugs and Chemical Substances Act (food labelling, additives, and standard (amendment) regulation 2015 on trans fats) is also key legislation central to the control of DRNCDs.

Additionally, the nutritionists and Dieticians Act 2007 (Cap 253b) has been set up to determine and set up a framework for the professional practice of nutritionists and dieticians; set and enforce standards of professional practice and ethics on nutrition and dietetics; enforce a programme of quality assurance for the nutrition and dietetic profession; research into and provide public education on nutrition and dietetics; and design programs and methods for sensitization on suitable dietary and nutritional habits through capacity-building, competency oriented trainings and specialization in nutrition service delivery policy coherence and alignment between different spheres of policy making is important.

The KNAP 2018–2022 which applies a multisectoral approach and promotes cross sectoral collaboration to address the social determinants of malnutrition sustainably adds to a series of strategic national policy actions that Kenya has taken in the last decade to improve the food and nutrition security of all Kenyans. This CNAP is aligned to National Food and Nutrition Security Policy (NFNSP) and its implementation framework (NFNSP-IF) 2017-2022. The NFNSP's main objective is that "all Kenyans, throughout their life-course enjoy safe food in sufficient quantity and quality to satisfy their nutritional needs for optimal health". Using the life-course approach, the policy identifies key nutrition interventions for each age cohort and provides the linkages of nutrition to food production and other relevant sectors that impact on nutrition and health.

Considering devolution and the functions ascribed to the two levels of government, the Kenya Nutrition Action Plan (KNAP) 2018–2022 provides an umbrella framework and guidance for counties like Kiambu, to develop their own County Nutrition Action Plans (CNAPs).

2.6 Rationale

The over-arching direction for nutrition sector planning in Kenya was guided by the Vision 2030, which is the long-term development plan for the country, aiming at creating "a globally competitive and prosperous country with a high quality of life by the year 2030"; and the overall global health and nutrition agenda as entrenched within the Constitution of Kenya 2010. Positioning nutrition interventions as a top priority for development and poverty reduction is paramount. This has been a big gap across the country and the need to develop a county specific nutrition action plan thus becomes of importance. Undernutrition is a major contributor to child mortality and leads to a significant loss in human and economic potential.

The action plan brings in different stakeholders to one common platform to discuss nutrition and emerging key nutrition issues. This Action Plan will be used as a resource mobilization tool by nutrition stakeholders and a guide to investment to cost effective and transformative nutrition interventions.

2.7 Kiambu CNAP objectives/purpose

The objective of the Kiambu CNAP is to accelerate and scale up efforts towards the elimination of malnutrition in Kiambu in line with Kenya's Vision 2030 and sustainable development goals, focusing on specific achievements by 2022. The expected result or desired change for the CNAP is that 'All Kenyans, women, men, boys, girls and children, achieve optimal nutrition for a healthier and better quality of life and improved productivity for the country's accelerated social and economic growth.

2.8 CNAP development process

The development of the Kiambu CNAP 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 Ministry of Education (MOE), Ministry of Agriculture, Livestock and Irrigation, Ministry of Finance and Planning and Gender and Social Services and the support from the County government through the Ministry of Health. The process also ensured that the Kiambu CNAP 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.

2.9 Target audience for CNAP

The target audience includes health care planners and policy makers at both national and county level, global and national decision makers, nutrition-sensitive sectors, nutrition officers and managers at all levels, donors, development partners, NGOs, civil society organizations, faith-based organizations, the private sector, academia, research institutions, the media and the Kiambu public at large. This will enable them to understand what the county government is doing to ensure optimal nutrition for Kiambu population and what they can do individually to contribute to the effort.

3 KEY RESULT AREAS (KRAs), OUTCOMES AND ACTIVITIES

3.1 Introduction

The overall expected result or desired change for the CNAP is to achieve optimal nutrition for the entire Kiambu population (men, women, boys and girls across all ages and diversities) thus, healthier and better quality of life and improved productivity for accelerated social and economic growth. To achieve the expected result, a total of 11 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 5: List of the Kiambu CNAP Key Result Areas (KRAs)

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, adolescents, adults, and older persons promoted
	3.Prevention, control, and management of Micronutrient Deficiencies scaled-up
	4.Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) in the life course scaled-up
	5.Clinical nutrition and dietetics in disease management including HIV and TB strengthened
	6.Integrated management of malnutrition and nutrition in emergencies strengthened
Nutrition sensitive interventions	7.Promote and scale up nutrition in nutrition sensitive sectors (Agriculture, Education (ECDE), WASH and Social Protection
Enabling environment interventions	8.Sectoral and multi-sectoral nutrition governance, coordination and legal/regulatory frameworks strengthened
	9.Sectoral and multi-sectoral nutrition information systems, learning and research strengthened
	10.Advocacy, Communication and Social Mobilization (ACSM) strengthened
	11. Supply chain management for nutrition commodities and equipment strengthened

3.2 Theory of change

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 3.1), defines long-term goals in this case realizing a Kiambu County free from malnutrition by using well-coordinated multisectoral and community-centred approaches. 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 Kiambu 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 11 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 Kiambu residents.

The logic framework outlining the key elements and process used to integrate "ToC" in the Kiambu CNAP development is captured in Figure 3.1. The expected outcomes expected outputs and priority activities in line with the process logic have been discussed in section 3.3.

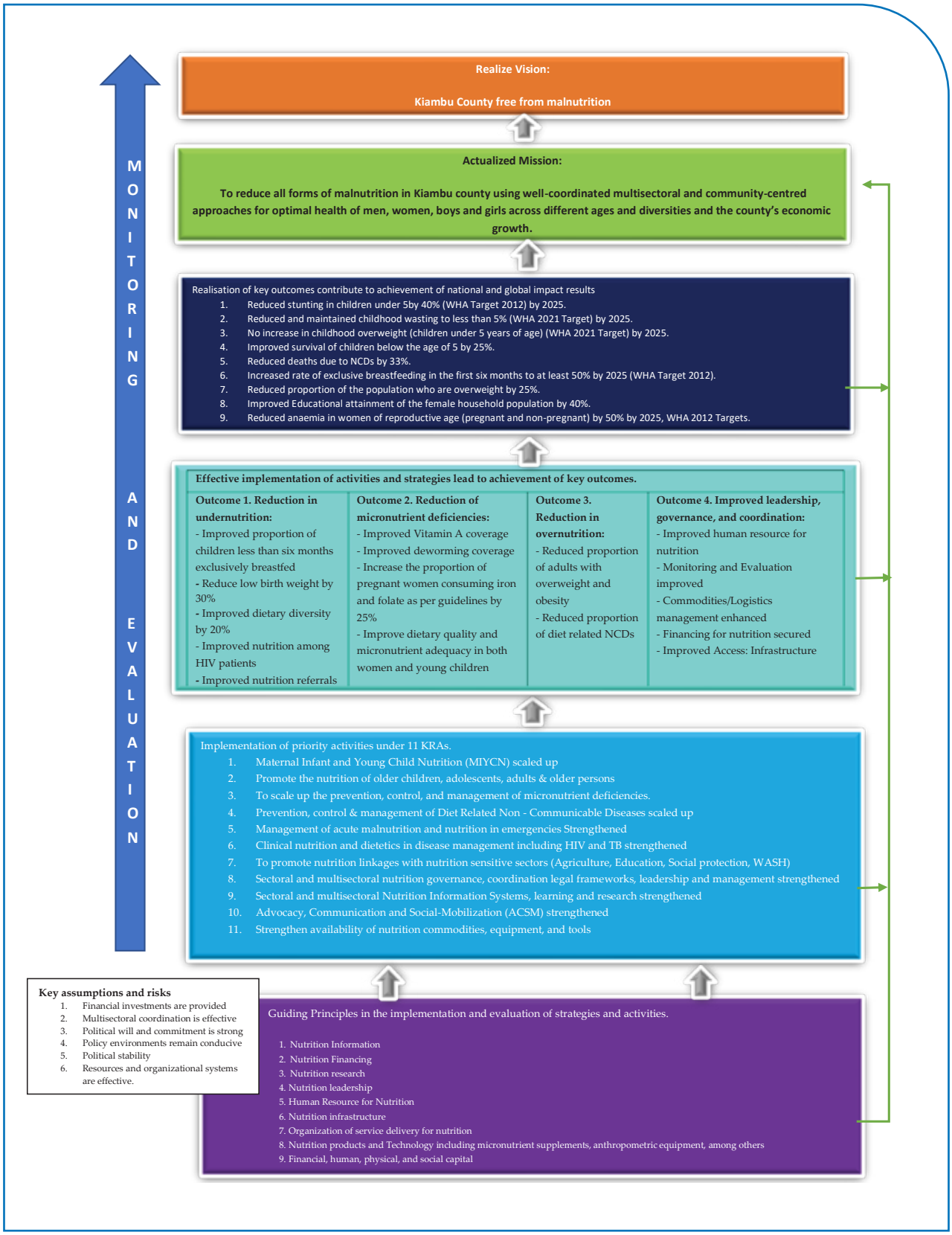


Figure 6:Kiambu CNAP Theory of Change

3.3 Key Result Areas with corresponding outcomes, outputs and activities

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

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

Output 1
Increased awareness on the existing MIYCN; IMNCI & ICCM policies, guidelines, and strategies among County and Sub-County Health Management Teams

Activities
- Sensitize and disseminate existing MIYCN, IMNCI & ICCM policies, guidelines, and strategies to CHMT and SCHMT
- Hold meetings to share feedback report on services statistics for MIYCN, IMNCI & ICCM by CHMT and SCHMT

Output 2
Strengthened capacity of male and female health care workers to deliver quality and gender transformative MIYCN services

Activities
- Train male and female HCWs on MIYCN
- Sensitize male and female CHVs in MIYCN
- Conduct outreaches to promote gender transformative MIYCN practices at community level targeting men and women of different ages, diversities and levels of influence using effective communication channels
- Promote increased engagement of men, boys, community leaders and other key influencers through sensitizing them on their important role in promoting and supporting optimal uptake of MIYCN practices and related services.

Output 3
Strengthened capacity of health care workers to deliver quality IMNCI services

Activities
- Train male and female HCWs on IMNCI
- Train male and female CHVs on ICCM
- Conduct health education to the community targeting men and women of different ages, diversities, and levels of influence on IMNCI using effective communication channels

Output 4
Strengthened and scaled up implementation of baby friendly hospital initiative (BFHI) in all level 5 and 4 health facilities

Activities
- Sensitize male and female health managers on BFHI
- Train male and female HCWs on BFHI
- Establish gender sand diversity inclusive BFHI committees in the implementing health facilities

• Sensitize the non-clinical staff on gender responsive BFHI in the implementing health facilities
• Carry out continuous CMEs on BFHI in the implementing health facilities
• Carry out baseline BFHI assessment
• Carry out continuous BFHI self-assessments and monitoring
• Carry out gender integrated BFHI external assessment
• Print and distribute BFHI assessment tools
• Establish county and sub county gender and diversity inclusive BFHI task force committee
• Hold quarterly county and sub-county BFHI task force meeting as per ToR

Output 5
Strengthened and scale up implementation of baby friendly community initiative (BFCI)

Activities
• Sensitize CHMT and SCHMT on BFCI
• Train male and female HCWs across all cadres on BFCI and to effectively mainstream gender in the implementation of gender transformative BFCI initiatives.
• Sensitize Community Health Committees, Health Facility Committee on BFCI
• Train male and female CHVs on CBFCI
• Establish gender and diversity inclusive BFCI committees in implementing community units
• Conduct household mapping and formation of MTMSGs and FTFSGs in the implementing community units to include women and men across different ages, diversities, and levels of influence, respectively.
• Carry out monthly MTMSG and FTFSG meetings at community unit level
• Carry out targeted home visits by CHVs
• Conduct bi-annual community baby friendly gatherings
• Carry out gender integrated community BFCI baseline assessment
• Carry out continuous support supervision for the BFCI Community units by CHMT, SCHMT in collaboration with the link health facility in charge
• Carry out continuous BFCI self-assessments
• Carry out external gender integrated BFCI assessment
• Print and distribute BFCI assessment tools
• Establish gender and diversity inclusive county and sub county BFCI task force committee
• Hold quarterly county and sub county BFCI task force meeting as per TOR

Output 6
Strengthened growth monitoring and promotion (GMP) in health facilities

Activities
• Train/sensitize male and female HCWs on growth standards using national guidelines as per WHO guidance
• Sensitize male and female CHVs on growth standards using a harmonized national package
• Procure CHV growth monitoring kits
• Carry out monthly growth assessment to all children aged 0-59 months
• Carry out health and nutrition education targeting male and female caregivers, spouses including key influencers of children aged 0-59 months
• Sensitize CHMT and SCHMT of both genders and diversities on growth standards using national guidelines as per WHO guidance

Output 7
Strengthened and promoted implementation for securing a friendly breastfeeding environment at workplaces

Activities
• Sensitize stakeholders in formal and non-formal setting on securing a user –friendly and gender responsive breastfeeding environment at workplaces
• Carry out CMEs on securing a user friendly and gender responsive friendly breastfeeding environment at workplaces in health facilities
• Advocate and promote establishment of lactation stations at workplaces to key decision makers in all sectors
• Sensitize CHMT and SCHMT on the implementation framework for securing a user-friendly and gender responsive breastfeeding environment at workplace
• Train/sensitize male and female health care workers on implementation framework for securing a user- friendly and gender responsive breastfeeding environment at workplace
• Sensitize male and female CHVs and the community targeting men and women across different ages and diversities on implementation framework for securing a user-friendly and gender responsive breastfeeding environment at workplace using far reaching and effective gender, age, and diversity sensitive communication channels

Output 8
Strengthened implementation of Breast Milk Substitute (regulations and control) Act, 2012 at county level

Activities
• Sensitize and disseminate BMS Act, 2012 to stakeholders in private and public sectors
• Train nutritionist, public health officers and other health care workers targeting both genders and diversities on BMS Act implementation framework
• Sensitize nutritionists, public health officers and other health care workers targeting both genders and diversities on BMS monitoring and enforcement framework
• Conduct market level surveillance to monitor adherence to BMS Act
• Establish and functionalize gender and diversity inclusive committees for monitoring and enforcement of BMS Act
• Report all BMS Act,2012 Violations through the agreed ministry of health channels

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

Expected outcome
Improved nutrition status of older children (5-9 years), adolescents (10-19 years), adults & the elderly

Output 1
Increased awareness among stakeholders on healthy diets and physical activity

Activities
• Sensitize school stakeholders on healthy diets and physical activity for older children and adolescents

• Integrate key messages on healthy diets and physical activity in the school health programs
• Sensitize stakeholders in adult and older persons institutions on healthy diets and physical activity
• Sensitization older children, adolescent, adults and older persons on healthy diets and physical activity using far reaching, all-inclusive and user friendly, communication channels for all gender, age, and diverse populations- school health program, churches, youth clubs

Output 2
Improved awareness on weekly iron folate supplementation (WIFAS) among stakeholders

Activities
• Sensitize key stakeholders on WIFAS
• Sensitize male and female teachers on WIFAS
• Sensitize adolescent girls in schools and out of school on WIFAS
• Carry out WIFAS targeting adolescent girls in schools and out of school using effective channels
• Monitor and evaluate the WIFAS program
• Sensitize key stakeholders, male and female parents, and other key influencers in the community on the importance of WIFAs.

Output 3
Increased awareness among health care workers, CHVs, caregivers and community on geriatric nutrition

Activities
• Sensitize male and female CHMT & SCHMTs representatives on geriatric nutrition guidelines
• Sensitize male and female HCWs on geriatric nutrition to provide quality and gender, age and diversity transformative health care and nutrition support for older people
• Sensitize male and female CHVs on geriatric nutrition to actively engage and empower older persons in gender and diversity transformative health and nutrition interventions/initiatives.
• Sensitize community targeting men and women across different ages and diversities and level of influence on optimal nutrition for geriatrics using far-reaching, user-friendly effective communication channels for all genders, ages, and diverse population such as media.

3.3.3 KRA 3: Prevention, control, and management of micronutrient deficiencies scaled-up

Expected outcome
Improved micronutrient status of the entire population (children, adolescent, women of reproductive age, men, and older persons)

Output 1
Increased dietary diversity and Bio-fortification of food

Activities
• Promote increased production of micronutrient rich foods and bio fortified foods at household level targeting both male and female across different ages and diversities.

• Carry out nutrition education through community forums targeting men and women across different ages and diversities on the importance of consuming micronutrient rich and bio-fortified foods
• Sensitize male and female extension staff and CHVs on micronutrient rich foods and bio-fortification
• Adopt legislations on blending of flours using traditional high value crops
• Sensitize the community targeting men and women across different ages, diversities, and level of influence on dietary diversification including production, preparation, and uptake of locally available nutritious traditional foods.

Output 2
Strengthened routine micronutrient supplementation (Vitamin A, Iron and Folate and micronutrient powders) for targeted groups

Activities
• Train male and female health care workers on micronutrient supplementation Vitamin A, MNPs, IFAS)
• Sensitize male and female CHVs on micronutrient supplementation (Vitamin A, MNPs, IFAS)
• Carry out routine Vitamin A supplementation as per the national guidelines
• Carry out IFAS supplementation targeting pregnant mothers as per national guidelines
• Carry out MNP supplementations for children aged 6-23 months as per national guidelines
• Carry out zinc supplementation for management of diarrhoea as per guidelines
• Carry out deworming of children aged 12 months and above, as well as pregnant women
• Sensitize health care workers on forecasting and quantification including inventory management of micronutrients commodities
• Carry out forecasting, quantification, and inventory management of micronutrients commodities
• Sensitize community, targeting men and women across different ages, diversities, and levels of influence on the importance of optimal uptake of micronutrient supplement, identification and addressing underlying issues affecting increased adherence and uptake of the recommended micronutrient supplements.

Output 3
Strengthened production, consumption, and compliance of fortified foods

Activities
• Carry out CMEs targeting male and female health care workers on fortified foods in the market including the fortification logo.
• Sensitize the private sector on mandatory law on food fortification (Capwell, Azuri, Bidco, Mama, Maycorn etc…)
• Sensitize male and female CHVs on food fortification including fortification logo
• Sensitize the community through community forums, targeting men and women across different ages and diversities, on food fortification including fortification logo using effective communication channels
• Carry out annual monitoring of salt iodization at county level
• Conduct quarterly regulatory monitoring of fortified foods at industry and market level to increase compliance with fortification standards in collaboration with the regional Kenya Bureau of Standards (KEBS) team and PHOs

Output 4
Strengthened monitoring and evaluation of the micronutrient activities at county level

Activities
- Carry out quarterly support supervision of micronutrient activities at sub county level
- Carry out monthly reporting of micronutrient activities at sub-county and county levels

3.3.4 KRA 4: Prevention, control & management of diet related non - communicable diseases scaled up

Expected outcome
Prevention, control & management of diet related non-communicable diseases (DRNCDs) improved

Output 1
Increased awareness among health care workers, CHVs and community on prevention, control, and management of DRNCDs

Activities
- Train male and female health workers on management of Diabetes, cancer & Hypertension
- Conduct screening in all health facilities for early detection of DRNCDs
- Sensitize male and female CHVs on DRNCDs
- Conduct screening for early detection of NCD in the community and refer clients with DRNCDs to link health facilities
- Develop and disseminate behaviour change communication strategy on nutrition and non-communicable diseases to CHMT, SCHMT, health care workers and other stakeholders
- Develop and disseminate key messages and advocacy tool kits on DRNCDs to CHMT, SCHMT, health care workers and other stakeholders
- Sensitize and work with media, journalists, and editors for wider coverage of gender transformative DRNCDs messages/information
- Promote screening of the public for early detection, control, management, and treatment of DRNCDs using various channels such as during world celebration of thematic day-world diabetes day etc…, churches, etc.

Output 2
Quality and timely provision of nutrition therapy in management of DRNCDs

Activities
- Carry out nutrition assessment and counselling to all DRNCDs clients in health facilities
- Promote and support establishment of a comprehensive DRNCD Centre
- Advocate and support establishment of wellness Centre's at workplaces
- Advocate and support establishment of gender inclusive DRNCDs support groups in health facilities
- Carry out nutrition education during support group sessions

3.3.5 KRA 5: Management of acute malnutrition and nutrition in emergencies strengthened

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

Output 1
Enhanced capacity of health care worker and CHVs to implement IMAM program

Activities
- Train male and female health care workers on IMAM Package
- Train male and female health care workers on IMAM surge kit
- Conduct monthly CME and OJTs to health care workers IMAM in health facilities.
- Train /sensitize male and female HCWs on LMIS for IMAM
- Sensitize male and female CHVs on IMAM using a harmonized national package
- Train/sensitize male and female HCWs on forecasting quantification of IMAM commodities

Output 2
IMAM programme performance monitored, and quality of services improved through evidence-based decision making

Activities
- Conduct supportive supervision of healthcare workers for gender responsive IMAM implementation
- Submission of monthly IMAM reports disaggregated by gender, age, and diversity.
- Utilize m-Health (data capturing, analysis, reporting, dissemination, and surveillance) for monitoring and reporting on IMAM
- Effectively utilize IMAM surge
- Promote gender integrated operational research on IMAM
- Promote appropriate documentation of gender integrated related research, best practices, and learning
- Adopt and implement key actions/recommendations from research, assessments/surveys, lessons learnt, routine data, programme review meetings and feedback from field experiences

Output 3
Strengthened linkages, partnerships and referral to the facility and community to improve access and coverage

Activities
- Sensitize community members (men and women) across different ages and diversities on IMAM through community forums
- Link and refer malnourished clients to facilities/community and vice visa
- Link and refer malnourished clients to social protection interventions and livelihood programs at community level
- Advocate for allocation of resources for IMAM commodities and equipment's to key county decision makers
- Promote improved linkage with programmes on behavioural change awareness creation or for prevention strategies at community and household level including MIYCN, social protection and livelihood support strategies.

Output 4
Scaled-up and improved quality delivery of IMAM services

Activities
- Adapt guidelines, strategies, treatment protocols and standard operating procedures (SOP) and disseminate at county level and sub county levels
- Carry out gender, age and diversity sensitive nutrition assessment, counselling, and support to clients with MAM and SAM at outpatient and in-patient care
- Develop a scaled-up plan to expand access to treatment in all sub-counties
- Integrate management of acutely malnourished children with other programmes in the health care system

Expected Outcome 2: Nutrition in emergencies strengthened
Improved multi-level and multisectoral capacity for risk preparedness, reduction, and mitigation against impact of disasters

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

Activities
- Map nutrition partners in preparedness and emergency risk reduction at county level
- Participate in county multisectoral emergency preparedness and risk reduction committees to ensure that specific needs of men, women, girls, children, are met in all emergency preparedness and response
- Form/establish gender, age, and diversity inclusive nutrition emergency task force

Output 2
Strengthened emergency preparedness and response

Activities
- Develop/review county nutrition emergency preparedness and response plan integrating gender equality
- Adopt nutrition emergency response standard operating procedures considering gender equality
- Train health care workers on gender responsive and transformative maternal infant and young child nutrition in emergencies (MIYCN-E)
- Sensitize male and female CHVs on MIYCN-E
- Promote gender, transformative MIYCN practices during emergencies for continued uptake of messages at community level and to counteract any misconceptions which may be brought about because of emergencies
- Hold joint planning and implementation meetings with other sectors on integrated preparedness and risk reduction
- Conduct joint resource mobilization activities with other sectors on integrated preparedness and risk reduction
- Adopt and implement of IMAM surge kit during emergencies where applicable

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
• Conduct nutrition outreaches in hard to reach areas and in urban areas to ensure access of children, women, and men to high-impact nutrition interventions in emergencies
• Activate emergency coordination for nutrition response monitoring during emergencies
• Conduct rapid gender, age and diversity integrated nutrition needs assessment during emergencies to adapt response to the context especially in hot spots areas
• Disseminate gender integrated rapid nutrition assessment findings to stakeholders for decision making

Output 4
Strengthened implementation of recovery interventions to enhance 'build back better' approaches

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

3.3.6 KRA 6: Clinical nutrition and dietetics in disease management including HIV and TB strengthened

Expected outcome 1
Improved and scaled-up services and practices related to clinical nutrition and dietetics

Output 1
Nutrition screening, assessment, and triage to all individuals across all gender, age and diversities seeking healthcare promoted

Activities
• Develop, disseminate, and adopt gender responsive standard operating procedures (SOP) for nutrition screening, assessment, and triage
• Advocate and support implementation of standard nutrition screening and assessment to the health management team (HMT) in health facilities
• Monitor functionality of anthropometric assessment tools to ensure standardization and maintenance

Output 2
Strengthened inter-facility referral system for nutrition services

Activities
- Develop county nutrition referral tools
- Sensitize male and female nutritionists and other HCW on the nutrition referral tool.
- Implement and monitor use of the nutrition referral tool

Output 3
Improved clinical nutrition and dietetics services in the management of diseases

Activities
- Carry out nutrition assessment, diagnosis, counselling, and support to provide appropriate dietary interventions responsive to the specific needs for all patients across different gender, age, and diversities in both in-patient and out-patient care
- Disseminate, print, and implement clinical nutrition and dietetics guideline
- Train male and female HCWs on clinical nutrition and dietetics using a standard national package
- Conduct CME on clinical nutrition and dietetics to health care workers in health facilities
- Adopt, print, and disseminate SOPs for clinical nutrition protocols.
- Develop and disseminate gender integrated clinical nutrition qualitative tool for data collection
- Carry out gender integrated bi-annual clinical nutrition qualitative data collection and analysis in high volume health facilities for informed decision making in matters clinical nutrition
- Advocate for nutrition counselling and demonstration corners/ space within health facilities
- Adopt, disseminate, and utilize appropriate clinical nutrition and dietetics monitoring & reporting tools and submit monthly reports
- Develop, disseminate, and utilize an electronic nutrition data template for integration into the county software
- Train /sensitize nutritionist and record officers of all genders on the utilization of the electronic nutrition data template

Output 4
Improved patient feeding in health care institutions and management of malnutrition in disease and illness strengthened

Activities
- Develop and disseminate hospital basic nutrition formula
- Sensitize and update male and female HCWs on prevention of hospital malnutrition
- Develop individualized gender, age, and diversity responsive feeding regimes for patients with acute malnutrition and other chronic diseases under inpatient care
- Develop and implement hospital menus that are responsive to patients' needs across different gender, age, and diversities.
- Revive catering/inpatient and therapeutic /food inspection committees in all healthcare institutions.
- Develop an assessment tool for inpatient feeding
- Carry out continuous quality assessment for the inpatient feeding

Output 5
Advocacy communication and social mobilization for clinical nutrition and dietetics strengthened

Activities
• Develop and disseminate BCC material for clinical nutrition and dietetics
• Advocate for gender integrated operational research in clinical nutrition, cost-effectiveness analysis of various clinical nutrition interventions and application of evidence-based nutrition in patient management
• Advocate for resources for clinical nutrition to the private sector and county government

Output 6
Improved quality of clinical nutrition and dietetics care in management of diseases

Activities
• Conduct mentorship and OJT to nutritionists targeting both genders on specialized technical areas under clinical nutrition and dietetics
• Advocate for sponsorship of male and female nutritionists to trainings on specialized technical clinical nutrition and dietetics areas such as renal, oncology etc.
• Advocate for financial support to sponsor male and female nutrition courses on clinical nutrition and dietetics such as enteral and parental nutrition among others

Expected Outcome 2: HIV/TB
Reduced impact of HIV-related co-morbidities among men and women of different ages and diversities living with HIV through targeted nutrition therapy

Output 1
Improved routine screening for nutrition related problems and referral for all male and female PLHIV and TB patients of different ages and diversities.

Activities
• Adopt and disseminate gender, responsive guidelines on nutrition in HIV and TB management to CHMT, SCHMT and HMT
• Train male and female health care workers on integrated nutrition therapy for TB/HIV management using various effective communication channels
• Adopt and disseminate context-specific job aids for patient-focused nutrition therapy and interpersonal counselling to HCWs

Output 2
Improved nutrition services and referral of male and female PLHIV and TB patients of different gender, age, and diversities.

Activities
• Conduct gender, age and diversity sensitive nutrition assessment, counselling, and support to all male and female TB/HIV clients in all HIV, TB, MNCH service delivery points to reduce missed opportunities and improve service uptake and retention into care
• Implement county and sub-county level forecasting, quantification, and supply planning exercises through integrated operationalized county-level commodity security committees
• Conduct quarterly supply chain monitoring, including electronic LMIS systems, to minimize stock outs, avoid expiries, and over/ under-stocking of HIV/TB nutrition commodities
• Conduct bi-annual surveillance for quality of nutrition commodities used in management of HIV/TB patients in health facilities by county and sub county health management teams

Output 3
Strengthened integration of nutrition interventions for home-based care at community level for PLHIVs towards the 90.90.90

Activities
- Develop small doable actions that enhance dietary diversity and physical exercises at household level for HIV and TB patients
- Adopt and train on use of m-Health systems to identify and follow up patients at community level
- Train/sensitize male and female CHVs and other community resource persons on good nutrition practices for HIV/TB patients to promote healthy and sustainable lifestyles at household level
- Disseminate key context-specific nutrition messages that promote positive lifestyles and behaviour for HIV /TB patients to the community targeting men and women across different ages and diversities through effective communication channels

Output 4
Strengthened referrals, and linkage systems to involve all community actors and optimize identification and linkage of PLHIV and TB patients with nutrition care and management

Activities
- Refer HIV/TB clients to other service delivery points within and outside the facility
- Refer and link malnourished HIV/TB clients to social protection programs
- Refer HIV/TB clients from community to facility by CHVs
- Establish partnership with social services departments to include TB/PLHIVs for social protection safety nets

Output 5
Enhanced monitoring and evaluation and use of implementation research and learning to generate evidence for cost-effective nutrition data for TB and HIV programming

Activities
- Conduct quarterly data quality assessment (DQA) for HIV/TB programs to inform programming
- Disseminate and sensitize male and female HCWs on nutrition TB/HIV data collection and reporting tools disaggregated by age gender and diversity.
- Conduct gender integrated county level operational research for TB/HIV programs in partnership with research institutions to inform programming
- Use county level scorecard and report on gender sensitive nutrition indicators for HIV/TB program
- Conduct county and sub county quarterly gender, age and diversity disaggregated TB/HIV data review meetings for decision making

Output 6
Improved nutrition collaboration for HIV/TB program

Activities
- Conduct TB/HIV nutrition partner mapping at county and sub-county level
- Hold quarterly TB/HIV nutrition partner sharing meeting
- Advocate for allocation of resources for TB/HIV nutrition commodities

3.3.7 KRA 7: Nutrition linkages with nutrition sensitive sectors (Agriculture, Education, Social Protection, and WASH) promoted

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

Output 1
Strengthened collaborations towards sustainable, gender, and diversity responsive food systems that are productive and profitable for improved nutrition

Activities
- Carry out joint gender responsive strategic planning forums with agriculture sector
- Carry out joint bi-annual review of the planned activities

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

Activities
- Promote and support kitchen gardening and rearing of small livestock in communities through gender, age, and diversity inclusive community forums in collaboration with agriculture
- Advocate and initiate demonstration kitchen gardens and rearing of small livestock in selected health facilities in collaboration with department of Agriculture
- Sensitize community on climate SMART agriculture targeting men and women across different ages and diversities in collaboration with department of Agriculture using effective communication channels

Output 3
Consumption of safe, diverse, and nutritious foods promoted

Activities
- Sensitize male and female health care workers on diversified and gender responsive food production strategies and consumption of safe, diverse, and nutritious foods
- Sensitize male and female CHVs on diversified and gender responsive food production strategies and consumption of safe, diverse, and nutritious foods
- Sensitize community targeting men and women across different ages and diversities on diversified and gender responsive food production strategies and consumption of safe, diverse, and nutritious foods using effective communication channels
- Promote community led fuel energy saving technologies at community level
- Sensitize HCWs, CHVs and community targeting men and women across different ages, diversities, and levels of influence on use and uptake of food composition tables and recipes for decision making
- Adapt and disseminate food safety regulations and enforcement mechanisms at county level
- Sensitize HCWs, CHVs and community targeting men and women of different ages and diversities on the nutrition dialogue cards and other related materials
- Utilize gender, age and diversity sensitive nutrition dialogue cards at community level when providing nutrition messages to the communities
- Adapt gender responsive Social behaviour change and communication (SBCC) strategy for increased consumption of nutritious foods and improved dietary diversity (including fortified foods) among the community members

Output 4
Value addition, preservation, storage, and agro-processing promoted

Activities
- Sensitize male and female CHVs on value addition, preservation, post-harvest handling, storage, and agro-processing in collaboration with agriculture
- Sensitize community targeting and women across different ages and diversities on value addition, preservation, post-harvest handling, storage and agro-processing using effective communication channels in collaboration with agriculture

Output 5
Strengthened gender sensitive M&E on agro-nutrition activities

Activities
- Carry out joint quarterly support supervision for the integrated and gender transformative agri-nutrition activities
- Quarterly submission of gender sensitive progress reports on agro-nutrition activities
- Bi-annual review meetings to assess progress of the joint gender responsive agro-nutrition activities

Expected outcome 2: WASH
Improved integration of nutrition into WASH strategies and activities

Output 1
Rainwater harvesting, recycling, protecting community water sources and safe storage facilities promoted

Activities
- Sensitize male and female CHVs on rainwater harvesting, recycling, protecting community water sources and safe storage facilities
- Sensitize male and female community members on rainwater harvesting, recycling protecting community water sources and safe storage facilities using effective communication channels

Output 2
Strengthened proper hygiene practices at community and household level

Activities
- Sensitize male and female community members across different ages and diversities on water treatment methods at household level
- Create awareness on safe water storage at community and household level targeting both men and women across different ages and diversities.
- Create awareness on hand washing at critical times at community and household level targeting both men and women across different ages and diversities
- Create awareness on food safety and hygiene at community and household level targeting both men and women across different ages and diversities
- sensitize food handlers of all genders on hazard analysis critical control point (HACCP) in collaboration with public health
- Sensitize community on good environmental hygiene practices and Covid 19 prevention measures through gender, age, and diversity inclusive community forums

Output 3
Proper sanitation at community and household level promoted

Activities
• Sensitize male and female community members on proper latrine use and proper disposal of household wastes
• Participate in gender responsive community led total sanitation in collaboration with public health department and promote nutrition messages especially for 1000 days window of opportunity

Output 4
Strengthened monitoring and evaluation of integrated WASH nutrition activities

Activities
• Conduct quarterly joint support supervision of WASH nutrition activities
• Monthly submission of reports on WASH nutrition activities
• Conduct Bi-annual review meetings to assess progress of the joint activities

Expected Outcome 3: Social protection
Integration of nutrition in social protection programmes strengthened

Output 1
Improved collaboration between nutrition and social protection sector

Activities
• Carry out joint planning meetings to identify areas of collaboration
• Carry out stakeholder mapping forums on social protection programs

Output 2
Nutrition promoted and linkages enhanced in social protection programmes including in crisis

Activities
• Sensitize male and female nutritionists on gender, age and diversity responsive social protection interventions including the target population
• Sensitize male and female CHVs on gender, age and diversity responsive social protection interventions including the target population
• Adapt and disseminate targeting criteria for nutrition in gender, age and diversity responsive social protection programmes, cash transfers, hunger safety nets, and others
• Advocate for inclusion of gender sensitive nutrition objectives and indicators in the M&E of social protection interventions
• Advocate for Scale up of social safety nets in times of crises
• participation of nutrition stakeholders in social protection coordination mechanisms
• Train/sensitize stakeholders in gender, age, and diversity social protection programmes on good and gender transformative nutrition practices
• Conduct a gender integrated baseline survey/situation analysis on status of nutrition and health for the vulnerable groups

Output 3
Strengthened advocacy, communication, and social mobilization for social protection

Activities
• Sensitize managers of children homes on integrated nutrition social protection activities
• Carry out follow ups on implementation of the agreed joint activities for the children homes on quarterly basis
• Advocate for governance and accountability for nutrition and social protection for vulnerable groups
• Advocate for harmonized nutrition and social protection services for vulnerable groups at county and sub county levels
• Advocate for high-level consultations for promotion of health and nutrition for vulnerable groups at County levels.
• Sensitize (a) the public and b) management of institutions of vulnerable persons and correction facilities on optimal health and nutrition for the vulnerable population
• Promote benchmarking/learning visits for policy makers and implementers in counties with best practices on health and nutrition for vulnerable groups

Output 4
Strengthened M&E for integrated nutrition social protection interventions

Activities
• Carry out quarterly support supervision of the integrated nutrition and social protection activities
• Submission of quarterly progress gender sensitive reports
• Carry out mid-year review on the progress of the agreed activities

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

Output 1
Nutrition assessment, Vitamin A, and deworming in ECDE conducted and promoted in education sector

Activities
• Sensitize ECDE teachers of all genders on Nutrition assessment
• Carry out deworming in all ECDE centres targeting both boys and girls
• Carry out quarterly nutrition assessment in all ECDE centres targeting both boys and girls
• Carry out bi-annual Vitamin A supplementation in all ECDE centres targeting both boys and girls
• Refer malnourished and sick children to the link facilities
• Carry out quarterly submission of gender, age and diversity disaggregated reports on nutrition assessment, Vitamin A, and deworming

Output 2
Healthy and safe food environment promoted in schools and other learning institutions

Activities

- Sensitize health and school stakeholders targeting both genders on school related policies on health and nutrition (school health policy, nutrition teacher's reference manual, school feeding guidelines/strategy etc…)
- Sensitize school and health stakeholders on healthy and safe food environment including WASH in schools and other learning institutions
- Sensitize school stakeholders on marketing and promotion of safe and healthy nutritious foods within the schools
- Regulate the food environment to control marketing of unhealthy foods for older children and adolescents in schools
- Advocate for sufficient and safe nutritious food supplies in schools
- sensitize stakeholders on school gardens and rearing small animals in collaboration with department of Agriculture
- Advocate and support for revival of 4K clubs/health and nutrition clubs/small farmers clubs in schools

Output 3

Strengthened M&E on the integrated nutrition education activities

Activities

- Carry out quarterly support supervision for the joint activities
- Submit quarterly submission of progress reports for the joint activities
- Carry out bi- annual joint progress review meetings

3.3.8 KRA 8: Sectoral and multisectoral nutrition governance, coordination, legal frameworks, leadership, and management strengthened

Expected outcome 1

Efficient and effective nutrition governance, coordination, and legal framework in place

Output 1

Enhanced existing nutrition coordination and collaborating mechanisms and linkages between county and sub county levels

Activities

- Map nutrition partners and stakeholders in the county
- Hold quarterly county Nutrition Technical Forums at county and sub-county levels as per TORs
- Develop, cost, review, and update sector-specific coordination annual plans
- Support the establishment and functionality of the Food and Nutrition Security Council and all other structures as approved in the NFNSP-IF at county levels
- Enhance representation of nutrition at other sectoral forums at county and sub county levels
- Conduct performance assessment reviews on coordination
- Support annual county and sub county nutrition learning forums

Output 2

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

Activities
• Advocate for establishment of multisectoral nutrition platform at county level
• Sensitize sectoral and multisectoral stakeholders on the existing policy, legal and regulatory framework
• Participate in annual nutrition standards and regulations summit at the national level

Output 3
Strengthened partnerships and collaboration for nutrition

Activities
• Adapt and disseminate national strategy and framework for enhancing public –private partnership (PPP)
• Map the private entities working in nutrition within the county
• Hold meetings with private partners to improve public private partnership for nutrition initiatives
• Adopt and sensitize county policy makers on SUN business strategy
• Sensitize stakeholders within the private sector on SUN business strategy

Output 4
Nutrition resource mobilization and accountability tracked

Activities
• Sensitize the community targeting men and women across different ages and diversities on nutrition representation and gender equality in citizen participation forum
• Establish a gender sensitive county nutrition task force for resource mobilization
• Develop costed 2nd generation County Nutrition Action Plans (CNAPs)
• Develop annual resource mobilization strategy
• Conduct nutrition resource tracking at county and sub-county levels
• Support participation and representation of nutrition sector in citizen-participation forums at county and sub county levels

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

Expected outcome
Sectoral and multisectoral Nutrition Information Systems, learning and research strengthened

Output 1
Enhanced monitoring of key nutrition implementation plans

Activities
• Develop and review progress of gender responsive AWP, CNAP and other multi-year plans
• Adapt gender sensitive nutrition M&E framework within MEAL chapter and integrate it with the county M&E framework
• Conduct midterm and end term reviews for CNAP using gender sensitive M&E framework implementation with corrective gender responsive action plans
• Participate in the development of gender integrated county health strategic plans such as CIDP among others

• Sensitize and disseminate Vitamin A monitoring chart to male and female CHMT, SCHMT and health care workers across all cadres
• Monitor technical working group (TWG) plan
• Conduct gender responsive annual target setting for nutrition indicators
• Sensitize HCWs on gender responsive annual nutrition targets for gender sensitive nutrition indicators
• Conduct annual performance review meeting

Output 2
Quality nutrition data generated for evidence-based programming

Activities
• Assess gaps on nutrition M&E at county and sub-county levels
• Sensitize male and female HCWs on routine nutrition data collection tools
• Sensitize male and female HCWs on nutrition data use for decision making
• Conduct quarterly data quality audits KHIS, LMIS and sentinel surveillance
• Conduct gender integrated nutrition SMART survey after every 2 years
• Conduct gender integrated MIYCN KAP and coverage assessment after every 2 years
• Conduct gender integrated nutrition capacity assessment after every 2 years
• Disseminate gender integrated survey and assessment findings at all levels for decision making
• Develop information products with nutrition findings

Output 3
Enhanced multisectoral linkages result in improved nutrition information efficiencies and cost-effectiveness

Activities
• Hold meeting with sectoral and multisectoral stakeholders and make use of existing forums to give nutrition feedback
• Use various technology platforms to give nutrition feedback to sectoral and multisectoral partners
• Develop and implement a county nutrition dashboard
• Adopt the national nutrition score card and sensitize HCWs on the score card
• Enhance linkages between county nutrition technical forum and national information technical working group (NITWG)
• Adapt national multisectoral Nutrition Information Platform (NIPN) for improved multisectoral data analysis, dissemination, and utilization

Output 4
Improved decision making through research evidence

Activities
• Establish a county research repository platform for nutrition department
• Advocate to academia and research departments to share gender integrated research data/findings with stakeholders
• Integrate nutrition evidence base research agenda into the county's health research unit
• Develop strategic partnerships and networks in addressing county gender integrated research agenda (county departments, partners, private sector, etc.)

• Advocate for research prioritization both at county and sub county levels
• Participate in county research committee meetings
• Participate in forums for dissemination of research findings and information sharing at all levels
• Advocate for systematic review of gender transformative nutrition-sensitive and nutrition-specific interventions within the county
• Participate in knowledge sharing forums such as symposiums and conferences, workshops, meetings at national, county, and international levels
• Train nutritionist and other frontline health care workers of both genders on gender integrated operational /implementation research skills
• Lobby for resources from sectoral and multisectoral for nutrition research
• Establish knowledge sharing forums for health care providers and the community.
• Establish a system for dissemination of nutrition research findings to the community

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

Expected outcome
Enhanced commitment and continued prioritization of nutrition in national and county agenda

Output 1
Political commitment and prioritization of nutrition at county level enhanced

Activities
• Hold high level sensitization forums with policy makers and county legislature on the value and impact of nutrition prioritization at county level
• Adopt, customize, and disseminate gender transformative nutrition advocacy messages and briefs to different audiences such as policy makers, community members, health care workers
• Develop and disseminate gender inclusive county nutrition advocacy, communication, and social mobilization plans.
• Conduct high level advocacy meeting targeting key decision makers on having a specific nutrition budget line within the heath budget for sustained and quality nutrition
• Identify and engage male and female nutrition champions to advocate for nutrition prioritization at all levels

Output 2
Enhanced and sustained multisectoral collaboration, social accountability and financial resources allocated across relevant sectors at county levels

Activities
• Develop county nutrition resource mobilization strategy
• Design, develop, print, and disseminate gender transformative nutrition BCC materials
• Advocate for relevant sectors to support establishment of multisectoral nutrition platforms

Output 3
Increased and strengthened human capital and capacity for nutrition advocacy

Activities

• Train male and female nutritionists, health promotion officers and community strategy focal person on nutrition advocacy
• Sensitize male and female nutritionists, health promotion officers and other HCWs on nutrition communication and writing skills for better packaging of nutrition information
• Advocate for recruitment of male and female nutritionists to fill county gaps to offer quality nutrition services at all levels
• Train/sensitize male and female nutrition champions and influencers on nutrition advocacy
• Share nutrition information on the website, all social media platforms, bulletin, newsletter, and SMS portal

Output 4

Effective engagements with media built and maintained

Activities

• Sensitize media fraternity on gender responsive nutrition advocacy for better packaging of nutrition information and better coverage
• Conduct media talk shows on Radio and TVs, features stories, documentaries, and short videos on various nutrition topics
• Identify and utilize male and female media nutrition champions
• Adapt a gender responsive training package on nutrition for journalists based on simplified messages and key information
• Support training of male and female nutrition professionals and other relevant stakeholders on communication and writing skills to help them better package information for media
• Participate in mass media nutrition education programme at all levels

Output 5

Community engagement in nutrition strengthened

Activities

• Sensitize male and female community own resource persons and CHVs to create demand for utilization of nutrition services through community structures.
• Sensitize communities on good nutrition practices to create awareness targeting men and women across different ages and diversities
• Sensitize community to participate in nutrition resilience building interventions and accountability mechanism targeting men and women across different ages and diversities
• Sensitize community through gender inclusive community groups on feedback mechanisms
• Commemorate annual World breastfeeding week (WBW)
• Carry out Malezi bora twice yearly
• Participate in celebration of world health days such as World pre-maturity day, World water day, World toilet days, World diabetes day, among others
• Conduct annual community health & nutrition education days

3.3.11 KRA 11: Supply chain management for nutrition commodities and equipment strengthened

Expected outcome

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

Output 1
Strengthened coordination and management capacity of supply chain of nutrition commodities, equipment, and allied tools

Activities
- Train male and female HCW on LMIS including inventory management
- Conduct quarterly nutrition commodity and security TWG meeting
- Conduct annual forecasting and quantification exercise across the nutrition programs
- Advocate and support creation of nutrition commodities storage space in facilities
- Hold quarterly meetings for nutrition commodity steering committee

Output 2
Increased county government budget allocation for nutrition commodities, equipment, and allied tools

Activities
- Procure and distribute micronutrient commodities and dewormers (IFAS, Vitamin A, Zinc, MNPs,)
- Procure and distribute micronutrient reporting and monitoring tools (IFAS, Vitamin A, Zinc, MNPs including dewormers)
- Procure and distribute IEC/BCC material for DRNCDs
- Procure nutrition supplies and equipment for DRNCD screening
- Procure and distribute IMAM commodities for management of MAM and SAM
- Procure and distribute anthropometric equipment and IMAM reporting tools
- Procure and distribute clinical nutrition equipment's
- Procure and distribute appropriate therapeutic and supplementary feeds to patients to prevent hospital malnutrition.
- Procure and distribute nutrition commodities for feeding and management of special medical conditions based on inpatient feeding protocols
- Procure and distribute nutrition assessment tools, commodities, and reporting tools for HIV/TB programs
- Advocate for Expansion of Essential Medicines & Medical Supplies (EMMS) lists (to incorporate new commodities), e.g. nutrition commodities for chronic diseases such as cancer etc.
- Ring-fence nutrition commodity funds at county level through review of the PFM Act 2012

Output 3
Quality of all nutrition commodities and equipment ensured

Activities
- Adapt and provide tools for quality assurance including data collection and summary
- Adapt national guidelines and SOPs for nutrition commodities and tools
- Conduct nutrition commodity data quality audits and data review meetings
- Conduct joint commodity supervision and end user monitoring
- Collaborate with the county food safety unit and regulatory bodies to ensure good quality of nutrition commodities and equipment

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 Kiambu 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 forms the basis for modification of interventions and assessment of the quality of activities being conducted.

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

An assessment of the technical M&E capacity of the program within the county is key. This includes the data collection systems that may already exist and the level of skills 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, capacity building of M&E staff including trainings and M&E coordination.

4.2 Background and context

The Kiambu 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 Kiambu 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, morbidity)
- Clients Access to services
- Quality of health and 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 Kiambu 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 7 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.

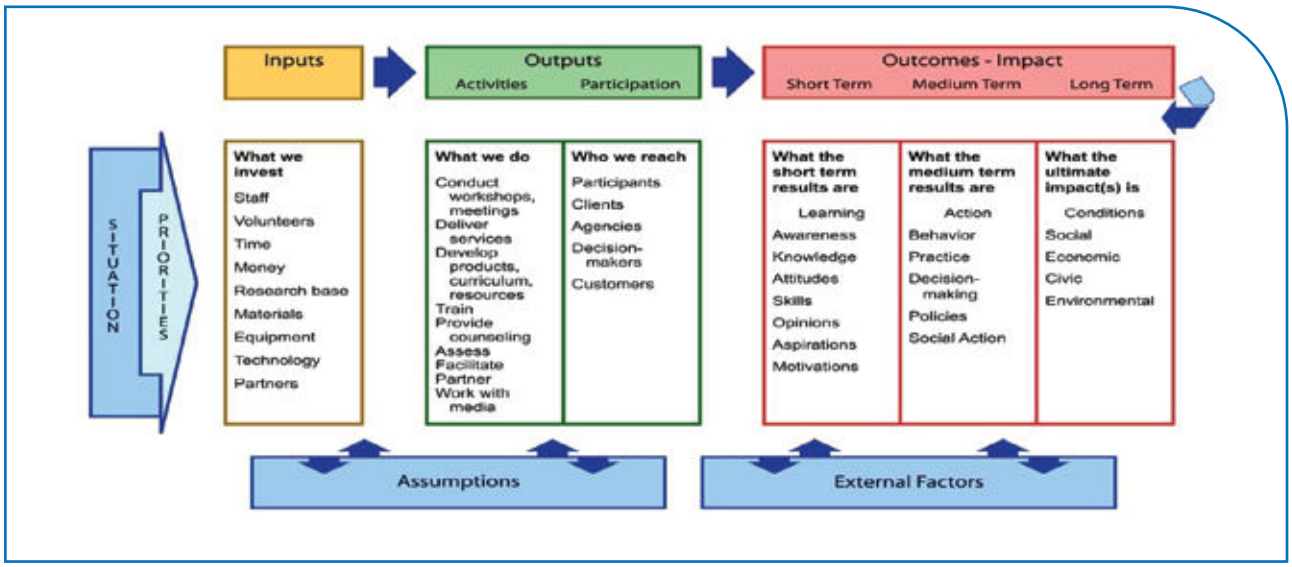


Figure 7: Monitoring and evaluation logical framework

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 5: CNAP results framework

IMPACT	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			
OUTCOMES	**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	**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	**Outcome 3. Reduction in overnutrition** - Reduced proportion of adults with overweight and obesity - Reduced proportion of diet related NCDs	**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
OUTPUTS	1. Maternal Infant and Young Child Nutrition (MIYCN) Scaled Up 2. Promote the Nutrition of Older Children, Adolescents, Adults & Older Persons 3. To scale up the Prevention, control, and management of Micronutrient Deficiencies. 4. Prevention, Control & Management of Diet Related Non - Communicable Diseases Scaled Up 5. Management of Acute Malnutrition and nutrition in emergencies Strengthened 6. Clinical Nutrition and Dietetics in disease management including HIV and TB strengthened 7. To promote nutrition linkages with nutrition sensitive sectors (Agriculture, education, social protection, WASH) 8. Sectoral and Multisectoral Nutrition Governance, Coordination legal frameworks, Leadership and Management strengthened 9. Sectoral and Multisectoral Nutrition Information Systems, Learning and Research Strengthened 10. Advocacy, Communication and Social-Mobilization (ACSM) strengthened 11. Strengthen availability of nutrition commodities, equipment, and tools			

INPUTS	1. Organization of service delivery for nutrition;	6. Nutrition Financing;
	2. Human Resource for Nutrition;	7. Nutrition research;
	3. Nutrition infrastructure;	8. Nutrition leadership;
	4. Nutrition products and Technology including micronutrient supplements, anthropometric equipment, among others;	9. Financial, human, physical and social capital;
	5. Nutrition Information;	

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 8 will involve:

Figure 8: Monitoring processes

Data generation

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

Data validation

• Data validation through regular data quality assessment to verify the reported progress from source to aggregated values to ensure that data are of the highest quality. Annual and quarterly data quality audits will be carried out, to review the data across all the indicators.

Data analysis

• This step ensures transformation of data into information which can be used for decision making at all levels.
• It requires a team with strong analytic skills to make sense out of the presented data.
• The analysis will be done during the quarterly and annual performance reviews, where achievements will be compared against set target in the CNAP. Trend analysis will also be conducted. The expected output will include quarterly nutrition bulletins and annual nutrition performance review reports.

Information dissemination

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

Stakeholders 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 nutrition program performance.

4.6 Monitoring reports

The following are the monitoring reports and their periodicity:

Table 6: 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 Kiambu 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 Kiambu 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 nutrition program over time. A midterm review and an end evaluation will be undertaken to determine the extent to which the objectives of this Kiambu CNAP are met.

Evaluation criteria

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

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

Effectiveness: The extent to which Kiambu 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 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 resources 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 Kiambu 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 Kiambu 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 Kiambu CNAP.
viii. Investments as input, will result in desired outputs and outcomes, and eventually, achievement of overall results as outlined in the Kiambu CNAP

4.10 Indicators and information sources

The Indicators that will guide monitoring of this Kiambu CNAP are outlined in the tables below.

Expected Results

Table 7: 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)	15.7% 28.1%	KDHS 2014 GBD 2017 https://vizhub.healthdata.org/lbd/cgf	10%	9.2%	Every 5 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).	2.3% 2.4%	KDHS 2014 GBD 2017 https://vizhub.healthdata.org/lbd/cgf	2.1%	2.0%	Every 5 years
	Percentage of under-weight under five years (low weight for age)	5.1% 7.3%	KDHS 2014 GBD 2017 https://vizhub.healthdata.org/lbd/cgf	4.0%	3.0%	Every 5 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)	4.3%	KDHS 2014	3.5%	3.0%	Every 5 years
Improved survival of children below the age of 5	Infant mortality rate	34.2 deaths per 1,000 live births	GBD 2017 https://vizhub.healthdata.org/lbd/under5	32 deaths per 1,000 live births	30 deaths per 1,000 live births	Every 3 years
	Neonatal Mortality Rate	20.8 deaths per 1,000 live births	GBD 2017 https://vizhub.healthdata.org/lbd/under5	18.2 deaths per 1,000 live births	15.6 deaths per 1,000 live births	Every 3 years
	Under-5 mortality rate	44.0 deaths per 1,000 live births	GBD 2017 https://vizhub.healthdata.org/lbd/under5	42 deaths per 1,000 live births	40 deaths per 1,000 live births	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 proportion children exclusively breastfed in the first 6months by 2025 to at least 50%	Exclusive breastfeeding rate for children under 6 months (population based)	44.7%	GBD 2017 https://vizhub.healthdata.org/lbd/ebf	50%	60%	Every 3 years
Reduction by 25% of the proportion of the population who are overweight	Prevalence of overweight in the population	17.05% All 16.3% F 17.8% M	GBD 2019 https://vizhub.healthdata.org/lbd/dbm	15% All 15% F 15% M	12% All 12% F 12% M	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	14.2%**	KDHS 2014	17%	19.9%	Every 5 years
	Average years of education among women aged 15-49	9.89	GBD 2017 https://vizhub.healthdata.org/lbd/education	11	12	Every 3 years
Improved food consumption	Minimum Dietary Diversification (MDD) Score***	41%	KDHS 2014	60%	70%	Every 5 years
Reduce anaemia in WRA (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
	Prevalence of ZINC deficiency among preschool children aged below 59 months	83%***	KNMS 2017	70%	60%	Every 5 Years
Water and sanitation	Proportion of population using a safely managed drinking water service (improved piped water)	47.1%	GBD 2017 https://vizhub.healthdata.org/lbd/wash	60%	70%	Every 5 years
	Proportion of population using a safely managed sanitation service	14.8%	GBD 2017 https://vizhub.healthdata.org/lbd/wash	30%	40%	Every 5 years

Table 8: Annual indicators per nutrition objectives

Target	Indicator	Baseline	Baseline Year/data source	Yr. 1	Yr. 2	Yr. 3	Yr. 4	Yr. 5
REDUCTION IN UNDERNUTRITION: WASTING, STUNTING, UNDERWEIGHT								
Improved rates of exclusive breastfeeding among children less than six months	Percentage of children 0-6 months visiting facilities exclusively breastfed.	93.6% All 99.4% F 87.5% M	KHIS 2019	94%	94.5%	95%	95.5%	96%
	Percentage of infants that were breastfed within one hour after delivery.	91.2%	KHIS 2019	92%	92.5%	93%	93.5%	94%
Reduce low birth weight by 20%	Percentage of new-borns in the facilities, with low birth weight	5.1%	KHIS 2019	4.9%	4.7%	4.5%	4.3%	4%
	Proportion of children under 5 attending CWC who are underweight	4.9%	KHIS 2019	4.5%	4.2%	4.0%	3.8%	3.5%
	Proportion of infants initiated on breast milk within the first 1 hour of birth	91.2%	KHIS 2019	92%	92.5%	93%	93.5%	94%
Nutrition and HIV	Number of PLHIV with SAM	205	KHIS 2019 (MOH 733B)	180	170	160	150	140
REDUCTION OF MICRONUTRIENT DEFICIENCIES								
Improved Vitamin A coverage	Percentage of children (6-59 months) receiving Vitamin A Supplementation twice annually (100,000 IU for children 6-12 months and 200,000 IU for children > 12 months).	48%	KHIS 2019	55%	60%	65%	75%	80%
Improved deworming coverage	Percentage of children (12-59 months) dewormed	21.1%	KHIS 2019	30%	40%	50%	60%	70%
	Proportion of school-aged children (6-14 years) dewormed	11.2%	KHIS 2019	20%	30%	40%	50%	60%
Improved Zinc intake	Percentage of children under five years with diarrhoea supplemented with zinc and ORS	88.8%	KHIS 2019	90%	91%	92%	93%	94%
Increase the proportion of pregnant women consuming iron and folate as per guidelines by 25%	Percentage of pregnant women attending ANC supplemented with Iron and Folic Acid	60.1%	KHIS 2019	64%	68%	72%	76%	80%
Improve dietary quality and micronutrient adequacy in both women and young children	Minimum dietary diversity among children 6-23 months	41%**	KDHS 2014	45%	50%	55%	60%	65%
	Proportion of children 6-23 months, percentage fed on minimum acceptable diet (four or more food groups)	22%**	KDHS 2014	30%	35%	40%	45%	50%
REDUCTION IN OVERNUTRITION AND DIET RELATED NON-COMMUNICABLE DISEASES								
Reduced proportion of adults with overweight and obesity	Prevalence of overweight among female adults	26.1%	KDHS 2014	20%	19%	18%	17%	16%
	Prevalence of obesity among female adults	19.6%	KDHS 2014	18%	17%	16%	15%	14%
Reduced proportion of diet related NCDs	Prevalence of Hypertension	12.8%***	KDHS 2014	12%	11%	10%	9%	8%
CROSS-CUTTING AREAS								
Monitoring and Evaluation	Proportion of facilities submitting routine information in a timely manner	85%	KHIS 2019	90%	100%	100%	100%	100%
Commodities/Logistics	Percentage of facilities that experience no stock out at any point during a given time	98%	LMIS data 2020	99%	100%	100%	100%	100%
	Percentage of health facilities with no stock out of Iron-Folic Acid (IFA)	100%	LMIS data 2020	100%	100%	100%	100%	100%

Output indicators

Table 9: KRA 01: Maternal Infant and Young Child Nutrition (MIYCN) scaled up

Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Capacity of health care workers in MIYCN strengthened	Number of male and female HCWs trained on MIYCN		2019	Nutrition activity report	Annually	60	60	60	60	60
	Number of male and female CHVs sensitized on MIYCN	No Data	2019	Nutrition activity report	Every 2 Years	360	0	360	0	360
Strengthened capacity of health care workers on IMNCI	Number of male and female HCWs trained on IMNCI	600	2019	Nutrition activity report	Annually	300	300	300	300	300
	Number of male and female CHVs trained on ICCM	0	2019	Nutrition activity report	Annually	360	360	360	360	360
	Number of health education sessions carried out	No Data	2019	Nutrition activity report	Annually	24	24	24	24	24
BFHI scaled up in all level 5 and 4 health facilities	Number of BFHI committees established	0	2019	Nutrition activity report	Annually	2	2	3	3	2
	Number of non-clinical staff sensitized on BFHI	0	2019	Nutrition activity report	Annually	30	30	30	30	30
	Number of Baseline BFHI assessments done	No Data	2019	Nutrition activity report	Every 3 years	0	3	0	0	0
	Number of continuous BFHI self-assessments carried out	No Data	2019	Nutrition activity report	Every 2 Years	0	0	6	6	0
	Number of external BFHI assessment carried out	No Data	2019	Nutrition activity report	Every 3 years	0	0	0	0	3
BFCI implementation scaled up	Number of male and female CHVs trained on BFCI	30	2019	Nutrition activity report	Annually	60	60	60	60	60
	Number of BFCI committees established	0	2019	Nutrition activity report	Annually	24	24	24	24	24
	Number of male and female HCWs across all cadres sensitized on BFCI	30	2019	Nutrition activity report	Annually	60	60	60	60	60
	Number of MTMSGs and FTFSGs formed	4	2019	Nutrition activity report	Annually	4	24	24	24	24
	Number of Community BFCI baseline assessment carried out	2	2019	Nutrition activity report	Annually	6	6	6	6	6
	Number of continuous BFCI self-assessments carried out	0	2019	Nutrition activity report	Quarterly	24	24	24	24	24
	Number. of external BFCI assessment carried out	0	2019	Nutrition activity report	Annually	2	2	2	2	2
Strengthened GMP	Number of male and female HCWs trained on WHO growth standards	0	2019	Nutrition activity report	Annually	60	60	60	60	60
	Number of male and female CHVs sensitized on WHO growth standards	0	2019	Nutrition activity report	Annually	360	360	360	360	360
	Proportion of CHVs with growth monitoring kits	0	2019	Nutrition activity report	Every 2 Years	60%	65%	70%	75%	80%
Breastfeeding at workplace and in the general population promoted & supported	Number of sessions held to sensitize stakeholders on workplace support for breastfeeding mothers	0	2019	Nutrition activity report	Every 2 Years	13	0	13	0	13
	Number of lactation stations established in workplaces	1	2019	Nutrition activity report	Annually	1	1	1	1	1
Enhanced adherence to BMS Act, 2012	Number of male and female nutrition stakeholders sensitized on BMS Act, 2012	0	2019	Nutrition activity report	Every 2 Years	12	0	12	0	12
	Number of nutritionists, public health officers and other health care workers of all genders trained on BMS Act implementation framework	0	2019	Nutrition activity report	Every 2 Years	48	0	48	0	48
	Number of nutritionists, public health officers and other health care workers of all genders sensitized on BMS monitoring and enforcement	0	2019	Nutrition activity report	Every 2 Years	30	0	30	0	30
	Market level surveillance for adherence to BMS Act conducted	No	2019	Nutrition activity report	Every 2 Years	Yes	No	Yes	No	Yes
	Compliance status of BMS Act in various entities.	No data	2019	Nutrition activity report / supervision reports	Every 2 Years	50%	60%	65%	70%	75%
Celebration of World thematic days/ National thematic days	World breastfeeding week commemorated at county level	Yes	2019	Nutrition activity report	Annually	Yes	Yes	Yes	Yes	Yes
	Number of Malezi bora activities carried out	2	2019	Nutrition activity report	Bi-annual	2	2	2	2	2
	Participation in celebration of world prematurity day	Yes	2019	Nutrition activity report	Annually	Yes	Yes	Yes	Yes	Yes

Table 10: KRA 02: Promote the nutrition of older children, adolescents, adults & older persons

Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Consumption and marketing of healthy food for older children and adolescents promoted	Number of sensitization sessions in schools for older children and adolescent on healthy diets and physical activity	0	2019	Nutrition activity report	Annually	60	60	60	60	60
Weekly iron folate supplementation for adolescent girls promoted	Number of male and female school stakeholders sensitized on healthy diets and physical activity for older children and adolescent	0	2019	Nutrition activity report	Every 2 Years	105	0	105	0	105
	Proportion of adolescent girls who received WIFAS	0	2019	Nutrition activity report	Annually	0	0	0	5	10
	Number of male and female teachers sensitized on WIFAS	0	2019	Nutrition Activity report	Annual	600	-	600	-	600
Increased knowledge of HCWs and the community on optimal nutrition of adults and the elderly	Number of male and female HCWs sensitized on geriatric nutrition	No data	2019	Nutrition activity report	Annually	360	360	360	360	360
	Number of male and female CHVs sensitized on geriatric nutrition	No data	2019	Nutrition activity report	Annually	600	600	600	600	600
Increased knowledge of HCWs and the community on optimal nutrition of adults and the elderly	Number of community groups sensitized on good nutrition for geriatrics done	No data	2019	Nutrition activity report	Every 2 Years	36	0	36	0	36
	Number of male and female HCWs trained on healthy diets and physical activity	No Data	2019	Nutrition activity report	Annually	60	60	60	60	60
	Number of male and female CHVs sensitized on healthy diets and physical activity	No Data	2019	Nutrition activity report	Every 2 Years	600	0	600	0	600

Table 11: KRA 03: To scale up the prevention, control, and management of micronutrient deficiencies

Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Enhanced uptake of diversified and bio- fortified foods	Number of male and female extension officers sensitized on production and consumption of micronutrient rich foods and bio fortified foods	0	2019	Nutrition and agriculture activity reports	Every 2 Years	180	180	60	0	60
Strengthened micronutrient supplementation	Proportion of boys and girls 6-59 months supplemented with MNPs	No data	2019	Nutrition activity report	Annually	15	20	25	30	35
Enhanced system for delivery of micronutrient supplementation	Number of male and female health workers trained on micronutrient supplementation, vitamin A. MNPs and IFAS	no data	2019	Nutrition activity report	Annually	60	0	60	0	60
	Number of male and female CHVs trained on micronutrient supplementation, vitamin A. MNPs and IFAS	no data	2019	Nutrition activity report	Annually	800	800	800	800	800
Production and consumption of fortified foods	Number of health workers educated on fortified foods in the market	no data	2019	Nutrition activity report	Annually	300	300	300	300	300
Production and consumption of fortified foods	Number of fortified food processors sensitized on food fortification	0	2019	Nutrition activity report	Annually	10	10	10	10	10
Strengthened monitoring and evaluation of the micronutrient activities	Number of support supervisions on micronutrient activities conducted	no data	2019	Nutrition activity report	Bi-annual	2	2	2	2	2

Table 12: KRA 04: Prevention, control & management of diet related non - communicable diseases scaled up

Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened capacity for prevention, control, and management of NCDs	Number of male and female CHVs trained on screening of DRNCDs	No Data	2019	Nutrition activity report	Annually	360	360	360	360	360
	Proportion of clients with DRNCDs referred to link health facilities	No Data	2019	Nutrition activity report	Annually	40%	50%	60%	70%	80%

Table 13: KRA 05: Management of acute malnutrition and nutrition in emergencies strengthened

Output	Key performance indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened IMAM supply chain	Proportion of MAM, SAM patients supported with IMAM commodities	20%	2019	DHIS	Monthly	30%	40%	50%	60%	70%
	Proportion of facilities equipped with anthropometric equipment	40%	2019	Nutrition report	Quarterly	50%	60%	65%	70%	75%
Enhanced capacity of health care worker and CHVs to implement IMAM program	Proportion of facilities reporting on IMAM	40%	2019	DHIS	Monthly	50%	60%	65%	70%	75%
	Number of male and female HCWs trained on IMAM	0	2019	Attendance list	Every 2 Years	0	34	0	34	0
	Number of male and female HCWs trained on IMAM Surge	0	2019	Attendance list	Every 2 Years	0	60	60	60	60
Strengthened monitoring and evaluation of IMAM program	Number of supportive supervision visits done on IMAM	4	2019	Supervision reports	Quarterly	4	4	4	4	4
Strengthened linkages and referral to the facility and community	Proportion of malnourished clients referred, disaggregated by sex	0	2019	Referral summary	Monthly	10%	40%	60%	70%	80%
	Proportion of malnourished clients linked and referred to social protection interventions and livelihood programs	0	2019	Referral summary	Monthly	10%	20%	30%	40%	50%
Strengthened emergency preparedness and response.	Gender age and diversity responsive nutrition in emergency plan developed	0	2019	Emergency plan	Annually	Yes	Yes	Yes	Yes	Yes
	Rapid gender, age and diversity responsive nutrition assessment in hot spots conducted	0	2019	Rapid assessment report	Every 2 Years	0	1	0	1	0
	Number of gender responsive outreaches conducted in hard to reach areas	4	2019	Outreach reports	Quarterly	4	4	4	4	4

Table 14: KRA 06: Clinical nutrition and dietetics in disease management including HIV and TB strengthened

Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened inter-facility referral system for nutrition services.	Number of male and female nutritionists and other HCW sensitized on the referral tool	0	2019	Summary report	Bi-annual	20	0	20	0	20
Strengthened clinical nutrition and dietetics services in management of diseases in inpatients and general hospital services.	Proportion of outpatients receiving NACS services	12	2019	KHIS	Monthly	40%	45%	50%	55%	60%
	Proportion of level 4/5 facilities with demonstration corners	5%	2019	Supervision reports	Monthly	10%	15%	25%	50%	55%
	Proportion of health facilities submitting gender sensitive clinical nutrition monthly reports	30%	2019	KHIS	Monthly	35%	50%	55%	60%	65%
Strengthen Management of malnutrition in disease and illness.	Proportion of facilities providing therapeutic feeds.	11%	2019	LMIS reports; Supervision reports	Monthly	18%	36%	53%	70%	90%
	Proportion of male and female HCW sensitized on prevention of hospital malnutrition in level 4/5 facilities	0	2019		Monthly	0.2	0.3	0.4	0.5	0.6
	Proportion of facilities with patients' special menus in level 4/5 facilities	0	2019	Nutrition County Report; Supervision Reports	Quarterly	5%	20%	40%	60%	70%
Strengthened patient feeding in healthcare institutions	Proportion of level 4/5 facilities holding catering committees' meetings	5%	2019	Catering committee reports	Quarterly	10%	40%	50%	60%	70%
	Number of genders integrated operational research conducted on clinical nutrition.	0	2019	Research reports	Every 2 years	0	1	0	2	0
Strengthened technical capacity for clinical nutrition	Number of trainings conducted by clinical nutrition specialists on technical areas.		2019		Bi-annual	2	2	2	2	2
	Number of male and female nutritionists sponsored for trainings on technical clinical nutrition areas.	0	2019	County nutrition reports	Bi-annual	2	2	2	2	2
	Number of male and female nutritionists sponsored for short courses on gender responsive clinical nutrition.	0	2019	County nutrition reports	Annually	2	2	2	2	2
	Number of male and female nutritionists sponsored for specialised courses on gender responsive clinical nutrition.	0	2019	County nutrition reports	Every 2 years	1	1	1	1	1
Enhanced skills and competence of public and private health workforce to provide patient-focused nutrition therapies	Number of male and female health workers trained through online and in person CPD on integrated nutrition therapy for TB/HIV	0	2019	Integrated nutrition therapy for TB/HIV training report	Bi-annual	80	80	80	80	80
Scaled up nutrition assessment, counselling and support at HIV/TB service points while simultaneously	Proportion of HIV/TB clients receiving NACS disaggregated by gender, age, and diversity	50%	2019	Nutrition activity report		70%	75%	78%	80%	85%

Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
strengthening facility referral linkages for the patients	Proportion of HIV/TB sites with nutrition assessment tools	60%	2019	Inventory	Bi-annual	65%	70%	75%	80%	85%
	Proportion of TB/HIV sites with nutrition commodities	50%	2019	KHIS	Quarterly	70%	80%	85%	88%	90%
	Proportion of facilities reporting use of nutrition assessment tools	40%	2019	County nutrition report	Quarterly	50%	60%	70%	80%	85%
	Proportion of facilities receiving nutrition commodities for nutrition and HIV	No Data	2019	Nutrition commodities distribution list	Annually	90%	90%	90%	90%	90%
Strengthened integration of nutrition interventions for home-based care at community level for PLHIVs	Number of male and female health workers trained on m-health systems	0	2019	m-health training report	Annually	50	50	0	0	0
	Number of male and female CHVs trained on promotion of gender transformative healthy and sustainable lifestyles at household level	0	2019	Training report	Annually	20	20	20	20	20
Strengthened referrals, and linkage systems to involve all community actors and optimize identification and linkage of PLHIV and TB patients with nutrition care and management	Proportion of TB/HIV clients referred to other service delivery points disaggregated by gender, age, and diversity.	50%	2019	Nutrition report	Monthly	80%	90%	90%	90%	90%
	Proportion of TB/HIV clients referred to social protection programs disaggregated by gender, age, and diversity	5%	2019	Referral summary	Monthly	50%	70%	80%	80%	80%
	Proportion of TB/HIV clients referred from community to facility disaggregated by gender, age, and diversity	0	2019	Referral summary	Monthly	50%	80%	90%	90%	90%
	Proportion of TB/HIV nutrition clients supported through social protection safety nets disaggregated by gender, age, and diversity	0	2019	Social services reports	Monthly	10%	20%	30%	40%	60%
Enhanced monitoring and evaluation and use of implementation research and learning to generate evidence for cost-effective nutrition data for TB and HIV programming.	Number of genders integrated operational research on nutrition in TB/HIV	0	2019	Nutrition activity report	Quarterly	1	0	1	0	1

Table 15: KRA 07: To promote nutrition linkages with nutrition sensitive sectors (Agriculture, Education, Social Protection, WASH)

Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Joint planning and monitoring with the agricultural sector promoted	Number of joint bi-annual review meetings held with the agriculture sector on planned activities	0	2019	Nutrition activity report	Bi-annual	2	2	2	2	2
	Number of community forum held on kitchen gardening and rearing of small livestock in collaboration with department of Agriculture	No data	2019	Nutrition and agriculture activity reports	Annually	24	24	24	24	24
	Number of health facilities with kitchen gardening and small livestock demonstrations	No data	2019	Nutrition and agriculture activity reports	Annually	24	24	24	24	24
	Number of male and female community members reached with gender responsive climate SMART agriculture technology	No data	2019	Nutrition and agriculture activity reports	Annually	60	60	60	60	60
Awareness created on consumption of safe, diverse, and nutritious foods	Number of male and female health workers sensitized on consumption of safe, diverse, and nutritious foods	No data	2019	Nutrition activity report	Annually	120	120	120	120	120
	Number of male and female CHVs sensitized on consumption of safe, diverse, and nutritious foods	No data	2019	Nutrition activity report	Annually	600	600	600	600	600
	Number of gender inclusive community forums held on the various agri-nutrition interventions	No data	2019	Nutrition activity report	Annually	48	48	48	48	48
Recycling and harvesting of water for use in kitchen gardening promoted	Number of male and female CHVs sensitized on water harvesting and recycling	0	2019	Nutrition and agriculture activity reports	Annually	600	600	600	600	600
Value addition, preservation, storage, and agro-processing promoted	Number of male and female CHVs sensitized on gender, age and diversity responsive value addition, preservation, post-harvest handling and agro-processing	0	2019	Nutrition and agriculture activity reports	Annually	600	600	600	600	600
Rainwater harvesting, protecting community water sources and safe storage facilities promoted	Number of male and female CHVs sensitized on rainwater harvesting, protecting community water sources and safe storage facilities	0	2019	Nutrition and agriculture activity reports	Annually	600	600	600	600	600
Strengthened proper hygiene practices at community and household level	Number of genders, age and diversity inclusive community forums on proper hand washing at critical time	No data	2019	Nutrition and WASH activities report	Annually	48	48	48	48	48
	Number of male and female food handlers trained on HACCP	No data	2019	Nutrition and WASH activities report	Annually	12	12	12	12	12
Synergy created between nutrition and social protection	Number of stakeholders' forums on gender responsive nutrition and social protection programs	0	2019	Nutrition and social protection activities	Every 2 Years	12		12		12
Nutrition staff capacity built on social protection interventions	Number of male and female nutritionists and CHVs sensitized on gender responsive social protection interventions	No data	2019	Nutrition and social protection activities	Annually	624	624	624	624	624

Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Social protection staff (social workers) and other stakeholders capacity built on nutrition for the target population in social protection programs	Number of male and female social protection staff (social workers) sensitized on nutrition for the target population	0	2019	Nutrition and social protection activities	Every 2 Years	36	0	36	0	36
	Number of children homes managers sensitized on gender responsive integrated nutrition social-protection activities	0	2019	Nutrition and social protection activities	Annually	50	50	50	50	50
Nutrition assessment, Vitamin A and deworming promoted in ECDE	Proportion of male and female malnourished, and sick children referred to the link facility	No data	2019	Nutrition and ECDE activity report	Annually	70%	75%	80%	85%	85%
Safe food environment promoted in schools	Number of male and female school stakeholders sensitized on healthy and safe food environment, and marketing of healthy food supplies in schools	No data	2019	Nutrition and ECDE activity report	Annually	60	60	60	60	60
	Number of advocacy forums held on sufficient and safe nutritious food supplies in schools	0	2019	Nutrition and ECDE activity report	Annually	12	12	12	12	12
	Number of school stakeholders' forums held to sensitize on school gardens and rearing of small animals in collaboration with department of Agriculture	0	2019	Nutrition, agriculture and ECDE activity report	Annually	12	12	12	12	12
	Proportion of schools with revived 4k clubs	0	2019	Nutrition, agriculture and ECDE activity report	Annually	20%	30%	40%	50%	60%
Monitoring of nutrition sensitive sector activities strengthened	Number of joint bi-annual progress review meetings held		2019	Nutrition activity report	Bi-annual	2	2	2	2	2

Table 16: KRA 08: Sectoral and multisectoral nutrition governance, coordination legal frameworks, leadership and management strengthened

Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened co-ordination mechanisms for program implementation, knowledge sharing and learning at County level	Number of CNTF and SCNTF meetings conducted.	4	2019	Nutrition activity reports	Quarterly	4	4	4	4	4
Strengthened partnerships in nutritional sector	Mapping of private sector conducted	0	2019	Mapping report	Annually	Yes	No	Yes	No	Yes
	Number of SUN stakeholders' meetings held.	none	2019	Stakeholders report	Annually	1	0	1	0	0
	Number of male and female members of the private sector sensitized on SUN business.	none	2019	Nutrition activities reports	Annually	20	0	20	0	0

Table 17: KRA 09: Sectoral and multisectoral Nutrition Information Systems, learning and research strengthened

Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Enhanced monitoring of key nutrition implementation plans	Number of gender responsive AWPs developed	1 AWP	2019	Nutrition activity report Nutrition performance review reports	Annually	1	1	1	1	1
	Number of annual performance review meetings for CNAP through the AWPs conducted	None	2019	Nutrition activity report Nutrition performance review reports	Every 3 Years	1	1	1	1	1
Strengthened quality of nutrition data	Number of data audits conducted	1 DQA	2019	Nutrition activity report	Bi-annual	2	2	2	2	2
Strengthened collaboration between the various sectors for enhanced data sharing	Number of genders, age and diversity disaggregated nutrition dashboard developed linking the data from various sectors	None	2019	Nutrition activity report	Every 5 Years	1	0	0	0	1
Strengthened linkages with research institutions and other stakeholders to share research findings	Gender integrated nutrition research repository platform established	None	2019	Nutrition activity report Nutrition performance review reports	Every 5 Years	No	Yes	Yes	Yes	Yes
Strengthened sectoral and multisectoral collaboration in promoting evidence-based research for evidence-based decision making.	Nutrition research agenda integrated into the county's health research department.	None	2019	Nutrition activity report Nutrition performance review reports	Annually	No	Yes	Yes	Yes	Yes
	Number of male and female nutritionists trained on gender integrated operation implementation research	0	2019	Nutrition activity report Nutrition performance review reports	Annually	0	0	28	0	0
Strengthened evidence-based nutrition information generation	Number of genders integrated SMART surveys on nutrition conducted and disseminated	0	2019	Nutrition activity report Nutrition performance review reports	Every 5 Years	0	0	0	1	0
	Number of gender integrated KAP survey conducted and disseminated	0	2019	Nutrition activity report	Every 5 Years	0	0	0	0	1
	Number of nutrition capacity assessment done and disseminated	0	2019	Nutrition activity report	Every 3 years	0	0	1	0	0

Table 18: KRA 10: Advocacy, Communication and Social-Mobilization (ACSM) strengthened

Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Enhanced high level engagement and advocacy to promote nutritional agenda in the county	Number of high-level sensitization meetings held with policy makers and county legislature on the value of prioritization of nutrition and gender mainstreaming	None	2019	Nutrition activity report	Annually	1	0	1	0	0
	Number of meetings held to advocate for specific nutrition budget line in the county budget	1	2019	Nutrition activity report	Annually	1	1	1	1	1
Strengthened capacity for nutrition advocacy	Number of male and female county nutritionists, health promotion officers and community strategy focal person trained on advocacy considering gender mainstreaming	1	2019	Nutrition activity report	Annually	40	40	40	40	40
	Number of male and female nutritionists sensitized on nutrition communication and writing skills for better packaging of nutrition information considering gender mainstreaming	None	2019	Nutrition activity report	Annually	60	60	60	60	60
Improved relationship between the mainstream media and the county	Number of media correspondents sensitized on gender responsive nutrition advocacy	None	2019	Nutrition activity report	Annually	25	25	25	25	25
	Number of nutrition programmes featured in the mainstream media	1	2019	Nutrition activity report	Quarterly	4	4	4	4	4
	Number of male and female nutrition media champions identified	None	2019	Nutrition activity report	Annually	2	2	2	2	2
Effective knowledge management and strengthened evidence-based advocacy	Number of conferences and forums on nutrition knowledge attended by the county nutritionists	None	2019	Nutrition activity report	Annually	5	5	5	5	5
Strengthened community engagement, participation and feedback mechanisms for nutrition services and decision-making processes.	Number of male and female community own resource persons and CHVs sensitized to create demand for utilization of nutrition services	1470	2019	Nutrition activity report	Annually	240	240	240	240	240
	Number of male and female community nutrition champions identified (1 per sub county and 1 for the county)	None	2019	Nutrition activity report	Annually	8	8	8	8	8

Table 19: KRA 11: Strengthen availability of nutrition commodities, equipment, and tools

Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened coordination and management capacity of supply chain of nutrition commodities and equipment	Number of male and female nutritionists trained on LMIS	0	2019	Training Report	Bi-annual	32	32	32	32	32
	Number of nutrition commodity and security TWG meetings held	0	2019	Attendance list	Quarterly	4	4	4	4	4
	Number of annual Forecasting and quantification exercise across the nutrition programs	1	2019	Nutrition activity reports	Annually	1	1	1	1	1
Improved availability of nutrition commodities	Proportion of facilities reporting no stock out of the essential nutrition commodities	No Data	2019	Nutrition activity reports	Quarterly	30%	40%	50%	70%	80%
Improved quality of nutrition commodities	Proportion of facilities with guidelines and SOPs for nutrition commodities and tools	No Data	2019	Nutrition activity reports	Bi-annual	50%	60%	70%	80%	100%
	Number of nutrition commodity data quality audits and data review meetings	No Data	2019	Nutrition activity reports	Bi-annual	2	2	2	2	2

4.11 Implementation plan

To ensure coordinated, structured, and effective implementation of the Kiambu 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

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

Table 20: Roles and responsibilities of different actors in the implementation of Kiambu 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
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

Actors	Roles and responsibilities
Implementing partners and agencies	• Aligning all their M&E activities to realize the goals of this plan as well as the institutional M&E goals articulated in sectoral, programmatic, and County specific M&E Plans • 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.

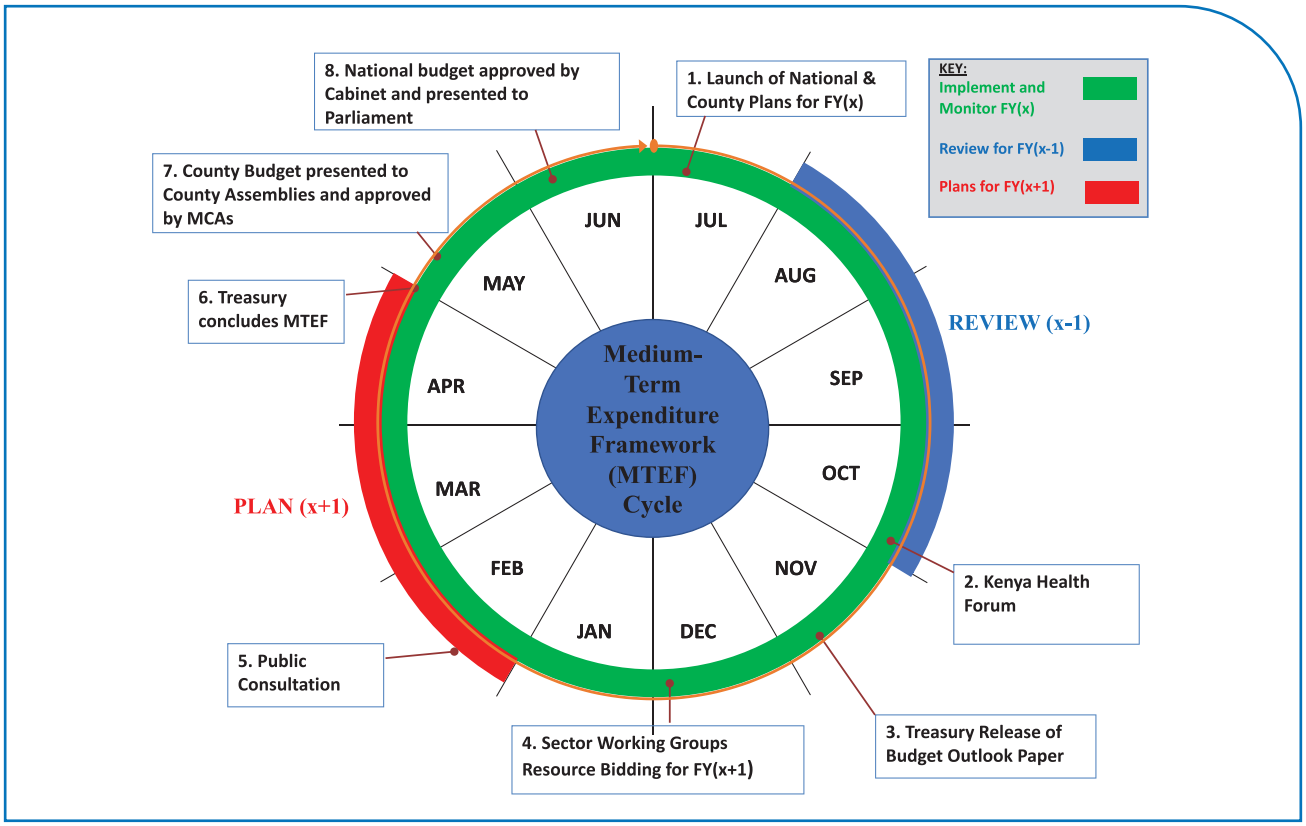


Figure 9: National health sector accountability cycle

4.14 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.

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

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

5.2 Costing approach

Financial resources need for the CNAP were estimated by costing all the activities necessary to achieve each of expected outputs in each of Key Result Area (KRA). The costing of the CNAP used Activity-Based Costing (ABC) approach to estimate the total resource need to implement the action plan for the next five years. 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 Activity Based Costing (ABC) approach 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 taking in mind the cost drivers like quantities and frequencies. According to the Activity Based Costing, to fully actualize the strategic plan, KSh. 2.5 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.2.5 billion for nutrition over the plan period. This further has been disaggregated by KRAs as shown in the table below.

Table 21: 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	74,773,300	66,291,400	75,955,300	65,793,850	75,391,800	358,205,650
KRA 02: Promote the nutrition of older children, adolescents, adults & older persons	7,315,100	6,925,100	7,315,100	3,953,600	10,286,600	35,795,500
KRA 03: To scale up the prevention, control, and management of micronutrient deficiencies	11,825,320	11,579,820	11,825,320	11,579,820	11,825,320	58,635,600
KRA 04: Prevention, control & management of diet related non - communicable diseases scaled up	9,240,200	7,916,700	9,240,200	5,036,700	12,120,200	43,554,000
KRA 05: Management of acute malnutrition and nutrition in emergencies strengthened	6,064,200	12,201,570	10,911,750	12,316,010	7,194,750	48,688,280
KRA 06: Clinical nutrition and dietetics in disease management including HIV and TB strengthened	16,696,540	14,325,740	16,377,740	12,612,740	12,878,740	72,891,500
KRA 07: To promote nutrition linkages with nutrition sensitive sectors (Agriculture, Education, Social Protection, WASH)	23,601,640	25,752,640	23,665,640	25,752,640	24,505,640	123,278,200
KRA 08: Sectoral and multisectoral nutrition governance, coordination legal frameworks, leadership and management strengthened	18,151,000	15,239,200	17,481,200	15,969,000	17,481,200	84,321,600
KRA 09: Sectoral and multisectoral Nutrition Information Systems, learning and research strengthened	17,657,500	18,349,700	24,850,800	17,561,200	19,986,000	98,405,200
KRA 10: Advocacy, Communication and Social-Mobilization (ACSM) strengthened	22,801,000	16,326,500	18,076,500	16,682,500	22,606,500	96,493,000
KRA 11: Strengthen availability of nutrition commodities, equipment, and tools	282,033,200	318,465,450	306,513,200	306,813,200	306,513,200	1,520,338,250
Grand Total	**490,159,000**	**513,373,820**	**522,212,750**	**494,071,260**	**520,789,950**	**2,540,606,780**

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

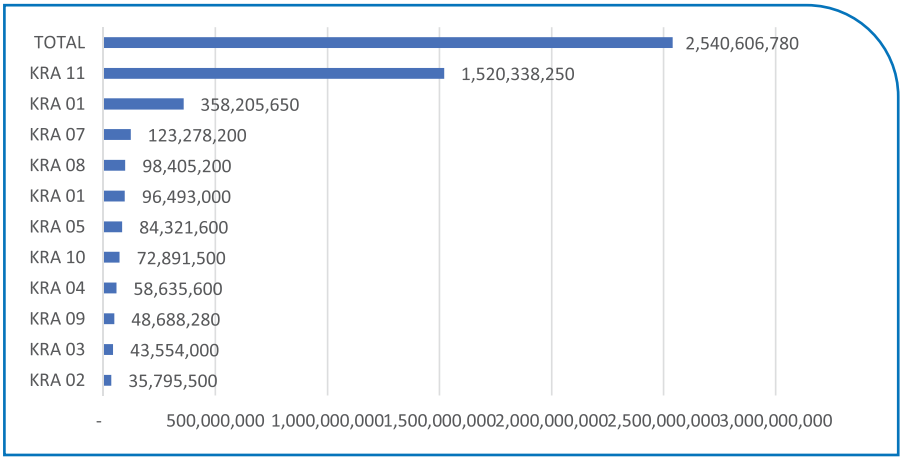


Figure 10: Total cost requirements (2020/21 – 2024/25)

Analysis of the cost requirements shows that 60 percent of the funds will be required to cater for KRA on Strengthening availability of nutrition commodities, equipment and tools; KRA on Maternal Infant And Young Child Nutrition(MIYCN) scaled up will require 14 percent while KRA on To promote nutrition linkages with nutrition sensitive sectors (Agriculture, education, social protection, WASH) will require 5 percent.

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

5.5.2 Strategies to ensure efficiency in resource utilization

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

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7 APPENDICES

Annex A: Summary table of resources needs by KRA 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	**74,773,300**	**66,291,400**	**75,955,300**	**65,793,850**	**75,391,800**	**358,205,650**
Carry out baseline BFHI assessment	65,850	65,850	65,850	65,850	65,850	329,250
Carry out continuous BFCI self-assessments	896,000	896,000	896,000	896,000	896,000	4,480,000
Carry out continuous BFHI self-assessments	-	-	-	65,850	-	65,850
Carry out Malezi bora	800,000	800,000	800,000	800,000	800,000	4,000,000
Carry out social mobilization	-	-	-	-	-	-
Commemorate World breastfeeding week	400,000	400,000	400,000	400,000	400,000	2,000,000
Conduct biannual community baby friendly gatherings	96,000	96,000	96,000	96,000	96,000	480,000
Conduct meetings in the community leveraging on other community activities	-	-	-	-	-	-
Participate in celebration of world prematurity day	-	-	-	-	-	-
Print ICCM IEC materials	500,000	500,000	500,000	500,000	500,000	2,500,000
Procure CHV growth monitoring kits	-	576,000	-	576,000	-	1,152,000
Sensitize male and female CHVs in MIYCN	764,000	360,000	764,000	360,000	764,000	3,012,000
Sensitize the Community Health Committees, Health Facility Committees on BFCI	828,000	828,000	828,000	828,000	828,000	4,140,000
Train male and female CHVs on cBFCI	4,700,000	4,700,000	4,700,000	4,700,000	4,700,000	23,500,000
Train male and female CHVs on ICCM	4,200,000	4,200,000	4,200,000	4,200,000	4,200,000	21,000,000
Train male and female HCWs on BFHI	2,267,500	2,267,500	2,267,500	2,267,500	2,267,500	11,337,500
Train male and female HCWs on IMNCI	126,000	126,000	126,000	126,000	126,000	630,000
Train male and female HCWs on MIYCN	1,512,000	1,512,000	1,512,000	1,512,000	1,512,000	7,560,000
Hold quarterly county and sub-county BFHI task force meeting as per ToR	234,000	234,000	234,000	234,000	234,000	1,170,000
Carry out monthly MTMSG and FTFSG meetings at community unit level	1,872,000	1,872,000	1,872,000	1,872,000	1,872,000	9,360,000
Carry out targeted home visits by CHVs	480,000	480,000	480,000	480,000	480,000	2,400,000
Hold quarterly county and sub county BFCI task force meeting as per TOR	494,000	494,000	494,000	494,000	494,000	2,470,000
Train/sensitize male and female HCWs on growth standards using national guidelines as per WHO guidance	1,684,000	1,684,000	1,684,000	1,684,000	1,684,000	8,420,000
Carry out monthly growth assessment to all children aged 0-59 months	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	6,000,000
Sensitize and disseminate existing MIYCN, IMNCI & ICCM policies, guidelines, and strategies to CHMT and SCHMT	513,000	-	513,000	-	513,000	1,539,000
Hold meetings to share feedback report on services statistics for MIYCN, IMNCI & ICCM by CHMT and SCHMT	4,650,000	-	4,650,000	-	4,650,000	13,950,000
Conduct outreaches to promote gender transformative MIYCN practices at community level targeting men and women of different ages, diversities and levels of influence using effective communication channels	4,512,000	4,512,000	4,512,000	4,512,000	4,512,000	22,560,000
Conduct health education to the community targeting men and women of different ages, diversities, and levels of influence on IMNCI using effective communication channels	3,612,000	3,612,000	3,612,000	3,612,000	3,612,000	18,060,000
Promote increased engagement of men, boys, community leaders and other key influencers through sensitizing them on their important role in promoting and supporting optimal uptake of MIYCN practices and related services.	130,000	130,000	130,000	130,000	130,000	650,000
Sensitize male and female health managers on BFHI	286,000	-	286,000	-	286,000	858,000
Establish gender and diversity inclusive BFHI committees in the implementing health facilities	117,750	117,750	117,750	117,750	117,750	588,750
Sensitize the non-clinical staff on gender responsive BFHI in the implementing health facilities	200,000	200,000	200,000	200,000	200,000	1,000,000
Carry out continuous CMEs on BFHI in the implementing health facilities	220,000	220,000	220,000	220,000	220,000	1,100,000
Establish county and sub county gender and diversity inclusive BFHI task force committee	-	-	531,000	-	-	531,000
Carry out gender integrated BFHI external assessment	-	-	-	-	331,500	331,500
Sensitize the CHMT and SCHMT on BFCI	513,000	-	513,000	-	513,000	1,539,000
Train male and female HCWs across all cadres on BFCI and to effectively mainstream gender in the and implementation of gender transformative BFCI initiatives.	3,334,200	3,334,200	3,334,200	3,334,200	3,334,200	16,671,000
Establish gender sensitive and diversity inclusive BFCI committees in implementing community units	638,400	638,400	638,400	638,400	638,400	3,192,000
Conduct household mapping and formation of MTMSGs and FTFSGs in the implementing community units to include women and men across different ages, diversities, and levels of influence, respectively.	60,000	230,400	180,000	180,000	180,000	830,400
Carry out gender integrated community BFCI baseline assessment	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	5,500,000
Carry out continuous support supervision for the BFCI Community units by CHMT, SCHMT in collaboration with the link health facility in charge	828,000	828,000	828,000	828,000	828,000	4,140,000

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	**74,773,300**	**66,291,400**	**75,955,300**	**65,793,850**	**75,391,800**	**358,205,650**
Carry out external gender integrated BFCI assessment	636,800	636,800	636,800	636,800	803,800	3,351,000
Establish gender and diversity inclusive county and sub county BFCI task force committee	-	-	531,000	-	-	531,000
Sensitize male and female CHVs on growth standards using a harmonized national package	3,840,000	3,840,000	3,840,000	3,840,000	3,840,000	19,200,000
Carry out health and nutrition education targeting male and female caregivers, spouses including key influencers of children aged 0-59 months	13,230,000	13,230,000	13,230,000	13,230,000	13,230,000	66,150,000
Sensitize stakeholders in formal and non-formal setting on securing a user - friendly and gender responsive breastfeeding environment at workplaces	2,086,500	39,000	2,086,500	39,000	2,086,500	6,337,500
Sensitize CHMT and SCHMT of both genders and diversities on growth standards using national guidelines as per WHO guidance	-	513,000	-	-	-	513,000
Sensitize CHMT and SCHMT on the implementation framework for securing a user-friendly and gender responsive breastfeeding environment at workplace	-	513,000	-	513,000	-	1,026,000
Carry out CMEs on securing a user friendly and gender responsive friendly breastfeeding environment at workplaces in health facilities	36,000	36,000	36,000	36,000	36,000	180,000
Train/sensitize male and female health care workers on implementation framework for securing a user- friendly and gender responsive breastfeeding environment at workplace	1,684,000	1,684,000	1,684,000	1,684,000	1,684,000	8,420,000
Sensitize male and female CHVs and the community targeting men and women across different ages and diversities on implementation framework for securing a user-friendly and gender responsive breastfeeding environment at workplace using far reaching and effective gender, age, and diversity sensitive communication channels	6,432,000	6,432,000	6,432,000	6,432,000	6,432,000	32,160,000
Advocate and promote establishment of lactation stations at workplaces	45,000	45,000	45,000	45,000	45,000	225,000
Sensitize and disseminate BMS Act, 2012 to stakeholders in private and public sectors	2,086,500	1,072,500	2,086,500	1,072,500	2,086,500	8,404,500
Train nutritionist, public health officers and other health care workers targeting both genders and diversities on BMS Act implementation framework	229,800	-	229,800	-	229,800	689,400
Sensitize nutritionist, public health officers and other health care workers targeting both genders and diversities on BMS monitoring and enforcement framework	237,000	-	237,000	-	237,000	711,000
Conduct market level surveillance to monitor adherence to BMS Act	-	-	-	-	-	-
Establish and functionalize gender and diversity inclusive sensitive committees for monitoring and enforcement of BMS Act	360,000	-	360,000	-	360,000	1,080,000
Report all BMS Act,2012 Violations through the agreed ministry of health channels	36,000	36,000	36,000	36,000	36,000	180,000
KRA 02: Promote the nutrition of older children, adolescents, adults & older persons	**7,315,100**	**6,925,100**	**7,315,100**	**3,953,600**	**10,286,600**	**35,795,500**
Integrate key messages on healthy diets and physical activity in the school health programs	180,000	-	180,000	-	180,000	540,000
Monitor and evaluate the WIFAS program	654,000	654,000	654,000	654,000	654,000	3,270,000
Print IEC materials	3,600	3,600	3,600	3,600	3,600	18,000
Sensitize education stakeholders on marketing & promotion of safe and nutritious foods within the school	492,000	-	492,000	-	492,000	1,476,000
Sensitize key stakeholders on WIFAS	492,000	-	492,000	-	492,000	1,476,000
Sensitize male and female teachers on WIFAS	1,728,000	1,608,000	1,728,000	1,608,000	1,728,000	8,400,000
Sensitize school stakeholders on healthy diets and physical activity for older children and adolescent	492,000	-	492,000	-	492,000	1,476,000
Sensitize stakeholders in adult and older persons institutions on healthy diets and physical activity	-	1,342,500	-	-	1,342,500	2,685,000
Sensitization older children, adolescent, adults and older persons on healthy diets and physical activity using far reaching, all-inclusive and user friendly, effective communication channels for all gender, age, and diverse populations- school health program, churches, youth clubs	198,000	198,000	198,000	198,000	198,000	990,000
Sensitize adolescent girls in schools and out of school on WIFAS	1,187,500	1,187,500	1,187,500	1,187,500	1,187,500	5,937,500
Carry out WIFAS targeting adolescent girls in schools and out of school using effective channels	-	-	-	-	-	-
Sensitize key stakeholders, male and female parents, and other key influencers in the community on the importance of WIFAs.	-	-	-	-	-	-

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 02: Promote the nutrition of older children, adolescents, adults & older persons	**7,315,100**	**6,925,100**	**7,315,100**	**3,953,600**	**10,286,600**	**35,795,500**
Sensitize male and female CHMT & SCHMTs representatives on geriatric nutrition guidelines	492,000	10,500	492,000	10,500	492,000	1,497,000
Sensitize male and female HCWs on geriatric nutrition to provide quality and gender, age and diversity transformative health care and nutrition support for older people	36,000	1,665,000	36,000	36,000	1,665,000	3,438,000
Sensitize male and female CHVs on geriatric nutrition to actively engage and empower older persons in solving problems gender and diversity transformative related to their health and nutrition interventions/initiatives.	1,320,000	216,000	1,320,000	216,000	1,320,000	4,392,000
Sensitize community targeting men and women across different ages and diversities and level of influence on optimal nutrition for geriatrics using far-reaching, user-friendly effective communication channels for all genders, ages, and diverse population such as media.	40,000	40,000	40,000	40,000	40,000	200,000
KRA 03: To scale up the prevention, control, and management of micronutrient deficiencies.	**11,825,320**	**11,579,820**	**11,825,320**	**11,579,820**	**11,825,320**	**58,635,600**
Adopt legislations on blending of flours using traditional high value crops	-	-	-	-	-	-
Carry out CMEs targeting male and female health care workers on fortified foods in the market including the fortification logo.	150,000	150,000	150,000	150,000	150,000	750,000
Carry out Zinc supplementation for management of diarrhea as per guidelines	-	-	-	-	-	-
Procure and distribute micronutrient commodities (IFAS, Vitamin A, Zinc, MNPs)	-	-	-	-	-	-
Sensitize male and female CHVs on micronutrient supplementation (Vitamin A, MNPs, IFAS)	336,000	336,000	336,000	336,000	336,000	1,680,000
Sensitize the private sector on food fortification (Capwell, Azuri, Bidco, Mama, Maycorn etc.)	48,000	48,000	48,000	48,000	48,000	240,000
Train both male and female health workers on micronutrient supplementation Vitamin A, MNPs, IFAS)	149,500	-	149,500	-	149,500	448,500
Carry out deworming of children aged 12 months and above including pregnant women	3,619,500	3,619,500	3,619,500	3,619,500	3,619,500	18,097,500
Sensitize health care workers on forecasting and quantification including inventory management of micronutrients commodities	474,000	474,000	474,000	474,000	474,000	2,370,000
Carry out forecasting, quantification, and inventory management of micronutrients commodities	474,000	474,000	474,000	474,000	474,000	2,370,000
Carry out annual monitoring of salt iodization at county level	72,000	72,000	72,000	72,000	72,000	360,000
Conduct quarterly regulatory monitoring of fortified foods at industry and market level to increase compliance with fortification standards in collaboration with the regional Kenya Bureau of Standards (KEBS) team and PHOs	576,000	576,000	576,000	576,000	576,000	2,880,000
Carry out quarterly support supervision of micronutrient activities at sub county level	2,041,920	2,041,920	2,041,920	2,041,920	2,041,920	10,209,600
Promote increased production of micronutrient rich foods and bio fortified foods at household level targeting both male and female across different ages and diversities.	240,000	180,000	240,000	180,000	240,000	1,080,000
Carry out nutrition education through gender inclusive community forums targeting men and women across different ages and diversities on the importance of consuming micronutrient rich and bio-fortified foods	24,000	24,000	24,000	24,000	24,000	120,000
Sensitize male and female extension staff and CHVs on micronutrient rich foods and bio-fortification	36,000	-	36,000	-	36,000	108,000
Carry out routine Vitamin A supplementation as per the national guidelines	2,688,000	2,688,000	2,688,000	2,688,000	2,688,000	13,440,000
Carry out IFAS supplementation targeting pregnant mothers as per the national guidelines	-	-	-	-	-	-
Carry out MNP supplementations for children aged 6-23 months as per the national guidelines	-	-	-	-	-	-
Sensitize community targeting men and women across different ages, diversities, and levels of influence of the importance of optimal uptake of micronutrient supplement, identification and addressing underlying issues affecting increased adherence and uptake of the recommended micronutrient supplements.						
Sensitize male and female CHVs on food fortification including fortification logo	336,000	336,000	336,000	336,000	336,000	1,680,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 03: To scale up the prevention, control, and management of micronutrient deficiencies.	**11,825,320**	**11,579,820**	**11,825,320**	**11,579,820**	**11,825,320**	**58,635,600**
Sensitize the community through gender inclusive community forums targeting men and women across different ages and diversities on food fortification including fortification logo using effective communication channels	24,000	24,000	24,000	24,000	24,000	120,000
Carry out quarterly support supervision of micronutrient activities at sub county level	536,400	536,400	536,400	536,400	536,400	2,682,000
Carry out monthly reporting of micronutrient activities at sub-county and county levels	-	-	-	-	-	-
KRA 04: Prevention, control & management of diet related non - communicable diseases scaled up	**9,240,200**	**7,916,700**	**9,240,200**	**5,036,700**	**12,120,200**	**43,554,000**
Sensitize the community on healthy diet and importance of physical activity through gender inclusive community groups	183,600	183,600	183,600	183,600	183,600	918,000
Train male and female HCWs on healthy diets and physical activity	298,800	298,800	298,800	298,800	298,800	1,494,000
Training of male and female health workers on management of Diabetes, cancer & Hypertension	336,800	336,800	336,800	336,800	336,800	1,684,000
Promote and support establishment of a comprehensive DRNCD Centre	1,530,000	200,000	1,530,000	200,000	1,530,000	4,990,000
Develop and disseminate behavior change communication strategy on nutrition and non-communicable diseases to CHMT, SCHMT, health care workers and other stakeholders	2,086,500	-	2,086,500	-	2,086,500	6,259,500
Develop and disseminate key messages and advocacy tool kits on DRNCDs to CHMT, SCHMT, health care workers and other stakeholders	1,320,000	216,000	1,320,000	216,000	1,320,000	4,392,000
Advocate and support establishment of wellness Centers at workplaces	-	-	-	-	-	-
Sensitize male and female CHVs on DRNCDs	1,836,000	1,836,000	1,836,000	1,836,000	1,836,000	9,180,000
Conduct screening for early detection of NCD in the community and refer clients with DRNCDs to link health facilities	1,296,000	4,176,000	1,296,000	1,296,000	4,176,000	12,240,000
Sensitize and work with media, journalist, and editors for wider coverage of gender transformative DRNCDs messages/information	-	317,000	-	317,000	-	634,000
Promote screening of the public for early detection, control, management, and treatment of DRNCDs using various channels such as during world celebration of thematic day-world diabetes day etc., churches, etc.	352,500	352,500	352,500	352,500	352,500	1,762,500
KRA 05: Management of acute malnutrition and nutrition in emergencies strengthened	**6,064,200**	**12,201,570**	**10,911,750**	**12,316,010**	**7,194,750**	**48,688,280**
Sensitize the community members (men and women) across different ages and diversities on IMAM through community forums.	-	-	828,000	-	-	828,000
Promote improved linkage with programmes on behavioral change awareness creation or for prevention strategies at community and household level including MIYCN, social protection and livelihood support strategies	232,000	232,000	168,000	168,000	168,000	968,000
Train male and female health care workers on IMAM Package	-	1,564,000	-	1,564,000	-	3,128,000
Train male and female health care workers on IMAM surge kit	744,000	744,000	1,365,000	744,000	744,000	4,341,000
Conduct monthly CME and OJTs to health care workers IMAM in health facilities.	102,000	182,000	102,000	182,000	102,000	670,000
Adapt guidelines, strategies, treatment protocols and standard operating procedures (SOP) and disseminate at county level and sub county levels	-	97,500	-	97,500	-	195,000
Develop a scaled-up plan to expand access to treatment in all sub-counties	-	30,000	-	30,000	-	60,000
Train /sensitize male and female HCWs on LMIS for IMAM	-	1,626,560	-	-	-	1,626,560
Sensitize male and female CHVs on IMAM using a harmonized national package	-	-	2,832,000	-	-	2,832,000
Train/sensitize male and female HCWs on forecasting quantification of IMAM commodities	720,000	720,000	720,000	720,000	720,000	3,600,000
Conduct supportive supervision of healthcare workers for gender responsive IMAM implementation	-	524,100	404,100	404,100	404,100	1,736,400
Submission of monthly IMAM reports disaggregated by gender, age, and diversity	-	450	450	450	450	1,800
Utilize m-Health (data capturing, analysis, reporting, dissemination, and surveillance) for monitoring and reporting on IMAM	-	-	75,000	70,000	-	145,000
Effectively utilize IMAM surge	-	-	-	2,400,000	-	2,400,000
Promote gender integrated operational research on IMAM	-	-	25,000	-	1,050,000	1,075,000
Promote appropriate documentation of gender integrated related research, best practices, and learning	-	876,000	-	876,000	-	1,752,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 05: Management of acute malnutrition and nutrition in emergencies strengthened	**6,064,200**	**12,201,570**	**10,911,750**	**12,316,010**	**7,194,750**	**48,688,280**
Adopt key actions/recommendations from research, assessments/surveys, lessons learnt, routine data, programme review meetings and feedback from field experiences	-	210,000	-	210,000	-	420,000
Link and refer malnourished clients to facility/community and vice visa	120,000	-	-	-	-	120,000
Link and refer malnourished clients to social protection interventions and livelihood programs at community level	-	-	-	-	-	-
Advocate for allocation of resources for IMAM commodities and equipment's to key county decision makers	90,000	90,000	90,000	90,000	90,000	450,000
Carry out gender, age and diversity sensitive nutrition assessment, counseling, and support to clients with MAM and SAM at outpatient and in-patient care	307,200	307,200	307,200	307,200	307,200	1,536,000
Integrate management of acutely malnourished children with other programmes in the health care system	262,500	262,500	262,500	262,500	262,500	1,312,500
Map nutrition partners in preparedness and emergency risk reduction at county level	115,000	115,000	115,000	115,000	115,000	575,000
Participate in county multisectoral emergency preparedness and risk reduction committees	8,000	8,000	8,000	8,000	8,000	40,000
Form/establish gender, age, and diversity inclusive nutrition emergency task force	70,000	70,000	70,000	70,000	70,000	350,000
Adopt and implement of IMAM surge kit during emergencies where applicable	-	40,000	-	-	-	40,000
Develop/review county nutrition emergency preparedness and response plan	140,000	-	140,000	-	-	280,000
Adopt nutrition emergency response standard operating procedures	-	105,000	-	-	-	105,000
Train health care workers on gender responsive and transformative maternal infant and young child nutrition in emergencies (MIYCN-E)	225,000	225,000	225,000	225,000	225,000	1,125,000
Sensitize male and female CHVs on MIYCN-E	225,000	225,000	225,000	225,000	225,000	1,125,000
Promote gender, transformative MIYCN practices during emergencies for continued uptake of messages at community level and to counteract any misconceptions which may be brought about as a result of emergencies	250,000	250,000	250,000	250,000	250,000	1,250,000
Strengthen participation in community-level dialogue and recovery initiatives targeting men and women across different ages and diversities while ensuring their equal and meaningful participation.	480,000	480,000	480,000	480,000	480,000	2,400,000
Hold joint planning and implementation meetings with other sectors on integrated preparedness and risk reduction	262,500	262,500	262,500	262,500	262,500	1,312,500
Conduct joint resource mobilization activities with other sectors on integrated preparedness and risk reduction	135,000	135,000	135,000	135,000	135,000	675,000
Conduct rapid gender, age and diversity integrated nutrition needs assessment during emergencies to adapt response to the context especially in hot spots areas	-	1,125,760	-	725,760	-	1,851,520
Conduct nutrition outreaches in hard to reach areas and in urban areas to ensure access to high-impact nutrition interventions in emergencies	960,000	960,000	960,000	960,000	960,000	4,800,000
Activate emergency coordination for nutrition response monitoring during emergencies	316,000	316,000	316,000	316,000	316,000	1,580,000
Disseminate gender integrated rapid nutrition assessment finding to stakeholders for decision making	-	118,000	-	118,000	-	236,000
Actively engage in the development of gender responsive livelihood and social protection programmes to enhance integration of nutrition	300,000	300,000	300,000	300,000	300,000	1,500,000
Participate in policy discussions related to post-disaster reviews to influence nutrition considerations	-	-	246,000	-	-	246,000
KRA 06: clinical nutrition and dietetics in disease management including HIV and TB strengthened	**16,696,540**	**14,325,740**	**16,377,740**	**12,612,740**	**12,878,740**	**72,891,500**
Conduct TB/HIV nutrition partner mapping at county and sub-county level	-	-	-	-	-	-
Adopt and disseminate context-specific job aids for patient-focused nutrition therapy and interpersonal counselling to HCWs	-	500,000	-	-	-	500,000
Advocate for allocation of resources for TB/HIV nutrition commodities	-	-	-	-	-	-
Advocate for resources for clinical nutrition to the private sector and county government	-	-	105,000	-	105,000	210,000
conduct CMEs on new guidelines and practices in clinical nutrition.	-	-	-	-	-	-
Conduct quarterly data quality assessment (DQA)to inform programming	440,000	440,000	440,000	440,000	440,000	2,200,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 06: clinical nutrition and dietetics in disease management including HIV and TB strengthened	**16,696,540**	**14,325,740**	**16,377,740**	**12,612,740**	**12,878,740**	**72,891,500**
Conduct quarterly supply chain monitoring, including electronic LMIS systems, to minimize stock outs, avoid expiries, and over/ under-stocking of HIV/TB nutrition commodities	150,000	150,000	150,000	150,000	150,000	750,000
Establish partnership with social services departments to include TB/PLHIVs of both genders for social protection safety nets	-	-	-	90,000	-	90,000
Hold quarterly TB/HIV nutrition partner sharing meeting	-	-	-	-	-	-
refer HIV/TB clients to other service delivery points within and outside the facility	-	-	-	-	-	-
Adopt, print, and disseminate SOPs for clinical nutrition protocols.	700,000	-	-	-	-	700,000
Refer and link malnourished HIV/TB clients to social protection programs	-	-	-	-	-	-
Develop, disseminate, and adopt of gender responsive standard operating procedures (SOP) for nutrition screening, assessment, and triage	126,000	-	-	-	-	126,000
Advocate and support implementation of standard nutrition screening and assessment to the health management team (HMT)I health facilities	-	-	-	-	-	-
Monitor functionality of anthropometric assessment tools to ensure standardization and maintenance	128,640	128,640	128,640	128,640	128,640	643,200
Develop county nutrition referral tools	80,000	-	-	-	-	80,000
Sensitize male and female nutritionists and other HCW on the nutrition referral tool.	-	-	-	-	-	-
Implement and monitor use of the nutrition referral tool	-	-	-	-	-	-
Carry out nutrition assessment, diagnosis, counseling, and support to provide appropriate dietary interventions responsive to the specific needs for all patients across different gender, age, and diversities in both in-patient and out-patient care	-	-	-	-	-	-
Disseminate, print, and implement clinical nutrition and dietetics guideline	200,000	-	-	-	-	200,000
Train male and female HCWs on clinical nutrition and dietetics using a standard national package	-	1,342,000	-	1,342,000	-	2,684,000
Conduct CME on clinical nutrition and dietetics to health care workers in health facilities	1,224,000	-	-	-	-	1,224,000
Develop and disseminate gender integrated clinical nutrition qualitative tool for data collection	80,000	50,000	-	-	-	130,000
Carry out gender integrated bi-annual clinical nutrition qualitative data collection and analysis in high volume health facilities for informed decision making in matters clinical nutrition	793,600	593,600	593,600	593,600	593,600	3,168,000
Advocate for nutrition counseling and demonstration corners/ space within health facilities	-	1,000,000	-	-	-	1,000,000
Develop an assessment tool for inpatient feeding	50,000	-	-	-	-	50,000
Carry out continuous quality assessment for the inpatient feeding	4,116,000	4,116,000	4,116,000	4,116,000	4,116,000	20,580,000
Develop and disseminate IEC material for clinical nutrition and dietetics	50,000	-	-	-	-	50,000
Advocate for gender integrated operational research in clinical nutrition, cost-effectiveness analysis of various clinical nutrition interventions and application of evidence-based nutrition in patient management	104,000	-	104,000	-	-	208,000
Adopt, disseminate, and utilize appropriate clinical nutrition and dietetics monitoring & reporting tools and submit monthly reports	-	-	-	-	-	-
Develop, disseminate, and utilize an electronic nutrition data template for integration into the county software	72,000	24,000	24,000	24,000	24,000	168,000
Sensitize and update male and female HCWs on prevention of hospital malnutrition	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	20,000,000
Develop and disseminate hospital basic nutrition formulary	60,000	-	-	-	-	60,000
Develop individualized gender, age, and diversity responsive feeding regimes for patients with acute malnutrition and other chronic diseases under inpatient care	1,998,000	-	-	-	-	1,998,000
Develop and implement hospital menus that are responsive to patients' needs across different gender, age, and diversities.	350,000	-	3,500,000	-	-	3,850,000
Revive catering/inpatient and therapeutic /food inspection committees in all healthcare institutions.	-	-	-	-	-	-
Conduct mentorship and OJT to nutritionists targeting both genders on specialized technical areas under clinical nutrition and dietetics	160,000	160,000	160,000	160,000	160,000	800,000
Advocate for sponsorship of male and female nutritionists to trainings on specialized technical clinical nutrition and dietetics areas such as renal, oncology etc..	-	-	-	-	-	-

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 06: clinical nutrition and dietetics in disease management including HIV and TB strengthened	**16,696,540**	**14,325,740**	**16,377,740**	**12,612,740**	**12,878,740**	**72,891,500**
Advocate for financial support to sponsor male and female nutrition courses on clinical nutrition and dietetics such as enteral and parental nutrition among others	-	-	-	-	-	-
Adopt and disseminate gender, responsive guidelines on nutrition in HIV and TB management to CHMT, SCHMT and HMT	-	-	-	-	-	-
Train male and female health care workers on integrated nutrition therapy for TB/HIV management using various effective communication channels	-	-	-	-	-	-
Conduct gender, age and diversity sensitive nutrition assessment, counseling, and support to all male and female TB/HIV clients in all HIV, TB, MNCH service delivery points to reduce missed opportunities and improve service uptake and retention into care	-	1,000,000	-	-	-	1,000,000
Implement county and sub-county level forecasting, quantification, and supply planning exercises through integrated operationalized county-level commodity security committees	230,000	230,000	230,000	230,000	230,000	1,150,000
Conduct bi-annual surveillance for quality of nutrition commodities used in management of HIV/TB patients in health facilities by county and sub county health management teams	135,500	135,500	135,500	135,500	135,500	677,500
Develop small doable actions that enhance dietary diversity and physical exercises at household level for HIV and TB patients	632,800	-	-	552,000	-	1,184,800
Adopt and train on use of m-Health systems to identify and follow up patients at community level	-	-	-	-	-	-
Train/sensitize male and female CHVs and other community resource persons on good nutrition practices for HIV/TB patients to promote healthy and sustainable lifestyles at household level	456,000	456,000	456,000	456,000	456,000	2,280,000
Disseminate key context-specific nutrition messages that promote positive lifestyles and behavior for HIV /TB patients to the community targeting men and women across different ages and diversities through effective communication channels	-	-	-	-	-	-
Disseminate and sensitize male and female HCWs on nutrition TB/HIV data collection and reporting tools disaggregated by age gender and diversity.	-	-	-	-	-	-
Conduct gender integrated county level operational research for TB/HIV programs in partnership with research institutions to inform programming	60,000	-	2,235,000	-	2,235,000	4,530,000
Use county level scorecard and report on gender sensitive nutrition indicators for HIV/TB program	195,000	-	-	195,000	-	390,000
Conduct county and sub county quarterly gender, age and diversity disaggregated TB/HIV data review meetings for decision making	105,000	-	-	-	105,000	210,000
KRA 07: To promote nutrition linkages with nutrition sensitive sectors (Agriculture, Education, Social protection, WASH)	**23,601,640**	**25,752,640**	**23,665,640**	**25,752,640**	**24,505,640**	**123,278,200**
Advocate for sufficient and safe nutritious food supplies in schools	-	-	-	-	-	-
Carry out education to the community targeting male and female across different ages and diversities on kitchen gardening and rearing of small livestock through community forums in collaboration with agriculture	120,000	120,000	120,000	120,000	120,000	600,000
Carry out quarterly support supervision for the joint activities	32,240	32,240	32,240	32,240	32,240	161,200
Carry out sensitization to male and female CHVs on rainwater harvesting, protecting community water sources and safe storage facilities	672,000	672,000	672,000	672,000	672,000	3,360,000
Carry sensitization to male and female managers of children homes on integrated nutrition social protection activities	185,500	185,500	185,500	185,500	185,500	927,500
Monthly submission of reports on WASH nutrition activities	-	-	-	-	-	-
Refer malnourished and sick children to the link facilities	-	-	-	-	-	-
Sensitize male and female CHVs on consumption of safe, diverse, and nutritious foods	408,000	408,000	408,000	408,000	408,000	2,040,000
Sensitize male and female ECDE teachers on nutrition assessment	726,000	726,000	726,000	726,000	726,000	3,630,000
Sensitize male and female health care workers on consumption of safe, diverse, and nutritious foods	240,000	240,000	240,000	240,000	240,000	1,200,000
Sensitize male and female school stakeholders on marketing and promotion of healthy foods within the schools	-	-	-	-	-	-
Update the existing data base of the social protection beneficiaries	-	-	-	-	-	-
Advocate and initiate demonstration kitchen gardens and rearing of small livestock in selected health facilities in collaboration with department of Agriculture	969,900	429,900	429,900	429,900	429,900	2,689,500

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 07: To promote nutrition linkages with nutrition sensitive sectors (Agriculture, Education, Social protection, WASH)	**23,601,640**	**25,752,640**	**23,665,640**	**25,752,640**	**24,505,640**	**123,278,200**
Sensitize community on climate SMART agriculture targeting men and women across different ages and diversities in collaboration with department of Agriculture using effective communication channels	120,000	120,000	120,000	120,000	120,000	600,000
Sensitize male and female health care workers on diversified food production strategies and consumption of safe, diverse, and nutritious foods	156,000	156,000	156,000	156,000	156,000	780,000
Sensitize male and female CHVs on diversified food production strategies and consumption of safe, diverse, and nutritious foods	246,000	246,000	246,000	246,000	246,000	1,230,000
Sensitize community targeting both genders on diversified food production strategies and consumption of safe, diverse, and nutritious foods using effective communication channels	-	-	-	-	-	-
Promote fuel energy saving technologies at community level	-	-	-	-	-	-
Sensitize HCWs, CHVs and community targeting both genders on use and uptake of food composition tables and recipes for decision making	2,823,000	2,823,000	2,823,000	2,823,000	2,823,000	14,115,000
Adapt and disseminate food safety regulations and enforcement mechanisms at county level	-	-	-	-	-	-
Sensitize male and female CHV on value addition, preservation, post-harvest handling and agro-processing in collaboration with agriculture	708,000	708,000	708,000	708,000	708,000	3,540,000
Carry out gender responsive stakeholder mapping forums on social protection programs	216,000	216,000	216,000	216,000	216,000	1,080,000
Conduct quarterly joint support supervision of WASH nutrition activities	386,880	386,880	386,880	386,880	386,880	1,934,400
Conduct Bi-annual review meetings to assess progress of the joint activities	432,000	432,000	432,000	432,000	432,000	2,160,000
Carry out joint gender responsive planning meetings to identify areas of collaboration	175,000	175,000	175,000	175,000	175,000	875,000
Sensitize male and female social protection staff (social workers) on nutrition for the target population in social protection programs	170,000	170,000	170,000	170,000	170,000	850,000
Conduct a gender integrated baseline survey/situation analysis on status of nutrition and health for the vulnerable groups	-	-	1,000,000	-	1,000,000	2,000,000
Sensitize the community through gender integrated community groups on importance of nutrition for the OVC, PLWD, elderly persons	-	-	-	-	-	-
Advocate for governance and accountability for nutrition and social protection for vulnerable groups	930,000	930,000	930,000	930,000	930,000	4,650,000
Advocate for harmonized nutrition and social protection services for vulnerable groups at county and sub county levels	840,000	-	-	-	840,000	1,680,000
Advocate for high-level consultations for promotion of health and nutrition for vulnerable groups at County levels	-	-	-	-	-	-
Sensitize (a) the public and b) management of institutions of vulnerable persons and correction facilities on optimal health and nutrition for the vulnerable population	-	-	-	-	-	-
Promote benchmarking/learning visits for policy makers and implementers in counties with best practices on health and nutrition for vulnerable groups	56,000	56,000	56,000	56,000	56,000	280,000
Carry out mid-year review on the progress of the agreed activities	462,000	462,000	462,000	462,000	462,000	2,310,000
Sensitize health and school stakeholders targeting both genders on school related policies on health and nutrition (School health policy, nutrition teacher's reference manual, school feeding guidelines/strategy etc….)	1,398,000	1,398,000	1,398,000	1,398,000	1,398,000	6,990,000
Sensitize school and health stakeholders on healthy and safe food environment including WASH in schools and other learning institutions	-	3,780,000	-	3,780,000	-	7,560,000
Advocate and support for revival of 4K clubs/health and nutrition clubs/small farmers clubs in schools	-	-	-	-	-	-
Carry out joint gender responsive planning forums with Agriculture sector	45,000	45,000	45,000	45,000	45,000	225,000
Carry out joint bi-annual review of the planned activities	90,000	90,000	90,000	90,000	90,000	450,000
Promote and support kitchen gardening and rearing of small livestock in communities through gender, age, and diversity inclusive community forums in collaboration with agriculture	5,000	5,000	5,000	5,000	5,000	25,000
Sensitize male and female health care workers on diversified and gender responsive food production strategies and consumption of safe, diverse, and nutritious foods	240,000	240,000	240,000	240,000	240,000	1,200,000
Sensitize male and female CHVs on diversified and gender responsive food production strategies and consumption of safe, diverse, and nutritious foods	738,000	738,000	738,000	738,000	738,000	3,690,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 07: To promote nutrition linkages with nutrition sensitive sectors (Agriculture, Education, Social protection, WASH)	**23,601,640**	**25,752,640**	**23,665,640**	**25,752,640**	**24,505,640**	**123,278,200**
Sensitize community targeting men and women across different ages and diversities on diversified and gender responsive food production strategies and consumption of safe, diverse, and nutritious foods using effective communication channels	120,000	120,000	120,000	120,000	120,000	600,000
Sensitize HCWs, CHVs and community targeting men and women of different ages and diversities on the nutrition dialogue cards and other related materials	296,500	296,500	296,500	296,500	296,500	1,482,500
Utilize gender, age and diversity sensitive nutrition dialogue cards at community level when providing nutrition messages to the communities	-	-	-	-	-	-
Adapt gender responsive Social behavior change and communication (SBCC) strategy for increased consumption of nutritious foods and improved dietary diversity (including fortified foods) among the community members	-	-	-	-	-	-
Sensitize male and female CHVs on rainwater harvesting, recycling, protecting community water sources and safe storage facilities	738,000	708,000	708,000	708,000	708,000	3,570,000
sensitize male and female community members on rainwater harvesting, recycling protecting community water sources and safe storage facilities using effective communication channels	-	-	-	-	-	-
Sensitize community targeting and women across different ages and diversities on value addition, preservation, post-harvest handling, storage and agro-processing using effective communication channels in collaboration with agriculture	-	-	-	-	-	-
Carry out joint quarterly support supervision for the integrated and gender transformative Agri-nutrition activities	276,720	276,720	276,720	276,720	276,720	1,383,600
Quarterly submission of gender sensitive progress reports	-	-	-	-	-	-
Bi-annual review meetings to assess progress of the joint gender responsive activities	90,000	90,000	90,000	90,000	90,000	450,000
Sensitize male and female community members across different ages and diversities on water treatment methods at household level	-	-	-	-	-	-
Create awareness on safe water storage at community and household level targeting both men and women across different ages and diversities.	-	-	-	-	-	-
Create awareness on hand washing at critical times at community and household level targeting both men and women across different ages and diversities	672,000	672,000	672,000	672,000	672,000	3,360,000
Create awareness on food safety and hygiene at community and household level targeting both men and women across different ages and diversities	-	-	-	-	-	-
Create awareness on food safety and hygiene at community and household level for both males and females CHVs	672,000	672,000	672,000	672,000	672,000	3,360,000
sensitize food handlers of both genders on hazard analysis critical control point (HACCP) in collaboration with public health	306,000	306,000	306,000	306,000	306,000	1,530,000
Sensitize community on good environmental hygiene practices through gender, age, and diversity inclusive community forums	672,000	672,000	672,000	672,000	672,000	3,360,000
Sensitize male and female community members on proper latrine use and proper disposal of household wastes	-	-	-	-	-	-
Participate in gender responsive community led total sanitation in collaboration with public health department and promote nutrition messages especially during 1000 days window of opportunity	732,000	732,000	732,000	732,000	732,000	3,660,000
Sensitize male and female nutritionists on gender, age and diversity responsive social protection interventions including the target population	96,500	96,500	96,500	96,500	96,500	482,500
Sensitize male and female CHVs on gender, age and diversity responsive social protection interventions including the target population	660,000	660,000	660,000	660,000	660,000	3,300,000
Adapt and disseminate targeting criteria for nutrition in gender, age, and diversity responsive social protection programmes; cash transfers, hunger safety nets, and others	-	-	276,000	-	276,000	552,000
Advocate for inclusion of gender sensitive nutrition objectives and indicators in the M&E of social protection interventions	-	-	198,000	-	198,000	396,000
Advocate for scale up of social safety nets in times of crises	-	-	-	-	-	-
Participation of nutrition stakeholders in social protection coordination mechanisms	40,000	40,000	40,000	40,000	40,000	200,000
Train/sensitize stakeholders in gender, age, and diversity social protection programmes on good and gender transformative nutrition practices						

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 07: To promote nutrition linkages with nutrition sensitive sectors (Agriculture, Education, Social protection, WASH)	**23,601,640**	**25,752,640**	**23,665,640**	**25,752,640**	**24,505,640**	**123,278,200**
Carry out follow ups on implementation of the agreed joint activities for the children homes on quarterly basis	96,720	96,720	96,720	96,720	96,720	483,600
Carry out quarterly support supervision of the integrated nutrition and social protection activities.	146,880	146,880	146,880	146,880	146,880	734,400
Submission of quarterly progress gender sensitive reports	240,000	240,000	240,000	240,000	240,000	1,200,000
Carry out deworming in all ECDE centers targeting both boys and girls	600,000	600,000	600,000	600,000	600,000	3,000,000
Carry out quarterly nutrition assessment in all ECDE centers targeting both boys and girls	-	-	-	-	-	-
Carry out bi-annual Vitamin A supplementation in all ECDE centers targeting both boys and girls	-	-	-	-	-	-
Carry out quarterly submission of gender, age and diversity disaggregated reports on nutrition assessment, Vitamin A, and deworming	-	-	-	-	-	-
Regulate the food environment to control marketing of unhealthy foods for older children and adolescents in schools	219,000	-	219,000	-	219,000	657,000
Sensitize stakeholders on school gardens and rearing small animals in collaboration with department of Agriculture	3,060,000	3,060,000	3,060,000	3,060,000	3,060,000	15,300,000
Submit quarterly progress reports for the joint activities	-	-	-	-	-	-
Carry out bi-annual joint progress review meetings	276,800	276,800	276,800	276,800	276,800	1,384,000
KRA 08: Sectoral and multisectoral nutrition governance, coordination legal frameworks, leadership and management strengthened	**18,151,000**	**15,239,200**	**17,481,200**	**15,969,000**	**17,481,200**	**84,321,600**
Adopt and sensitize county policy makers on SUN business strategy	1,194,000	-	1,194,000	-	1,194,000	3,582,000
Hold meetings with private partners to improve public private partnership for nutrition initiatives	1,279,200	1,279,200	1,279,200	1,279,200	1,279,200	6,396,000
Identify male and female community nutrition champions.	20,000	20,000	20,000	20,000	20,000	100,000
Map the private entities within the county	625,000	-	625,000	-	625,000	1,875,000
Nutrition education and creating awareness	2,940,000	2,940,000	2,940,000	2,940,000	2,940,000	14,700,000
Participate in conferences and forums for nutrition knowledge sharing	312,000	312,000	312,000	312,000	312,000	1,560,000
Develop, cost, review, and update sector-specific coordination annual plans	141,000	141,000	141,000	141,000	141,000	705,000
Support the establishment and functionality of the Food and Nutrition Security Council and all other structures as approved in the NFNSP-IF at county levels	141,000	141,000	141,000	141,000	141,000	705,000
Enhance representation of nutrition at other sectoral forums at county and sub county levels	-	-	-	-	-	-
Conduct performance assessment reviews on coordination	834,000	834,000	834,000	834,000	834,000	4,170,000
Support annual county and sub county nutrition learning and best practice forums	231,000	231,000	231,000	231,000	231,000	1,155,000
Advocate for establishment of multisectoral nutrition platform at county level	456,000	-	-	456,000	-	912,000
Participate in annual nutrition standard and regulation summit at the national level	832,000	832,000	832,000	832,000	832,000	4,160,000
Adapt and disseminate national strategy and framework for enhancing public –private partnership (PPP)	141,000	-	141,000	60,000	141,000	483,000
Sensitize stakeholders within the private sector on SUN business strategy	282,000	-	282,000	-	282,000	846,000
Establish a gender sensitive county nutrition task force for resource mobilization	262,000	262,000	262,000	262,000	262,000	1,310,000
Develop costed 2nd generation County Nutrition Action Plans (CNAPs)	1,865,000	1,865,000	1,865,000	1,865,000	1,865,000	9,325,000
Develop annual resource mobilization strategy	76,000	76,000	76,000	76,000	76,000	380,000
Conduct nutrition resource tracking at county and sub-county levels	325,000	325,000	325,000	325,000	325,000	1,625,000
Support participation and representation of nutrition sector in citizen-participation forums at county and sub county levels	325,000	325,000	325,000	325,000	325,000	1,625,000
Linkage between gender transformative nutrition and media for improved nutrition coverage	600,000	600,000	600,000	600,000	600,000	3,000,000
Hold quarterly county Nutrition Technical Forums at county and sub-county levels as per TORs	4,516,000	4,516,000	4,516,000	4,516,000	4,516,000	22,580,000
Sensitize sectoral and multisectoral stakeholders on the existing policy, legal and regulatory framework	213,800	-	-	213,800	-	427,600
Sensitize the community targeting men and women across different ages and diversities on nutrition representation and gender equality in citizen participation forum	540,000	540,000	540,000	540,000	540,000	2,700,000

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	**17,657,500**	**18,349,700**	**24,850,800**	**17,561,200**	**19,986,000**	**98,405,200**
Conduct annual performance review meeting	1,389,200	1,389,200	1,389,200	1,389,200	1,389,200	6,946,000
Develop and review progress of AWP, CNAP and other multi-year plans and policies	4,221,000	295,500	1,069,700	295,500	4,289,000	10,170,700
Develop information products with nutrition findings	60,000	60,000	60,000	60,000	60,000	300,000
Establish knowledge sharing forums for health care providers and the community.	-	724,200	724,200	724,200	724,200	2,896,800
Assess gaps on nutrition M&E at county and sub-county levels·	-	121,000	-	121,000	-	242,000
Use various technology platforms to give nutrition feedback to sectoral and multisectoral partners	577,000	50,000	50,000	50,000	50,000	777,000
Monitor technical working group (TWG) plan	560,000	560,000	560,000	560,000	560,000	2,800,000
Enhance linkages between county nutrition technical forum and NITWG	440,000	440,000	440,000	440,000	440,000	2,200,000
Adapt national multisectoral Nutrition Information Platform (NIPN) for improved multisectoral data analysis, dissemination, and utilization	165,000	165,000	165,000	165,000	165,000	825,000
Advocate for research prioritization both at county levels	644,000	644,000	644,000	644,000	644,000	3,220,000
Participate in knowledge sharing forums such as symposiums and conferences, workshops, meetings at national, county, and international levels	83,200	83,200	83,200	83,200	83,200	416,000
establish a system for dissemination of nutrition research findings to the community	-	1,062,000	1,062,000	1,062,000	1,062,000	4,248,000
Adapt gender sensitive nutrition M&E framework within MEAL chapter and integrate it with the county M&E framework	1,577,600	156,000	-	-	1,187,600	2,921,200
Conduct midterm and end term reviews for CNAP using gender sensitive M&E framework implementation with corrective gender responsive action plans	-	-	874,800	-	874,800	1,749,600
Participate in the development of gender integrated county health strategic plans such as CIDP among others	-	-	-	-	-	-
Sensitize male and female HCWs on routine nutrition data collection tools	399,500	799,000	799,000	799,000	799,000	3,595,500
Sensitize male and female HCWs on nutrition data use for decision making	278,000	-	278,000	-	-	556,000
Conduct quarterly data quality audits KHIS, LMIS and sentinel surveillance	2,858,000	2,858,000	2,858,000	2,858,000	2,858,000	14,290,000
Hold meeting with sectoral and multisectoral stakeholders and make use of existing forums to give nutrition feedback	454,000	454,000	454,000	454,000	454,000	2,270,000
Develop and implement a county nutrition dashboard	-	-	-	-	-	-
Adopt the national nutrition score card and sensitize HCWs on the score card	551,000	551,000	551,000	551,000	551,000	2,755,000
Establish a county research repository platform for nutrition department	1,135,000	1,135,000	1,135,000	1,135,000	1,135,000	5,675,000
Advocate to academia and research department to share gender integrated research data/ findings with stakeholders	452,000	452,000	452,000	452,000	452,000	2,260,000
Lobby for resources from sectoral and multisectoral for nutrition research.	955,000	955,000	955,000	955,000	955,000	4,775,000
Integrate nutrition evidence base research agenda into the county's health research unit	90,500	90,500	90,500	90,500	90,500	452,500
Develop strategic partnerships and networks in addressing county gender integrated research agenda (county departments, partners, private sector)	270,000	270,000	270,000	270,000	270,000	1,350,000
Participate in county research committee meetings	-	-	-	-	-	-
Participate in forums for dissemination of research findings and information sharing at all levels	47,000	47,000	47,000	47,000	47,000	235,000
Advocate for systematic review of gender transformative nutrition-sensitive and nutrition-specific interventions within the county	210,000	210,000	210,000	210,000	210,000	1,050,000
Train nutritionist and other frontline health care workers of both genders on gender integrated operational /implementation research skills	-	-	1,819,200	-	-	1,819,200
Conduct gender integrated nutrition SMART survey after every 2 years	-	4,142,600	-	3,510,100	-	7,652,700
Conduct gender integrated MIYCN KAP and coverage assessment after every 2 years	-	-	5,000,000	-	-	5,000,000
Conduct gender integrated nutrition capacity assessment after every 2 years	-	-	1,000,000	-	-	1,000,000
Disseminate gender integrated survey and assessment findings at all levels for decision making	-	-	1,174,500	-	-	1,174,500
Sensitize and disseminate Vitamin A monitoring chart to male and female CHMT, SCHMT and health care workers across all cadres	-	-	-	-	-	-
Conduct gender responsive annual target setting for nutrition indicators	240,500	240,500	240,500	240,500	240,500	1,202,500
Sensitize HCWs on gender responsive annual nutrition targets for gender sensitive nutrition indicators	-	395,000	395,000	395,000	395,000	1,580,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 10: Advocacy, Communication and Social-Mobilization (ACSM) strengthened	**22,801,000**	**16,326,500**	**18,076,500**	**16,682,500**	**22,606,500**	**96,493,000**
Sensitize communities on good nutrition practices to create awareness targeting men and women across different ages and diversities	576,000	576,000	576,000	576,000	576,000	2,880,000
Conduct media talk shows on Radio and TVs, features stories, documentaries, and short videos on various nutrition topics	4,500,000	4,500,000	4,500,000	4,500,000	4,500,000	22,500,000
Identify male and female community nutrition champions.	20,000	20,000	20,000	20,000	20,000	100,000
Participate in conferences and forums for nutrition knowledge sharing	312,000	312,000	312,000	312,000	312,000	1,560,000
Sensitize male and female community own resource persons and CHVs to create demand for utilization of nutrition services through community structures.	739,500	739,500	1,479,000	739,500	1,479,000	5,176,500
Sensitize community through gender inclusive community groups on feedback mechanisms	-	-	-	-	-	-
Develop and disseminate gender inclusive county nutrition advocacy, communication, and social mobilization plans.	218,000	218,000	218,000	218,000	218,000	1,090,000
Identify and engage male and female nutrition champions to advocate for nutrition prioritization at all levels	159,000	159,000	159,000	159,000	159,000	795,000
Advocate for recruitment of male and female nutritionists to fill county gaps to offer quality nutrition services at all levels	112,000	112,000	112,000	112,000	112,000	560,000
Train/sensitize male and female nutrition champions and influencers on nutrition advocacy	150,000	150,000	150,000	150,000	150,000	750,000
Linkage between gender transformative nutrition and media for improved nutrition coverage	600,000	600,000	600,000	600,000	600,000	3,000,000
Identify and utilize male and female media nutrition champions	20,000	20,000	20,000	20,000	20,000	100,000
Adapt a gender responsive training package on nutrition for journalists based on simplified messages and key information	-	-	-	-	-	-
Support training of male and female nutrition professionals and other relevant stakeholders on communication and writing skills to help them better package information for media	80,000	80,000	80,000	80,000	80,000	400,000
Participate in mass media nutrition education programme at all levels	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000
Hold high level sensitization forums with policy makers and county legislature on the value and impact of nutrition prioritization at county level	1,028,000	-	1,028,000	-	-	2,056,000
Adopt, customize, and disseminate gender transformative nutrition advocacy messages and briefs	1,188,000	1,188,000	1,188,000	1,188,000	1,188,000	5,940,000
Conduct high level advocacy meeting targeting key decision makers on having a specific nutrition budget line within the heath budget for sustained and quality nutrition	988,000	988,000	988,000	988,000	988,000	4,940,000
Develop county nutrition resource mobilization strategy	2,448,000	-	234,000	-	2,448,000	5,130,000
Design, develop, print, and disseminate gender transformative nutrition BCC materials	3,200,000	144,000	-	-	3,344,000	6,688,000
Advocate for relevant sectors to support establishment of multisectoral nutrition platforms	-	607,500	-	607,500	-	1,215,000
Train male and female nutritionist, health promotion officers and community strategy focal person on nutrition advocacy	1,575,000	1,575,000	1,575,000	1,575,000	1,575,000	7,875,000
Sensitize male and female nutritionists, health promotion officers and other HCWs on nutrition communication and writing skills for better packaging of nutrition information	279,000	279,000	279,000	279,000	279,000	1,395,000
Sensitize media fraternity on gender responsive nutrition advocacy for better packaging of nutrition information and better coverage	118,500	118,500	118,500	118,500	118,500	592,500
Share nutrition information in the website, all social media platforms, bulletin, newsletter, and SMS portal	550,000	-	500,000	500,000	500,000	2,050,000
Sensitize community to participate in nutrition resilience building interventions and accountability mechanism targeting men and women across different ages and diversities	-	-	-	-	-	-
Conduct annual community health & nutrition education days	2,940,000	2,940,000	2,940,000	2,940,000	2,940,000	14,700,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 11: Strengthen availability of nutrition commodities, equipment, and tools	**282,033,200**	**318,465,450**	**306,513,200**	**306,813,200**	**306,513,200**	**1,520,338,250**
Conduct annual forecasting and quantification exercise across the nutrition programs	456,000	456,000	456,000	456,000	456,000	2,280,000
Conduct joint commodity supervision and end user monitoring	624,000	624,000	624,000	624,000	624,000	3,120,000
Conduct nutrition commodity data quality audits and data review meetings	636,000	636,000	636,000	636,000	636,000	3,180,000
Conduct quarterly nutrition commodity and security TWG meetings	228,000	228,000	228,000	228,000	228,000	1,140,000
Hold quarterly meetings for Nutrition Commodity Steering Committee	832,000	832,000	832,000	832,000	832,000	4,160,000
Procure nutrition supplies and equipment for NCD screening	-	300,000	-	300,000	-	600,000
Procure referral tools	1,296,000	1,296,000	1,296,000	1,296,000	1,296,000	6,480,000
Train male and female HCW on LMIS including inventory management	1,180,000	1,180,000	1,180,000	1,180,000	1,180,000	5,900,000
Carry out nutrition education during support group sessions	-	480,000	480,000	480,000	480,000	1,920,000
Advocate and support creation of nutrition commodities storage space in facilities	118,000	118,000	118,000	118,000	118,000	590,000
Procure and distribute appropriate therapeutic and supplementary feeds to patients to prevent hospital malnutrition.	136,000,000	136,000,000	136,000,000	136,000,000	136,000,000	680,000,000
Procure and distribute micronutrient commodities and dewormers (IFAS, Vitamin A, Zinc, MNPs,)	58,240,000	58,240,000	58,240,000	58,240,000	58,240,000	291,200,000
Procure and distribute anthropometric equipment and IMAM reporting tools	10,700,000	22,050,000	10,700,000	10,700,000	10,700,000	64,850,000
Procure and distribute IEC/BCC material for DRNCDs	240,000	240,000	240,000	240,000	240,000	1,200,000
Carry out nutrition assessment and counseling to all DRNCDs clients in health facilities	-	-	-	-	-	-
Advocate and support establishment of gender inclusive DRNCDs support groups in health facilities	72,000	72,000	72,000	72,000	72,000	360,000
Procure and distribute IMAM commodities for management of MAM and SAM	58,945,760	82,945,760	82,945,760	82,945,760	82,945,760	390,728,800
Adapt and provide tools for quality assurance including data collection and summary	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	50,000,000
Adapt national guidelines and SOPs for nutrition commodities and tools	-	302,250	-	-	-	302,250
Collaborate with the county food safety unit and regulatory bodies to ensure good quality of nutrition commodities and equipment	624,000	624,000	624,000	624,000	624,000	3,120,000
Ring-fence nutrition commodity funds at county level through review of the PFM Act 2012	-	-	-	-	-	-
Advocate for Expansion of Essential Medicines & Medical Supplies (EMMS) lists (to incorporate new commodities), e.g. nutrition commodities for chronic diseases such as cancer etc.	-	-	-	-	-	-
Procure and distribute nutrition assessment tools, equipment, and reporting tools	1,341,440	1,341,440	1,341,440	1,341,440	1,341,440	6,707,200
Procure and distribute nutrition commodities for feeding and management of special medical conditions based on inpatient feeding protocols	-	-	-	-	-	-
Procure and distribute micronutrient reporting and monitoring tools (IFAS, Vitamin A, Zinc, MNPs including dewormers)	500,000	500,000	500,000	500,000	500,000	2,500,000
Grand Total	**490,159,000**	**513,373,820**	**522,212,750**	**494,071,260**	**520,789,950**	**2,540,606,780**

8 LIST OF KEY CONTRIBUTORS

NAME	GENDER	DESIGNATION	ORGANIZATION
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