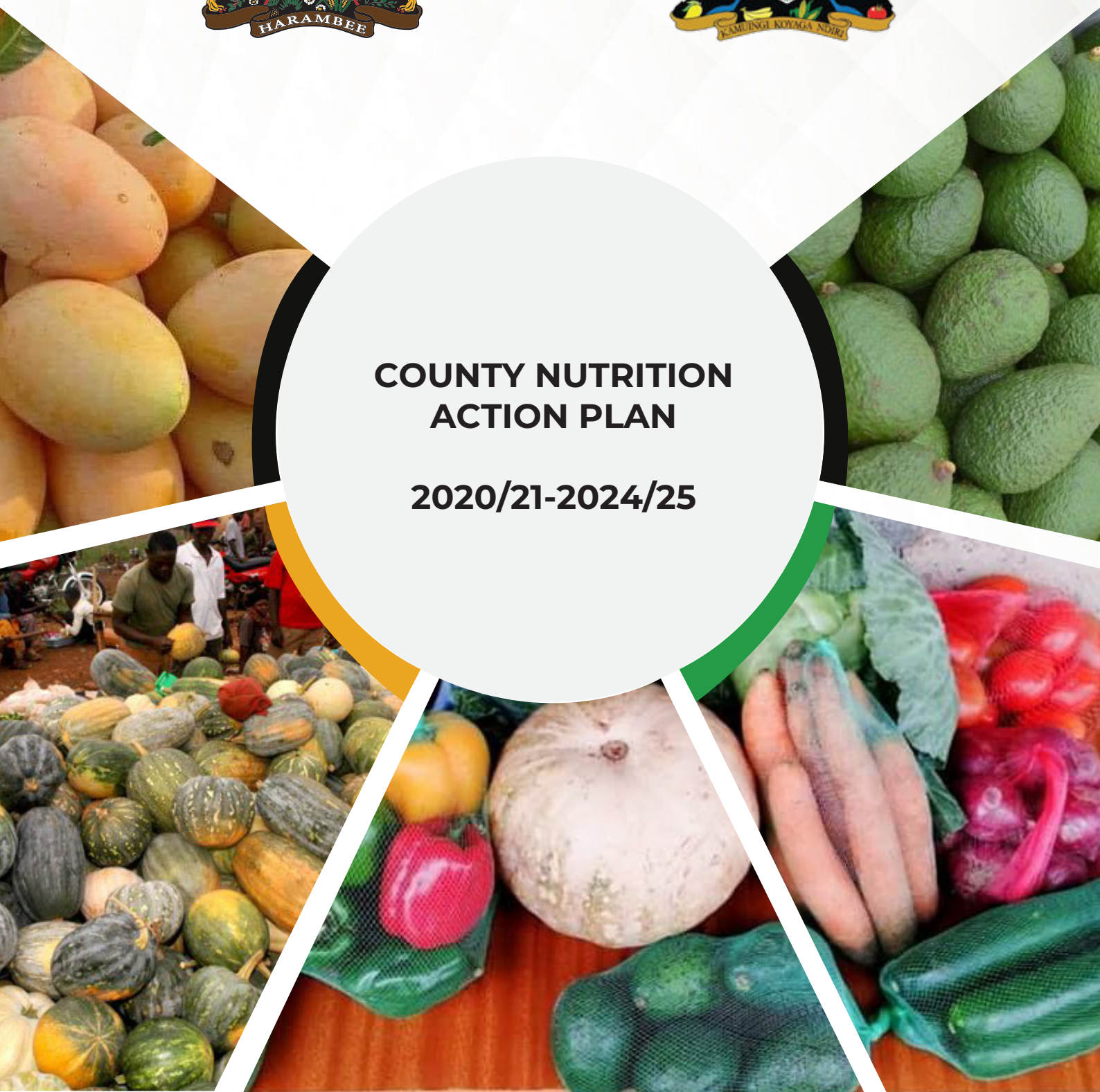
COUNTY GOVERNMENT OF MURANG'A

DEPARTMENT OF HEALTH SERVICES



COUNTY NUTRITION ACTION PLAN

2020/21-2024/25

TABLE OF CONTENTS

LIST OF TABLES

LIST OF TABLES

LIST OF ABBREVIATIONS AND ACRONYNMS

ABC	Activity Based Costing
ACSM	Advocacy, Communication and Social Mobilization
ASL	Above Sea Level
AIDS	Acquired ImmunoDeficiency Syndrome
BCC	Behaviour Change Communication
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
BMS	Breast Milk Substitute
BOM	Board of Management
CBCC AFRICA	Centre for Behavior Change and Communication
CCC	Comprehensive Care Centre
CECM	County Executive Committee Member
CDoH	County Department of Health
CHAs	Community Health Assistants
CHCs	Community Health Committees
CHEWs	Community Health Extension Workers
CHMT	County Health Management Team
CHOs	Community Health Officers
CHVs	Community Health Volunteers
CHWs	Community Health Workers
CIDP	County Integrated Development Plan
CME	Continuous Medical Education
CMR	Child Mortality Rate
CNAP	County Nutrition Action Plan
CNTF	County Nutritional Technical Forum
CRAF	Common Results and Accountability Framework
CSO	Civil Society Organization
CUs	Community Units
DND	Division of Nutrition and Dietetics
DRNCDs	Diet-Related Non-Communicable Diseases
EBF	Exclusive Breastfeeding
ECD	Early Childhood Development
ECDE	Early Childhood Development Education
FBO	Faith-Based Organization
GMP	Growth Monitoring and Promotion
GOK	Government of Kenya

HCWs	Health Care Workers
HIV	Human Immunodeficiency Virus
IFAS	Iron Folic Acid Supplementation
IMAM	Integrated Management of Malnutrition
IQ	Intelligence Quotient
ISG	Institutional Support Grant
KAP	Knowledge Attitude and Practices
KDHS	Kenya Demographic Health Survey
KHIS	Kenya Health Information System
KHSSP	Kenya Health Sector Strategic Plan
KIHBS	Kenya Integrated Household Budget Survey
KNAP	Kenya Nutrition Action Plan
KNBS	Kenya National Bureau of Statistics
KRAs	Key Result Areas
LMIS	Logistic Management Information System
M&E	Monitoring & Evaluation
MEAL	Monitoring Evaluation Accountability and Learning
MIYCN	Maternal Infant and Young Child Nutrition
MMR	Maternal Mortality Rate
MNP	Micronutrient Powder
MoALC	Ministry of Agriculture, Livestock, Fisheries and Cooperatives
MoE	Ministry of Education
MoH	Ministry of Health
MTEF	Medium Term Evaluation Framework
MTMSG	Mother to Mother Support Groups
MTP	Medium Term Plan
MUAC	Mid Upper Arm Circumference
NACS	Nutrition Assessment Counselling and Support
NCD	Non-Communicable Disease
NEMA	National Environmental Management Authority
NFNSP	National Food and Nutrition Security Policy
NFNSP-IF	National Food and Nutrition Security Policy Implementation Framework
NGAOs	National Government Administration Officers
NGO	Non-Governmental Organization
NI	Nutrition International
OJT	On-Job Training
ORS	Oral Rehydration Solution
OVC	Orphans and Vulnerable Children

PWD	People with Disability
SCHMT	Sub-County Health Management Team
SDG	Sustainable Development Goal
SMART	Standardized Monitoring Assessment for Relief and Transition
SOPs	Standard Operating Procedure
SUN	Scaling Up Nutrition
TAN	Technical Assistance for Nutrition
TB	Tuberculosis
TOC	Theory of Change
TOR	Terms of Reference
TOT	Trainer of Trainers
TWG	Technical Working Group
UHC	Universal Health Coverage
VAS	Vitamin A Supplementation
WARMA	Water Resources Management Authority
WASH	Water Sanitation and Hygiene
WBW	World Breastfeeding Week
WHA	World Health Assembly
WHO	World Health Organization
WRA	Women of Reproductive Age

FOREWORD

It is with great pleasure that I present to you the Murang'a County Nutrition Action Plan (CNAP) for the period 2020/21 – 2024/25. This plan is aligned with the Kenya National Nutrition Action Plan (KNAP) 2018/19-2022/23 and recognizes the role of nutrition as a fundamental human right and a driver to accelerating economic development as envisioned in the Kenya Vision 2030.

It comprises key nutrition priorities that are costed and will lead towards attainment of improved quality nutrition services.

The plan will also act as a roadmap for county nutrition programs, powerful advocacy tool for nutrition, a guide to stakeholders on where they could direct their support, a resource mobilization tool and a monitoring tool for the nutrition program. Murang'a County has a stunting rate of 19.3 %, wasting rate of 4.6 % and underweight rate of 5.6 % (KDHS, 2014). The County's maternal mortality rate (MMR) is at 75/100,000 and child mortality rate (CMR) is at 58 deaths per 1000 lives (KHIS, 2019).

Despite these figures being slightly lower than the national level, this means that 2 out of 10 children below 5 years in the county may never exploit their full potential in life and thus need for action. Beyond early exposure to adverse conditions such as illness and/or inappropriate diets and feeding practices, poor diets as the immediate causes of malnutrition, underlies the socio-cultural, political and economic factors contributing to malnutrition.

The Constitution of Kenya Article 43 (1) (a) and (c) states that every person has the right to the highest attainable standard of health, which includes the right to healthcare services including reproductive health care as well as freedom from hunger and to have adequate food of acceptable quality. The Murang'a County Nutrition Action Plan (CNAP) 2020/21 – 2024/25, is cognizant of lessons learnt in the planning and implementation of health and nutrition interventions in the county, and further is anchored in the KNAP 2018/19-2022/23.

The main objective of the Murang'a CNAP is to accelerate and scale up efforts towards the elimination of malnutrition as a problem of public health significance, focusing on specific achievements by 2025. This plan will assist the County in meeting its vision on developmental agenda while contributing to the overall national goal of a healthy nation.
Therefore, the CNAP will guide the County government, donors, developmental partners, civil society and all other stakeholders to achieve our desired goal of having a healthy and economically viable population.

Hon Joseph Mbai,
County Executive Committee Member - Health Services
Government of Murang'a County

PREFACE

The Murang'a County Department of Health and Sanitation is committed to improving access to quality nutrition services. It recognizes nutrition as an essential component of the County health development agenda. This County Nutrition Action Plan (CNAP) is a significant milestone for the County Government to realize its mandate in improving quality of life of its people.

Malnutrition in all its forms is linked directly and indirectly, to major causes of death and disability worldwide.

The causes of malnutrition are directly related to inadequate dietary intake as well as disease, but indirectly to many factors, among others household food insecurity, inadequate maternal and childcare, health services and the environment. Childhood malnutrition is the underlying cause of more than one in three deaths among children under the age of 5 years and negatively affects cognitive development, school performance and productivity.

Optimal nutrition is essential for achieving several of the Sustainable Development Goals (SDGs) which impact on nutrition security. Nutrition is hence linked to Goals and indicators beyond Goal 2 which strives to end hunger achieve food security & improved nutrition and promote sustainable agriculture. A multisectoral approach is necessary for success, thus lead to attainment of Vision 2030 and achievement of the Big 4 Agenda in Kenya.

While most nutrition interventions are delivered through the health sector, non-health interventions are also critical. Gender equality and good nutrition are mutually reinforcing; improving nutrition is critical to achieving gender equality, and in turn improving gender equality leads to improved nutrition (Nutrition International, 2018). To ensure effective and sustainable nutrition outcomes and health related outcomes, this action plan has integrated gender responsive interventions to address the underlying and deep-rooted gender inequalities, socio-cultural and economic differences closely affecting improved food and nutrition security and wellbeing of men and women across different ages and diversities in the county.

Murang'a County Government is committed to facilitating financing and implementation of the County Nutrition Action Plan 2020/21 – 2024/25 that will enable us to achieve our goal of improved nutrition status among the population. Full and successful implementation of the CNAP requires multi-sectoral efforts of the County Government, the private sector, civil society, and development partners. The Murang'a County Department of Health and Sanitation is committed to provide the required leadership to coordinate and implement the CNAP while ensuring that each citizen has the right to health and quality nutrition.

Dr. James Kanyi Gitau
Chief Officer Health and Sanitation

ACKNOWLEDGEMENT

The Murang'a County Nutrition Action Plan (CNAP) 2020/21 – 2024/25 has been developed through extensive consultations at county level with the technical guidance of a dedicated Technical Task Force. The County Department of Health and Sanitation would like to express their sincere gratitude to all the stakeholders who contributed to the development process.

This CNAP was developed with financial support from Nutrition International under the Technical Assistance for Nutrition (TAN) project, funded with UK Aid from the UK government. We express our sincere gratitude and indebtedness to Nutrition International (NI) led by Martha Nyagaya; Joy Kiruntimi, Sarah Kihianyu, the technical experts from NI Headquarters and Charles Ndiritu for the immense technical leadership in the entire process of developing the CNAP 2020/21 – 2024/25.

The CNAP could not have been finalized without the valuable contributions and full commitment of the technical committee members from different government departments and partners. The support of the Government of Murang'a County is highly appreciated.

County Department of Health greatly appreciates the technical support of the Division of Nutrition and Dietetics (DND), through Caroline Kathiari who provided guidance of linking the CNAP to the national umbrella framework.

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

Dr. Winnie Kanyi
County Director of Health
Murang'a County

1 INTRODUCTION

1.1 General demographic information for Murang'a County

1.1.1 Location and Size

Murang'a County is one of the five Counties in Central region of the Republic of Kenya and occupies a total area of 2,558.8Km^2. It is bordered to the North by Nyeri, to the South by Kiambu, to the West by Nyandarua and to the East by Kirinyaga, Embu and Machakos counties. It lies between latitudes 0^0 34" South and 10^0 7" South and Longitudes 360 East and 37^0 27" East. The county lies between 914m above sea level (ASL) in the East and 3,353m above sea level (ASL) along the slopes of the Aberdare Mountains in the West. Administratively, the County has seven constituencies namely Kiharu, Kangema, Gatanga, Mathioya, Kigumo, Kandara and Murang'a South which also constitute the 7 sub-counties. There are 35 electoral wards.

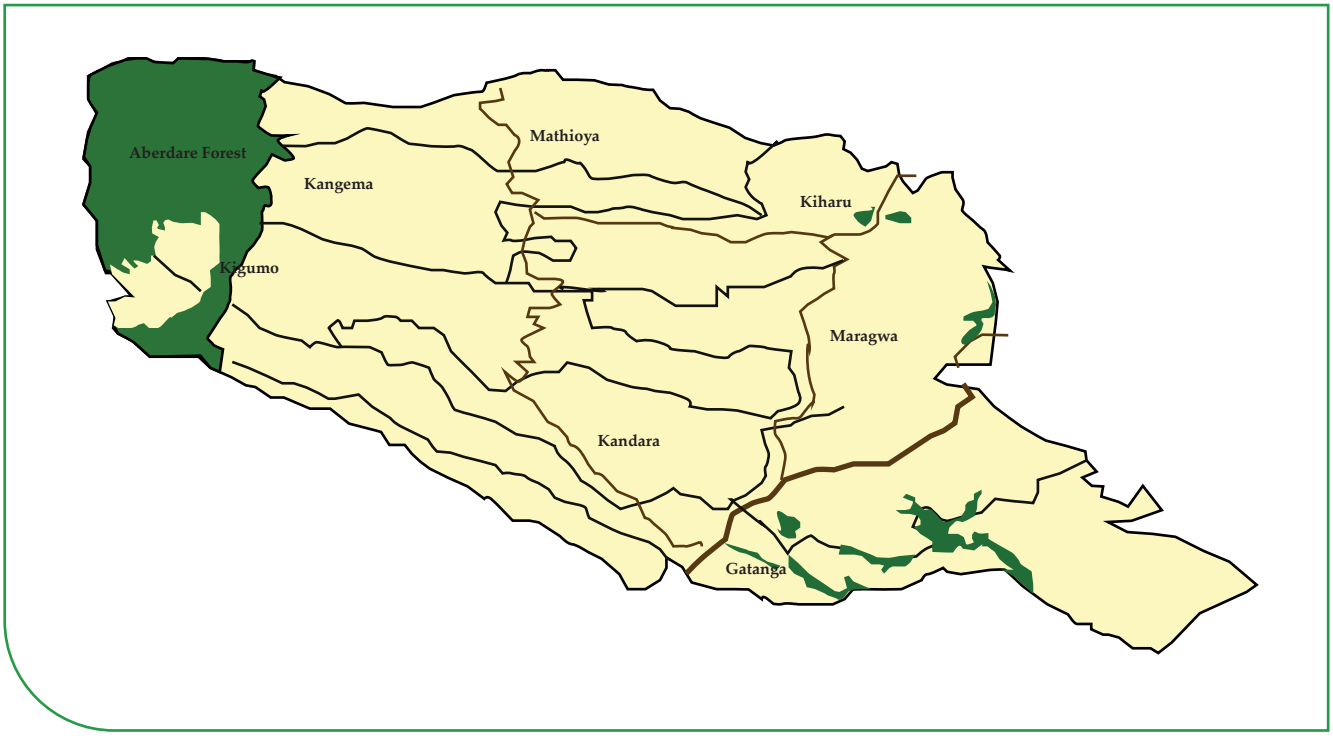


Figure 1:1:Map for Murang'a County

1.1.2 Population distribution by Sub-county

The total population of the region according to Kenya Population and Housing Census (KPHC) 2019, is 1,056,640 (523,940 males & 532,669 females and 31 intersex). For the first time intersex population was also populated. The largest household in the county has an average size of 3.4 persons at household level (KNBS, November 2019).

Table 1.1: Population and Household distribution by sub-county

Sub-county	Population	Male	Female	Intersex
Gatanga	187,989	94,437	93,548	4
Kiharu	198,504	98,017	100,479	8
Murang'a South	184,824	91,732	93,087	5
Kandara	175,098	86,698	88,393	7
Mathioya	92,814	45,454	47,359	1
Kangema	80,447	39,582	40,862	3
Kigumo	136,921	67,989	68,929	3
Aberdare forest	43	31	12	0
Murang'a County	**1,056,640**	**523,940**	**532,669**	**31**

Source : 2019 KPHC Census report volume 1

Table 1.2: Murang'a County Population Disaggregation by Age and Sex

AGE	MALE	FEMALE	TOTAL
0-4 years	55,695	54,819	110,514
5-9 years	57,564	56,687	114,251
10-14 years	59,951	57,807	117,758
15-19 years	55,307	50,160	105,467
20-24 years	38,214	37,212	75,426
25-29 years	31,823	32,975	64,798
30-34 years	35,380	36,354	71,734
35-39years	34,374	34,523	68,897
40-44 years	31,951	31,021	62,972
45-49 years	28,548	28,255	56,803
50-54 years	22,188	23,528	45,716
55-59 years	20,187	22,035	42,222
60-64 years	14,624	15,823	30,447
65-69 years	13,356	14,856	28,212
70-74 years	11,534	13,123	24,657
75-79 years	5,793	9,160	14,953
80-84 years	3,811	6,312	10,123
85-89 years	2,163	4,001	6,164
90-94 years	866	2,112	2,978
95-99years	451	1,205	1,656
100+	152	695	847
Not Stated	8	6	14
TOTAL	523,940	532,669	1,056,609

Source: (KNBS, 2019)

Table 1.3: Murang'a County Population Disaggregated by Age Cohort

AGE GROUP	MALE	FEMALE
Under 5 years	55,695	54,819
Primary School Age 6-13yrs	94,172	92,411
Secondary School Age 14-17yrs	47,766	44,267
Youth Population 15-34yrs	160,724	156,701
Women of Reproductive Age 15-49 yrs.		250,500
Labor force 15-64yrs	312,596	311,886
65+yrs	38,134	51,470

Source: (KNBS, 2019)

1.1.3 Health Facility distribution per Sub County

Murang'a County is served by 145 Public Health Facilities, 70 Private Health Facilities, 32 faith-based organization (FBO) facilities and 187 community units (CUs). These sums up to a total of 247 health facilities in the County. Only a few facilities have inpatient services, mostly the Level 4 health facilities.

Table 1.4: Health Facility distribution per Sub County

Sub-county	Public	Private	FBOs	No. of CUs
Kangema	17	6	2	21
Mathioya	18	4	3	15
Kiharu	25	18	7	24
Kigumo	19	5	8	36
Murang'a South	17	17	3	34
Kandara	25	6	5	30
Gatanga	24	14	4	27
TOTAL	**145**	**70**	**32**	**187**

Source: (KHMFL, 2020)

1.2 County Nutrition Situation

1.2.1 Undernutrition

According to KDHS 2014, Murang'a County reported stunting levels of 19.3 percent with 4.8 percent of children under five years severely stunted. Wasted children were 1.4 percent and those underweight were 5.6 percent. The Kenya Integrated Household Budget Survey (KIHBS) 2016, reported a worsening trend of under-five malnutrition in Murang'a County, with the levels of stunting and wasting rising, while the proportion of those underweight reduced significantly. The levels of stunting, wasting and underweight were 20.1%, 5% and 3.8% respectively, though the data was analyzed from a smaller sample size than the KDHS.

The immediate cause of undernutrition includes child illnesses and poor dietary intake. Beyond this, there are other underlying socio-cultural, political and economic factors.

These include but not limited to: household food insecurity; cultural and religious norms and practices influencing food sharing and uptake; inadequate care of vulnerable household members: poor access to clean water, hygiene and sanitation; poor health seeking behaviors and care practices among men and women across different ages and diversities; excessive alcohol intake especially among men; low community and male support in relieving women of overburdening maternal workload; inadequate and inequitable access to health and nutrition education, unequal access, use and control of benefits from productive assets disproportionately affecting women and girls.

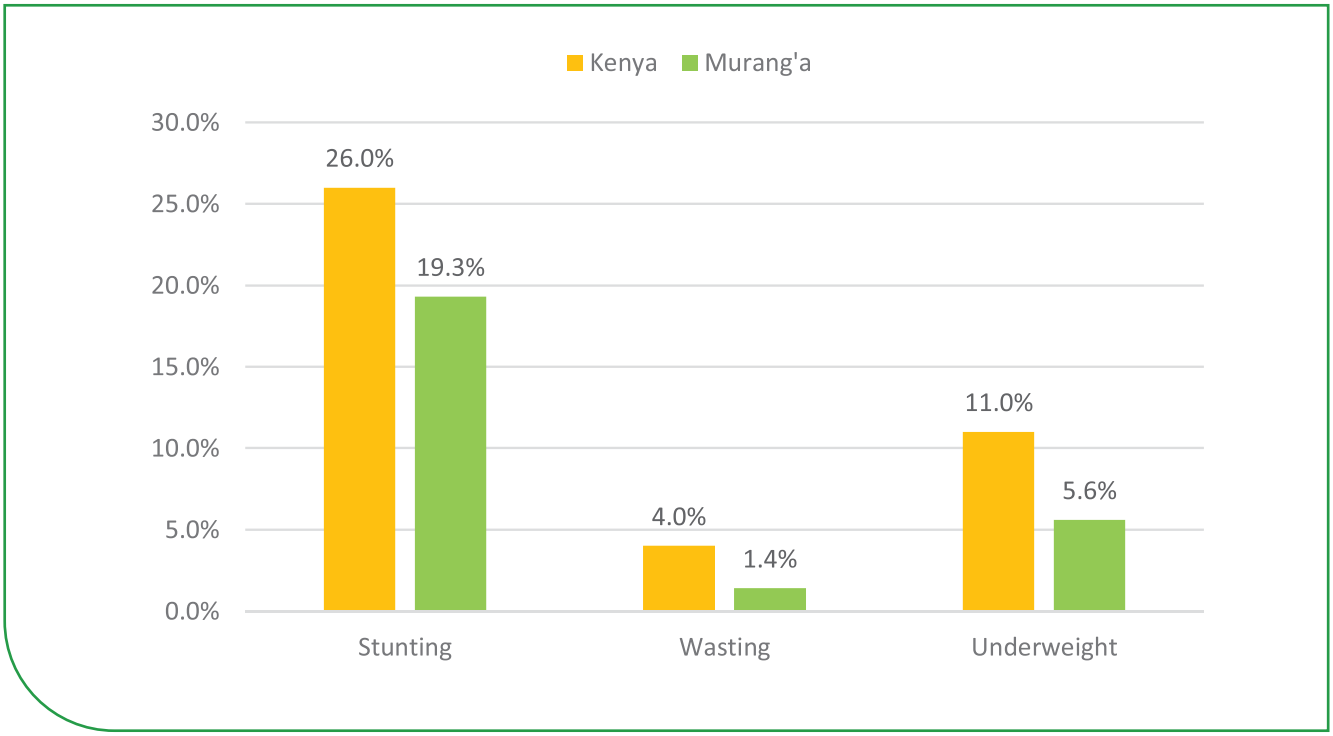


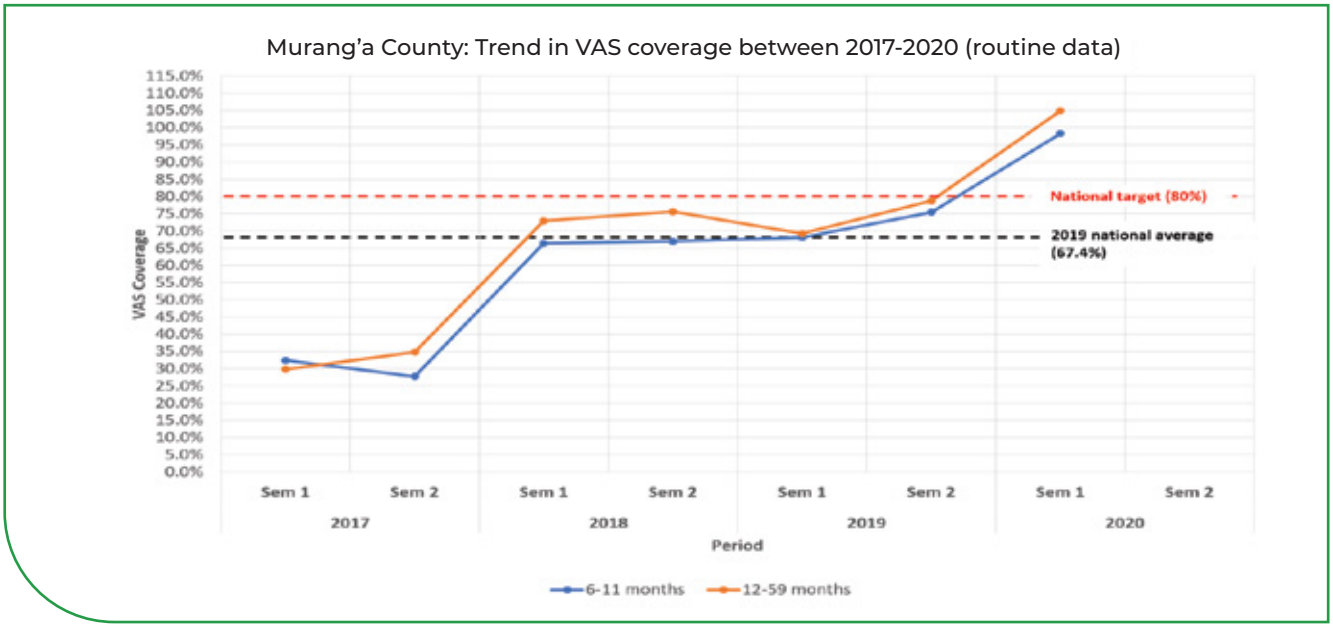
Figure 1:2: Stunting, Wasting and Underweight in Murang'a County

Source: (KDHS, 2014)

1.2.2 Micronutrient deficiencies

In Kenya, the prevalence of anemia among pregnant women stands at 46.1 percent with much higher prevalence in rural pregnant women at 50.8 percent (MOH, 2011). According to a baseline survey conducted by Nutrition International in January 2020, only 53.6 percent of pregnant women consumed Iron and Folic Acid for at least 90 days or more. There was sub-optimal knowledge of benefits of IFAS at 56.4 percent while the knowledge of diarrhea management using zinc and ORS was at 10.3%.

In Murang'a County, Vitamin A supplementation coverage for children 6-59 months according to the Institutional Support Grant is at 76.2 % (ISG, 2020). Going by Vitamin A routine administrative data, Murang'a County has registered an increase in VAS coverage from below 35% in 2017, for both children 6 to 11 months and 12 to 59 months to 73.9% for children between age 6-59 months. This could be a true reflection of the situation or could be a case of poor data quality.



Source: (KHIS, 2020)

Figure 1:3: Trend in VAS coverage for the period 2017-2020 in Murang'a County

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

There is currently no population-based data on Diet Related Non-Communicable Diseases (DRNCDs) for Murang'a County. However, KDHS 2014 report showed that in the Central region of Kenya, overweight stood at 29.4 percent and Obesity at 17.6 percent among older adults and older persons. For Non-Communicable Diseases (NCDs), hypertension was at 12.8 percent and 2.6 percent among females and males respectively while diabetes was at 1.7 percent and 0.9 percent for females and males respectively.

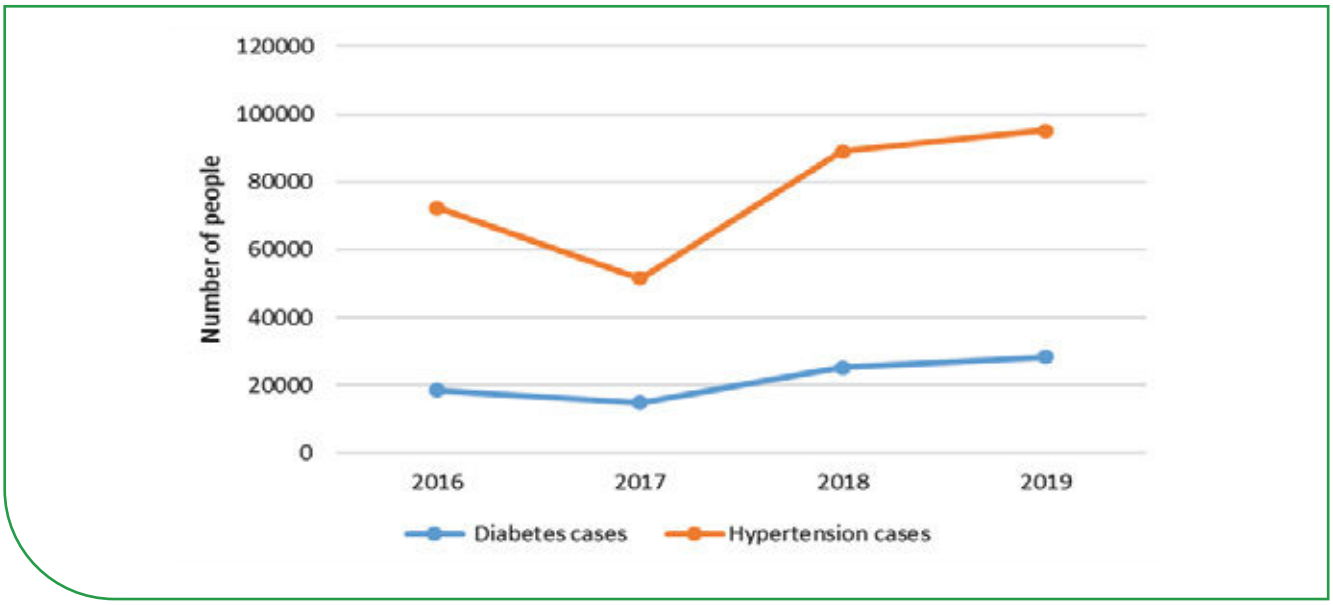


Figure 1:4: Trend of Diabetes and Hypertension cases loads in Murang'a

Source: (KDHS, 2014)

1.2.4 Infant and young child feeding practices

Good infant and young child feeding practices helps to improve child survival and promote healthy growth and development. Optimal nutrition during the first two years of a child life is very critical because it lowers morbidity and mortality, reduces the risk of chronic disease, and fosters better overall growth and development. Optimal breastfeeding is so critical that it could save the lives of over 820 000 children under the age of five years each year (Lancet, 2016). In Murang'a County, 87.5 percent of children below 6 months are exclusively breastfed (KHIS, 2019). The figure below shows the trend of children initiated on breast-feeding within one hour after birth and those exclusively breast fed for the first six months from 2016 to 2019.

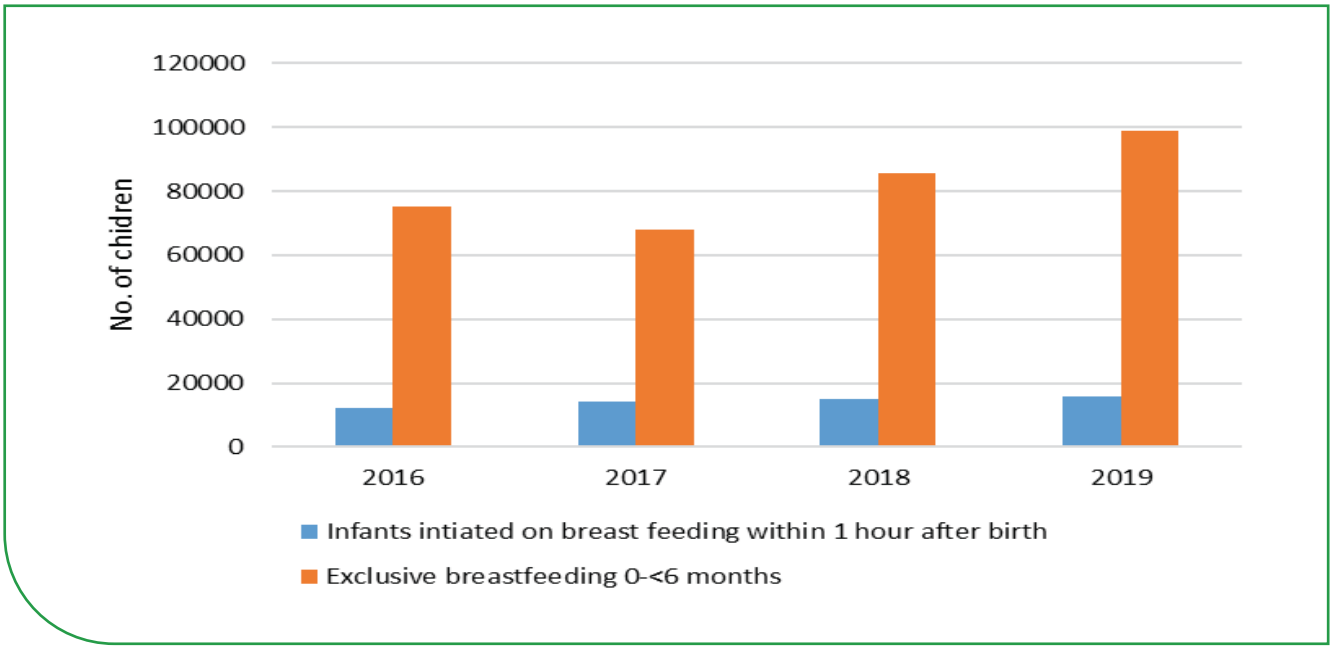


Figure 1:5: Trend showing children initiated on breast-feeding within 1 hour and EBF

Source: (KHIS, 2019)

1.3 Nutrition integration in nutrition sensitive sectors

1.3.1 Agriculture, access to food and economic activities

Murang'a County is a cosmopolitan County. The upper part of the county is mainly dependent on agriculture due to the fertile soils while the lower part depends on various informal businesses such as boda riding, quarry mining, and bee keeping. Other economic activities in the county include fruit farming (mangoes, bananas, avocados, pawpaws), dairy farming, small-scale fishing, banking, hotel and tourism (mainly in Mukurwe Wa Nyagathanga), nut processing, and other small scale businesses spread across the various towns within the county. The county augments its fresh farm products from markets in neighbouring counties, such as Kagio Market in Kirinyaga County.

Some parts of the lower side of the county like Makuyu, Kambiti, Maragwa ridge, Muthithi, Gaichanjiru, Kakuzi, Ithanga and Githuuri Locations often experience food shortages. Food insecurity is contributed by several factors that include inadequate and unreliable rainfall, poor terrain, small parcels of land, poor soil fertility, and poor coverage by extension services, and concentration in growing of cash crops such as coffee, tea, high prices of farm inputs and poor storage facilities.

1.3.2 Early Childhood Development Education

Every child has the right to education which should be directed to the development of the child's personality, talents, mental and physical abilities to their fullest potential. Good nutrition is essential to realize the learning potential of children and maximize returns on educational investments. Good nutrition promotes optimal brain development hence high IQ. Poor child nutrition is associated with poor school enrolment, low attendance and high school drop-outs.

Nutrition education in schools is known to foster healthy eating habits in children themselves and in their families. School meals ensure children are well nourished and they can learn. The County Government of Murang'a provides the ECDE centres with flour for porridge and lunch to all the learners. The table below shows the ECDEs enrolment and the number reached with school meals program.

Table 1.5: Number of ECD Centres & Pupils Enrolled

S/No.	Sub-county	No. of Centres			Pupil Enrolment per year		
		Public	Private	Total	Public	Private	Total
1.	Kandara	89	30	**119**	6,260	700	**6,960**
2.	Gatanga	103	78	**181**	6,588	2,761	**9,349**
3.	Kahuro	63	18	**80**	2,761	501	**3,262**
4.	Mathioya	85	15	**100**	3,625	218	**3,843**
5.	Kiharu	69	29	**98**	3,692	1,223	**4,915**
6.	Kangema	71	26	**97**	3,820	651	**4,471**
7.	Maragua	109	93	**202**	7,391	3,674	**11,065**
8.	Kigumo	78	45	**123**	3,108	987	**4,095**
TOTAL		**667**	**334**	**1,000**	**37,245**	**10,715**	**47,960**

Source: CIDP 2018-2022

Vitamin A Supplementation is a widely recognized high-impact and cost-effective intervention for increasing child survival. The World Health Organization recommends twice-yearly VAS in areas where vitamin A deficiency (VAD) is a public health concern to reduce all-cause mortality in children aged 6–59 months. Twice-yearly delivery of VAS through integrated Child Health Days (CHDs) and in ECDE centres is an effective method for reaching high and equitable coverage of child survival interventions. Worm infections contribute to Vitamin A deficiency while deworming reduces anaemia associated with increased Vitamin A deficiency.

Both worm infections and vitamin A deficiency pose serious health repercussions and there are several similarities between these two health programmes, both in terms of programme logistics and health impact, making it logical to deliver both interventions at the same time. One of the clearest advantages is simply the coverage opportunity offered by Vitamin A programmes. Murang'a County Nutrition Action Plan has recognized and incorporated the recommendations drawn from the Vitamin A Supplementation demonstration project end of project evaluation report for Murang'a County during its development process.

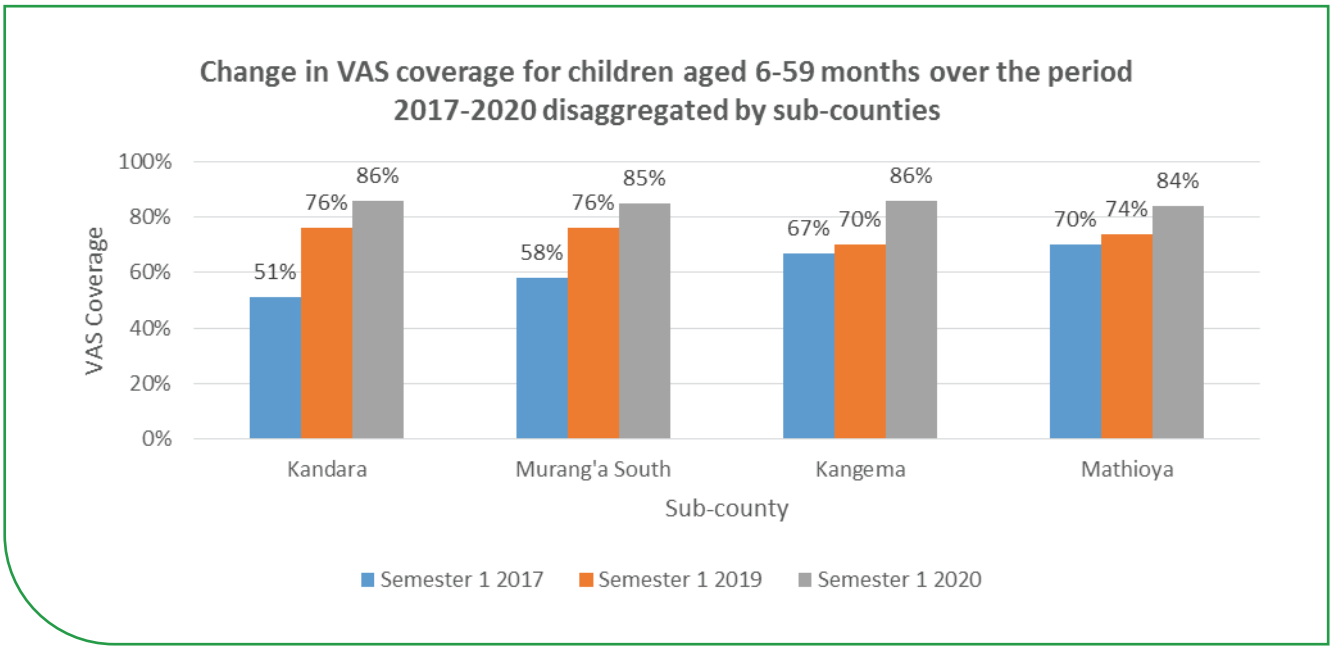


Figure 1:6: Change in VAS Coverage for children aged 6-59 months over the period 2017-2020 disaggregated by sub-counties

Source: VAS Demonstration Project End of Project Evaluation Report

1.3.3 WASH

Proper sanitation and hygiene and safe drinking water can reduce undernutrition and stunting in children by preventing diarrhoeal and parasitic diseases, and damage to intestinal development (environmental enteropathy). According to the World Health Organization (Annette, Robert, Fiona, & Jamie, 2008), roughly 50% of all malnutrition is associated with repeated diarrhoea or intestinal worm infections as a direct result of inadequate water, sanitation and hygiene. Diarrhoea is the second-leading cause of death globally in children under five years. Where children regularly suffer from diarrhoea, they are also highly likely to be malnourished as a result. For infants, particularly those under six months of age, diarrhoea can cause permanent damage to intestinal development, reducing a child's ability to absorb nutrients.

Access to safe drinking water, sanitation, and hygiene (WASH) services is a fundamental element of healthy communities and has an important positive impact on nutrition. Hand washing with soap and water, treatment and safe storage of drinking water and safe disposal of faeces reduces the risk of diarrheal diseases. Murang'a county drinking water coverage is at 60 % while latrine coverage is at 99% according to CIDP 2018-2022. Poor nutrition status can also lead to weak immunity and/or vulnerability to infectious diseases, thus diarrhoea. Poor nutrition status can also lead to weak immunity and vulnerability to infectious diseases resulting to diarrhoea.

Murang'a County is committed to integrated WASH activities in nutrition programs which include upscale of WASH under SDG 6 on achieving universal and equitable access to safe and affordable drinking water, access to adequate and equitable sanitation and hygiene and an end to open defecation. This will be achieved through inclusion of messaging on water, sanitation and hygiene contextualized for the specific community, making them appropriate for any family in the community to practice.

1.3.4 Social Protection

Social protection policies and programmes hold immense potential for improving the nutrition situation of vulnerable populations. Social protection has positive impact to nutrition by improving dietary quality, increasing income and improving access to health services. Additionally, social protection can also influence other determinants of nutrition, e.g. practices related to care, sanitation and education or basic causes of malnutrition such as inadequate access to resources.

Murang'a County will continue to scale up and sustain social protection interventions to ensure a long-lasting and positive impact on food security and nutrition as guided by the National model/approach of integrating Nutrition into Social Protection programmes. Such programs include cash transfers targeting Orphans and Vulnerable Children, Older Persons and for people with severe disabilities, safe motherhood, and health vouchers. Currently, there is no existing data in Murang'a County of integrating nutrition into social protection. However, implementation of this CNAP is expected to generate the data.

1.4 Human resource for nutrition

Murang'a County is currently inadequately staffed for provision of both clinical and preventive nutrition services within the health facilities and at community level even with its increased health services. It is envisioned that through high level nutrition advocacy targeting the county leadership, consideration of additional human resource for nutrition will be realized in the coming financial years.

Additionally, there is need for training clinical nutrition specialities to offer services in the specialized 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). As part of efforts towards health system strengthening, the 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.

Table 1.6: Human Resource for Nutrition

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 01. Maternal, Infant, Young Child Nutrition (MIYCN) including IMAM scaled up	7,436,000	20,064,600	67,282,600	18,825,100	68,495,350	182,103,650
KRA 02. Nutrition of older children and adolescents promoted	687,500	687,500	749,500	749,500	687,500	3,561,500
KRA 03. Prevention, control, and management of Micronutrient Deficiencies scaled-up	434,200	1,902,000	507,700	2,113,000	2,371,700	7,328,600
KRA 04. Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) in the life course scaled-up	594,500	494,500	1,179,500	89,000	1,179,500	3,537,000
KRA 05. Clinical nutrition and dietetics in disease management including HIV and TB strengthened	487,500	1,638,500	1,638,500	1,638,500	1,638,500	7,041,500
KRA 06. Nutrition in nutrition sensitive sectors promoted (Agriculture, ECDE, WASH and Social Protection)	1,758,500	1,880,000	2,286,000	2,286,000	2,286,000	10,496,500
KRA 07. Sectoral and multi-sectoral Nutrition governance, Coordination Information Systems, Learning and Research, legal and regulatory frameworks, leadership and strengthened	6,030,500	5,650,500	5,204,500	5,264,500	8,397,500	30,547,500
KRA 08. Advocacy, Communication and Social Mobilization (ACSM) strengthened	2,994,500	2,994,500	2,837,000	2,837,000	2,837,000	14,500,000
KRA 09. Supply chain management for nutrition commodities and equipment's strengthened	188,932,500	188,932,500	186,290,000	188,932,500	186,000,000	939,087,500
Grand Total	**209,355,700**	**224,244,600**	**267,975,300**	**222,735,100**	**273,893,050**	**1,198,203,750**

Source: (IHRIS, 2019)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2 COUNTY NUTRITION ACTION PLAN FRAMEWORK (CNAP)

2.1 Vision, Mission and Guiding Principles

The Kenya Health Policy 2012-2030 and the quest to achieve the Sustainable Development Goals (SDGs) by 2030 have guided the County Nutrition Action Plan. The National Food and Nutrition Security Policy (NFNSP) defines the vision, mission and guiding principles to be followed by the CNAP while the National Food and Nutrition Security Policy Implementation Framework (NFNSP-IF) defines the overarching strategies and framework for implementation covering the multiple dimensions of food security and nutrition improvement including the national and county institutional frameworks and the County Integrated Development Plan (CIDP 2018-2022) among others.

2.1.1 Our Vision

Our vision is "A malnutrition free county''

2.1.2 Our Mission

To provide efficient, effective, and sustainable nutrition services that are equitable, responsive, accessible ,gender sensitive and accountable to the population of Murang'a and to contribute to reduction of all forms of preventable malnutrition.

2.2 Rationale

Murang'a County Nutrition Action Plan is the road map for the implementation of nutrition services in the County for the next 5 years. This CNAP 2021-2025, is a "triple duty" strategic action plan that addresses malnutrition in Murang'a County in all its forms and for all ages and when fully implemented it will result in significant reductions in all forms of malnutrition. Of major concern is the emerging triple burden of malnutrition, where undernutrition is declining, but overweight, obesity and Diet Related Non-Communicable Diseases (DRNCDs) are increasing at a fast pace (KDHS, 2014).

The CNAP recognizes the fact that since risk factors for malnutrition are multi-sectoral and multifactorial and that malnutrition occurs in households and communities, interventions must be multi-sectoral, address the multiple causative factors, and focus at the county level to have the required community-level impact. The County Nutrition Action Plan (CNAP) is aligned to the Kenya National Nutrition Action Plan (KNAP) 2018–2022 strategic framework consistent with the roles of the National Government. The CNAP emphasizes provision of technical support, advocacy, and development of capacity for nutrition for the County Governments, while sub counties concentrate on implementation.

2.3 CNAP Objectives

The objective of the CNAP is to contribute to the national agenda for KNAP in accelerating and scaling up efforts towards the elimination of malnutrition in Kenya. The County Nutrition Action Plan is geared towards contributing to the national agenda on ending malnutrition in all its forms in line with Kenya's Vision 2030 and Sustainable Development Goals (SDGs) focusing on specific achievements by 2025.

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

2.4 National policy and legal framework for CNAP

The CNAP adds to a series of strategic national and county policy actions developed over the last decade to improve food and nutrition security at the national and county levels. These levels actualize the aspiration contained in the 2012 National Food and Nutrition Security Policy (NFNSP) and its implementation framework (NFNSP-IF) 2017-2022. The CNAP is the first County Nutrition Action Plan for the implementation of the NFNSP, and it is expected to enable realization of the country nutrition targets and commitment as captured in the KNAP 2018-2023.

The NFNSP aspire to ensure all Kenyans, throughout their life-cycle enjoy at all times safe food in sufficient quantity and quality to satisfy their nutritional needs for optimal health'. Using the life cycle (course) approach, the policy identifies key nutrition interventions for each age cohort and provides the linkages of nutrition to food production and other relevant sectors that impact on nutrition. Policy coherence between different spheres of policymaking is important, with policies across governments actively supporting, rather than undermining, nutrition goals. Collaboration and coordination across several actors (government, civil society, private sector, research, and national development partners) must exist to ensure coherence between policies, strategies, and action plans.

In addition, the CNAP derives its policy basis from several other sectoral county and National policies and frameworks then translates them into action. These sectors include Health and Sanitation, Agriculture, Livestock and Fisheries, Environment, Education, co-operatives, Social Protection, Public Service, Youth and Gender Affairs, Water and Irrigation, Trade and Commerce, and Devolution and Planning. The National Policy on Gender and Development of 2000 which calls for gender mainstreaming in all policies, programmes and sectors across the country, provides the policy approach for tackling gender issues in this CNAP.

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

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

(1) Article 43 (1) (c) - the right of every Kenyan to be free from hunger and a right to adequate food of acceptable quality.
(2) Article 53 (l) (c) - the right of every child to basic nutrition, shelter and health care; and
(3) Article 21 - establishes the progressive realization of social and economic rights and obligates the State to "observe, respect, protect, promote, and fulfil the rights and fundamental freedoms in the Bill of Rights."

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

From the global policy perspective, Kenya is a state party to several nutrition related global agreements and mechanisms including the SUN Movement, the World Health Assembly (WHA) 2025 nutrition targets, the Sustainable Development Goals (SDGs) , the UN International Decade on Food and Nutrition, and the ICN2 Declaration and Plan of Action.

Being high-level policy and strategy documents, they lay down the foundation for addressing the immediate, underlying and basic causes of malnutrition including expanding the political, economic, social and technological space for nutrition actions. The Murang'a CNAP aims at helping the country move towards meeting these commitments by implementing high impact nutrition interventions.

The financing framework and implementation of nutrition activities is anchored in the broader county of Murang'a agenda as presented in the County Integrated Development Plan (CIDP) and county financing systems, which aim at enabling quality nutrition for all the residents of the county.

2.5 The CNAP Development Process

Murang'a County Department of Health and Sanitation began developing its County Nutrition Action Plan 2020/21 – 2024/25, when the CECM Health and Sanitation held a meeting with all the nutritionists in the county to start off the thought process. At the time CBCC Africa, through Nutrition international (NI), supported the process by providing financial and technical support in the initial process of establishing a County Nutrition Technical Forum (CNTF). The CNTF terms of reference (TOR) was developed outlining 6 sub-technical working groups being established. All the 7 sub-county nutrition coordinators participated.

Similarly, with support from Nutrition International (NI), led by a team of consultants, the process commenced in July 2020. The process was widely consultative and involved all key nutrition stakeholders through a multi-sectoral process that was open, inclusive, and built on existing and emerging alliances, institutions and initiatives.

Division of Nutrition and Dietetics were represented from the national level while at county level, key nutrition sensitive sectors (Agriculture, social protection and gender; education), development partners, Civil Society Organizations, NGOs and the Private Sector, participated in the entire process. The process ensured that the plan is evidence-informed and recognized successes, challenges and lessons learnt from the development of the CNAP.

The process also ensured that the 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 and information from key sectors. Various meetings were planned both virtual and physical during the development of CNAP.

2.6 Key Principles of the CNAP

The key principles adopted for the implementation of CNAP include:

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

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

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

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

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

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

2.7 Gender mainstreaming in CNAP

Improved nutrition and gender equality are development priorities as reflected in several international, national, and county commitments, including the Murang'a County Integrated Development Plan 2020/21 – 2024/25. Gender inequalities are a cause as well as an effect of malnutrition and hunger. Higher levels of gender inequality are associated with higher levels of undernutrition, both acute and chronic undernutrition (FAO, 2012).

Gender equality is firmly linked to enhanced productivity, better development outcomes for future generations, and improvements in the functioning of institutions (IBRD & World Bank, 2012). Studies examining the relationship between gender inequality, nutrition and health have consistently shown that gender-related factors have an effect on nutrition and health related outcomes (Ndiku, Jaceldo-Siegh, Singh, & Sabate, 2010) (UNICEF, 2011).

The following domains of gender equality have been observed to have an far-reaching influence on nutrition and health related outcomes (Nutrition International, 2018):
• Gender roles and responsibilities leading to overburdening maternal roles and responsibilities among women and girls,
• Exclusion of men from nutrition due to societal perception of nutrition as women's work,
• Limited opportunities to engage in competitive and skilled productive work especially among women and youths,
• Beliefs, attitudes and norms pertaining to the way women and men relate to each other within the household or community,
• Lack of autonomy in decision-making, power and idea sharing for women,
• Unequal access to, use and control over productive economic resources, services and opportunities by women and girls,
• Attitudes about or experience of gender-based violence disproportionately affecting women, girls and children.

In any given society, men and women across different ages and diversities equally have a role to play in realizing good nutrition and health. However, the distinct roles and relations of women, girls, men and boys of different ages and diversities in a given culture, may bring about differences that give rise to inequalities in access to and uptake of optimal nutrition and health related services and practices, especially for women, girls and children (UN, 2010).

In addition, other socio-economic and cultural factors such as poverty, girls' levels of education, with non-schooling adolescents and those with primary school level education being more vulnerable, early marriage has significant influence on the probability of increased incidences of teenage pregnancies which remain a key driver of school drop outs among girls and consequently leading to a cycle of poverty which is a serious risk factor for malnutrition.

This CNAP aligns itself to the Murang'a County strategy of mainstreaming gender across all sectors and subsectors as stipulated in the Murang'a County Integrated Development Plan 2018 – 2022. It aims to contribute towards achieving gender equality and promote gender transformation on matters nutrition by targeting to include both men and women across different ages and diversities in all its activities.

This is in recognition of the interdependent role at household and community level played by both genders in acquiring and consuming good nutrition. It also seeks to promote an equal reach of the nutrition messages and services among the genders; advocate for a more equal distribution of gender roles and responsibilities by advocating for increased male involvement in care work and other household work while equally advocating for greater and meaning involvement of women in decision making. Using gender transformative IEC materials, this CNAP targets to transform community attitudes towards gender roles and responsibilities involved in nutrition. Gender sensitive indicators in the M & E framework provide for collection, analysis, reporting and use of sex disaggregated data to inform gender transformative programming.


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

3.1 Introduction

The overall expected result or desired change for the CNAP is to achieve optimal nutrition for the entire Murang'a population thus, healthier, and better-quality life and improved productivity for accelerated social and economic growth. To achieve the expected result a total of 9 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 3.1: Prioritized KRAs per Focus Area

CATEGORY OF KRAs BY FOCUS AREA	KEY RESULT AREAS (KRAs)
Nutrition specific interventions	1. Maternal, Infant, Young Child Nutrition (MIYCN) including Integrated Management of Acute Malnutrition (IMAM) scaled up 2. Nutrition of older children, adolescents 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
Nutrition sensitive interventions	6. Nutrition in nutrition sensitive sectors promoted (Agriculture, ECDE, WASH and Social Protection)
Enabling environment interventions	7. Sectoral and multi-sectoral nutrition governance, coordination and legal/regulatory frameworks, Nutrition Information Systems, learning and research strengthened 8. Advocacy, Communication and Social Mobilization (ACSM) strengthened 9. Supply chain management for nutrition commodities and equipment's strengthened

3.2 Theory of Change and CNAP logic framework

The "Theory of Change" (ToC) is a specific type of methodology for planning, participation, and evaluation that is used to promote social change – in this case nutrition improvement. ToC defines long-term goals and then maps backward to identify necessary preconditions. It describes and illustrates how and why a desired change is expected to happen in a particular context. The pathway of change for the Murang'a CNAP is therefore best defined through the theory of change. The ToC was used to develop a set of result areas that if certain strategies are deployed to implement prioritized activities, then a set of results would be realized and if at scale, contribute to improved nutritional status of Murang'a residents.

The logic framework outlining the key elements and process used to integrate "ToC" in Murang'a CNAP development is captured in Figure 3.1. The expected outcome, expected output and priority activities in line with the process logic have been discussed in section 3.3.

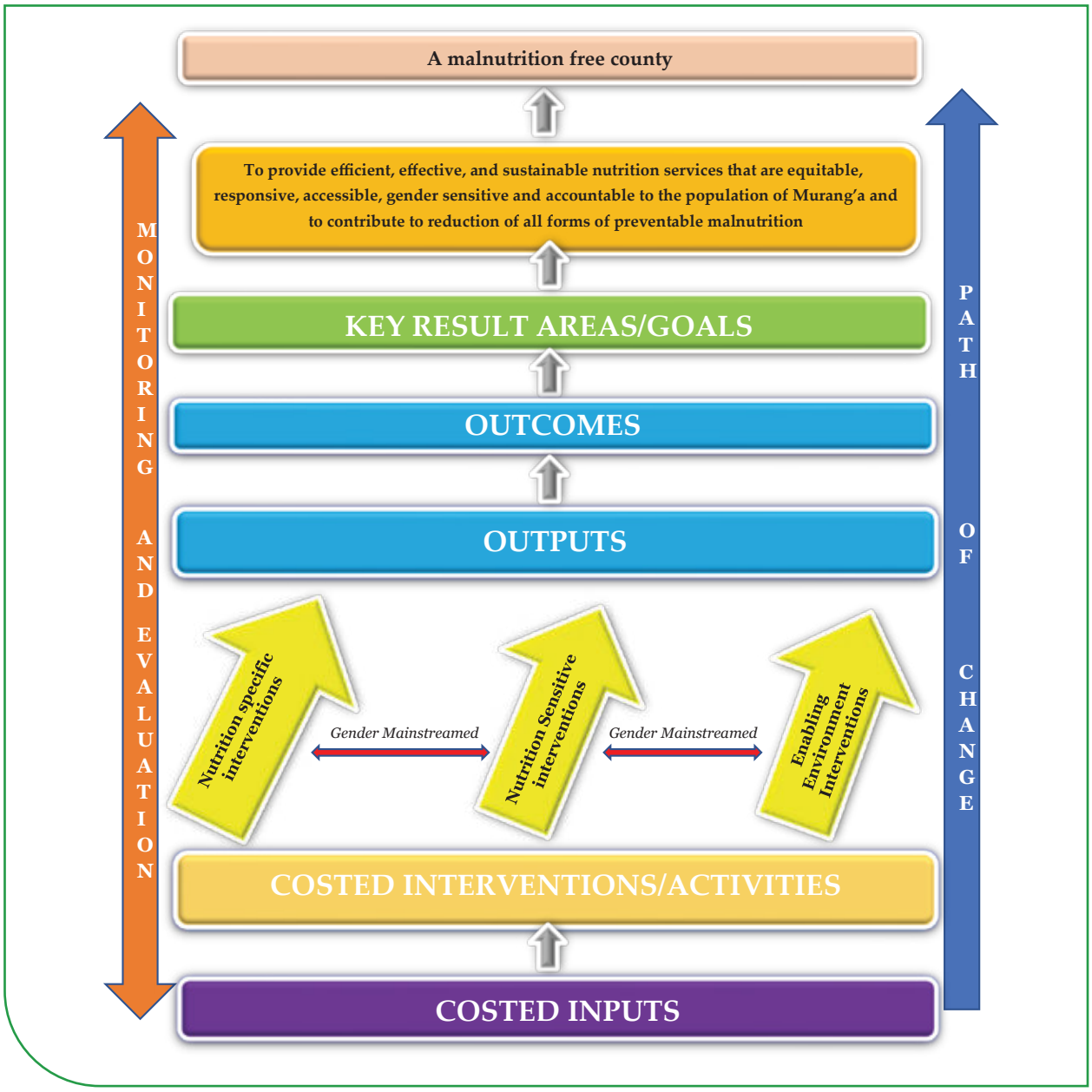


Figure 3:1: The CNAP Logic Process

3.3 Key Result Areas, Corresponding Outcome, Outputs and Activities

KRA 1: Maternal, Infant, Young Child Nutrition (MIYCN) including Integrated Management of Acute Malnutrition (IMAM) scaled up

Expected Outcome 1

Strengthened care practices and services for improved Maternal, Infant and Young Child Nutrition (MIYCN) at both health facility and community levels.

Output 1

Improved MIYCN policy environment at county, sub-county and community levels

Activities

- Sensitize County Health Management Team (CHMT) and Sub-County Health Management Team (SCHMT) on MIYCN policy, guidelines, and other related documents

• Sensitize front line male and female health and nutrition workers on MIYCN policy and guidelines at County, Sub-County and community levels
• Sensitize the male and female Community Health Extension Workers (CHEWs) and Community Health Assistants (CHAs) on MIYCN policy and guidelines
• Sensitize the male and female Community Health Volunteers (CHVs) on MIYCN policy and guidelines
• Print and disseminate MIYCN policy, guidelines and other related documents

Output 2
Increased proportion of care givers who take their children (under five years) for growth monitoring and promotion (GMP) services

Activities
• Train female and male health care workers on growth monitoring and promotion (GMP) on World Health Organization (WHO) growth standards
• Sensitize male and female community health volunteers (CHVs) on growth monitoring including family mid upper arm circumference (MUAC)
• Conduct on-job training (OJT), continuous medical education (CMEs) mentorship for health care workers on GMP
• Conduct growth monitoring and promotion services for children aged 0-59 months in all levels of health care
• Conduct support supervision on growth monitoring and promotion by SCHMTs and CHMTs
• Conduct community mobilization and awareness session on growth monitoring

Output 3
Increased proportion of hospitals-(level 5, 4 and 3) implementing Baby Friendly Hospital Initiative (BFHI)

Activities
• Sensitize hospital managers on baby friendly hospital initiative (BFHI)
• Train health male and female care workers on BFHI
• Conduct continuous CMEs on BFHI to health workers
• Form BFHI committee in implementing health facilities
• Conduct BFHI baseline self-assessment
• Conduct BFHI continuous self-assessment
• Conduct BFHI external assessment
• Conduct supportive supervision on BFHI compliance
• Establish county and sub county BFHI sub-committee with clear TOR
• Conduct quarterly county and sub-county BFHI review meetings

Output 4
Increased proportion of women of reproductive age (15–49 years) and caregivers who practice optimal behavior's for improved nutrition through implementation of baby friendly community initiative (BFCI)

Activities

- Sensitize key stakeholders and health managers on BFCI
- Train HCWs /CHEWs/CHAs/CHOs on BFCI
- Sensitize the community leaders, community health committees, community facility committees on BFCI
- Train male and female CHVs on c-BFCI
- Form BFCI committee in implementing community units.
- Conduct mapping households for mother to mother support group (MTMSGs) [formation of MTMSGs]
- Carry monthly MTMSGs meetings at community level
- Conduct BFCI baseline self-assessment at community unit level
- Conduct continuous BFCI self-assessment at community unit level
- Conduct BFCI external assessment at community unit level
- Establish BFCI county and sub county sub committees with a clear TOR
- Hold quarterly county and sub county sub-county BFCI review meetings
- Disseminate complementary feeding recipe book & guide to health care workers and CHVs
- Conduct cooking demonstration targeting caregivers of children aged 0-59 months using locally available foods to demonstrate texture and diversity
- Conduct continuous supportive supervision on BFCI activities at community unit level.

Output 5

Improved capacity of male and female health care workers in implementation of MIYCN services

Activities

- Train male and female health care workers on MIYCN
- Conduct community health and nutrition education targeting men for their increased engagement on their role and support on MIYCN
- Conduct OJT, CMEs and mentorship on MIYCN to health workers
- Sensitize male and female health care workers on NACS for pregnant and lactating women
- Conduct supportive supervision on NACS for pregnant and lactating mothers

Output 6

Increased demand and access for MIYCN services

Activities

- Conduct quarterly MIYCN TWG meetings
- Conduct advocacy meeting with key influencers on MIYCN prioritization
- Conduct gender integrated community dialogue days/ community action days for male and female CHVs on MIYCN
- Establish community father to father support groups to be used as platforms for peer to peer support and health education on MIYCN.
- Identify and promote positive role models among partners and men who demonstrate good MIYCN practices
- Conduct community health and nutrition education targeting men for their increased engagement on their role and support on MIYCN.
- Commemorate celebration of world breastfeeding week
- Participate in celebration of world prematurity day
- Plan and celebrate Malezi Bora months bi-annually

Output 7
Improved Breastmilk Substitute (BMS) Act, 2012 implementation at county and sub county levels

Activities
- Train nutritionist and public health officers on BMS monitoring and enforcement
- Conduct continuous monitoring of the BMS Act, 2012 and report any violations
- Train or/and sensitize HCWS of all genders on BMS Act implementation framework
- Conduct CMEs on BMS Act implementation framework at health facility level
- Establish BMS Act, task force at county level
- Sensitize stakeholders in both public and private sectors including the media fraternity on BMS Act implementation framework
- Sensitize CHVs and community members on BMS Act using effective communication channels.

Output 8
Workplace support for breastfeeding mothers rolled out within public, private, formal and informal setups

Activities
- Sensitize the stakeholders, employers, and health care workers on workplace support for breastfeeding mothers
- Sensitize formal & informal day care centers on optimal nutrition care practices
- Support establishment of lactation rooms at Murang'a county headquarters (HQs), Murang'a county referral and Maragua hospitals workplace
- Advocate and support establishment of lactation station in both public and private sectors

Output 9
Strengthened MIYCN in emergencies at county level

Activities
- Sensitize stakeholders on MIYCN-E operational guidelines and assessment guide
- Train/ Sensitize health care workers on MIYCN-E
- Carry out CMEs on MIYCN-E at health facility levels
- Sensitize CHVs on MIYCN-E
- Develop and disseminate county nutrition emergency preparedness and response plan
- Participate in county disaster coordination forums

Expected Outcome 2
Reduced cases of acute malnutrition and increased recovery rates

Output 1
Standards operating procedure (SOPs) for the integrated management of malnutrition (IMAM) program adapted and disseminated

Activities
- Adapt national standard operating procedures (SOPs) for IMAM
- Sensitize male and female health care workers on IMAM SOPs
- Print and distribute IMAM SOPs to health facilities

Output 2
Capacity enhanced for IMAM Service delivery and programming

Activities
- Disseminate IMAM guidelines to CHMT/SCHMT
- Train male and female health care providers on IMAM
- Train male and female CHVs on IMAM.
- Conduct continuous CMEs at facility level to health care workers on IMAM
- Carry out screening of children at community level and refer malnourished children to link health facilities for further management by CHVs
- Carry out nutrition assessment, counseling, support and follow-up to all children with moderate and severe acute malnutrition

Output 3
Improved IMAM supply chain for commodities, supplies and equipment

Activities
- Procure and distribute IMAM commodities to the implementing health facilities
- Procure and distribute IMAM reporting tools to the implementing health facilities.

Output 4
Strengthened partnerships including public–private partnership (PPP) to improve access and coverage of IMAM services and linkages with other interventions

Activities
- Link malnourished IMAM clients to other programmes at community level (Wash, social safety net interventions)

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

Expected Outcome
Increased uptake of nutrition services for improved nutritional status of older children and adolescents

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

Activities
- Sensitize key stakeholders (teachers, faith-based leaders, youth leaders, targeting all genders across different ages and diversities) on healthy diets and physical activity and Adolescent guidelines for older children
- Disseminate nutrition policies, guidelines (food-based dietary guidelines; tuck shop guidelines; menu guidelines; sports nutrition guidelines; school garden guidelines), training packages (healthy diet and physical activity) to teachers, Board of Management (BOM) and any other relevant key stakeholders

Output 2
Increased awareness on healthy diets and physical activities among caregivers, social influencers, older children, adolescents and older persons themselves.

Activities
- Train key stakeholders (BOMs, teachers, caregivers incorporating both genders) on healthy diets and physical activity for older children, adolescents and older persons.
- Sensitize older children, adolescents and communities targeting both genders on healthy diets and physical activity using context-specific communication channels in both rural and urban setups
- Adapt/ customize recipes for older children and adolescents in institutions
- Integrate nutrition activities for both boys and girls into existing youth friendly centers within the county

Output 3
Enhanced linkages & collaboration with stakeholders and sensitize them to promote good nutrition in older children, adolescents and older persons.

Activities
- Advocate for integration messaging on healthy diets and physical activity in school heath programs
- Conduct intersectional sensitization on childcare development
- Sensitize stakeholders including communities on workplace wellness programs using effective communication channels
- Sensitize stakeholders within institutions such as training colleges, prisons on optimal nutrition for adults and older persons

Output 4
Strengthened Monitoring and Evaluation of nutrition services for older children and adolescents

Activities
- Hold joint bi-annual performance review meetings for intervention on older children, adolescent and older persons in collaboration with key stakeholders at county and sub-county level
- Conduct joint supportive supervision on interventions for older children, adolescents and older persons in collaboration with key stakeholders

KRA 3: Prevention, Control, and Management of Micronutrient Deficiencies Scaled-Up

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

Output 1
Micronutrient deficiency control policies, guidelines and other related documents disseminated and implemented

Activities

• Sensitize CHMT/SCHMT on micronutrient disease prevention and control policies and guidelines [IFAS, VAS, MNPs]
• Train male and female health workers on micronutrient disease prevention and control policies and guidelines [IFAS, VAS, MNPs]
• Sensitize male and female CHVs on micronutrient disease prevention and control [IFAS, VAS, MNPs]
• Sensitize CHVs and community (men and women including community leaders and other key influencers) on food fortification and on the importance of micro-nutrient supplementation for pregnant women, adolescent girls, and children.

Output 2

Strengthened routine micronutrient supplementation (vitamin A, iron and folate and micronutrient powders) for targeted groups

Activities

• Procure and distribute micronutrient supplements (Vitamin A capsules, IFAS, multiple micronutrient powders)
• Train health workers on VAS, IFAS and MNPs
• Sensitize the male and female CHVs on VAS, IFAS and MNPs
• Sensitize the community through effective communication channels on VAS, IFAS and MNPS for target populations to create demand for services
• Procure and distribute Zinc/ORS co-pack, ReSoMal for management of diarrhea

Output 3

Increased awareness on locally available fortified foods.

Activities

• Conduct annual household monitoring of salt iodization
• Sensitize industries and companies on food fortification compliance
• Sensitize the public health officers and nutritionists on monitoring of fortified foods in the markets
• Monitor the availability and compliance of fortified foods in market in urban and rural setups
• Sensitize the CHVs and community (men and women including community leaders and other key influencers) on food fortification including food fortification logo and on the importance of micro-nutrient supplementation for pregnant women, adolescent girls and children.

Output 4

Increased uptake of diversified and bio-fortified foods

Activities

• Develop and disseminate key messages to the community targeting all genders on the consumption of diversified micronutrient rich foods and bio-fortified foods.
• Conduct nutrition education and counseling on dietary diversification and bio-fortification at the facility and community levels

KRA 4: Prevention, Control, and Management of Diet Related Non-Communicable Diseases (DRNCDs) in the life course scaled-up

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

Output 1
Improved policy and legal environment for nutrition in DRNCDs

Activities
- Conduct dissemination meetings targeting CHMT and SCHMT on guidelines, policies and strategies related to nutrition under non-communicable disease programt (Kenya National Strategy for the Prevention and Control of Non-Communicable Diseases, National guideline on management of Diabetes, Kenya National clinical guide line for the management of Diabetes Mellitus 2018, National guidelines for healthy diets and physical activity 2017)
- Develop standard operating procedures on DRNCDS for nutrition
- Disseminate SOPs for DRNCDs on nutrition to health care workers for implementation.

Output 2
Increased Competences, knowledge, and skills for health care workers in prevention, control and management of DRNCDs

Activities
- Train health care workers on healthy diets and physical activity
- Sensitize CHVs (male and female) on healthy diets and physical activity
- Train health care workers on geriatric nutrition
- Sensitize CHV and the community on nutrition for the elderly using effective communication channels.

Output 3
Increased community awareness on prevention, control, and management of DRNCDs

Activities
- Participate in commemoration of world diabetic day, hypertension day and cancer month
- Conduct sensitization meetings to the community members through various channels (chief barazas, MTMSGs, churches, Mosques, father to father support groups) on importance of healthy diets and physical activities towards prevention of DRNCDs
- Hold radio talk shows on DRNCDs in relation to nutrition
- Participate in medical camps and community screening, assess, counsel and refer clients with DRNCDs to health facilities

Output 4
Quality and timely provision of nutrition therapy in management of DRNCDs

Activities
- Carry out continuous CME on importance of nutrition in the management of DRNCDS in all facilities
- Carry out nutrition assessment and counseling to all clients with DRNCDs

• Refer malnourished clients with DRNCDs for nutritional support both at facility level and to mapped out social protection services
• Refer DRNCDs clients to support groups where they exist and encourage formation of the same where they do not exist

KRA 5: 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 and dietetics guidelines, standards, screening, and assessment tools disseminated and implemented

Activities
• Disseminate policies, guidelines and strategies related to clinical nutrition and dietetics (such as Kenya National clinical nutrition and dietetics manual 2010) to CHMT and SCHMT

Output 2
Improved technical capacity among health care workers on clinical nutrition and dietetics in disease management

Activities
• Train health care workers on clinical Nutrition and dietetics
• Conduct on job training and CMEs at the health facilities on clinical nutrition and dietetics
• Carry out CMEs to health care workers on nutrition management for preterm and low birth weight babies

Output 3
Improved access to quality clinical nutrition services at health facility level

Activities
• Support male and female nutrition officers and selected health care providers to specialized clinical Nutrition care trainings e.g. Renal, Oncology, Critical Care etc.
• Support participation of nutritionist in short clinical nutrition trainings such as enteral and parental nutrition courses
• Carry out nutrition assessments, counseling and support to patients in out-patient and in-patient care
• Adapt /develop and disseminate SOPs for clinical nutrition to health care workers

Output 4
Strengthened supply chain for nutrition commodities and equipment for clinical nutrition and dietetics

Activities
• Carry out CMEs for health care workers on commodity management for clinical nutrition and dietetics

• Carry out integrated commodity management supervision
• Procure and distribute enteral and parental nutrition commodities
• Procure and distribution therapeutic feeds for management of severe malnutrition
• Procure and distribute supplementary feeds for management of moderate malnutrition
• Advocate for appropriate feeding alternative in cases of OVC, very sick mothers who cannot breastfeed or any other medical reasons as indicated within MIYCN guidelines
• Procure and distribute clinical nutrition and dietetics assessment equipment's
• Procure and distribute assessment and reporting tools for clinical nutrition and dietetics

Output 5
Strengthened in-patient feeding for all facilities offering in -patient care

Activities
• Establish in-patient feeding committee in all facilities offering in-patient care
• Conduct continuous monitoring of in-patient feeding in health facilities offering in-patient care
• Advocate for adequate resources for in-patient feeding

Expected Outcome 2
Reduced impact of HIV-related co-morbidities among people living with HIV through targeted nutrition therapy

Output 1
Improved policy environment for nutrition in HIV and TB management

Activities
• Conduct dissemination meeting on policies and guidelines for nutrition management in HIV and TB targeting CHMT and SCHMT

Output 2
Improved competences, skills, and knowledge among health care workers on HIV and TB

Activities
• Train male and female health care workers on nutrition care in HIV management
• Train male and female health care workers on nutrition care in TB management
• Conduct CMEs and mentorship at the health facilities on nutrition management in HIV and TB

Output 3
Improved nutrition care process in HIV and TB services/clinics

Activities
• Carry out nutrition assessment and counseling to all HIV and TB clients
• Carry out nutrition support for all malnourished HIV and TB clients

Output 4
Strengthened supply chain for nutrition commodities, equipment and reporting tools in HIV and TB

Activities
- Conduct nutrition commodity and equipment audit in all CCC and TB clinics
- Procure and distribute food by prescription commodities for malnourished HIV and TB clients
- Procure and distribute nutrition equipment's for CCC and TB clinics
- Procure nutrition assessment and reporting tools for CCC and TB clinics

Output 5
Well-structured linkage and referral system for HIV and TB clients

Activities
- Map out stakeholders who offer nutrition, livelihood and social safety net support for HIV and TB malnourished clients within the county
- Link malnourished HIV and TB clients to mapped sites for livelihoods and social safety nets programs within the county
- Refer HIV and TB clients to other medical services at facility level appropriately

KRA 6: Nutrition in nutrition sensitive sectors promoted (Agriculture, Education ECDE, WASH and Social Protection)

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

Output 1
Enhanced joint planning and dissemination of strategic policy documents (guidelines and strategies)

Activities
- Conduct planning meetings with relevant stakeholders
- Carry out dissemination of strategic policy documents with identified relevant stakeholders

Output 2
Availability and accessibility of safe, diverse nutritious food crops promoted

Activities
- Promote integrated kitchen garden/home gardens within household to both men and women, girls and boys in collaboration with Department of Agriculture personnel
- Promote integrated kitchen garden/ vegetable in schools for boys and girls in collaboration with Department of Agriculture personnel
- Promote integrated kitchen garden/vegetable gardens within the health facilities to act as demonstration sites in collaboration with Department of Agriculture personnel
- Participate in trainings on climate smart agriculture targeting both men and women extension staff as TOTs and lead farmers (farmer field schools) in collaboration with Department of Agriculture
- Sensitize community members (men and women across different ages and diversities) and other stakeholders on climate smart agriculture in collaboration with Department of Agriculture personnel

• Sensitize community members (men and women across different ages and diversities) on food processing, preservation, and storage technologies in collaboration with Department of Agriculture personnel

Output 3
Consumption of safe diverse nutritious foods promoted

Activities
• Sensitize extension staff and lead farmers on food consumption tables (men and women)
• Carry out nutrition education on meal planning and preparation to the community (men and women) using effective communication channels to promote dietary diversity in collaboration with department of Agriculture personnel
• Carry out nutrition education on food safety and hygiene to the community (men and women) using effective communication channels
• Conduct cooking demonstrations targeting community members (men and women) through community forums using locally available foods.

Output 4
Enhanced capacity of different stakeholders on nutrition sensitive agriculture and food systems

Activities
• Sensitize extension staff (men and women) on agri-nutrition manual in collaboration with Department of Agriculture personnel
• Train agriculture extension workers on nutrition sensitive food systems
• Sensitize lead farmers (men and women) on agri-nutrition manual in collaboration with Department of Agriculture personnel
• Sensitize nutritionists on agri-nutrition dialogue cards in collaboration with Department of Agriculture personnel
• Sensitize CHVs (men and women) on agri-nutrition manual in collaboration with Department of Agriculture personnel
• Advocate for nutrition sensitive agricultural production
• Trainings decision makers in the agriculture department and stakeholders on nutrition sensitive agriculture food systems

Output 5
Fuel and energy saving technologies promoted

Activities
• Sensitize Agriculture extension staff (men and women) and nutritionists on fuel energy saving technologies in collaboration with department of Agriculture personnel
• Sensitize farmers (men and women) and CHVs on fuel energy saving technologies in collaboration with department of Agriculture personnel
• Sensitize the community through community groups on fuel energy saving technologies in collaboration with department of Agriculture personnel

Output 6
Strengthened M&E mechanism for scaling up nutrition in agriculture

Activities
- Conduct joint support supervision and follow up of integrated activities at community level
- Write quarterly report on agri-nutrition activities carried out at the community level

Expected Outcome 2 - Education Sector
Nutrition mainstreamed in education sector policies, strategies, and action plans

Output 1
Improved nutrition policy environment for male and female education stakeholders (ECDE Coordinators, teachers, parents)

Activities
- Conduct joint planning meeting with relevant stakeholders (MOE, MOH, MOA)
- Carry out dissemination of strategic policy documents (Vitamin A supplementation guide for teachers; ECD feeding program policy, National guidelines on ECDE, School meals and Nutrition Strategy, Home Grown School Meal Implementation Guidelines, School Meals menu guide, School Health Policy, School Health Implementation Guidelines,) targeting ECDE program officers, county and sub county education officer and teachers
- Sensitize and disseminate food and nutrition reference manual to all key stakeholders in education and health at county and sub county levels

Output 2
Safe food environment in education institutions promoted

Activities
Carry out joint routine inspections to all ECDE centers to ensure compliance to the set standards on food safety and hygiene

Output 3
Strengthened nutrition service delivery in ECDE and other education institutions

Activities
- Sensitization of male and female ECDE and other education program officers on importance of VAS and deworming
- Sensitization of ECDE teachers and parents (men and women) on VAS and deworming
- OJT teachers (men and women) on how to conduct nutrition growth monitoring to ensure optimal growth and development and conduct nutrition assessment in classes using a MUAC for screening
- Refer malnourished children to the link health facility
- Conduct deworming of children in mainstream schools in collaboration with the school health program

Output 4
Technical support to ECDE centers and mainstream schools on establishment, improvement of existing school gardens and nutrition education promoted

Activities
- Collaborate with MoALC to hold sensitization meetings on dietary diversification to teachers and parents (men and women)

• Support MoALC to establish school integrated gardens in ECDE centers
• Sensitize BOM, teachers and parents on dietary diversification and establishment of kitchen gardens at school level
• Advocate for establishment of nutrition clubs in schools to promote nutrition education and activities

Output 5
Strengthened M&E system for nutrition interventions in ECDE centers and other education institutions improving nutrition status of school going children

Activities
• Conduct joint supportive supervision (MOH, MOE) to all ECDE Centres
• Conduct evaluation of nutrition activities is ECDE and mainstream schools
• Report on interventions conducted in ECDE centers and other education institutions on quarterly basis

Expected Outcome 3 - WASH
Nutrition integrated into WASH strategies, plans and programmes

Output 1
Adequate WASH practices in households, schools, institutions and food establishments promoted

Activities
• Carry out CMEs at health facility level on WASH practices (hand washing, safe drinking water, latrine use, waste management, food safety and hygiene, environmental hygiene) in collaboration with the public health department
• Sensitize male and female CHVs on WASH practices (hand washing, safe drinking water, latrine use, waste management, food safety and hygiene, environmental hygiene,) in collaboration with the public health department
• Promote WASH practices at community level through various channels (chief barazas, MTMSG, father to father support groups, churches , mosques, farmer field school) (hand washing, safe drinking water, latrine use, waste management, food safety and hygiene, environmental hygiene) in collaboration with the public health department,
• Conduct sensitization meeting to institutions on WASH practices (hand washing, safe drinking water, latrine use, waste management, food safety and hygiene, environmental hygiene) in collaboration with the public health department
• Participate in triggering community through community led total sanitation to integrate nutrition in collaboration with the public health department
• Participate in commemoration important international WASH days (World Toilet Day, Global Hand Washing Day, World Menstrual Hygiene Day)

Output 2
Strengthened collaboration with relevant stakeholders (NEMA, Water service providers, WARMA, food establishments, community members)

Activities
• Advocate for joint resource mobilization for integrated WASH and nutrition activities
• Hold stakeholder's partnership meetings on the importance of integrating nutrition in WASH practices

Output 3
Strengthened nutrition service delivery in ECDE and other education institutions

Activities
• Hold quarterly joint performance review meetings for integrated WASH and nutrition activities at county level
• Conduct quarterly monitoring and evaluation of integrated WASH and nutrition practices

Expected Outcome 4 - Social Protection
Integration of nutrition in social protection programmes strengthened

Output 1
Improved collaboration with relevant stakeholders for enhanced nutrition outcomes

Activities
Carry out joint planning with key stakeholders (MOH, social protection, CSOs)

Output 2
Improved knowledge of stakeholders in social protection programmes on good nutrition practices

Activities
• Sensitize nutritionists on link between nutrition and social protection
• Sensitize social protection officers on the link between nutrition and social protection

Output 3
Strategies that enable beneficiaries to diversify their diet and livelihoods promoted

Activities
• Train social protection officers as TOT on nutrition for vulnerable groups (men and women)
• Conduct gender integrated awareness forums on nutrition to beneficiary welfare committees in collaboration with social protection department
• Conduct awareness forums on nutrition to vulnerable groups (OVCs, elderly, PWDs) targeting all genders in collaboration with social protection department

Output 4
Strengthened M&E mechanism for integrating nutrition into social protection programs

Activities
• Conduct quarterly joint supportive supervision with social protection focal persons (MOH and Social protection)
• Conduct quarterly performance review of integrated social protection and nutrition activities
• Develop a customized tool for monitoring integrated nutrition and social protection activities

• Conduct quarterly monitoring and evaluation of integrated social protection and nutrition programs/Activities

KRA 7: Sectoral and multi-sectoral nutrition governance, coordination and legal/regulatory frameworks, Nutrition Information Systems, learning and research strengthened

Expected Outcome 1
To improve sectoral and multi-sectoral Nutrition leadership and governance including coordination and legal/regulatory framework

Output 1
Improved coordination mechanism, partnerships, and collaborations for program implementation at county and sub county levels

Activities
• Disseminate relevant policies, guidelines and legal/regulatory frameworks to the sectoral and multisectoral coordination forum (BMS Act,2012, Workplace support Guideline, Marketing of unhealthy food mandatory law on food fortification)
• Map nutrition partners and stakeholders in the county
• Establish multisectoral platform working group
• Hold Biannual stakeholders' meetings
• Conduct quarterly multisectoral working group meetings to strengthen prioritization of nutrition for county agenda,
• Hold quarterly county nutrition technical forum (CNTF)
• Hold quarterly sub county nutrition technical forum (SCNTF)
• Conduct quarterly partnership and collaboration meeting with nutrition stakeholders
• Implement Scaling Up Nutrition (SUN) Business network strategy
• Conduct market surveillance with sector and multisectoral teams on compliance of legal/regulatory frameworks

Output 2
Knowledge sharing and learning at county, national, regional, and global levels on nutrition promoted

Activities
• Hold monthly data sharing meetings with key stakeholders
• Participation by nutrition officers in conference and symposium at all levels
• Participation by nutrition officers in county, regional, and national meetings on nutrition

Output 3
Resource mobilization strategy for nutrition covering all aspects of resources-financial, human, and organizational developed and implemented

Activities
• Map out existing and new potential donors and partners for the county
• Hold resource mobilization meetings with potential donors and partners

Expected Outcome 2
To improve nutrition information system, learning and research

Output 1
CNAP and M&E framework for nutrition sector developed, implemented, monitored and evaluated

Activities
- Develop nutrition annual work plan (AWP) to operationalize CNAP
- Monitor implementation of nutrition AWP
- Conduct Biannual nutrition AWP review
- Conduct mid and end term CNAP review/evaluation
- Develop, launch, and disseminate second generation CNAP in collaboration with line ministries

Output 2
Capacity for quality nutrition data collection analysis and dissemination enhanced

Activities
- Conduct Quarterly Data Quality assessment
- Conduct quarterly data quality review meeting
- Conduct MIYCN KAP survey targeting all genders after every two years
- Conduct SMART nutrition survey after every two years
- Conduct nutrition capacity assessment (NCA) after every two years
- Strengthen collection, analysis and use of sex-age disaggregated data for decision making
- Train male and female nutrition officers, health information officers and other frontline health care workers on nutrition data elements and indicators and sentinel surveillance-Early Warning System

Output 3
Nutrition M&E in the relevant sectors mainstreamed

Activities
- Incorporate explicit gender sensitive nutrition objectives and indicators in the relevant sectors

Output 4
Evidence-based decision making through research enhanced

Activities
- Participate in dissemination forum for research findings and information sharing at all levels
- Participate in research technical working group (TWG) at county level
- Advocate for nutrition related research to male and female health care professionals going for further studies

Output 5
Strengthened utilization of data/information to enhance decision making

Activities
- Develop Nutrition information product(factsheet) for the county
- Disseminate Nutrition information product(factsheet) to CHMT, SCHMTs, health care workers and other stakeholders (including the private sector food industries, etc.)

Output 6
Strengthened integration of nutrition data into KHIS

Activities
- Sensitize sub county nutritionists and other frontline health care workers on nutrition data management
- Conduct quarterly support supervision for nutrition M&E

KRA 8: Advocacy, Communication and Social Mobilization (ACSM) strengthened

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

Output 1
Capacity for nutrition advocacy at county and sub county levels strengthened

Activities
- Train nutrition professionals and other frontline health care workers on gender responsive nutrition advocacy
- Train media personnel on gender responsive nutrition advocacy

Output 2
Effective knowledge management supported, and evidence-based advocacy strengthened

Activities
- Document and disseminate nutrition best practices case studies research finding and success stories within the county and at national level
- Develop, disseminate, and implement a gender responsive nutrition advocacy package for county targeting nutrition stakeholders in public, civil society and the private sectors

Output 3
Strengthened community engagement, participation and feedback mechanism for nutrition services and decision-making processes

Activities
- Hold community dialogues to promote community participation in nutrition resilience building activities and accountability mechanism targeting all genders
- Sensitize the community on various nutrition thematic days targeting men and women, boys and girls across different ages and diversities

Output 4
High level nutrition advocacy for the county government held

Activities
- Carry out high level nutrition advocacy meeting targeting the county members of health committee, executive members, and other relevant stakeholders
- Identify male and female county nutrition champions across different ages and diversities
- Engage male and female county nutrition champions on various nutrition activities

Output 5
Strengthened nutrition awareness through advocacy initiatives

Activities
- Commemorate world breastfeeding week
- Commemorate Malezi Bora
- Participate in the celebration of their health days (World Prematurity day, World Toilet Day, World AIDS Day, World Diabetes Day, World TB Day, World Water Day)
- Adopt and distribute gender transformative nutrition related BCC materials (MIYCN counseling cards, 1000 days booklet, IMAM protocol guidance, nutrition Job Aids)
- Carry out radio talks on nutrition in local FMs that incorporate gender issues in nutrition
- Develop/ customize gender transformative behavior change communication material on nutrition key messages

KRA 9: Supply chain management for nutrition commodities and equipment's strengthened

Expected Outcome
Strengthened supply chain and management of nutrition commodities, equipment, and reporting tools

Output 1
Improved availability of nutrition commodities, equipment's, and reporting tools

Activities
- Conduct training of health care workers on logistic information and management system (LMIS)
- Participate in commodity technical working group
- Carry out nutrition supplies data quality audit
- Procure and distribute nutrition commodities for micronutrient program, IMAM, HIV/TB and for clinical nutrition in disease management
- Procure and distribute nutrition equipment for health facilities
- Procure and distribute nutrition reporting tools for all programs
- Support repair and maintenance of nutrition equipment's when applicable in collaboration with the medical engineering department
- Develop and submit/share annual nutrition procurement plan for nutrition commodities and equipment's to be integrated within the County integrated procurement plan

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

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

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

4.2 Background and Context

The Murang'a 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 described 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 Murang'a CNAP MEAL Plan aims to provide strategic information needed for evidence-based decisions at county level through development of a Common Results and Accountability Framework (CRAF).

The CRAF will form the basis of one common results framework that integrates the information from the various sectors related to nutrition, and other non-state actors e.g. Private sector, CSOs, NGOs; and external actors e.g. Development partners, technical partners resulting in overall improved efficiency, transparency and accountability.
The current nutrition situation and strategic interventions have been defined in earlier chapters, while the MEAL Plan outlines what indicators to track when, how and by whom data will be collected, and suggests the frequency and the timeline for collective, program performance reviews with stakeholders.

Elements to be monitored include:
- Service delivery statistics
- Service coverage/Outcomes
- Client/Patient outcomes (behavior change, morbidity)
- Clients Access to services
- Quality of health services
- Impact of interventions

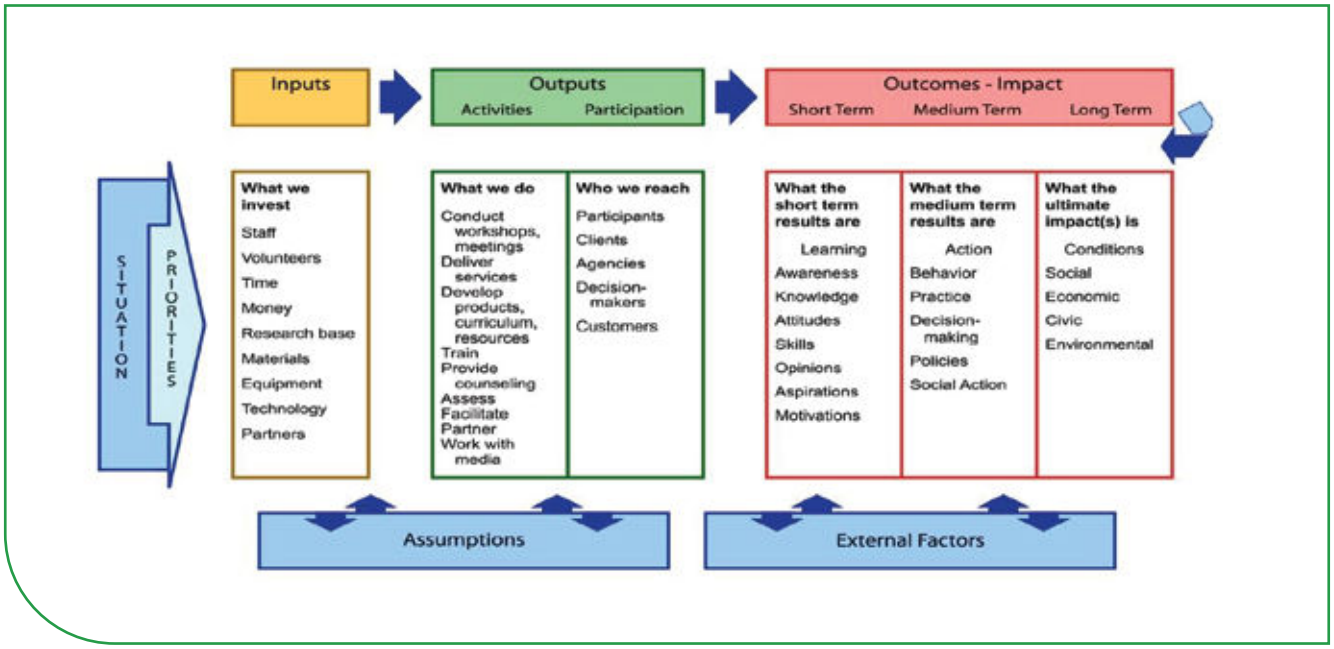
The evaluation plan will elaborate on the periodic performance reviews/surveys and special research that complement the knowledge base of routine monitoring data. Evaluation questions, sample and sampling methods, research ethics, data collection and analysis methods, timing/schedule, data sources, variables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

In an effort to ensure gender integration at all levels of the Murang'a CNAP, all data collected, analyzed, and reported on will be disaggregated by gender and age to provide information and address the impact of any gender issues and relations including benefits from the nutrition programming between men and women. Sex disaggregated data and monitoring will help detect any negative impact of nutrition programming or issues with targeting in relation to gender. Similarly, positive influences and outcomes from the interventions supporting gender equality for improved nutrition and health outcomes shall be documented and learned from to improve and optimize interventions. Other measures that will be put in place to mainstream gender in the MEAL plan will include:

- Development / review M&E tools and methods to ensure they document gender differences.
- Ensuring that terms of reference for reviews and evaluations include gender-related results.
- Ensuring that M&E teams (e.g. data collectors, evaluators) include men and women as diversity can help in accessing different groups within a community.
- Reviewing existing data to identify gender roles, relations and issues prior to design of nutrition programming to help set a baseline.
- Holding separate interviews and FGDs with women and men across different gender, age and diversities including other socio-economic variations.
- Inclusion of verifiable indicators focused on the benefits of the nutrition programming for women and men.
- Integration of gender-sensitive indicators to point out gender-related changes leading to improved nutrition and related health outcomes over time.

4.4 Logic Model

The logic model as outlined in Figure 4:1 looks at what it takes to achieve intended results, thus linking results expected, with the strategies, output and input, for shared understanding of the relationships between the results expected, activities conducted, and resources required.



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

Figure 4:1: Monitoring and Evaluation Logical Framework

4.5 Monitoring process

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

The key monitoring processes as outlined in Figure 4:2 will involve:

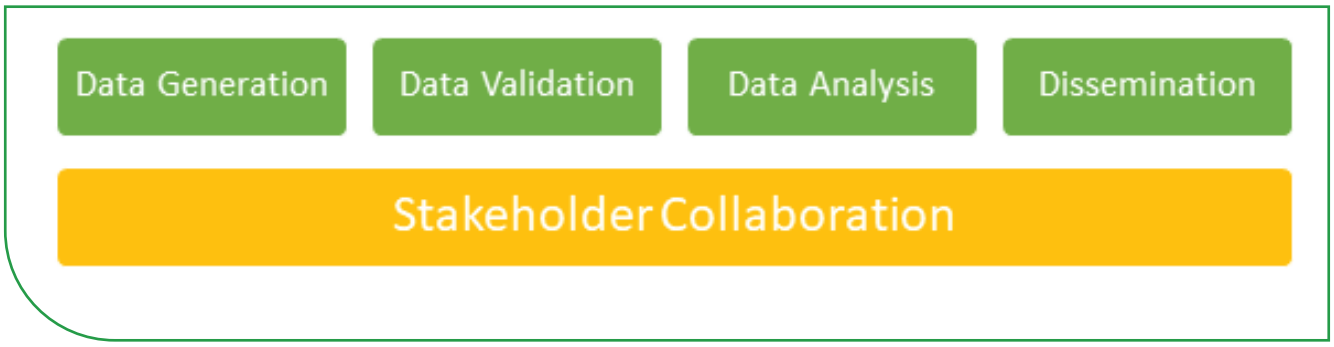


Figure 4:2: Monitoring Processes

Data Generation

• Various types of data will be collected from different sources to monitor the implementation progress. These data are collected through routine methods, surveys, sentinel surveillance and periodic assessments, among others.
• Routine 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 verifies the reported progress from source to aggregated values to ensure that data is of the highest quality. Annual and quarterly verification process should be carried out, to review the data across all the indicators.

Data analysis

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

Information dissemination

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

Stakeholder Collaboration

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

4.6 Monitoring Reports

The following are the monitoring reports and their periodicity:

Table 4.1: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 Murang'a 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 Murang'a CNAP by all stakeholders.

Evaluation ensures both the accountability of various stakeholders and facilitates learning with a view to improving the relevance and performance of the health sector over time.

A midterm review and an end evaluation will be undertaken to determine the extent to which the objectives of this Murang'a CNAP are met.

Evaluation Criteria

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

Relevance: The extent to which the objectives of the Murang'a 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 Murang'a CNAP objectives have been achieved with the appropriate amount of resources

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

Sustainability: The continuation of benefits from an outlined intervention after its termination.

4.8 MEAL Team

The County M&E units will be responsible for overall oversight of M&E activities. The functional linkage of the nutrition program to the department of health and the overall county inter-sectoral government M&E will be through the county M&E TWG. Health department M&E units will be responsible for the day to day implementation and coordination of the M&E activities to monitor this action plan.

The nutrition program will share their quarterly progress reports with the County Department of Health (CDOH) M&E unit, who will take lead in the joint performance reviews at national level. The county management teams will prepare the quarterly reports and in collaboration with county stakeholders and organize the county quarterly performance review forums. These reports will be shared with the national M&E unit during the annual health forum, which brings together all stakeholders in health to jointly review the performance of the health sector for the year under review.

For a successful monitoring of this action plan, the county will have to strengthen their M&E function by investing in both the infrastructure and the human resource for M&E. Technical capacity building for data analysis will be promoted through collaboration with research institutions or training that target the county M&E staff. Low reporting from other sectors on nutrition sensitive indicators is still a challenge due to the use of different reporting systems that are not inter-operational. Investment on Health Information System (HIS) infrastructure to facilitate e-reporting is therefore key. Timely collection and quality assurance of health data will improve with institutionalization of a functional team dedicated to this purpose.

4.9 Critical-Assumptions

i. Adequate resources and organizational systems will be available to implement the plan.
ii. Trainings offered during implementation will result in knowledge gain and behavior change.
iii. Data and information used during development and implementation of the Murang'a CNAP is credible, accurate, reliable, and timely.
iv. Information passed to members of the community and various stakeholders will result in actual change in behavior and practices.
v. The various sectors will embrace this plan, monitor, and evaluate their specific action points outlined in this Murang'a 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 favorable prevailing evidence-based policy and political environment during the implementation of this Murang'a CNAP.
viii. Investments as input, will result in desired outputs and outcomes, and eventually, achievement of overall results as outlined in the Murang'a CNAP

4.10 Indicators and information sources

The Indicators that will guide monitoring of this Murang'a CNAP are outlined in the tables below

Expected Results

Table 4.2: 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)	20.1%	KIHBS 2016	15.4	11.6	Every 2 years
Reduce and maintain childhood wasting to less than 5% (WHA 2021 Target) by 2025	Percentage of wasted children under five years (low weight for height).	5%	KIHBS 2016	4.5	4.0	Every 2 years
	Percentage of under-weight under five years (low weight for age)	3.6%	KIHBS 2016	3.0	2.5	Every 2 years
No increase in childhood overweight (children under 5 years of age) (WHA 2021 Target) by 2025	Percentage of overweight children less than 5 years (high weight for height>2SD)	3.1	KDHS 2014	3.0	2.9	Every 5 years
Improved survival of children below the age of 5	Infant mortality rate	33.2 deaths per 1,000 live births	GBD 2017 https://vizhub.healthdata.org/lbd	29.5	25.8	Every 3 years
	Under-5 mortality rate	42.8 deaths per 1,000 live births	GBD 2017 https://vizhub.healthdata.org/lbd	37.9	32.9	Every 3 years
Reduction of deaths due to NCDs by 33%	NCD mortality rate (18-59 years) (per 100,000)	161	WHO NCD Progress Monitor, Kenya Vital Statistics Report	135	108	Every 3 years
Increase the rate of exclusive breastfeeding in the first six months to at least 50% by 2025 (WHA Target 2012)	Exclusive breastfeeding under 6 months (population based)	65.3%	GBD 2017 https://vizhub.healthdata.org/lbd	69.9%	74.4%	Every 3 years
Reduction by 25% of the proportion of the population who are overweight	Prevalence of overweight in the population	15.2%	GBD 2017 https://vizhub.healthdata.org/lbd	13%	11.4%	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
Reduce anemia in women of reproductive age (pregnant and non-pregnant) by 50% by 2025, WHA 2012 Targets.	Estimates of anemia prevalence in pregnant women	46.1%	KMNS 2011	38%	23%	Every 5 Years
Improved micronutrient consumption	Percentage of households consuming salt with any iodine	98	KDHS 2014	99.9	99.9	Every 5 Years
	Prevalence of ZINC deficiency among preschool children aged below 59 months	83	KNMS 2017	70	60	Every 5 Years
Enhanced political commitment to nutrition	County annual budget allocation to nutrition	300,000	2015/2016 FY Budget	20 M	100 M	Every 5 years
Human Resource for nutrition/Nutritionist's density	Number of nutritionists per 100,000 population	4	County HR office 2020	6	10	Every 5 years
Social protection enhanced	Proportion of women (and adolescent girls, where appropriate) reached through social protection measures which include a	No data				

IMPACT/OUTCOME	Indicator	Baseline	Baseline Data Source	Mid-term Target (2022)	End-Term target (2025)	Frequency of data collection
	nutrition component (i.e. explicit nutrition objectives and actions to be monitored					
Water and sanitation enhanced	Proportion of population using a safely managed drinking water service	60%	CIDP 2018-2022	70%	80%	Every 5 years

***Data for the greater central region

Table 4.3: Annual Indicators Per Nutrition Objectives

Target	Indicator	Baseline	Baseline Year	Yr. 1	Yr. 2	Yr. 3	Yr. 4	Yr. 5
REDUCTION IN UNDERNUTRITION: WASTING, STUNTING, UNDERWEIGHT								
Improved proportion of children less than six months exclusively breastfed	Percentage of children 0-6 months visiting facilities exclusively breastfed.	87.5%	KHIS 2019	88%	88.5%	89%	89.5%	90%
	Percentage of infants that were breastfed within one hour after delivery.	90.6%	KHIS 2019	91%	91.5%	92%	92.5%	93%
Reduce low birth weight by 20%	Percentage of newborns 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	2.8%	KHIS 2019	2.7%	2.5%	2.3%	2.1%	2%
	Proportion of infants initiated on breast milk within the first 1 hour of birth	85.7	KHIS 2020 Monthly	86%	87%	88%	89%	90%
Nutrition and HIV	Proportion of undernutrition among PLHIV	10%	KHIS 2019 (MOH 733B)	8%	6%	5%	4%	3%
	Proportion of undernourished PLHIV provided with therapeutic or supplementary food	69%	KHIS 2019 (MOH 733B)	70%	72%	75%	77%	80%
Improved referrals	Proportion of under 5s with severe and moderate malnutrition referred for management	67%	KHIS 2019 (MOH 733B)	70%	75%	77%	80%	85%
REDUCTION OF MICRONUTRIENT DEFICIENCIES								
Improved Vitamin A coverage	Percentage of children (6-59 months) receiving Vitamin A Supplementation every six months (100,000 IU for children 6-12 months and 200,000 IU for children > 12 months).	73.9%	KHIS 2019	75%	76%	77%	78%	79%
	Percentage of postnatal women receiving Vitamin A supplementation (200,000 IU) within 8 weeks after delivery.	0.71%	KHIS 2019	25%	30%	35%	40%	45%
Improved deworming coverage	Percentage of children (12-59 months) receiving de-worming (Albendazole 1 to < 2 years 200 mg and > 2 years 400 mg or Mebendazole 1 to < 2 years 250 mg and > 2 years 500 mg) every six months.	42%	KHIS 2019	45%	48%	50%	52%	55%
	Proportion of school-aged children (6-14 years) dewormed	7.2%	KHIS 2019	10%	12%	14%	16%	20%
Increase the proportion of pregnant women consuming iron and folate as per guidelines by 25%	Percentage of pregnant women attending ANC visits receiving Iron and folate supplementation	86.2	KHIS 2019 KHIS 2019	86.5%	87%	87.5%	88%	88.5%
	Proportion of pregnant women consuming iron and folic for at least 90 days or more	67.3	ISG Baseline survey 2020	70.6%	73.9%	77.2%	80.5%	83.8%

Target	Indicator	Baseline	Baseline Year	Yr. 1	Yr. 2	Yr. 3	Yr. 4	Yr. 5
Improve dietary quality and micronutrient adequacy in both women and young children	Minimum dietary diversity among children 6-23 months	31.9%	KDHS 2014	45%	50%	55%	60%	65%
REDUCTION IN OVERNUTRITION AND DIET RELATED NON-COMMUNICABLE DISEASES								
Reduced proportion of adults with overweight and obesity	Prevalence of overweight among female adults	29.4%***	KDHS 2014	28%	27%	26%	25%	24%
	Prevalence of obesity among female adults	17.6%***	KDHS 2014	17%	16%	15%	14%	13%
Reduced proportion of diet related NCDs	Prevalence of Hypertension among female adults	12.8%***	KDHS 2014	12%	11%	10%	9%	8%
CROSS-CUTTING AREAS								
Improved human resource for nutrition	Percentage of key nutrition positions filled	7.8%	Program data 2019	7.8%	15%	15%	20%	20%
Monitoring and Evaluation	Proportion of facilities systematically using information to monitor performance	85%	Program data 2019	90%	95%	98%	100%	100%
	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 difference between the quantity of products ordered and the quantity received	0%	LMIS data 2020	0%	0%	0%	0%	0%
	Percentage of health facilities with no stock of Iron-Folic Acid (IFA) and Vitamin A.	0%	LMIS data 2020	0%	0%	0%	0%	0%
Gender	Participation of women in household decision making index (Women empowerment index)	29%	Kenya Women's Empowerment Index (WEI) survey, 2020[1]	32%	35%	38%	40%	45%
	Percent of personnel who receive training in gender sensitivity	1%	Program data 2019	5%	10%	15%	20%	30%
Financing	Resources available for nutrition (absolute numbers, or a proportion of health budget)	300,000	2015/2016 FY Budget	10M	20M	60M	80M	100M
Access: Infrastructure	Number of facilities offering nutrition services per 100,000 people	3	KHIS 2019	4	5	6	8	10

***Data for former Central Region

Output indicators

Table 4.4: KRA 1: Maternal, Infant, Young Child Nutrition (MIYCN) including Integrated Management of Acute Malnutrition (IMAM) scaled up

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
MIYCN policy, guidelines and related documents disseminated within the county.	Number of health managers sensitized on MIYCN policy and guidelines disaggregated by gender	69	2020	Nutrition Program Reports	Every 5 Years	0	69	0	0	0
	Number of health workers sensitized on MIYCN policy and guidelines s disaggregated by gender	No Data	2020	Nutrition Program Reports	Every 5 Years	0	250	0	0	0

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
Growth monitoring and promotion services strengthened	Number of male and female CHEWs/CHAs/CHOs sensitized on MIYCN policy and guidelines	No Data	2020	Nutrition Program Reports	Every 5 Years	0	0	162	0	0
	Proportion of Children under 5 years attending Child welfare clinic for the first visit in the calendar year	18.0%	2020	KHIS	Monthly	18.5	19	19.5	20	20.5
	Number of health workers trained in growth monitoring and promotion	No data	2020	Nutrition Program Reports	Every 5 Years	250	0	0	0	0
	Number of male and female community health volunteers trained in growth monitoring and promotion [family MUAC]	0	2020	Nutrition Program Reports	Annually	0	750	750	0	0
Increased proportion of hospitals-(level 5, 4 & 3) implementing baby friendly hospital initiative (BFHI)	Number of health workers trained in BFHI	2	2020	Nutrition Program Reports	Bi-annual	0	33	0	0	0
	Proportion of infants initiated on breast milk within the first 1 hour of birth	85.7	2020	KHIS	Monthly	86%	87%	88%	89%	90%
	Proportion of newborns with Low birth weight [birth weight less than 2500gms]	4.9%	2020	KHIS	Quarterly	4.6%	4.2%	3.8%	3.5%	3%
	Number of health facilities implementing BFHI	2	2020	Program Report	Bi-annual	3	5	7	8	10
	Number of health facilities accredited as baby friendly	3	2003	Nutrition Program Reports	Annually	3	5	7	8	10
	Number of health workers trained in BFHI	2	2020	Nutrition Training Reports	Bi-annual	0	33	0	0	0
Increased proportion of women of reproductive age (15–49 years) and caregivers who practice optimal behavior is for improved nutrition through implementation of Baby Friendly Community Initiative (BFCI)	Number of health workers trained in BFCI	3	2019	Nutrition Program Reports	Annually	0	0	75	75	0
	Number of male and female CHVS trained in C-BFCI	0	2020	Nutrition Program Reports	Annually	0	375	375	375	375
	Number of community units implementing BFCI	0	2020	Nutrition Program Reports	Annually	0	35	70	100	137
	Proportion of community units accredited as baby friendly	0	2020	Nutrition Program Reports	Annually	0	20	50	80	100
Enhanced MIYCN Practices	Number of Health workers trained in MIYCN	60	2015	Nutrition Program Reports	Annually	0	250	140	0	0
	Number of male and female CHVs sensitized on MIYCN	360	2019	Nutrition Program Reports	Annually	0	375	375	375	375

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
	Proportion of health facilities providing NACs	14.3	2020	Nutrition Program Reports	Annually	25	30	35	38	40
	Number of community engagement platforms on MIYCN conducted	36	2019	Nutrition Program Reports	Annually	40	45	50	55	60
	Number of health workers sensitized on BMS act	0	2020	Nutrition Program Reports	Every 5 years	0	170	0	0	0
	Number of lactation stations established	0	2020	Nutrition Program Reports	Every 5 Years	0	0	1	1	1
MIYCN in emergencies strengthened.	Number of health care workers trained in MIYCN-e	0	2020	Nutrition Program Reports	Annually	0	250	140	0	0
	Number of stake holders sensitized on MIYCN-e	0	2020	Nutrition Program Reports	Every 5 years	0	0	30	0	0
Integrated management of acute malnutrition (IMAM) services strengthened.	Number of Health care workers trained on IMAM.	0	2020	Nutrition Program Reports	Annually	0	100	100	0	0
	Number of Health facilities implementing IMAM guidelines	21	2020	Nutrition Program Reports	Annually	25	30	35	40	45
	Number of health facilities reporting no stock out of IMAM commodities	21	2020	KHIS	Monthly	25	30	35	40	45

Table 4.5: KRA 2: Nutrition of older children, adolescents and older persons promoted

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
Policy environment at county level for older children (5-9 years) and adolescents (10-19 yrs.) strengthened.	Number of health managers sensitized on nutrition for older children and adolescent's policy and guidelines	0	2020	Program Data	Quarterly	0	0	69	0	0
Consumption of healthy foods for older children, adolescents, and older persons promoted	Number of food demonstrations on meal planning and preparation conducted	0	2020	Program Data	Quarterly	3	4	4	4	4
Micronutrients supplementation for adolescent girls promoted	Proportion of adolescent 10-19 years girls who received the recommended scheme (at least 12 tablets in the last 6	0	2020	Program data	Quarterly	0	0	20%	30%	50%

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
	months or 24 in the last 12 months) of WIFA									

Table 4.6: KRA 3: Prevention, control and management of Micronutrient Deficiencies scaled-up

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened routine consumption of micronutrient supplements (vitamin A, iron and folate and micronutrient powders) for targeted groups	Proportion of children aged 6-59 months receiving vitamin a supplement twice a year	78.9	2020	KHIS	Monthly	80	82	84	85	86
	Proportion of children with diarrhea supplemented with zinc and ORS	72.4%	2019	KHIS	Monthly	74%	76%	78%	80%	80%
	Proportion of children aged 6-59 months receiving MNPS	no data	2019	Nutrition Program Reports	Monthly	20%	30%	40%	50%	60%
	Proportion of facilities reporting no stock out of IFAS, VITAMIN A and MNPs	95%	2020	LMIS	Monthly	95%	95%	95%	95%	95%
Increased uptake of diversified and bio-fortified foods	Number of industries and companies sensitized on food fortification compliance	0	2020	Nutrition Program Reports	Biannually	0	30	0	0	30
	Proportion of sampled maize flour brands in the local markets meeting the minimum fortification standards	No Data	2020	Surveillance reports	Biannual	40%	45%	50%	55%	60%
	On the number of fortification surveillance visits conducted by PHOS	No Data	2020	Nutrition Program Reports	Quarterly	4	4	4	4	4
	Number of education sessions held on fortified foods	0	2020	Nutrition Program Reports	Quarterly	0	21	21	21	21
	Number of male and female CHVs sensitized on food fortification	0	2020	Nutrition Program Reports	Annually	0	500	500	500	500

Table 4.7 KRA 4: Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) in the life course scaled-up

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
Policies, strategies, and guidelines related to DRNCDs disseminated	Number of dissemination meetings on policies and guidelines on DRNCDs conducted	1	2018	Nutrition Program Reports	Bi-annual	1	0	1	0	1
Increased Competences, knowledge, and skills for health care workers to control and manage DRNCDs	Number of health care workers trained on healthy diets and physical activity	No data	2020	Nutrition Program Reports	Bi-annual	60	0	60	0	60
	Number of CHVs (male and female) sensitized on healthy diets and physical activity	No data	2018	Nutrition Program Reports	Annually	720	720	720	720	720
	Number of health care workers trained on geriatric nutrition	No data	2018	Nutrition Program Reports	Bi-annual	0	0	60	0	60
Increased community awareness on prevention and management of DRNCDs	Number of radio talk shows on DRNCDs in relation to nutrition conducted	10	2019	Nutrition Program Reports	Quarterly	12	12	12	12	12
Nutrition activities integrated in management of DRNCDs at outpatient clinic and inpatient care	Percentage of clients with DM and HTN using diet and physical exercise as part of management	70%	2019	KHIS (MoH 740)	Annually	75%	80%	85%	90%	95%

Table 4.8 KRA 5: Clinical nutrition and dietetics in disease management including HIV and TB strengthened

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
Policies, strategies, and guidelines related to clinical nutrition and dietetics disseminated	Number of dissemination meetings on policies, strategies, SOPS, and guidelines conducted	No data	2019	Nutrition Program Reports	Every 3 Years	1	0	0	0	1
Improved competences skills, and knowledge for health care workers on clinical nutrition	Number of health care workers trained on clinical nutrition therapy disaggregated by gender	No data	2019	Nutrition Program Reports	Every 3 Years	0	30	0	0	30
	Number of nutritionists trained on specialized nutrition disaggregated by gender	2	2019	Departmental Reports	Annually	5	5	5	5	5
Improved access to quality clinical nutrition services at health facility level	Number of health facilities providing clinical nutrition care services	21	2020	KHIS	Annually	25	30	35	40	45
Strengthened supply chain for nutrition commodities and equipment for clinical nutrition	Number of health facilities visited for integrated commodity supportive supervision	70	2019	Support Supervision Reports	Quarterly	84	84	84	84	84

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
In-patient feeding for all facilities offering in -patient care strengthened	Number of health facilities with active in-patient feeding committees	0	2020	Health Facility Reports	Annually	5	7	10	10	10
Policies, strategies, and guidelines related to HIV and TB disseminated	Number of dissemination meetings on policies, strategies and guidelines conducted	1	2015	Program Reports	Every 3 Years	1	0	0	1	0
Policies, strategies, and guidelines related to clinical nutrition and dietetics disseminated	Number of dissemination meetings on policies, strategies, SOPS and guidelines conducted	No data	2019	Nutrition Program Reports	Every 3 Years	1	0	0	0	1
Improved competences, skills, and knowledge for health care workers on HIV and TB	Number of health care workers trained on nutrition care in HIV and TB disaggregated by gender	10	2016	Nutrition Program Reports	Annually		25	25	25	25
Improved nutrition care process in HIV and TB services/clinics	Proportion of new HIV clients receiving nutrition services disaggregated by gender	40.9%	2019	Nutrition Program Reports (Nutrition Services Summary Tool MOH 733 and MOH 731-3)	Annually	50%	55%	60%	70%	80%
	Proportion of new TB clients receiving nutrition services	100%	2019	TB 4 book	Annually	100%	100%	100%	100%	100%
Strengthened supply chain for nutrition commodities, equipment and reporting tools in HIV and TB	Number of health care workers trained on commodity management for clinical nutrition and dietetics disaggregated by gender	7	2018	Nutrition Departmental Reports	Annually	25	25	25	25	25
Well-structured linkage and referral system for HIV and TB clients	Proportion of undernourished HIV and TB clients who received supplemental feeds	36.7%	2019	HIV program reports (MOH 731 - 3)	Annually	50%	60%	70%	80%	85%

Table 4.9 KRA 6: Nutrition in nutrition sensitive sectors promoted (Agriculture, Education ECDE, WASH and Social Protection)

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
Availability and accessibility of safe, diverse nutritious food crops promoted	Number of male and female community members receiving demonstrations on diverse nutritious food crops	No Data	2019	Agri-nutrition Manual	Quarterly	80	80	80	80	80
Consumption of safe diverse nutritious foods promoted	Number of male and female community members receiving demonstrations on meal planning and preparation methods	No Data	2019	Agri-nutrition Manual	Quarterly	300	300	300	300	300
Fuel energy saving technologies promoted	Number of male and female community members sensitized on energy saving technologies	No Data	2019	Department of Agriculture	Quarterly	300	300	300	300	300
Enhanced policy environment for stakeholders (ECDE Coordinators, teachers, parents)	Number of stakeholder forums conducted	No Data	2019	County ECDE Reports	Annually	1	1	1	1	1
Safe food environment in ECDE centers promoted	Proportion of ECDE centers with safe food environment.	No Data	2019	County ECDE Reports	Quarterly	54%	70%	75%	80%	85%
Strengthened growth monitoring and promotion of ECDE learners through nutrition assessment, Vitamin A Supplementation and deworming	Proportion of ECDE learners receiving Vitamin A and dewormers	No Data	2019	County ECDE Reports	Bi-annual	100%	100%	100%	100%	100%
	Number of nutrition assessment conducted at ECD centers	No Data	2019	County ECDE reports	Bi-Annual	2	2	2	2	2
Technical support to ECDE centers on establishment, improvement of existing school gardens and nutrition education promoted	Proportion of ECDE centers receiving technical support on school gardens and nutrition education	No Data	2019	County ECDE Reports	Annually	60%	70%	80%	85%	90%
Enhanced collaboration with relevant stakeholders (health, agriculture)	Number collaborative activities conducted	No Data	2019	County ECDE Reports	Quarterly	2	2	2	2	2
Strengthened M&E system for improving nutritional status of school going children	Number of joint performance review meetings with ECD representatives conducted	No Data	2019	M&E Documents	Bi-annual	2	2	2	2	2

Table 4.10: KRA 7: Sectoral and multi-sectoral nutrition governance, coordination and legal/regulatory frameworks, Nutrition Information Systems, learning and research strengthened

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
Improved coordination mechanism for program implementation knowledge sharing and learning at county and sub county levels	Number of sector and multisectoral coordination meetings held	1	2020	Nutrition Activity Report	Quarterly	4	4	4	4	4
Knowledge sharing and learning at county and all sub counties promoted	Number of sharing and learning meetings held	0	2020	Nutrition Activity Report	Monthly	4	4	4	4	4
Joint sector and multisectoral planning enhanced	Number of joint sector forum held	0	2020	Nutrition Activity Report	Bi-annual	2	2	2	2	2
Nutrition M&E in the relevant sectors mainstreamed	Number M&E reports	1	2020	M&E Report	Monthly	12	12	12	12	12
Evidence-based decision making through research enhanced	Number of researches conducted	2	2020	Research Reports	Annually	2	2	2	2	2
Strengthened Integration of nutrition data into KHIS	Number DQA conducted	1	2020	DQA report	Bi-annual	2	2	2	2	2

Table 4.11 KRA 8: Advocacy, Communication and Social Mobilization (ACSM) strengthened

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
Capacity for nutrition advocacy at county and subcounty levels strengthened	Number of officers disaggregated by gender attending advocacy meetings	0	2020	Meeting report	Annual	30	30	30	30	30
Effective knowledge management supported, and evidence-based advocacy strengthened	Number of supportive meetings held	0	2020	Meeting report	Monthly	12	12	12	12	12
Stronger relationship with media houses and journalist built and maintained	Number of male and female journalists attending media engagement meetings	0	2020	Meeting reports	Quarterly	10	10	10	10	10
Strengthened community engagement, participation and feedback mechanism for nutrition services and decision-making processes	Number of gender integrated community dialogue meetings	2	2020	Meeting reports	Quarterly	4	4	4	4	4
High level nutrition advocacy for the county government done	Number of advocacy meetings targeting the politicians and key decision makers, held	1	2020	Project reports	Annually	2	2	2	2	2
Strengthened nutrition awareness through advocacy initiatives	Number of advocacy awareness forums targeting the general public, held	1	2020	Project reports	Annually	2	2	2	2	2

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
Capacity for nutrition advocacy at county and subcounty levels strengthened	Number of officers trained on advocacy disaggregated by gender	0	2020	Meeting report	Annually	30	30	30	30	30

Table 4.12 KRA 9: Supply chain management for nutrition commodities and equipment's strengthened

Output	Indicator	Baseline	Baseline year	Data Source	Frequency of data collection	2020/21	2021/22	2022/23	2023/24	2024/25
Improved availability of nutrition commodities, equipment and reporting tools	Percentage of health facilities stocked with supplemental feeds	78.2%	2019	KHIS	Quarterly	100%	100%	100%	100%	100%

4.11 Implementation Plan

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

To ensure coordinated, structured, and effective implementation of the Murang'a 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 Murang'a CNAP

Nutrition M&E Staff Members

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

Management at program level

- Determining what resources, human and financial, should be committed to M&E activities and assess them
- 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 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 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

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 stakeholders' 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.

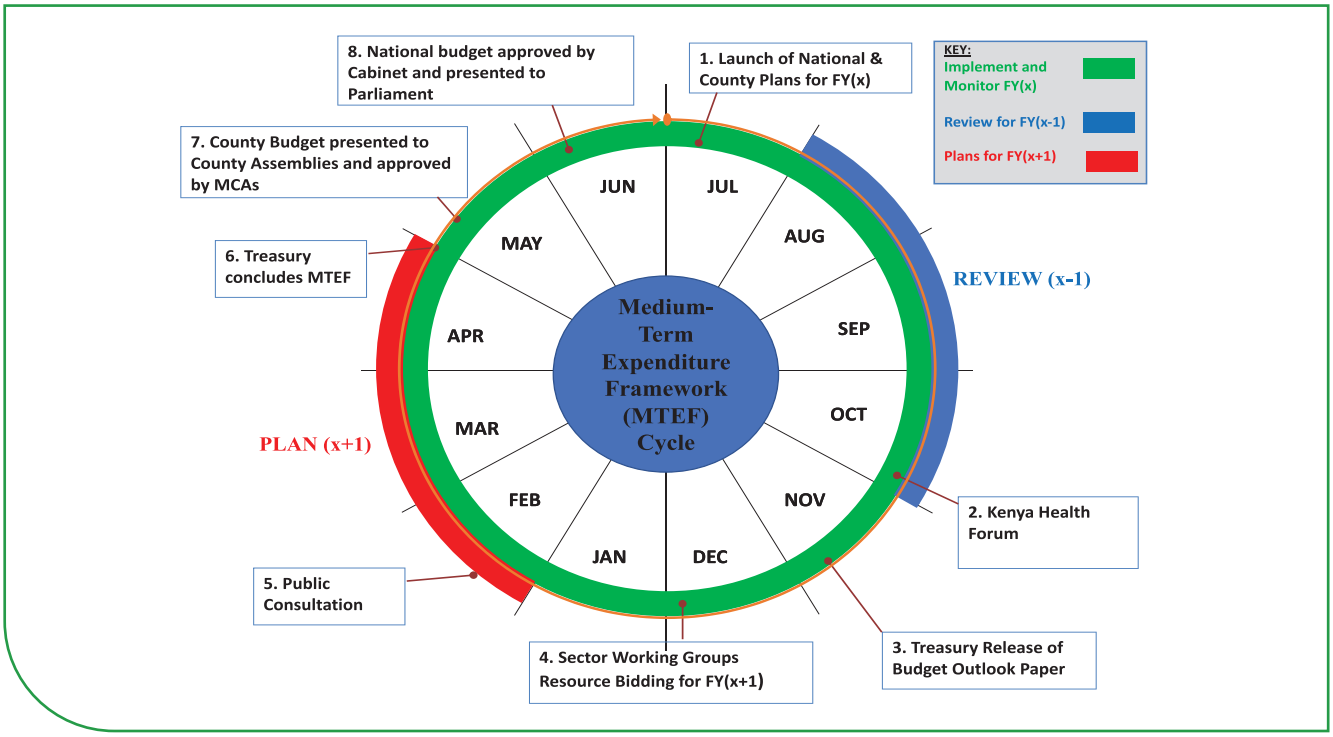


Figure 4:3 Kenya Health Sector Accountability Cycle

Updating of the Framework

Regular update of the M&E framework will be done based on learnings experienced along the implementation way. It will be adjusted to accommodate new interventions to achieve any of the program-specific objectives. A mid-term review of the framework will be conducted in 2020/21 to measure progress of its implementation and hence facilitate necessary amendments.

4.14 Implementation of the Murang'a 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 was estimated by costing all the activities necessary to achieve each of expected outputs in each of Key Result Area (KRA). The costing of the CNAP used Activity-Based Costing (ABC) approach to estimate the total resource need to implement the action plan for the next five years. ABC uses a bottom-up approach, indicating the cost of all inputs required to achieve each of the Key results in the CNAP.

All costs of activities are traced to the product or service for which the activities are performed. The premise of the methodology under the ABC approach will be as follow; (i)The activities require **inputs**, such as labour, conference hall etc.; (ii) These inputs are required in certain **quantities**, and with certain **frequencies**; (iii) It is the product of the **unit cost**, the **quantity,** and the **frequency** of the input that gave the **total input cost;** (iv) The sum of all the input costs gave the **Activity Cost.** These were added up to arrive at the **Output Cost,** the **Objective Cost,** and **eventually the budget.**

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

5.3 Total Resource Requirements (2020/21 – 2024/25)

The CNAP was costed using the Activity Based Costing (ABC) approach. The ABC uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve planned targets for the financial years of 2020/21 – 2024/25. The cost over time for all the Key Result Areas provides important details that will initiate debate and allow County health management and development partners to discuss priorities and decide on effective resource allocation.

The KRAs provided targets to be achieved within the plan period and the corresponding inputs to support attainment of the targets. Based on the targets and unit costs for the inputs, the costs for the strategic plan were computed. According to the Activity Based Costing, to fully actualize the strategic plan, KSh. 1.2 Billion is required as shown in the figure below. Further annual breakdown of cost requirement (s) is also presented.

5.4 Resource Requirements

According to the costing estimates, the County Department of Health requires an investment worth KSh.1.2 billion for nutrition over the plan period. This further has been disaggregated by KRAs as shown in the table below.

Table 5.1: Resource requirements

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 01. Maternal, Infant, Young Child Nutrition (MIYCN) including Integrated Management of Acute Malnutrition (IMAM) scaled up	7,436,000	20,064,600	67,282,600	18,825,100	68,495,350	182,103,650
KRA 02. Nutrition of older children, adolescents and older persons promoted	687,500	687,500	749,500	749,500	687,500	3,561,500
KRA 03. Prevention, control, and management of Micronutrient Deficiencies scaled-up	434,200	1,902,000	507,700	2,113,000	2,371,700	7,328,600
KRA 04. Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) in the life course scaled-up	594,500	494,500	1,179,500	89,000	1,179,500	3,537,000
KRA 05. Clinical nutrition and dietetics in disease management including HIV and TB strengthened	487,500	1,638,500	1,638,500	1,638,500	1,638,500	7,041,500
KRA 06. Nutrition in nutrition sensitive sectors promoted (Agriculture, ECDE, WASH and Social Protection)	1,758,500	1,880,000	2,286,000	2,286,000	2,286,000	10,496,500
KRA 7: Sectoral and multi-sectoral nutrition governance, coordination and legal/regulatory frameworks, Nutrition Information Systems, learning and research strengthened	6,030,500	5,650,500	5,204,500	5,264,500	8,397,500	30,547,500
KRA 08. Advocacy, Communication and Social Mobilization (ACSM) strengthened	2,994,500	2,994,500	2,837,000	2,837,000	2,837,000	14,500,000
KRA 09. Supply chain management for nutrition commodities and equipment's strengthened	188,932,500	188,932,500	186,290,000	188,932,500	186,000,000	939,087,500
Grand Total	**209,355,700**	**224,244,600**	**267,975,300**	**222,735,100**	**273,893,050**	**1,198,203,750**

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

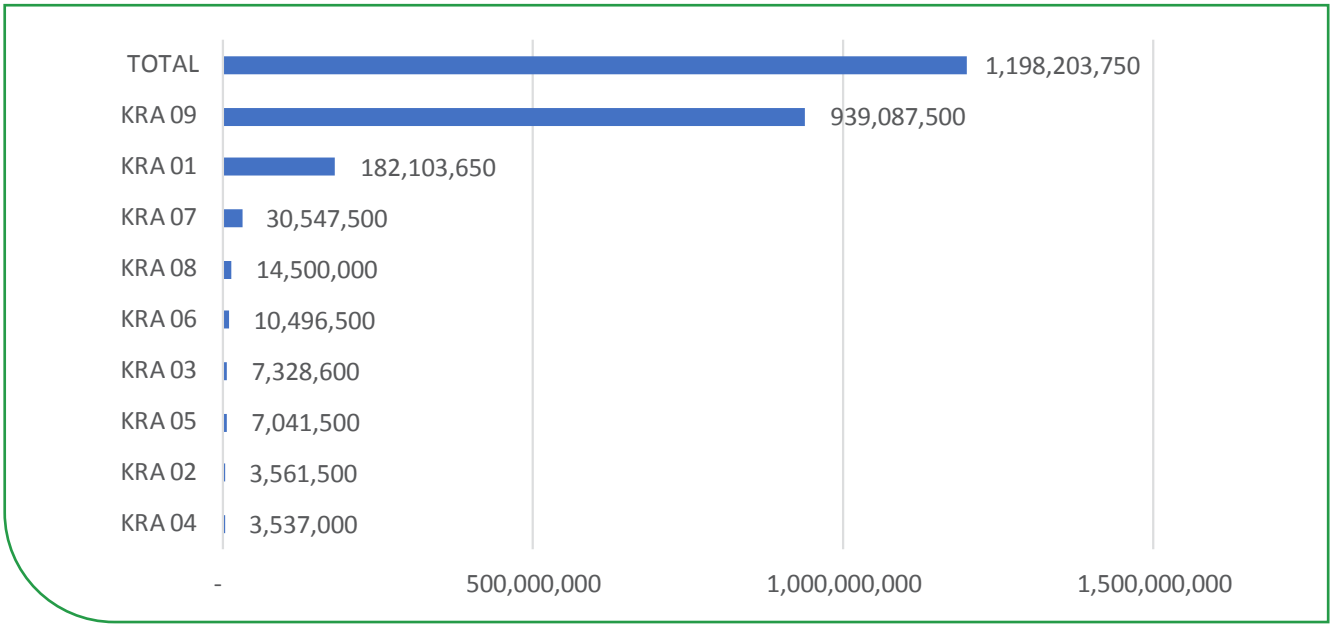


Figure 5:1: Proportion contribution of each KRA to total resource need (2020/21 – 2024/25)

Analysis of the cost requirements shows that 78.4 percent of the funds are required to cater for KRA on Supply chain management for nutrition commodities and equipment's strengthened; KRA on Maternal, Infant, Young Child Nutrition (MIYCN) including IMAM scaled up utilized 15.2 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 stakeholders mapping
- Call the partners to resource mobilization 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.
- 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

KRAs by Activities	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 01. Maternal, Infant, Young Child Nutrition (MIYCN) including IMAM scaled up	**18,323,000**	**28,949,850**	**81,689,600**	**27,408,100**	**79,136,350**	**235,506,900**
Adapt national standard operating procedures (SOPs) for IMAM	-	302,250	-	-	-	302,250
Advocate and support establishment of lactation station in both public and private sectors.	810,000	810,000	810,000	810,000	810,000	4,050,000
Carry monthly MTMSGs meetings at community level.	-	1,689,000	1,689,000	1,689,000	1,689,000	6,756,000
Carry out CMEs on MIYCN-e at health facility levels	220,000	220,000	220,000	220,000	220,000	1,100,000
Carry out nutrition assessment, counseling, support and follow up to all children with moderate and severe acute malnutrition	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	6,000,000
Carry out screening of children at community level and refer malnourished children to link health facilities for further management by CHVs	-	-	-	-	-	-
Commemorate celebration of World Breastfeeding Week.	-	-	-	-	-	-
Conduct continuous BFCI self-assessment at community level.	-	-	-	-	-	-
Conduct advocacy meeting with key influencers on MIYCN prioritization.	-	-	-	-	-	-
Conduct BFCI baseline self-assessment at community level.	-	36,800	-	-	37,500	74,300
Conduct BFCI external assessment at community level.	-	-	-	-	239,250	239,250
Conduct BFHI baseline self-assessment.	-	36,800	-	-	-	36,800
Conduct BFHI continuous self-assessment.	-	-	-	-	-	-
conduct BFHI external assessment.	-	-	-	176,000	176,000	352,000
Conduct CMEs on BMS Act implementation framework at health facility level	-	-	-	-	-	-
Conduct community health and nutrition education targeting men for their increased engagement on their role and support on MIYCN.	221,500	221,500	221,500	221,500	221,500	1,107,500
Conduct community mobilization and awareness session on growth monitoring	2,445,000	2,445,000	2,445,000	2,445,000	2,445,000	12,225,000
Conduct continuous CMEs on BFHI to health workers.	-	-	321,000	321,000	321,000	963,000
Conduct continuous CMEs at facility level to health care workers on IMAM	396,000	396,000	396,000	396,000	396,000	1,980,000
Conduct continuous monitoring of the BMS Act, 2012 and report any violations	213,300	213,300	213,300	213,300	213,300	1,066,500
Conduct continuous supportive supervision on BFCI activities at community level.	208,250	208,250	208,250	208,250	208,250	1,041,250
Conduct cooking demonstration targeting caregivers of children aged 0-59 months using locally available foods to demonstrate texture and diversity	-	-	3,520,000	-	-	3,520,000
Conduct gender integrated community dialogue days/ community action days for male and female CHVs on MIYCN.	297,500	297,500	297,500	297,500	297,500	1,487,500
Conduct growth monitoring and promotion services for children aged 0-59 months at all levels of health care.	-	-	-	-	-	-
Conduct mapping households for MTMSGs [formation of MTMSGs]	-	-	2,460,000	-	-	2,460,000
Conduct OJT, CMEs, and mentorship for Health Care Workers on GMP.	140,000	140,000	140,000	140,000	140,000	700,000
Conduct OJT, CMEs, and mentorship on MIYCN to health workers.	-	-	-	-	-	-
Conduct quarterly count and sub-county BFHI review meetings.	1,470,000	1,470,000	1,470,000	1,470,000	1,470,000	7,350,000
Conduct quarterly MIYCN TWG meetings.	480,000	480,000	480,000	480,000	480,000	2,400,000
Conduct support supervision on growth monitoring and promotion by SCHMTs and CHMTs.	196,700	196,700	196,700	196,700	196,700	983,500
Conduct supportive supervision on BFHI compliance.	208,250	208,250	208,250	208,250	208,250	1,041,250
Conduct supportive supervision on NACs for pregnant and lactating mothers.	-	-	-	-	-	-
Develop and disseminate a county nutrition emergency preparedness and response plan.	-	-	-	-	-	-
Disseminate complementary feeding recipe book & guide to Health Care Workers and CHVs.	-	-	-	-	-	-
Disseminate IMAM guidelines to CHMT and SCHMT	513,000	-	513,000	-	513,000	1,539,000
Establish BFCI county and sub county sub committees with a clear TOR	168,500	-	168,500	-	168,500	505,500
Establish BMS Act, task force at county level.	168,500	-	168,500	-	168,500	505,500
Establish community father to father support groups to be used as platforms for peer to peer support and health education on MIYCN.	-	-	-	-	-	-

KRAs by Activities	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 01. Maternal, Infant, Young Child Nutrition (MIYCN) including IMAM scaled up	**18,323,000**	**28,949,850**	**81,689,600**	**27,408,100**	**79,136,350**	**235,506,900**
Establish county and sub county BFHI sub-committee with clear TOR	168,500	-	168,500	-	168,500	505,500
Form BFCI committee in implementing community units.	262,500	262,500	262,500	262,500	262,500	1,312,500
Form BFHI committee in implementing health facilities						
Hold quarterly county and sub county BFCI review meetings	1,470,000	1,470,000	1,470,000	1,470,000	1,470,000	7,350,000
Identify and promote positive role models among partners and men who demonstrate good MIYCN practices.	-	-	-	-	-	-
Link malnourished IMAM clients to other programmes at community level (Wash, social safety net intervention)	-	-	-	-	-	-
Participate in celebration of World Pre-Maturity Day	-	-	-	-	-	-
Participate in county disaster coordination forums	246,000	-	246,000	-	-	492,000
Plan and celebrate Malezi Bora months bi-annually	-	-	-	-	-	-
Print and disseminate MIYCN policy, guidelines, and other related documents.	-	600,000	-	-	-	600,000
Print and distribute IMAM SOPs to health facilities	150,000	150,000	150,000	150,000	150,000	750,000
Procure and distribute IMAM commodities to the implementing facilities.	-	-	-	-	-	-
Sensitize CHVs and community members on BMS Act using effective communication channels.	228,000	228,000	228,000	228,000	228,000	1,140,000
Sensitize CHVs on MIYCN-e.	-	-	-	-	-	-
Sensitize County Health Management Team (CHMT) and Sub-County Health Management Team (SCHMT) on MIYCN policy, guidelines, and other related documents	-	242,500	-	-	-	242,500
Sensitize formal & informal day care centers on optimal nutrition care practices.	612,500	612,500	612,500	612,500	612,500	3,062,500
Sensitize front line male and female health and nutrition workers on MIYCN policy and guidelines at County, Sub-County, and community levels	-	410,000	-	-	-	410,000
Sensitize hospital managers on BFHI.	-	158,000	-	-	-	158,000
Sensitize key stakeholders and health managers on BFCI.	-	1,123,500	-	-	-	1,123,500
Sensitize male and female CHVs on growth monitoring including family MUAC.	-	3,220,000	-	3,220,000	3,220,000	9,660,000
Sensitize male and female health care workers on IMAM SOPs	1,225,500	1,225,500	1,225,500	1,225,500	1,225,500	6,127,500
Sensitize male and female health Care Workers on NACs for pregnant and lactating women.	126,000	126,000	126,000	126,000	126,000	630,000
Sensitize stakeholders on MIYCN-e operational guidelines and assessment guide.	111,000	111,000	111,000	111,000	111,000	555,000
Sensitize stakeholders in both public and private sectors including the media fraternity on BMS Act implementation framework	1,102,500	63,000	1,102,500	63,000	1,102,500	3,433,500
Sensitize the male and female community leaders, community health committees, community facility committees on BFCI.	-	1,340,000	-	1,340,000	-	2,680,000
Sensitize the male and female Community Health Extension Workers (CHEWs) and Community Health Assistants (CHAs) on MIYCN policy and guidelines	-	311,500	-	-	-	311,500
Sensitize the male and female Community Health Volunteers (CHVs) on MIYCN policy and guidelines	-	1,713,500	-	-	-	1,713,500
Sensitize the stakeholders, employers, and Health Care Workers on workplace support for breastfeeding mothers.	58,500	58,500	58,500	58,500	58,500	292,500
Support establishment of lactation rooms at Murang'a County HQs, Murang'a County Referral and Maragua hospitals workplace.	-	900,000	-	-	-	900,000
Train female and male health Care Workers on growth monitoring and promotion - WHO growth standards.	2,270,000	2,270,000	2,270,000	2,270,000	2,270,000	11,350,000
Train health male and female Care Workers on BFHI.	-	847,000	-	847,000	-	1,694,000
Train male and female CHVs on c-BFCI.	-	-	46,887,000	-	46,887,000	93,774,000
Train male and female CHVs on IMAM.	368,500	368,500	368,500	368,500	368,500	1,842,500
Train male and female HCWs /CHEWs/CHAs/CHOs on BFCI.	-	-	3,796,100	3,796,100	3,796,100	11,388,300
Train male and female health care providers on IMAM.	-	-	-	-	-	-
Train male and female health care workers on MIYCN	-	-	4,693,500	-	4,693,500	9,387,000
Train nutritionist and public health officers on BMS monitoring and enforcement	414,500	414,500	414,500	414,500	414,500	2,072,500
Train or/and sensitize HCWS of all genders on BMS Act implementation framework	152,500	152,500	152,500	152,500	152,500	762,500
Train/Sensitize Health Care Workers on MIYCN-e	-	-	-	-	-	-

KRAs by Activities	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 02. Nutrition of older children and adolescents promoted	**982,750**	**1,278,000**	**1,340,000**	**1,340,000**	**1,278,000**	**6,218,750**
Adapt/customize recipes for older children and adolescents in institutions.	-	-	-	-	-	-
Advocate for Integration messaging on heathy diets and physical activity in school heath programs.	-	-	-	-	-	-
Conduct intersectional sensitization on childcare development.	-	-	62,000	62,000	-	124,000
Conduct joint supportive supervision on interventions for older children, adolescents, and older persons with key stakeholders.	-	-	-	-	-	-
Disseminate nutrition policies, guidelines (food-based dietary guidelines; tuck shop guidelines; menu guidelines; sports nutrition guidelines; school garden guidelines), training packages (healthy diet and physical activity) to teachers, BOMs and any other relevant key stakeholders.	-	-	-	-	-	-
Hold joint performance review meetings for intervention on older children, adolescent and older persons in collaboration with key stakeholders at county and sub-county level.	-	-	-	-	-	-
Integrate nutrition activities for both boys and girls into existing youth friendly centers within the county	-	-	-	-	-	-
Sensitize key stakeholders (teachers, faith-based leaders, youth leaders, targeting all genders across different ages and diversities) on healthy diets and physical activity. Adolescent guidelines for older children and adolescents.	260,500	260,500	260,500	260,500	260,500	1,302,500
Sensitize older children, adolescents and communities targeting all genders on healthy diets and physical activity using context-specific communication channels in both rural and urban setups.	-	-	-	-	-	-
Sensitize stakeholders including communities on workplace wellness programs using effective communication channels	43,250	86,500	86,500	86,500	86,500	389,250
Sensitize stakeholders within institutions such as training colleges, prisons on optimal nutrition for adults and older persons.	252,000	504,000	504,000	504,000	504,000	2,268,000
Train key stakeholders (BOMs, teachers, caregivers) incorporating all genders on healthy diets and physical activity for older children, adolescents, and older persons.	427,000	427,000	427,000	427,000	427,000	2,135,000
KRA 03. Prevention, control, and management of Micronutrient Deficiencies scaled-up	**198,141,860**	**71,406,000**	**232,715,360**	**71,617,000**	**71,875,700**	**645,755,920**
Conduct annual household monitoring of salt iodization.	-	-	132,000	132,000	132,000	396,000
Conduct nutrition education and counselling on dietary diversification at the facility and community levels.	-	-	-	-	-	-
Develop and disseminate key messages to the community targeting all genders on the consumption of diversified micronutrient rich foods and bio-fortified foods.	96,500	-	-	96,500	-	193,000
Monitor the availability and compliance of fortified foods in urban and rural setup.	-	-	-	-	-	-
Procure and distribute micronutrient supplements (Vitamin A capsules, IFAS, multiple micronutrient powders)	162,703,660	-	162,703,660	-	-	325,407,320
Procure and distribute Zinc/ORS co-pack, Resomal for management of diarrhea	34,500,000	69,000,000	69,000,000	69,000,000	69,000,000	310,500,000
Sensitize CHMT/SCHMT on micronutrient disease prevention and control policies and guidelines [IFAS, VAS, MNPs].	337,700	-	337,700	-	337,700	1,013,100
Sensitize CHVs and community (men and women including community leaders and other key influencers) on food fortification and on the importance of micro-nutrient supplementation for pregnant women, adolescent girls, and children.	-	-	38,000	38,000	-	76,000
Sensitize industries and companies on food fortification compliance.	-	55,500	-	-	55,500	111,000
Sensitize male and female CHVs on micro-nutrient disease prevention and control [IFAS, VAS, MNPs].	-	-	-	-	-	-
Sensitize male and female CHVs on VAS, IFAS and MNPs.	-	-	-	-	-	-
Sensitize the CHVs and community (men and women including community leaders and other key influencers) on food fortification logo and on the importance of micro-nutrient supplementation for pregnant women, adolescent girls, and children.	-	-	-	-	-	-
Sensitize the community through effective communication channels on VAS, IFAS and MNPs for target populations to create demand for services.	504,000	504,000	504,000	504,000	504,000	2,520,000
Sensitize the public health officers and nutritionists on monitoring of fortified foods in the markets.	-	-	-	-	-	-

KRAs by Activities	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 03. Prevention, control, and management of Micronutrient Deficiencies scaled-up	**198,141,860**	**71,406,000**	**232,715,360**	**71,617,000**	**71,875,700**	**645,755,920**
Train health workers on VAS, IFAS and MNPs.	-	1,846,500	-	1,846,500	1,846,500	5,539,500
Train male and female health workers on micro-nutrient disease prevention and control policies and guidelines [IFAS, VAS, MNPs].	-	-	-	-	-	-
KRA 04. Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) in the life course scaled-up	**594,500**	**3,506,700**	**1,179,500**	**3,101,200**	**1,179,500**	**9,561,400**
Carry out continuous CME on importance of Nutrition in the management of DRNCDS in all facilities.	-	-	-	-	-	-
Carry out nutrition assessment and counselling to all clients with DRNCDs.	-	-	-	-	-	-
Conduct dissemination meetings targeting CHMT and SCHMT on guidelines, policies and strategies related to nutrition (Kenya National Strategy for the Prevention and Control of Non-Communicable Diseases, National guideline on management of Diabetes, Kenya National Clinical guideline for the Management of Diabetes Mellitus 2018, National guidelines for healthy diets and physical activity 2017).	-	-	-	-	-	-
Conduct sensitization meetings to the community members through various channels (chief barazas, MTMSGs, churches, Mosques, father to father support groups) on importance of healthy diets and physical activities towards prevention of DRNCDs.	36,000	36,000	36,000	36,000	36,000	180,000
Develop Standard Operating Procedures on DRNCDS for nutrition.	100,000	-	-	-	-	100,000
Disseminate SOPs for DRNCDs on nutrition to Health Care Workers for implementation.	-	-	-	-	-	-
Hold radio talk shows on DRNCDs in relation to nutrition.	12,000	12,000	12,000	12,000	12,000	60,000
Participate in commemoration of World Diabetic Day, Hypertension day and Cancer month.	-	-	-	-	-	-
Participate in medical camps and community screening, assess, counsel, and refer clients with DRNCDs to health facilities	5,000	5,000	5,000	5,000	5,000	25,000
Refer DRNCDs clients to support groups where they exist and encourage formation of the same where they do not exist.	-	-	-	-	-	-
Refer malnourished clients with DRNCDs for nutritional support both at facility level and to mapped out social protection services.	-	-	-	-	-	-
Sensitize CHV and the community on nutrition for the elderly using effective communication channels.	-	3,012,200	-	3,012,200	-	6,024,400
Sensitize CHVs (male and female) on healthy diets and physical activity.	36,000	36,000	36,000	36,000	36,000	180,000
Train Health Care Workers on geriatric nutrition.	-	-	685,000	-	685,000	1,370,000
Train health care workers on healthy diets and physical activity	405,500	405,500	405,500	-	405,500	1,622,000
KRA 05. Clinical nutrition and dietetics in disease management including HIV and TB strengthened	**920,800**	**2,169,300**	**2,071,800**	**2,071,800**	**2,169,300**	**9,403,000**
Adapt /develop and disseminate SOPs for clinical nutrition to health care workers	-	97,500	-	-	97,500	195,000
Advocate for adequate resources for in-patient feeding.	-	-	-	-	-	-
Advocate for appropriate feeding alternative in cases of OVC, very sick mothers who cannot breastfeed or any other medical reasons as indicated within MIYCN guidelines	-	-	-	-	-	-
Carry out CMEs for Health Care Workers on commodity management for clinical Nutrition and Dietetics.	-	-	-	-	-	-
Carry out CMEs to Health Care Workers on nutrition management for preterm and Low Birth Weight babies.	-	-	-	-	-	-
Carry out integrated commodity management supervision.	-	-	-	-	-	-
Carry out nutrition assessment and counselling to all HIV and TB clients.	-	-	-	-	-	-
Carry out nutrition assessments, counseling, and support to patients in outpatient and in-patient care	220,000	220,000	220,000	220,000	220,000	1,100,000
Carry out nutrition support for all malnourished HIV and TB clients.	-	-	-	-	-	-
Conduct CMEs and mentorship at the health facilities on nutrition management in HIV and TB.	-	-	-	-	-	-
Conduct continuous monitoring of in-patient feeding in health facilities offering in-patient care	213,300	213,300	213,300	213,300	213,300	1,066,500
Conduct dissemination meeting on policies and guidelines for nutrition management in HIV and TB targeting CHMT and SCHMT.	-	-	-	-	-	-

KRAs by Activities	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 05. Clinical nutrition and dietetics in disease management including HIV and TB strengthened	**920,800**	**2,169,300**	**2,071,800**	**2,071,800**	**2,169,300**	**9,403,000**
Conduct nutrition commodity and equipment audit in all CCC and TB clinics.	-	-	-	-	-	-
Conduct on job training and CMEs at the health facilities on clinical nutrition and dietetics	-	-	-	-	-	-
Disseminate policies, guidelines and strategies related to clinical nutrition and dietetics (such as Kenya National clinical nutrition and dietetics manual 2010) to CHMT and SCHMT	-	-	-	-	-	-
Establish in-patient feeding committee in all facilities offering in-patient care.	-	-	-	-	-	-
Link malnourished HIV and TB clients to mapped sites for livelihoods and social safety nets programs within the county	-	-	-	-	-	-
Map out stakeholders who offer nutrition, livelihood and social safety net support for HIV and TB malnourished clients within the county	-	-	-	-	-	-
Procure and distribute assessment and reporting tools for clinical Nutrition and Dietetics.	-	-	-	-	-	-
Procure and distribute clinical Nutrition and Dietetics assessment equipment.	-	-	-	-	-	-
Procure and distribute enteral and parental nutrition commodities.	-	-	-	-	-	-
Procure and distribute food by prescription commodities for malnourished HIV and TB clients.	-	-	-	-	-	-
Procure and distribute nutrition equipment for CCC and TB clinics.	-	-	-	-	-	-
Procure and distribute supplementary feeds for management of moderate malnutrition.	-	-	-	-	-	-
Procure and distribute therapeutic feeds for management of severe malnutrition.	-	-	-	-	-	-
Procure nutrition assessment and reporting tools for CCC and TB clinics.	-	-	-	-	-	-
Refer HIV and TB clients to other medical services at facility level appropriately	-	-	-	-	-	-
Support male and female nutrition officers and selected health care providers to specialized clinical Nutrition care trainings e.g. Renal, Oncology, Critical Care etc.	487,500	487,500	487,500	487,500	487,500	2,437,500
Support participation of nutritionist in short clinical nutrition trainings such as enteral and parental nutrition courses	-	-	-	-	-	-
Train health care workers on clinical Nutrition and dietetics	-	571,000	571,000	571,000	571,000	2,284,000
Train male and female health care workers on nutrition care in HIV management	-	290,000	290,000	290,000	290,000	1,160,000
Train male and female health care workers on nutrition care in TB management	-	290,000	290,000	290,000	290,000	1,160,000
KRA 06. Nutrition in nutrition sensitive sectors promoted (Agriculture, ECDE, WASH and Social Protection)	**10,874,500**	**12,411,500**	**12,410,000**	**12,732,500**	**11,487,000**	**59,915,500**
Advocate for joint resource mobilization for integrated WASH and nutrition activities.	-	-	-	-	-	-
Advocate for establishment of nutrition clubs in schools to promote nutrition education and activities	-	-	-	-	-	-
Advocate for nutrition sensitive agricultural production	-	85,000	-	-	85,000	170,000
Carry out CMEs at health facility level on WASH practices (hand washing, safe drinking water, latrine use, waste management, food safety and hygiene, environmental hygiene,) in collaboration with the public health department	-	-	-	-	-	-
Carry out dissemination of strategic policy documents (Vitamin A supplementation guide for teachers; ECD feeding program policy, National guidelines on ECDE) targeting ECDE program officers, county and sub county education officer and teachers.	-	-	-	-	-	-
Carry out dissemination of strategic policy documents with identified relevant stakeholders.	-	-	-	-	-	-
Carry out joint planning with stakeholders (MOH, social protection, CSOs).	-	-	-	-	-	-
Carry out joint routine inspections to all ECDE centers to ensure compliance to the set standards on food safety and hygiene.	-	-	-	-	-	-

KRAs by Activities	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 06. Nutrition in nutrition sensitive sectors promoted (Agriculture, ECDE, WASH and Social Protection)	**10,874,500**	**12,411,500**	**12,410,000**	**12,732,500**	**11,487,000**	**59,915,500**
Carry out nutrition education on food safety and hygiene to the community (men and women) using effective communication channels.	-	-	-	-	-	-
Carry out nutrition education on meal planning and preparation to the community (men and women) using effective communication channels to promote dietary diversity in collaboration with department of Agriculture personnel.	-	-	-	-	-	-
Collaborate with MoALC to hold sensitization meetings on dietary diversification to teachers and parents (men and women)	210,000	210,000	210,000	210,000	210,000	1,050,000
Conduct joint planning meeting with relevant stakeholders (MOE, MOH, MOA).	-	-	-	-	-	-
Conduct awareness forums on nutrition to vulnerable groups (OVCs, elderly, PWDs) targeting all genders in collaboration with social protection department.	-	-	-	-	-	-
Conduct cooking demonstrations targeting community members (men and women) through community forums using locally available foods.	-	-	1,008,000	-	-	1,008,000
Conduct deworming of children in mainstream schools in collaboration with the school health program	2,927,500	2,927,500	2,927,500	2,927,500	2,927,500	14,637,500
Conduct evaluation of nutrition activities is ECDE and mainstream schools.	-	-	-	-	-	-
Conduct gender integrated awareness forums on nutrition to beneficiary welfare committees in collaboration with social protection department.	-	-	-	-	-	-
Conduct joint support supervision and follow up of integrated activities at community level	-	-	-	-	-	-
Conduct joint supportive supervision (MOH, MOE) to all ECDE centers.	-	-	-	-	-	-
Conduct planning meeting with relevant stakeholders.	325,000	325,000	325,000	325,000	325,000	1,625,000
Conduct quarterly joint supportive supervision with social protection focal persons (MOH and Social protection)	-	-	-	-	-	-
Conduct quarterly monitoring and evaluation of integrated WASH and nutrition practices.	-	-	-	-	-	-
Conduct quarterly monitoring and evaluation of integrated social protection and nutrition programs and activities.	-	-	-	-	-	-
Conduct quarterly performance review of integrated social protection and nutrition activities	-	-	-	-	-	-
Conduct sensitization meeting to institutions on WASH practices (hand washing, safe drinking water, latrine use, waste management, food safety and hygiene, environmental hygiene) in collaboration with the public health department	-	-	-	-	-	-
Develop a customized tool for monitoring integrated nutrition and social protection activities	-	-	-	-	-	-
Hold quarterly joint performance review meetings for integrated WASH and nutrition activities at county level.	-	-	-	-	-	-
Hold stakeholder's partnership meetings on the importance of integrating nutrition in WASH practices.	-	-	406,000	406,000	406,000	1,218,000
OJT teachers (men and women) on how to conduct nutrition assessment in classes using a MUAC for screening.	-	-	-	-	-	-
Participate in commemoration important international WASH days (World Toilet day, Global Hand Day, World Menstrual Hygiene day).	-	-	-	-	-	-
Participate in trainings on climate smart agriculture targeting both men and women extension staff as TOTs and lead farmers (farmer field schools) in collaboration with Department of Agriculture	-	-	-	-	-	-
Participate in triggering community through community led total sanitation to integrate nutrition in collaboration with the public health department.	-	-	-	-	-	-
Promote integrated kitchen garden/ vegetable in schools for boys and girls in collaboration with Department of Agriculture personnel.	200,000	200,000	200,000	200,000	200,000	1,000,000
Promote integrated kitchen garden/home gardens within household to both men and women girls and boys in collaboration with Department of Agriculture personnel	420,000	420,000	420,000	420,000	420,000	2,100,000

KRAs by Activities	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 06. Nutrition in nutrition sensitive sectors promoted (Agriculture, ECDE, WASH and Social Protection)	**10,874,500**	**12,411,500**	**12,410,000**	**12,732,500**	**11,487,000**	**59,915,500**
Promote integrated kitchen garden/vegetable gardens within the health facilities to act as demonstration sites in collaboration with Department of Agriculture personnel.	-	-	-	-	-	-
Promote WASH practices at community level through various channels (chief barazas, MTMSG, father to father support groups, churches , mosques, farmer field school) (hand washing, safe drinking water, latrine use, waste management, food safety and hygiene, environmental hygiene,) in collaboration with the public health department	-	-	-	-	-	-
Refer malnourished children to the link health facility.	-	-	-	-	-	-
Report on interventions conducted in ECDE centers and other education institutions on quarterly basis	-	-	-	-	-	-
Sensitization of ECDE teachers and parents (male and female) on VAS and deworming.	-	-	-	-	-	-
Sensitization of male and female ECDE program officers on importance of VAS and deworming.	71,000	71,000	71,000	71,000	71,000	355,000
Sensitize Agriculture extension staff (men and women) and nutritionists on fuel energy saving technologies in collaboration with department of Agriculture personnel	180,000	180,000	180,000	180,000	180,000	900,000
Sensitize and disseminate food and nutrition reference manual to all key stakeholders in education and health at county and sub county	-	1,330,500	-	1,330,500	-	2,661,000
Sensitize BOM, teachers and parents on dietary diversification and establishment of kitchen gardens at school level	3,950,000	3,950,000	3,950,000	3,950,000	3,950,000	19,750,000
Sensitize CHVs (men and women) on Agri-nutrition manual in collaboration with Department of Agriculture personnel.	-	-	-	-	-	-
Sensitize community members (men and women across different ages and diversities) and other stakeholders on climate smart agriculture in collaboration with Department of Agriculture personnel.	-	-	-	-	-	-
Sensitize community members (men and women across different ages and diversities) on food processing, preservation, and storage technologies in collaboration with Department of Agriculture personnel.	-	-	-	-	-	-
Sensitize extension staff and lead farmers (men and women) on food consumption tables.	192,500	192,500	192,500	192,500	192,500	962,500
Sensitize farmers (men and women) and CHVs on fuel energy saving technologies in collaboration with department of Agriculture personnel.	-	-	-	-	-	-
Sensitize lead farmers (men and women) on Agri-nutrition manual in collaboration with Department of Agriculture.	-	-	-	-	-	-
Sensitize male and female extension staff on Agri-nutrition manual in collaboration with Department of Agriculture.	-	-	-	-	-	-
Sensitize nutritionists on Agri-nutrition dialogue cards in collaboration with Department of Agriculture.	-	-	-	-	-	-
Sensitize nutritionists on link between nutrition and social protection	80,000	80,000	80,000	80,000	80,000	400,000
Sensitize social protection officers on the link between nutrition and social protection	80,000	80,000	80,000	80,000	80,000	400,000
Sensitize the community through community groups on fuel energy saving technologies in collaboration with department of Agriculture personnel	-	-	-	-	-	-
Sensitize male and female CHVs on WASH practices (hand washing, safe drinking water, latrine use, waste management, food safety and hygiene, environmental hygiene,) in collaboration with the public health department	-	-	-	-	-	-
Support MoALC to establish school integrated gardens in ECDEs	-	-	-	-	-	-
Train agriculture extension workers on nutrition sensitive food systems	2,238,500	2,238,500	2,238,500	2,238,500	2,238,500	11,192,500
Train social protection officers as TOT on nutrition for vulnerable groups (men and women)	-	121,500	121,500	121,500	121,500	486,000
Trainings decision makers in the agriculture department and stakeholders on nutrition sensitive agriculture food systems	-	-	-	-	-	-
Write quarterly report on Agri-nutrition activities carried out at the community level.	-	-	-	-	-	-

KRAs by Activities	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 07. Sectoral and multi-sectoral Nutrition governance, Coordination Information Systems, Learning and Research, legal and regulatory frameworks, leadership and strengthened	**8,361,500**	**7,981,500**	**7,535,500**	**7,595,500**	**10,728,500**	**42,202,500**
Advocate for research TWG at county level.	75,000	75,000	75,000	75,000	75,000	375,000
Advocate to CHMT and Sub-County teams for nutrition research for officers going for further studies.	-	-	-	-	-	-
Conduct bi-annual nutrition AWP review.	176,000	176,000	176,000	176,000	176,000	880,000
Conduct Data Quality assessment.	672,000	672,000	672,000	672,000	672,000	3,360,000
Conduct market surveillance with sector and multisectoral teams on compliance of legal/regulatory frameworks.	45,000	45,000	45,000	45,000	45,000	225,000
Conduct market surveillance with sector and multi-sectoral teams.	-	97,500	97,500	97,500	97,500	390,000
Conduct mid and end term CNAP review/evaluation	-	-	-	-	93,500	93,500
Conduct nutrition capacity assessment after every two years.	-	-	1,200,000	-	-	1,200,000
Conduct quarterly data quality review meeting.	420,000	420,000	420,000	420,000	420,000	2,100,000
Conduct quarterly multi-sectoral working group meeting to strengthen prioritization of nutrition for county agenda.	260,000	260,000	260,000	260,000	260,000	1,300,000
Conduct quarterly partnership and collaboration meeting with nutrition stakeholders.	-	-	-	-	-	-
Conduct quarterly support supervision for nutrition M&E.	262,500	262,500	262,500	262,500	262,500	1,312,500
Conduct SMART nutrition survey after every two years.	1,200,000	-	-	1,200,000	-	2,400,000
Conduct MIYCN KAP survey after every two years targeting all genders.	-	1,646,000	-	-	1,616,000	3,262,000
Develop nutrition annual work plan (AWP) to operationalize CNAP	85,000	85,000	85,000	85,000	85,000	425,000
Develop Nutrition information product (factsheet).	60,000	-	-	60,000	-	120,000
Develop, launch, and disseminate second generation CNAP in collaboration with line ministries	337,500	337,500	337,500	337,500	1,597,500	2,947,500
Disseminate Nutrition information product(factsheet) to CHMT and SCHMTs health care workers and other stakeholders (including the private sector food industries, etc.).	-	-	-	-	-	-
Disseminate relevant policies, guidelines, and frameworks on sectoral and multi-sectoral coordination forum (BMS Act,2012, Workplace support Guideline, Marketing of unhealthy food mandatory law on food fortification)	-	-	-	-	-	-
Establish multisectoral platform working group	-	-	-	-	-	-
Hold bi-annual stakeholders meeting.	-	560,000	560,000	560,000	560,000	2,240,000
Hold monthly data sharing meetings with key stakeholders.	-	-	-	-	-	-
Hold quarterly county nutrition technical forum (CNTF)	210,000	210,000	210,000	210,000	210,000	1,050,000
Hold quarterly sub county nutrition technical forum (SCNTF)	1,876,000	1,876,000	1,876,000	1,876,000	1,876,000	9,380,000
Hold resource mobilization meetings with potential donors and partners	1,423,500	-	-	-	1,423,500	2,847,000
Implement Scaling Up Nutrition (SUN) Business network strategy	125,000	125,000	125,000	125,000	125,000	625,000
Incorporate explicit gender sensitive nutrition objectives and indicators in the relevant SECTORS	-	-	-	-	-	-
Map nutrition partners and stakeholders in the county.	-	-	-	-	-	-
Map out existing and new potential donors and partners for the county	-	-	-	-	-	-
Monitor implementation of nutrition AWP	410,000	410,000	410,000	410,000	410,000	2,050,000
Participate in dissemination forum for research findings and information sharing at all levels.	188,000	188,000	188,000	188,000	188,000	940,000
Participation by nutrition officers in conference and symposium at all levels	168,000	168,000	168,000	168,000	168,000	840,000
Participation by nutrition officers in county, regional, and national meetings on nutrition	218,000	218,000	218,000	218,000	218,000	1,090,000
Sensitize and disseminate sectors and multisectoral on the existing relevant legal and regulatory framework during coordination meeting (BMS Act,2012, Workplace support Guideline, Marketing of unhealthy food mandatory law on food fortification).	150,000	150,000	150,000	150,000	150,000	750,000
Sensitize sub county nutritionists and other frontline health care workers on nutrition data management	-	-	-	-	-	-
Strengthen collection, analysis and use of sex-age disaggregated data for decision making.	-	-	-	-	-	-
Train male and female nutrition officers, health information officers and other frontline health care workers on nutrition data elements and indicators and sentinel surveillance-Early Warning System						

KRAs by Activities	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 08. Advocacy, Communication and Social Mobilization (ACSM) strengthened	**2,994,500**	**2,994,500**	**2,837,000**	**2,837,000**	**2,837,000**	**14,500,000**
Adopt and distribute gender transformative nutrition related BCC materials (MIYCN counseling cards, 1000 days booklet, IMAM protocol guidance, nutrition Job Aids)	-	-	-	-	-	-
Carry out high level nutrition advocacy meeting targeting the county members of health committee, executive members, and other relevant stakeholders	1,070,000	1,070,000	1,070,000	1,070,000	1,070,000	5,350,000
Carry out radio talks on nutrition in local FMs that incorporate gender issues in nutrition.	24,000	24,000	24,000	24,000	24,000	120,000
Commemorate Malezi Bora.	-	-	-	-	-	-
Commemorate World Breastfeeding Week.	-	-	-	-	-	-
Develop / customize gender transformative behavior change communication material on nutrition key messages.	157,500	157,500	-	-	-	315,000
Develop, disseminate, and implement a gender responsive nutrition advocacy package for county targeting nutrition stakeholders in public, civil society, and the private sectors	492,500	492,500	492,500	492,500	492,500	2,462,500
Document and disseminate nutrition best practices case studies research finding and success stories within the county and at national level.	-	-	-	-	-	-
Engage male and female county nutrition champion on various nutrition activities.	-	-	-	-	-	-
Hold community dialogues to promote community participation in nutrition resilience building activities and accountability mechanism, targeting all genders.	368,000	368,000	368,000	368,000	368,000	1,840,000
Identify male and female county nutrition champions, across different ages and diversities.	60,000	60,000	60,000	60,000	60,000	300,000
Participate in the celebration of other health days (World Pre-Maturity day, World Toilet Day, World AIDS Day, World Diabetes Day, World TB day, World Water Day)	-	-	-	-	-	-
Sensitize the community on various nutrition thematic days targeting men and women, boys and girls across different ages and diversities.	545,000	545,000	545,000	545,000	545,000	2,725,000
Train media personnel on gender responsive nutrition advocacy	67,500	67,500	67,500	67,500	67,500	337,500
Train nutrition professionals and other frontline health care workers on gender responsive nutrition advocacy.	210,000	210,000	210,000	210,000	210,000	1,050,000
KRA 09. Supply chain management for nutrition commodities and equipment's strengthened	**189,682,500**	**189,682,500**	**187,040,000**	**189,682,500**	**186,750,000**	**942,837,500**
Carry out nutrition supplies data quality audit.	-	-	-	-	-	-
Conduct training of Health Care Workers on logistic information and management system (LMIS).	290,000	290,000	290,000	290,000	-	1,160,000
Develop and submit/share annual nutrition procurement plan for nutrition commodities and equipment's to be integrated within the County integrated procurement plan	750,000	750,000	750,000	750,000	750,000	3,750,000
Participate in commodity technical working group.	-	-	-	-	-	-
Procure and distribute nutrition commodities for micronutrient program, IMAM, HIV/TB and for clinical nutrition in disease management.	183,600,000	183,600,000	183,600,000	183,600,000	183,600,000	918,000,000
Procure and distribute nutrition equipment for health facilities.	2,642,500	2,642,500	-	2,642,500	-	7,927,500
Procure and distribute nutrition reporting tools for all programs.	2,400,000	2,400,000	2,400,000	2,400,000	2,400,000	12,000,000
support repair and maintenance of nutrition equipment in collaboration with the medical engineering department	-	-	-	-	-	-
Grand Total	**430,875,910**	**320,379,850**	**528,818,760**	**318,385,600**	**367,441,350**	**1,965,901,470**

Appendix B: List of Key Contributors

1.	Ann Wanjiru	Sub-County Nutrition Coordinator (Kigumo)
2.	Beatrice Gachie	County Director - Gender
3.	Catherine Mwaura	County Director - Education
4.	Charles Mumbi	County Program Coordinator (Nutrition International)
5.	Collins Gichure	Nutrition Officer (Kiharu)
6.	Danson Mwangi	County Health Promotion Officer – Advocacy Communication and Social Mobilization
7.	Dr. James Kanyi	Chief Officer – Health & Sanitation
8.	Dr. Joseph Mbai	County Executive Committee Member – Health Services
9.	Dr. Winnie Kanyi	County Director - Health & Sanitation
10.	Elias Muigai	Sub-County Nutrition Coordinator (Kangema)
11.	Elizabeth Mwaura	Sub-County Nutrition Coordinator (Murang'a South)
12.	Esther Maina	County Director - Social Services
13.	Jane Githinji	Sub-County Nutrition Coordinator (Gatanga)
14.	Judy Thiong'o	Sub-County Nutrition Coordinator (Kandara)
15.	Nancy Mwangi	County Nutrition Coordinator
16.	Nancy Nguru	P. A. O
17.	Nanis Mutegi	County Children's' Officer
18.	Peter Thuo	County Health Records and Information Officer
19.	Purity Gitonga	Nutrition Officer (Kiharu)
20.	Rosemary Gikonyo	Sub-County Nutrition Coordinator (Kiharu)
21.	Zablon Wambani	Public Health Officer (WASH)