NAKURU COUNTY
COUNTY OF UNLIMITED OPPORTUNITIES

NAKURU COUNTY NUTRITION

ACTION PLAN (CNAP) 2020/21 – 2024/25

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

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ABBREVIATIONS AND ACRONYMS

ABC	Activity Based Costing
ACSM	Advocacy Communication and Social Mobilization
AGPO	Access to Government Procurement Opportunities
ANC	Antenatal Care
AWP	Annual Work Plan
BCC	Behaviour Change Communication
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
BMI	Body Mass Index
BMS	Breast Milk Substitute
CCC	Comprehensive Care Centre
CDoH	County Department of Health
CECM	County Executive Committee Member
CHEWs	Community Health Extension Workers
CHMT	County Health Management Team
CHS	Community Health Strategy
CHSSIP	County Health Sector Strategic & Investment Plan
CHV	Community Health Volunteer
CIDP	County Integrated Development Plan
CME	Continuous Medical Education
CMSG	Community mother support groups
CNAP	County Nutrition Action Plan
CRAF	Common Results and Accountability Framework
CSO	Civil Society Organization
DQA	Data Quality Assessment
DRNCDs	Diet-Related Non-Communicable Diseases
ECD	Early Childhood Development
ECDE	Early Childhood Development Education
EMTCT	Elimination of Mother-to-Child Transmission
FBO	Faith-Based Organization
FGD	Focus Group Discussion
GAP	Good Agricultural Practices
GMP	Growth Monitoring and Promotion
HCWs	Health Care Workers
HEIs	Highly Exposed Infants
HINI	High Impact Nutrition Intervention

HIV/AIDS	Human Immunodeficiency Virus / Acquired ImmunoDeficiency Syndrome
HRIOs	Health Records and Information Officers
ICC	Inter-agency Coordinating Committee
ICT	Information Communication and Technology
IEC	Information, Education, and Communication
IFAS	Iron Folic Acid Supplementation
IHRIS	Integrated Human Resource Information System
IMAM	Integrated Management of Malnutrition
IYCF	Infant and Young Child Feeding
KAPs	Knowledge, Attitude and Practices
KDHS	Kenya Demographic Health Survey
KEPHIS	Kenya Plant Health Inspectorate Services
KHIS	Kenya Health Information System
KNAP	Kenya Nutrition Action Plan
KNBS	Kenya National Bureau of Statistics
KRAs	Key Result Areas
LICs	Low Income Countries
LMIS	Logistic Management Information System
M&E	Monitoring & Evaluation
MAM	Moderate Acute Malnutrition
MEAL	Monitoring Evaluation Accountability and Learning
MIYCN	Maternal Infant and Young Child Nutrition
MIYCN-E	Maternal Infant and Young Child Nutrition-Emergency
MNCH	Maternal, New-born and Child Health
MNPs	Micronutrient Powders
MoALF&C	Ministry of Agriculture, Livestock, Fisheries and Cooperatives
MoE	Ministry of Education
MoH	Ministry of Health
MoW	Ministry of Water
MSP	Multi Stakeholder Platform
MTMSG	Mother to Mother Support Groups
MUAC	Mid Upper Arm Circumference
NACS	Nutrition Assessment Counselling and Support
NCDs	Non-Communicable Disease
NGO	Non-Governmental Organization
NI	Nutrition International
NR	No Result
NA	Not Available

ND	No Data
ODF	Open Defecation Free
OJT	On-Job Training
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PLW	Pregnant and Lactating Women
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public Private Partnership
PTA	Parents Teachers Association
RTAs	Road Traffic Accidents
SAM	Severe Acute Malnutrition
SBCC	Social behaviour Change and Communication
SCHMT	Sub-County Health Management Team
SDG	Sustainable Development Goal
SOPs	Standard Operating Procedures
TAN	Technical Assistance for Nutrition
TB	Tuberculosis
TOC	Theory of Change
TOR	Terms of Reference
TWG	Technical Working Group
URTIs	Upper Respiratory Tract Infections
USAID	United States Agency for International Development
VAS	Vitamin A Supplementation
WASH	Water Sanitation and Hygiene
WDD	World Diabetes Day
WHA	World Health Assembly
WHO	World Health Organization
WIFS	Weekly Iron Folic-Acid Supplementation
WKD	World Kidney Day
WRA	Women of Reproductive Age

FOREWORD

The Constitution of Kenya article 43 (1) gives every person the right to: the highest attainable standard of health, freedom from hunger and access to adequate food of acceptable quality.

The National and County Governments are committed to creating an enabling environment for citizens to realize these rights as evidenced in the Vision 2030, Kenya Health Policy (2014–2030) and the National Food and Nutrition Security Policy, 2012.

The Nakuru County Nutrition Action Plan (CNAP) 2020/21-2024/25 is aligned with the Kenya Nutrition Action Plan (KNAP 2018 - 2022), Nakuru County Health Sector Strategic & Investment Plan (CHSSIP) 2018-2022 and County Integrated development Plan (CIDP) 2018 – 2022. The plan recognizes the role of nutrition as a fundamental human right and a driver to accelerating economic development as envisioned in Vision 2030.

Food and nutrition security are characterized by people's physical and economic access to enough safe and nutritious food to meet their dietary needs and food preferences. This translates to how well the citizens across all ages and diversities are empowered and provided with an enabling environment to meaningfully participate and contribute as strong agents of change, in addressing the key long-term drivers of food and nutrition security. To achieve this, there is need to understand the specific needs and vulnerabilities of women, men, boys, and girls across all diversities in the county. This will ensure nutrition programming builds on their capacities; knowledge, and experiences and human and material resources are directed as best needed.

The Nakuru CNAP is a product of a consultative process which involved stakeholders in addressing nutrition challenges in the County. The five-year plan focuses on three areas of interventions, namely nutrition-specific, nutrition-sensitive, and enabling environment. These interventions address the immediate, underlying and basic causes of malnutrition including expanding the political, economic, socio-cultural, human capital, technological and gender equality space for nutrition actions. These lay ground for strengthening multi-sectoral collaboration in addressing malnutrition which is multi-dimensional.

The alignment of the CNAP to CHSSIP 2018-2022 facilitates mainstreaming of nutrition budget into the County budgeting process, hence, allocation of resources to nutrition specific and nutrition sensitive programmes in the county. The plan will be used as an advocacy tool for resource mobilization within and without the County borders.
We believe this five-year plan will contribute to achieving the development agenda of Nakuru County and the Department of Health's vision of "A Healthy County".

H.E Lee Kinyanjui
Governor
County Government of Nakuru

PREFACE

Nutrition is a vital building block in the foundation of human health and development. Nutrition has a direct relationship with child survival, physical and mental growth, learning capacity, adult productivity and overall social and economic development.

Unacceptably, high levels of malnutrition remain a public health concern and a hindrance to achieving the country's developmental agenda.

Nakuru County is among the counties with high levels of malnutrition in Kenya. According to KDHS 2014, the prevalence of stunting among children under five years in Nakuru county is at 27.9% which is above the national level of 26%; wasting is at 5% while underweight is at 10.2%, which are unexpectable levels compared to the National levels of 4% and 11% respectively.

The Nakuru CNAP 2020/2021-2024/25 outlines high impact nutrition specific and nutrition sensitive interventions to be undertaken at all levels in the health sector and other line departments in the county. In line with the Constitution of Kenya, the CIDP 2018-2022 and the SDGs, the CNAP has integrated other cross cutting nutrition sensitive sector-based legislations, policy, plans and guidelines in support of an enabling environment for optimal food and nutrition security in the county. This is aimed at addressing poverty alleviation, gender equality and empowerment of women and girl child and maternal health, reducing HIV/AIDS and communicable diseases and environmental sustainability to support reduction of malnutrition.
The CNAP will provide an umbrella framework and guidance to the department of health, health related sectors, partners and other relevant non-state actors interested in the implementation of nutrition objectives. The document will be reviewed periodically as new ideas, innovations, programs and policies are developed.

We urge all partners, line departments and stakeholders to familiarize themselves with the contents of this document as we all work towards achieving effective and sustainable food and nutrition security leading to improved nutrition and health related outcomes.
The Department of Health Services will provide the required stewardship and oversight to ensure full implementation of this plan. The department is committed to enhance efficiency in the utilization of existing resources and advocate with the relevant arms of the County and National Government on the need for additional resources. We encourage our stakeholders and partners to complement the department's resource mobilization efforts to fully realize the plan.

Dr Z. K. Gichuki CECM-Health
County Government of Nakuru

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The Department of Health Services takes this opportunity to appreciate everyone who participated in the development of the Nakuru County Nutrition Action Plan (CNAP) 2020/21–2024/25.

The CNAP could not have been finalized without the valuable contributions and full commitment of the technical committee members of different working groups drawn from both the government and partner organizations.
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The contributions of the following ministries in providing overall leadership and technical inputs to the CNAP are also highly appreciated: this particularly goes to Departments of; but not limited to Health, Agriculture Livestock and Fisheries, Gender, Education, Water, Social and Children services.

The contribution of the County Executive Committee Member (CECM), the Directors, the County Health Management Team (CHMT) the Sub-County Nutrition Coordinators and other Nutrition Officers during the development and/or validation of the CNAP is gratefully acknowledged.

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

Dr Solomon Sirma.
Chief officer, Medical Services

Mr Samuel Kingori,
Chief Officer Public Health

1 INTRODUCTION

1.1 Location and size

1.1.1 Location and size

Nakuru County is one of the 47 Counties in the republic of Kenya. The County lies within the Great Rift Valley and borders eight other Counties namely, Kericho and Bomet to the West, Baringo and Laikipia to the North, Nyandarua to the East, Narok to the South-West and Kajiado and Kiambu to the South. It is comprised of 11 Sub-Counties/constituencies namely, Naivasha, Nakuru Town West, Nakuru Town East, Kuresoi South, Kuresoi North, Molo, Rongai, Subukia, Njoro, Gilgil and Bahati (Nakuru North) and 55 wards. The County headquarters are in Nakuru Town.

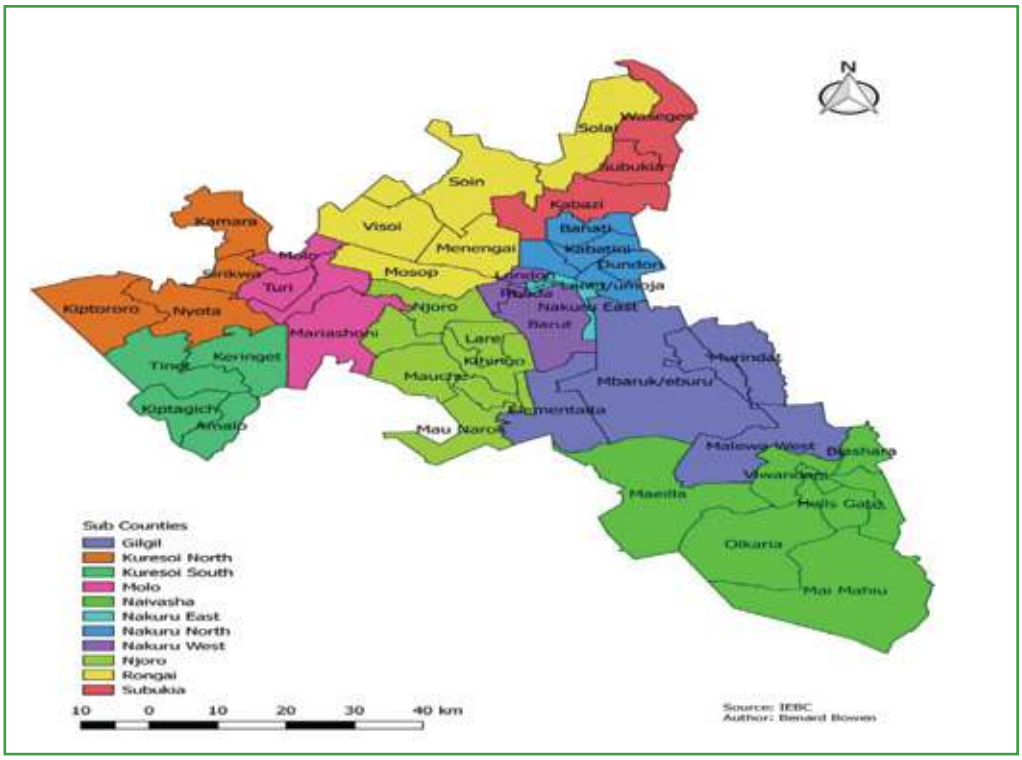

Figure 1: Nakuru County administrative map

1.2 Physiographic and natural conditions

1.2.1 Physical and topographic features

The County has good geographical features that make it a preferable tourism destination. The Great Rift Valley floor runs across the County Northwards with Mau Escarpment covering the Western part. The County hosts the two volcanoes in Mt. Longonot and Menengai crater both important in renewable power generation by the geo-thermal development company.

The County hosts 3 inland main lakes; Lake Nakuru which is served by River Njoro and River Makalia and Lake Naivasha which is served by River Malewa and Lake Elementaita. There are also two small lakes: the crater lake in Mt. Longonot and Lake Solai.

Other scenic physical features and major tourist attractions in which the County prides itself include Hells Gate Gorges in Naivasha, Mountain Ranges and Savannah Plain Lands in Gilgil Sub-County.

1.2.2 Ecological conditions

Climatic conditions and physical features influence the ecological system in the county. These favourable conditions are evident in areas around Mau Escarpment, which is established at 2,400m above sea level and host most forests.

Among the forests which are found in the Nakuru side include, Menengai Crater, Mbogoini, Solai, Mau, Bahati, Subukia, Eburru and Dundori. It is important to note that the famous Mau forest which is one of the major water towers in East Africa is found in the County and is also home to the indigenous Ogiek Community. There are hot springs in Olkaria and Elementaita areas which are recreational sites.

1.2.3 Economic situation

The major economic activities include agriculture, tourism and financial services. Nakuru is an agricultural rich County whose background was shaped by the early white settlement schemes. People living in the region practice mixed farming as a main economic activity. Other economic activities commonly practiced in the County are tourism and banking financial services.

1.2.4 Road network

The County also boasts of good road network which shapes transport infrastructure with some originating from early colonial era e.g. rail network and roads. The Trans Africa Highway - Northern Corridor traverses the County with both positive and negative effects.

The positive impact is ease of transport for both human and goods to and from all corners of the country. These have made Nakuru town one of the fastest growing towns in Africa. In addition, transportation of good commodities in and out of the County is good with the population being able to benefit from diverse food products from within and outside the County faster.

However, some of the notable negative effects include high mortality from motor vehicle crashes as the road is one of the major contributors to road traffic accidents (RTAs) in the country. It is also a conduit to communicable diseases, such as HIV/AIDs since Nakuru is a major transit town in Kenya.

1.3 County population by administrative and political units

The county has a population of 2,162,202 million as per 2019 population census. The number of males is at 1,077,272, the number of females is at 1,084,835 and the number of intersexes is at 95. The total households are 628, 591 and the total land mass is 7,504.9 Km/sq. with a population density of 288/sq. Km.

The table below shows population distribution across the administrative units. Naivasha Sub-County is the most populated and contributes 17% of the total County population. It is followed by Njoro with 11% and Nakuru North with 10%. Subukia is the least populated, contributing to 4% of the County's population.

Table 1: Population distribution by administrative and political units

Sub-County/constituencies	Male	Female	Intersex	Total
Gilgil	92,955	92,247	7	185,209
Kuresoi North	87,472	87,599	3	175,074
Kuresoi South	78,204	77,117	3	155,324
Molo	78,129	78,598	5	156,732
Naivasha	179,222	176,132	29	355,383
Nakuru East	92,956	100,960	10	193,926
Nakuru North (Bahati)	106,155	111,880	15	218,050
Nakuru West	101,797	96,854	10	198,661
Njoro	118,361	120,408	4	238,773
Rongai	99,976	99,922	8	199,906
Subukia	42,045	43,118	1	85,164
Total	**1,077,272**	**1,084,835**	**95**	**2,162,202**

Source: (KNBS, November 2019)

1.3.1 Population projections by age cohort

The County's population is estimated at 2.2 million in 2020 with a growth rate of 2.6% as per the 2019 National Population and Housing Census (KNBS, 2019). Currently, 68.9% of the County's overall population is below 30 years of age. This population is estimated to increase by 13.9% by the year 2022.

This high and growing population calls for the need for the County Government to set up policies targeting this age cohort since its dependency ratio is high. Resources should be increased especially in education systems and training institutions. The County should promote programmes that will cater for the needs of the youth since they are in their productive age and are also seeking for employment opportunities.

The County envisions to encourage the youth to participate in agriculture, sensitize the youth on the Access to Government Procurement Opportunities (AGPO) and tap various talents through sporting activities. Moreover, more job opportunities also need to be created to meet the needs of this population and encourage them to form groups to enable them to acquire funds at low interest rate especially the youth fund which helps them to run small businesses and to create self- employment opportunities.

The aged population 65+ stands at 2.7% and is expected to increase by 19.7% by the year 2022.

Table 2: population projections by age cohort

S/No	Description	Population Proportion	Estimated Number 2020
1	Total population in the county	Growth Rate 2.6%	2,218,419
	Male	48.8%	1,105,281
	Female	50.2%	1,113,041
2	Number of households		628,591
3	Children under one year (12 months)	3.1%	68,771
4	Children under five years (60 months)	12.60%	279,521
5	Under fifteen-year population	37.70%	836,344
6	Women of childbearing age (15 – 49 years)	26.3%	583,444
7	Estimated number of pregnant women	3.70%	82,082
8	Estimated number of deliveries	3.60%	79,863
9	Estimated live births (98.1% of Deliveries)	3.7%	78,346
10	Number of adolescents (15-24)	20.7%	459,213
11	Adults (25-59)	36.60%	811,941
12	Elderly (60+)	5%	110,921
13	Neonatal Deaths 0- 28 days (1.4% of Deliveries)	1.4%	1,118
14	Estimate of Emergency obstetric complications	0.75%	616
15	Population 6-11 Months (50% of <1yrs)	1.55%	34,386
16	Population 12-59 Months (80% of < 5yrs)	10.08%	223,617

Source: (CIDP, June 2018)

1.4 Facility distribution per Sub-County

Nakuru County population relies on health services provided by 674 health facilities spread across the County; of these 206 are public facilities with 249 community units offering level-one health services. Geospatial mapping of facilities shows that the county is approaching the WHO recommendation of facility reach being within a radius of 5kms. The table below shows the distribution of public health facilities across the sub-counties by level of care (CIDP, June 2018).

Table 3: Public health facilities' distribution per Sub-County

Sub-County	Dispensary	Health Centre	Hospitals (Level 4)	Hospitals (Level 5)	Total
Gilgil	18	4	1	0	23
Kuresoi North	19	5	0	0	24
Kuresoi South	22	2	2	0	26
Molo	10	3	2	0	15
Naivasha	19	4	1	0	24
Nakuru East	5	1	3	0	9
Nakuru North	4	5	1	0	10
Nakuru West	10	3	1	1	14
Njoro	21	0	1	0	22
Rongai	19	6	1	0	26
Subukia	10	1	2	0	13
Total	**157**	**34**	**15**	**1**	**206**

Source: (CIDP, June 2018)

Table 4: Distribution of health facilities in Nakuru County by ownership

OWNERSHIP	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5	GRAND TOTAL
FBO	21	14	1	0	36
GOK	141	23	12	1	177
NGO	2	1	0	0	3
PRIVATE	410	35	11	1	457
GRAND TOTAL	**574**	**73**	**24**	**2**	**674**

Source: (CIDP, June 2018)

1.5 Trends in nutrition and health situation in Kenya

The Kenya National Nutrition Action Plan (KNAP) addresses the triple burden of malnutrition in Kenya, characterized by the co-existence of undernutrition as manifested by stunting, underweight, micronutrient deficiencies, wasting, and overweight and obesity including diet-related non-communicable diseases (DRNCDs). All three forms of malnutrition occur within individuals, households, and populations throughout the life course – pregnant women, children, adolescents, adults and older persons – throughout the country at different levels of public health significance.

Undernutrition, including micronutrient deficiencies, affects children and women especially during the first 1,000 days of life due to their high nutrient requirement, while obesity and DRNCDs affect women of reproductive age and adults in general. Because of the ageing of body organs and systems, older persons too are at a high risk of malnutrition.

In Kenya, out of 7.22 million children under five years, 1.8 million are stunted (26%); 290,000 are wasted (4%); 794,200 (11%) are underweight. However, there are geographical and social demographic variations in the severity of malnutrition. Consistent with other low-income countries, stunting is highest in the 19–23-month age group (36%); with boys having a higher stunting prevalence (30%) as compared to girls (22%) and rural areas having higher rates (29%) than urban areas with 20%. Stunting decreases with the level of education of the mother, with women who have not completed primary school having children who are twice as likely to suffer from stunting (34%) as mothers with secondary or higher education (17%). Although the KHIS (KHIS, 2020) showed the nutrition status of women of reproductive age (WRA) being a triple burden, the trend indicated a reduction in undernutrition while overweight and obesity increased. Comparing the 2008–9 and 2014 KDHS (KDHS, December 2014), the proportion of thin women Body Mass Index (BMI) (18.5 or below) declined from 12% to 9%.

1.6 Trends in health sector for Nakuru County

Nakuru health sector faces several health challenges ranging from communicable diseases, non-communicable diseases (NCDs), injuries from road traffic accidents, domestic injuries, violence and emerging global health issues. In 2016/2017 Communicable conditions accounted for 1,023,048 (42%) and non-communicable conditions accounted for 1,411,928 (58%) of all morbidity cases including reviews and revisits (KHIS, 2020).

Non-communicable conditions that are among the top 10 causes of Mortality for all ages include: Prematurity and low birth weight (6.9%), Ill-defined diseases (5.3%) (ICD10 R00- R99), other cardiovascular diseases (5.0%), and birth asphyxia and birth trauma (5.0%). According to the KHIS data, the prevalence of NCDs has been on the rise in recent years. This shows the county should place more emphasis on addressing the NCDs with a focus on nutrition as one of the preventions and management strategies.

1.6.1 Maternal, neonatal child, adolescent health and nutrition

Nakuru health sector faces several challenges in maternal, neonatal child, adolescent health and nutrition. Some of these health problems include underutilization of services related to ANC, new-born/child health, youth adolescent health and nutrition services.

As a result, most of the performance indicators are below the expected targets hence reducing the County's effort to make its population healthy. Other factors contributing to the poor outcomes include socio- economic vulnerabilities especially among women and girls leading to poor utilization and/or frequency of antenatal health care services; overburdening maternal roles; age and literacy levels; low knowledge, inadequate counselling and clarity on the importance of different micronutrient supplements before, during and after pregnancy; beliefs against consuming medications during pregnancy; low/lack of male and community support on maternal and child health, including lack of support for teenage mothers to seek health services in a timely manner.

Nakuru County Integrated Development Plan (CIDP 2018-2022) has prioritized primary and maternal health care, the priorities include:

• To reduce the level of malnutrition (wasting, stunted, underweight and overweight) to an acceptable level.

• To enhance health education on good nutrition at all levels by training Community Health Volunteers (CHVs) and Community Health Extension Workers (CHEWs) on Community Health Strategy (CHS) module on nutrition, Agri-nutrition, Baby Friendly Community Initiative (BFCI) and communication skills for improved nutrition.

• To enhance growth monitoring program and nutrition surveillance and strengthen IMAM/MIYCN by training CHVs on growth monitoring and promotion, procuring weighing scales, height boards and MUAC tapes and establishing community growth monitoring centres in each ward

• Strengthening micronutrient supplementation at all levels by training HCWs and CHVs on Vitamin A Supplementation and IFAS and conducting Vitamin A Supplementation during Malezi bora through ECDE policy twice a year

• Strengthening inter-sectoral collaboration by mapping of nutrition stakeholders per sub county and establishing a county multi-sectoral platform for quarterly nutrition stakeholders meeting

• Improved health infrastructure for improved access and quality health care.

1.6.2 Infant and young child feeding in Nakuru County

Appropriate feeding practices are of fundamental importance for the health, nutrition, survival and development of infants and children everywhere. Children have the right to access safe and nutritious food, and nutrition is a universally recognized component of the child's right to enjoyment of the highest attainable standard of health. Poor nutrition among infants and young children results primarily from inappropriate feeding practices where the timing, quantity and quality of foods given to infants are often inadequate.

Exclusive breastfeeding is recommended during the first six months of life because breast milk contains all the nutrients required for development, growth and child survival. Exclusive breastfeeding rates in Kenya have markedly improved from 32 % in 2008–9 to 61 % in 2014, while no data exist for Nakuru County. It is recommended that infants be initiated to breastfeeding within one hour after delivery. According to the Lancet series 2016 this can save 22 % and 16 % of neonatal deaths within the first hour of birth and 48 hours respectively. In Kenya, trends in early initiation of breastfeeding show an increase from 58 % in 2008–9 to 62 % in 2014. while Nakuru early initiation stands at 97% (KHIS, 2020).

Timely, adequate and safe introduction of complementary foods is critical at six months when breast milk alone is no longer enough to meet the nutritional requirements of infants and young children. According to Nakuru KAP survey 2017, minimum acceptable dietary diversity among children aged 6-23 months was quiet low at 23 % like the national percentage. Furthermore, the proportion of mothers who introduced complementary feeding at the recommended age of at 6 months was 46.8% indicating a dire nutritional situation hence need for investment in this area.

Behaviour Change and Communication (BCC) strategies and interventions have been put in place to address the socio -cultural factors affecting infant and young child feeding practices in Nakuru county i.e., low community and male support in relieving women of overburdening maternal workload. These include the roll out of the BFCI approach which is a community-based behaviour change strategy to promote, protect and support breastfeeding including timely introduction of complementary feeds among other practices. BFCI advocates and promotes for increased involvement of men and other key influencers e.g., mothers in law in supporting increased uptake of MIYCN related services and practices by mothers and children.

1.6.3 Under nutrition situation for Nakuru County

An estimated 27.9% of children under the age of 5 years living in Nakuru County are stunted while 5 % are wasted and 10.2% are underweight (KDHS 2014). These high levels of malnutrition remain a public health concern and a hindrance to achieving the county's developmental agenda and hence reduction of the same is a priority in the CIDP 2018-2022.

Poor diets and morbidity are the immediate causes of malnutrition, while socio-cultural, political, and economic factors are underlying causes that need to be addressed.

These include but are not limited to.
- Household food insecurity
- Poor access to clean water, hygiene, and sanitation
- Poor health seeking behaviour and care practices across different genders and age cohorts
- Inadequate and inequitable access to nutrition and health education, particularly for women and children
- Cultural norms and practices influencing food sharing and uptake; men being given a priority and larger food share as the household heads, traditional feeding practices, related taboos and stereotypes all affecting optimal nutrition uptake and practices especially among women and children under five years old.
- Unequal access use and control of benefits from productive assets, services, and opportunities disproportionately affecting women and girls which hinders their capacity and effectiveness as strong agents for improved food and nutrition security.

All these factors must be addressed as part of effective and sustainable ways in addressing malnutrition. Further, collection and use of context-based gender integrated nutrition analysis on the underlying socio-cultural, economic and rights related issues affecting affordability and improved uptake of nutrition and related health services and practices to inform gender transformative nutrition interventions is paramount.

1.6.4 Micronutrient supplementation

Micronutrient deficiencies form an important global health issue, with malnutrition affecting key development outcomes including poor physical and mental development in children, vulnerability or exacerbation of disease, mental retardation, blindness and general losses in productivity and potential. The health impacts of micronutrient deficiencies are not always acutely visible; it is therefore sometimes termed 'hidden hunger'. Although any individual can experience micronutrient deficiency, pregnant women and children are at the greatest risk of developing deficiencies.

This is not only because of low dietary intake, but also from higher physiological requirements; pregnancy and childhood development often increase demand for specific vitamins and minerals. Socio – cultural practices surrounding food uptake during pregnancy and breastfeeding e.g., food taboos that prohibit the uptake of certain foods during pregnancy also need to be identified and addressed.

Micronutrient deficiencies most notably Vitamin A, Zinc, Iodine, and Iron deficiencies are a major public health problem carrying the highest burden of disease. Young children and pregnant & breastfeeding women are the main groups affected, because their relative requirements for micronutrients are higher and thus the impact of deficiency is more severe than in other population subgroups.

Vitamin A deficiency is a public health problem hitting hardest young children and pregnant women in low-income countries. Nakuru County Vitamin A Supplementation target is 75%. However, the challenge has been coverage and suitability of children aged 12-59 months because of many factors including limited resource allocation, inadequate knowledge among caregivers on when and where to receive the supplementation, among others. Nutrition International (NI) baseline survey done in January 2020, provides the data below for Vitamin A Supplementation coverage within the County.

Table 4: Coverage data for VAS in Nakuru County

AGE	JULY-DEC 2018	JAN-JUNE 2019	JULY-DEC 2019	JAN-JUNE 2020
6-11months	48.0%	63.1	65.4	54.1
12-59months	29.9	60.4	35.4	15.3
6-59months	32	60.7	38.7	19.6

Source: (KHIS, 2020)

Iron is critical for motor and cognitive development. Children and pregnant women are especially vulnerable to the consequences of Iron deficiency. Anaemia during pregnancy increases the risk of death for the mother and low birth weight for the infant. Iron Folic Acid Supplementation (IFAS) coverage for Nakuru County is reflected in the table below showing a positive upward trend.

Table 5: IFAS Coverage in Nakuru County

YEAR	COVERAGE
2018	63.9%
2019	79.1%
2020 (Jan-June)	80.1%

Source: (KHIS, 2020)

1.6.5 Trends in overweight, obesity and diet-related non-communicable diseases (DRNCDs)

The Kenya 2015 STEPwise Survey, (MOH, 2015) confirmed an increasing rate of overweight/obesity and diet-related non-communicable diseases (DRNCDs) in adults. A total of 28 % of adults aged 18–69 years were either overweight or obese, with the prevalence in women being 38.5 % and men 17.5 %. Similar trends are seen when comparing the 2008–2014 KDHS. The proportion of women who were overweight increased from 25 % to 33 % and those who were obese increased from 7 % to 10 %. The prevalence of overweight or obesity is higher in urban areas (43 %) than in rural areas (26 %). In Rift Valley, an estimated 30% of adults were either overweight or obese; this can be used as a proxy indicator for Nakuru County. The County lacks population-based data for DRNCDs, however according to facility data and KHIS, hypertension and diabetes are among the top 10 leading causes of morbidity in the county.

1.7 Multisectoral sectors

1.7.1 WASH and nutrition

Proper sanitation and hygiene and safe drinking water can reduce under-nutrition and stunting in children by preventing diarrhoeal and parasitic diseases, and damage to intestinal development (environmental enteropathy). Further, insufficient, unsafe water close at the household level has many indirect effects on childcare and feeding practices especially for women and children, as a result of more time being spent covering long distances in search for water, coupled with traditional roles placing household hygiene and sanitation as women's responsibility. Where safe water is available to purchase from vendors, it is in limited quantity leaving little for good hygiene practices.

Water supply coverage in Nakuru County is at 66%. Hence, there is an immediate need to boost water supply in the county. The County government is committed to increasing water supply to its residents through the following strategies:

- Sink bore holes and construct water pans/dams and piping extensions for the supply of clean, Fluoride free water for domestic and agricultural use.
- Promote and invest in water harvesting techniques/technologies for the community including schools.
- Rehabilitate existing water works.
- Construct water pans in arid areas.
- Rehabilitate and desilt already existing dams.
- Enhance modern sewerage systems and promote effective sanitation programs.

Sanitation programs targeting both urban and rural areas have been established and coordinated through the Water, Sanitation and Hygiene inter agency coordinating committee (WASH – ICC).

The County scaled up open free defecation (ODF) villages from zero in 2013 to 326 in 2017 in a bid to improve sanitation. This will in turn have huge impact on human health and nutrition including diarrhoea, parasitic infections, and reduction in nutrition-related factors, such as low birth weight, stunting (low height for age) and severe wasting.

1.7.2 Agriculture, food security and nutrition

An estimated 243, 711 ha and 71, 416 ha of the Nakuru arable land are under food and cash crop farming, respectively. A significant number of farmers in the county have an average land holding of 0.77 hectares (that is about 1.9 acres) and the main crops produced in the county include: maize, beans, Irish potato, and wheat.

The County has a lot of potential in the horticulture industry especially in the floriculture sub-sector. In 2016, the County realized approximately 180,388 tons of maize valued at KSh. 2.91 Billion. For several years, maize production in Nakuru County has been declining due to a mix of factors such as prevalence of pest and diseases; climate risks; in addition to problems along the value chain. Nevertheless, Nakuru County has the potential to produce over 500,000 tons of maize if modern farming methods can be applied to increase production per unit area.

Gender inequalities in ownership and control of productive assets such as land are pervasive in the country. Only 7% of women own land alone and 39% of women own land (alone, jointly, or both) (KDHS, 2014). Though women contribute close to 80% labor in crop production, lack of ownership and control of productive assets such as land, influences their ability to produce nutritious foods or to control the income generated from the land to buy nutritious food. A report by OECD on developing countries provides evidence that links women lack rights and opportunities on land to an increase in levels of malnourished children.

Nakuru County is also endowed with a high capacity for livestock production. The main livestock reared include cattle, poultry, sheep, and goats. Dairy industry is the leading livestock enterprise.

About a third of people in the County do not have access to healthy and nutritious food. To improve livelihoods of the hundreds of thousands of people who solely depend on agriculture, the County Government is implementing the following measures to increase production, productivity as well as enhance value addition.

- Increasing productivity through addressing incidents of pests and diseases both in crops and livestock, in addition to diffusion of Good Agricultural Practices (GAP).
- Improving sanitary and phyto-sanitary measures in the County through working with various national government agencies such as the Kenya Plant Health Inspectorate Services (KEPHIS) Nakuru branch to ensure that farmers in Nakuru County have readily available high quality and disease-free planting materials;
- Involving youth and women in crucial projects that will transform their livelihoods
- Initiate various value addition measures and at the same time link farmers with markets that will pay them.

1.7.3 Education and nutrition

Malnutrition among school children may contribute to adverse health consequences such as non-communicable diseases, poor cognitive performance, psychological distress, and poor quality of life that may persist into adulthood. Young children with adequate nutrition, nurturing caregiving, and opportunities for early learning have the best chances of thriving hence the need for integration of nutrition in learning institutions.

There are 1,465 ECDE Centres in Nakuru; 771 of these are public while the rest 694 private. Enrolment in these child learning centres is 70,714 and 40,598, respectively. The 70,714 learners in public centres benefit from school feeding. Nutritional programs such as Vitamin A Supplementation, deworming and growth monitoring are targeted at learners in both public and private institutions.

Nakuru County has 1,077 primary schools with a total enrolment of 435, 819 pupils and 395 high schools with a total enrolment of 110,025 students. The learners in both primary and secondary schools receive nutrition education through the school health programs in the County hence contribute to improved household and child practices later in life when they became mothers

1.7.4 Social protection, gender, and nutrition

Social protection holds immense potential for improving nutrition sustainably by lifting people out of poverty and enhancing access to a greater quantity and diversity of food as well as health, sanitation, and education. It also addresses a range of basic, underlying, and immediate causes of malnutrition. However, social protection needs to be part of a carefully targeted, multi-sectoral approach tailored to reach the most vulnerable and embedded in the broader rural development agenda to ensure coverage of the poorest, most disadvantaged and marginalised populations. Such integration requires institutional mechanisms within and across relevant sectors – social protection, health, agriculture, education, and planning, among others – at all levels, to facilitate policy coordination and coherence which has been factored in this CNAP.

Poverty in Kenya has a gender dimension with women being poorer than men according to various economic surveys. According to the National Policy on Gender and Development (2019), the causes of poverty among women are structural and systemic hinging on the social cultural institutions that cause women to have lesser power over opportunities, resources, and assets. Yet women are key actors in the provision of good nutrition to themselves and their families through their roles as principal care givers and as income earners. Gender equality and economic empowerment of women and girls matters for nutrition because they have a bearing on the determinants of nutrition i.e., food security, care practices and health seeking behavior. A disempowered woman has less income to spend on nutrition. Empowering women is central to tackling malnutrition without which the effectiveness of nutrition sensitive programming would be compromised.

One of the main objectives of the social protection sector as articulated in the Nakuru CIDP 2018 – 2022, is to promote gender equality and the empowerment of women and girls and enhance inclusion and participation of youths and persons with disabilities in socio-economic development. This CNAP incorporates gender and social concerns that have an impact on livelihoods, economic risks, and nutrition outcomes.

1.7.5 Human resource for nutrition

There are insufficient human resource competencies needed to implement gender responsive nutrition-specific and nutrition-sensitive activities that can reduce undernutrition. There are currently inadequate nutrition staff to be deployed in sections of the hospital which requires clinical nutrition services. Additionally, there is need for training clinical nutrition specialties to offer services in these units as well as public health nutrition services including community nutrition as per the human resource norms and standards for the Ministry of Health (IHRIS, 2019). The department will further 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.

The County staffing situation on nutrition is presented below outlining the availability, requirements, and gaps across the 11 sub-counties based on number of facilities and their level of care:

Table 6: Nutrition human resources distribution in Nakuru County

Sub-County	Nutrition Staff Available	Nutrition Staff Required	Gaps
Nakuru West	10	112	102
Nakuru East	2	89	87
Nakuru North	2	74	72
Subukia	3	82	79
Naivasha	5	110	105
Gilgil	2	108	106
Rongai	4	127	123
Molo	4	98	94
Njoro	4	85	81
Kuresoi North	1	97	96
Kuresoi South	2	126	124
Total	**39**	**1,109**	**1,070**

Source: IHRIS, 2019

1.8 Constraints

The following factors collectively contribute to the low uptake of health and nutrition services within the County:

Constraints to delivery of nutrition services

- Inadequate resource allocation for nutrition
- Poor dissemination of policies
- Inadequate nutrition staff
- Low capacity for provision of specialized nutrition services (e.g., clinical nutrition, IMAM)
- Inadequate capacity among nutrition and health related staff to effectively integrate gender in nutrition –health related policies and interventions.

• Inadequate data collection and reporting tools and dashboards at County, Sub-County, and facility level to track nutrition indicators
• Limited quality data to support prioritization and appropriate decision-making by the relevant actors
• Inadequate Information Communication and Technology (ICT) infrastructure
• Inadequate anthropometric and medical diagnostic equipment at health facilities
• Lack of youth friendly centres to address knowledge gap and poor feeding practices among pregnant teens
• Frequent stock-outs of nutrition commodities (therapeutic and supplementary) due to parallel uncoordinated supply chains and poor data on consumption.
• No local production for therapeutic milk products (F100 and F75) leading to erratic supplies
• Inadequate storage facilities for nutrition commodities at the facility and county levels
• Increase in morbidity and mortality resulting from DRNCD, especially diabetes, hyper-tension, cancers, cardiovascular and chronic respiratory diseases
• Lack of coordinated approach to nutrition across sectors
• Poor linkages between health facilities and CHVs for community–based nutrition services
• Low community awareness of the available nutrition services

Constraints to adoption of optimal health and nutrition practices

• High levels of poverty and the gendered dimension of poverty with women and children being the most affected
• Dependency on rain fed agriculture
• Inadequate production of diversified food
• Poor post-harvest handling and storage leading to wastage and destruction of farm produce by rodents and pests
• Knowledge gap on maternal, infant, and young child nutrition among health workers and caregivers
• Poor dietary practices among children and women of reproductive age
• Inadequate male involvement on Infant and Young Child Feeding (IYCF)
• Prevalent alcoholism among the population (both men and women)
• Lifestyle changes especially among urbanized communities
• Insecurity due to inter-clan conflicts in some parts of the county
• Poor hygiene practices with low coverage of hand washing at critical times, low latrine coverage and few households consuming treated water
• Poor health seeking behaviours (e.g., low uptake of growth monitoring and Vitamin A supplementation after 9 months)
• Inadequate technical personnel
• Lack of coordinated approach across sectors

2 COUNTY NUTRITION ACTION PLAN (CNAP) FRAMEWORK

2.1 Introduction

Malnutrition is caused by factors which are broadly categorized as immediate, underlying, and basic.

The **immediate** causes of malnutrition include disease and inadequate food intake. This means that diseases can affect nutrient intake and absorption, leading to malnutrition; not taking sufficient quantities and the right quality of food can also lead to malnutrition.

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

Lastly, the basic causes of malnutrition appear at the macro level and include issues such as knowledge gap, politics and governance, leadership, infrastructure, and socio-cultural and financial resources. In general, nutrition specific interventions address the manifestation and immediate causes of malnutrition, whereas nutrition sensitive interventions address the underlying causes and enabling environment interventions for the basic causes of malnutrition. Further, food and nutrition security are characteristics of people's physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences. To achieve this, it is essential to understand the specific needs and vulnerabilities of women, men, girls, and boys across all diversities in the county. This will help design tailor-made nutrition programming while equitably building on citizens' capacities, knowledge, and experiences, and directing capacity, human and material resources as best needed.

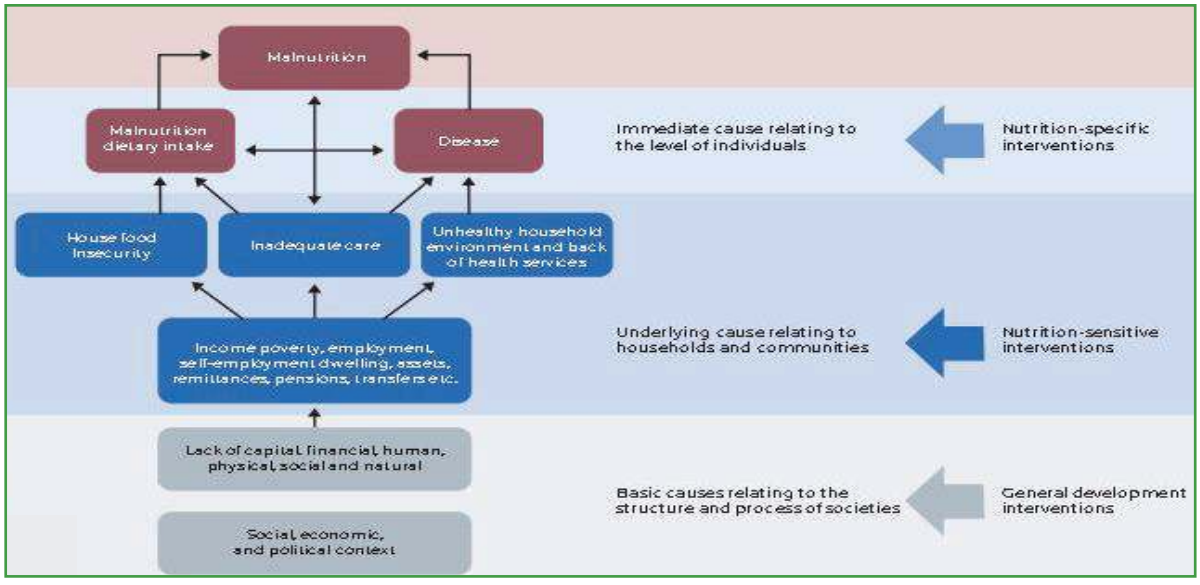

Figure 2: Conceptual framework

Source: (UNICEF, June 2015)

Nutrition is neither a sector nor a domain of one ministry or discipline. It is a multi-sectoral and multi-disciplinary issue with ramifications at the individual, household, community, national and global levels. Addressing all forms of malnutrition at all three levels of causation, (immediate, underlying, and basic), requires triple-duty actions that have the potential to improve nutrition outcomes across the spectrum of malnutrition through integrated initiatives, policies, and programmes. The potential for triple-duty actions emerge from the shared drivers behind different forms of malnutrition, and from shared platforms that can be used to address these various forms. Examples of shared platforms for delivering triple-duty actions include health systems, agriculture and food security systems, education systems, social protection systems, water, sanitation, and hygiene (WASH) systems, as well as nutrition sensitive policies, strategies, and programmes.

Strategies to integrate nutrition specific and nutrition sensitive interventions have been tested and proven effective according to case studies of successful multi-sectoral efforts to integrate actions on nutrition in Senegal and Colombia (Garrett, Natalicchio, & eds, 2010).

2.2 Vision

A healthy Nakuru County free from malnutrition.

2.3 Mission

To provide integrated quality health services for men and women, boys and girls across different ages and diversities in Nakuru County

2.4 Guiding Principles

The department is dedicated to espousing these core values as per the guiding principles for the operations in the County:

1. Customer-focused

To consistently endeavour to create enduring relationships with our customers; in so doing, our approach goes beyond standard people participation methods and makes their input an integral formalized part of setting county projects/program goals, performance measures, and standards. At the heart of our activities, is a County ready to provide solutions in the short and long term.

2. Professionalism

Competency and uncompromising service delivery is exuded in every facet of our work. We reward merit amongst colleagues while applying the most appropriate skills and competencies to serve our clients. We apply the same ethics and ethos with our stakeholders.

3. Integrity

Truthfulness and uprightness are an integral part of our operations. The Department shall advocate these firmly to all practices in every undertaking to the society.

4. Equity and equality

We approach our work as guided by principles of fairness and non-bias. The department is committed to equity, equality, inclusivity and non – discrimination in all its activities and interventions for all genders, ages, social status, ethnicities, or creeds.

5. Transparency and accountability

The department endeavours to act in a transparent, unequivocal, predictable, and understandable manner in all its businesses. We will remain accountable to our stakeholders and will acknowledge responsibility for our actions and decisions

6. Teamwork

Every person is important and has a part in development. We endeavour to build a workplace environment that cultivates person's uniqueness, encourages staff participation, collaboration and incorporation of diverse skills and capabilities.

7. Creativity and innovation

We promote an innovative culture and attitude; strive to apply innovative thinking and creativity. The department is open to new ideas and methods and encourages individuals to explore new opportunities to improve performance and results

2.5 National policy and legal framework for CNAP

The Constitution of Kenya states that every person has the right to be free from hunger and the right to adequate food of acceptable quality (Article 43c), and that every child has the right to basic nutrition (Article 53). Article 27 provides for equal treatment, equal opportunities for both men and women and freedom from discrimination based on race, sex, marital status, age, disability, among others.

The country has the significant responsibility of ensuring communities have access to good quality health care and individuals can live healthy lives. To achieve the goals set out in the Constitution and Vision 2030, Kenya has given legislative force to some key aspects of nutrition interventions including the mainstreaming of gender in all policies and programmes.

Legislation includes:
1. Mandatory salt iodization for the prevention and control of Iodine deficiency disorders
2. Food Drugs and Chemical Substances Act for mandatory fortification of cooking fats and oils, and cereal flours
3. The Breast Milk Substitutes (Regulation and Control Act) 2012 protects the benefits of breast feeding
4. Mandatory establishment of lactation stations at workplaces (Health Act Art 71 & 72)
5. The Food, Drugs and Chemical Substances Act (food labelling, additives, and standard
6. (Amendment) Regulation 2015 on trans fats) provides key legislation central to the control of DRNCDs
7. The Nutritionists and Dieticians Act 2007 (Cap 253b) determines and establishes a framework for the professional practice of nutritionists and dieticians

Monitoring compliance is even more critical in the light of devolution. The County's ability to implement and monitor the regulations is crucial and hence is considered within the scope of the CNAP. The County will have a key role in implementing, monitoring, and enforcing legislation.

2.6 CNAP Rationale

The CNAP has been developed to further accelerate and scale up efforts towards eliminating malnutrition as a significant public health problem in Kenya by 2030, focusing on specific achievements by 2025.

The three basic rationales for the action plan are:

I. The impact on health: improved nutrition status leads to a healthier population and enhanced quality of life.
II. The economic impact: improved nutrition and health make up the foundation for rapid economic growth; and
III. The ethical argument: optimal nutrition is a human right.

There is existing evidence that improving nutrition contributes to economic productivity, development, and poverty reduction by improving physical work capacity, mental capacity, and school performance. Improving nutrition is tremendous value for money as it reduces the costs related to lost productivity and health care expenditures.

Every dollar spent on nutrition in the first 1,000 days of a child's life can give a saving of an average USD45 and in some cases as much as USD166. "The returns to investments in nutrition have high benefit cost ratios, and that this should be a top development priority." (John, Harold, Jere R., Lawrence, & Susan, 18 September 2013). Investing in early nutrition is one of the best values for money development actions. Additionally, improved nutrition outcomes can have ripple effects across an individual's livelihood and productivity (World Bank, 2016)

2.7 CNAP objectives/purpose

The objective of the CNAP is to contribute to the national agenda for KNAP in accelerating and scaling up efforts towards the elimination of malnutrition in Kenya in line with Kenya's Vision 2030 and sustainable development goals, focusing on specific achievements by 2025. The key strategies that will be adopted in the implementation of CNAP will include

- Life-course approach to nutrition programming which is a holistic approach to nutrition issues for all population groups
- Gender mainstreaming towards ensuring consistent application of gender transformative approaches across all interventions in all sectors
- Coordination and partnerships targeting sectoral and multisectoral approaches to enhance programming across various levels and sectors,
- Integration which will consider the various platforms in place to deliver gender transformative nutrition responsive to the specific nutrition and health related needs of populations across different gender age and diversities, e.g., health centres, schools and at the community level.
- Capacity strengthening for implementation of nutrition services responsive to the specific needs of men and women across different ages and diversities targeting service providers and related systems
- Advocacy, communication, and social mobilization thus acknowledging that nutrition improvements require political goodwill for increased investments and raising population level awareness, their increased support and participation for improved food and nutrition security for all.

• Promoting equity and human rights especially among vulnerable and marginalized populations in effort to ensure that every person is free from hunger and have adequate food of acceptable quality including equitable access to quality health services.
• Resilience and risk-informed programming that focus on anticipating, planning, and reducing disaster risks to effectively protect persons, communities, livelihoods, and health
• Monitoring, evaluation, accountability, and learning (MEAL) hence promotion of use of the triple A (assessment, analysis & action) cyclic process to provide feedback, learn lessons and adjust strategy as appropriate
• Empowerment for sustainability of results – the need to ensure predictable flow of resources, develop technical and managerial capacity of implementers, motivate implementers, ensure vertical and horizontal linkages, and gradual exit when exiting an intervention.

2.8 CNAP development process

The CNAP development process was widely consultative with stakeholders from all units of the Department of Health, representatives from other county departments in (i.e., Health, Agriculture, Education, Water, Gender and Social Services), academia as well as development partners and Civil Society Organizations (CSOs).

The process ensured that the plan is evidence-informed and recognizes successes, challenges and lessons learnt from the implementation of nutrition activities within the county. The process also ensured that the CNAP is results-based and provides a common results and accountability framework for performance-based Monitoring and Evaluation (M&E).

2.9 Target audience for CNAP

The CNAP's target audience includes health care planners and policymakers at the national and county levels, global, national, and county decision-makers, nutrition specific and sensitive sectors, nutrition officers and health managers at all levels, donors, development partners, NGOs, CSOs, FBOs, the private sector, academia, research institutions, the media, and the Kenyan public at large. This will enable stakeholders to understand what the county government is doing to ensure optimal nutrition for all and what they can do individually to contribute to the effort.

2.10 Gender mainstreaming in the Nakuru CNAP

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

Gender inequalities are a cause as well as an effect of malnutrition and hunger (Nutrition International, 2018). Higher levels of gender inequality are associated with higher levels of undernutrition, both acute and chronic undernutrition (FAO, 2012). Studies examining the relationship between gender inequality, nutrition and health have consistently shown that gender-related factors influence nutrition and health related outcomes (M. Ndiku et al, 2010).

In any given society, men and women across different ages and diversities equally have a role to play in realizing good nutrition and health. However, the distinct roles, responsibilities 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 (R. Oniang'o & E. Mukudi, 2002).

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

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

In order to achieve effective and sustainable nutrition and health outcomes, this CNAP seeks to contribute to ongoing efforts at the county of tackling gender inequality by targeting to include both men and women across different ages and diversities throughout its development, implementation, monitoring and evaluation process. This is aimed at promoting an equal reach of the nutrition messages and services across the genders. It also seeks to promote a more equal distribution of gender roles and responsibilities by advocating for increased male involvement in care work and other household work while equally advocating for greater and meaning involvement of women in decision making and other socio-economic opportunities. Using gender transformative BCC materials, this CNAP targets to transform community attitudes towards nutrition related roles and responsibilities. Gender sensitive indicators in the M&E framework provide for collection, analysis, reporting and use of sex disaggregated data to inform gender transformative programming.

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

3.1 Introduction

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

Table 5: Prioritized KRAs per focus area

CATEGORY OF KRAs BY FOCUS AREA	KEY RESULT AREAS (KRAs)
Nutrition specific interventions	1. Maternal, Infant, Young Child Nutrition (MIYCN) scaled up
	2. Nutrition of older children and adolescents promoted
	3. Prevention, control, and management of Micronutrient Deficiencies scaled-up
	4. Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) in the life course scaled-up
	5. Clinical nutrition and dietetics in disease management including HIV and TB strengthened
	6. Integrated management of malnutrition and nutrition in emergencies strengthened
Nutrition sensitive interventions	7. Promote and scale up nutrition in nutrition sensitive sectors (Agriculture, Education (ECDE), WASH and social protection)
Enabling environment interventions	8. Sectoral and multi-sectoral nutrition governance, coordination and legal/regulatory frameworks, nutrition information systems, learning and research strengthened
	9. Advocacy, Communication and Social Mobilization (ACSM) strengthened
	10. Supply chain management for nutrition commodities and equipment strengthened

3.2 Theory of Change and CNAP logic framework

The "Theory of Change" (ToC) is a specific type of methodology for planning, participation, and evaluation that is used to promote social change – in this case nutrition improvement. The ToC outlined below (Figure 3), defines long-term goals in this case realizing a healthy Nakuru County free of malnutrition by providing integrated quality health services for men and women, boys and girls across different ages and diversities in the County. It then goes ahead to map backwards to identify necessary pre-conditions.

It describes and illustrates how and why a desired change is expected to happen in a context. The pathway of change for the Nakuru CNAP is therefore best defined through the theory of change. The ToC was used to develop a set of result areas, that if certain strategies are deployed to implement the 10 prioritized activities, then a set of results which in extension contribute to the national and global nutrition impact results would be realized and if at scale, contribute to the improved nutritional status of Nakuru residents.

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

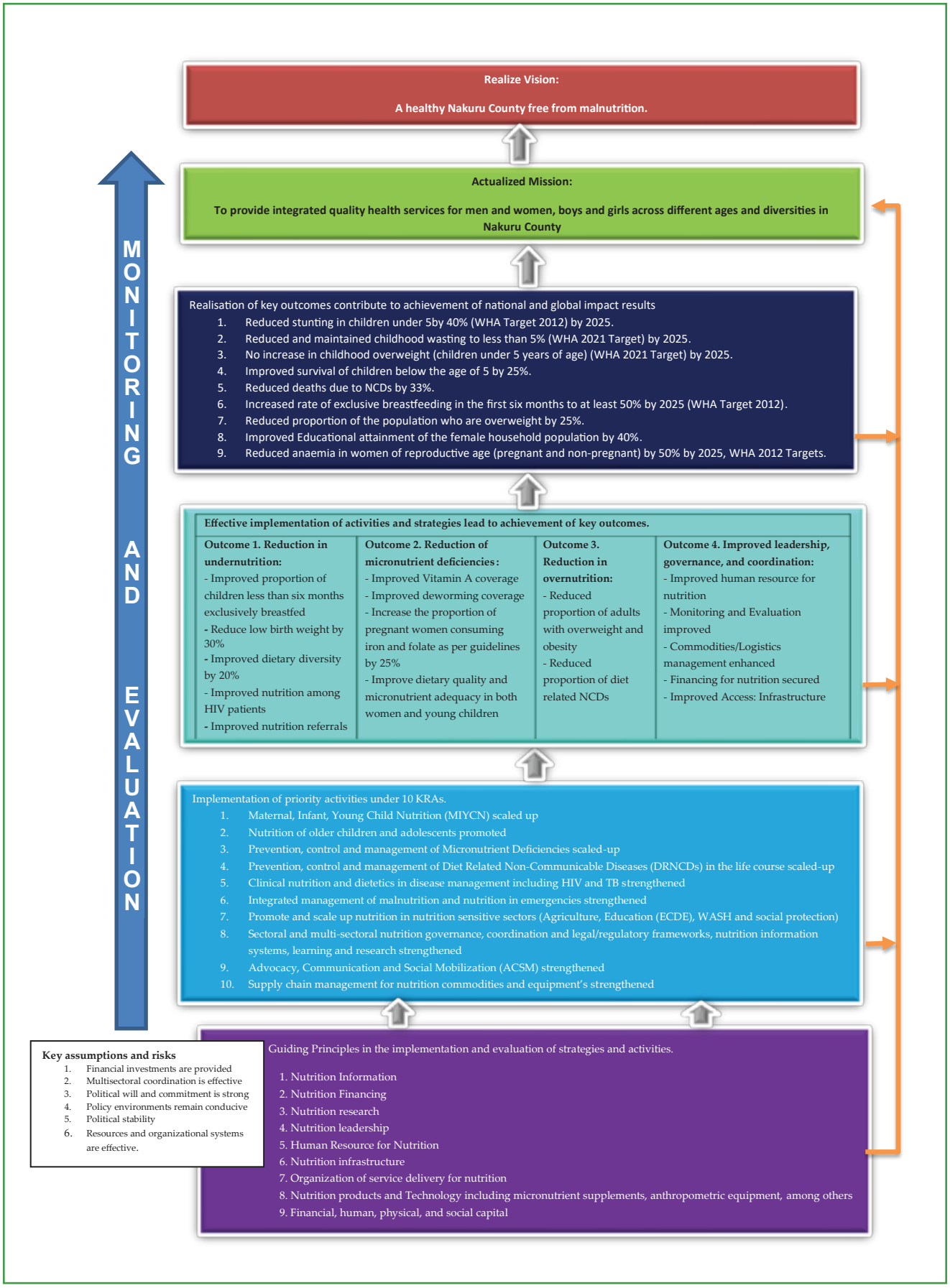

Figure 3: The Nakuru CNAP theory of change

3.3 Key Result Areas with corresponding outcomes, outputs, and activities

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

Expected outcome

To improve the nutrition status of women of reproductive age (15-49 years) and young children (0-59 months)

Output 1

Strengthened policy, legal and regulatory environment at county and sub county level for delivery of quality MIYCN services

Activities

- Sensitize and disseminate MIYCN policies/guidelines to CHMT, SCHMT and facility in-charges
- Adopt and customize complementary feeding strategy specific to Nakuru County

Output 2

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

Activities

- Sensitize CHMT, SCHMT and facility health management team on BFHI.
- Train male and female HCWs on BFHI
- Establish gender, age, and diversity inclusive BFHI committees in implementing health facilities
- Carry out facility baseline assessment for BFHI.
- Carry out continuous health facility continuous medical education (CME) on BFHI
- Carry out continuous self-assessments of the facilities on BFHI
- Carry out external BFHI assessment.
- Carry out mentorship and on-job training (OJT) on BFHI by CHMT and SCHMT
- Print and distribute monitoring and reporting tools for BFHI

Output 3

Scale up implementation of baby friendly community initiative (BFCI) at community unit level

Activities

- Sensitize CHMT, SCHMT and health facility in charges on BFCI.
- Train male and female HCWs on BFCI
- Establish gender, age, and diversity inclusive BFCI committees at community unit level.
- Carry out gender integrated BFCI baseline assessment at community unit level
- Train male and female CHVs on CBFCI
- Carry out continuous self-assessments at community level on BFCI
- Carry out external BFCI assessment.
- Carry out mentorship and OJT to HCWs on BFCI by CHMT and SCHMT
- Conduct BFCI stakeholder sensitization in selected implementing sub counties
- Conduct bi-monthly CMSG meetings in selected implementing community units
- Carry out mapping of households for establishment of mother-to-mother support groups (MTMSG) in selected implementing community units

- Carry out monthly MTMSG meetings at community unit level
- Carry out targeted home visits by CHVs
- Print and distribute monitoring and reporting tools for BFCI

Output 4
Strengthened Monitoring & Evaluation for quality delivery of MIYCN services

Activities
- Carry out quarterly data review meetings for MIYCN interventions
- Carry out quarterly data quality audits for MIYCN services
- Carry out support supervision for MIYCN services
- Carry out monthly submission and verification of MIYCN reports

Output 5
Strengthened growth monitoring and promotion (GMP) in health facilities

Activities
- Sensitize CHMT and SCHMT on the new WHO growth standards.
- Train male and female HCWs on the new WHO growth standards
- Carry out CMEs at health facility level on GMP
- Carry out nutrition assessment for children aged 0-59 months
- Carry out health and nutrition education / counselling to caregivers of children aged 0-59 months
- Procure and distribute anthropometric equipment's to maternal child health clinics
- Print and distribute reporting tools for GMP

Output 6
Strengthened implementation for securing a friendly breastfeeding environment at workplaces

Activities
- Sensitize CHMT and SCHMT on implementation framework for securing a friendly breastfeeding environment at workplace
- Train/sensitize male and female health care workers on implementation framework for securing a friendly breastfeeding environment at workplace
- Sensitize male and female CHVs and the community on implementation framework for securing a friendly breastfeeding environment at workplace using effective communication channels
- Sensitize key stakeholders in formal and informal sectors on implementation framework for securing a friendly breastfeeding environment at workplace
- Carry out CMEs at health facility level on implementation framework for securing a friendly breastfeeding environment at workplace
- Establish lactation rooms/breastfeeding corners in health facilities

Output 7
Strengthened implementation of Breastmilk substitute (regulations and control) Act, 2012 at County level

Activities

- Sensitize CHMT and SCHMT on BMS Act,2012
- Sensitize private sector on BMS Act,2012
- Train/sensitize male and female HCWs on the BMS implementation framework
- Train PHOs, nutritionists, Police officers on monitoring and enforcement of the BMS Act
- Carry out continuous monitoring, enforcement, and reporting of BMS Act,2012

Output 8

Scale up advocacy communication social mob and resource mobilization for MIYCN

Activities

- Identify and engage male and female key influencers across different ages and diversities in MIYCN activities and promote increased engagement of men by sensitizing them on their important role in promoting and supporting optimal uptake of MIYCN practices.
- Advocate for adaptation of Health Act, 2017, Workplace support for breastfeeding at county level in both public and private workplaces
- Advocate for oversight, monitoring and enforcement of Breast Milk Substitute (BMS) Act, 2012
- Collaborate with print and electronic media to scale up gender transformative MIYCN messaging at all levels

3.3.2 KRA 2: Nutrition of older children and adolescents promoted

Expected outcome

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

Output 1

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

Activities

- Sensitize and disseminate the relevant policies for older children and adolescents to the School stakeholders, County and Sub County Health Management Teams
- Identify and sensitize male and female key influencers, policy makers, role models, and nutrition champions across different ages and diversities on nutrition for older children and adolescents

Output 2

Reduction of marketing of unhealthy foods among older children and adolescents

Activities

- Sensitize school stakeholders on marketing and promotions of healthy foods within the school: enough safe and nutritious foods in school
- Create awareness on healthy diets, marketing, and promotions within the school: enough safe and nutritious foods in school to the older children and adolescents through school clubs, out of school youth groups and other youth forums
- Control marketing of unhealthy foods for older children and adolescents within the school environment

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

Activities
- Train key stakeholders on healthy diets and physical activity for older children and adolescents
- Sensitize households, caregivers on healthy diets and physical activity using context-specific communication channels in both rural and urban setups targeting men and women, boys, and girls
- Integrate messaging on healthy diets and physical activity in the school health programme targeting older children and adolescents
- Collaborate with MoALF&C on establishment of diverse food production (crops, livestock, insects, and fisheries) by households
- Promote collaboration with other sector interventions to promote good nutrition of older child and adolescent (MoE, MOALF&C, MoH, Industry, Finance, Gender, Sports, and Social protection) and the private sector

Output 4
Strengthened joint Monitoring and Evaluation of nutrition activities targeting the older children and adolescents

Activities
- Carry out joint quarterly support supervision of nutrition activities targeting the older children and adolescents by CHMT and SCHMT
- Carry out quarterly submission of gender, age disaggregated reports on interventions carried out for older children and adolescents

3.3.3 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
Strengthened enabling environment for prevention, control, and management of micronutrient deficiency in the county

Activities
- Sensitize and disseminate micronutrient policies and guidelines to CHMT and SCHMT and MOE. (Vitamin A, IFAS, WIFs, MNPs, Food Fortification)
- Sensitize and disseminate the food fortification strategy to CHMT and SCHMT
- Sensitize and disseminate the National Food Fortification Strategy to both male and female small and medium scale flour millers

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, dewormers, IFAS, MNPs and Zinc)
- Carry out bi-annual Vitamin A supplementation for both boys and girls aged 6-59 months in health facilities, ECDs, outreaches and using door to door visits
- Carry out weekly iron and folic acid supplementation for adolescent girls in schools
- Carry out health talks in facilities on IFAS, Vitamin A, dewormers and MNPs supplementation targeting male and female caregivers and other clients
- Carry out MNP supplementation for both boys and girls aged 6-23 months as per national guidelines
- Carry out Iron and folic acid supplementation to all pregnant women

Output 3

Strengthened documentation system for monitoring and reporting of micronutrient program

Activities

- Carry out supportive supervision for micronutrient program by CHMT and SCHMT.
- Incorporate micronutrients program in the quarterly data review meetings.
- Print and distribute gender sensitive micronutrient monitoring and reporting tools to health facilities.

Output 4

Promote uptake of micronutrient supplementation through context specific SBCC strategies

Activities

- Adapt, print, and distribute gender transformative behaviour change communication (BCC) materials on micronutrients.
- Carry out road shows, radio talks targeting community members of different genders, age, and diversities to pass micronutrient messages

Output 5

Increased awareness among health care workers and school stakeholders on prevention, control, and management of micronutrient deficiencies

Activities

- Train male and female HCWs on Vitamin A supplementation using the national guidelines
- Train male and female HCWs on IFAS using the national guidelines
- Train male and female teachers on weekly iron folic supplementation (WIFS)
- Train male and female HCWs on MNPs using the national guidelines
- Sensitize male and female CHVs on IFAS, MNPs, Vitamin A and Dewormers

Output 6

Strengthened production, consumption, and compliance of fortified foods

Activities

- Train small and medium scale millers of both gender on food fortification
- Carry out routine market and industry level surveillance of fortified foods to increase compliance with fortification standards by public health officers
- Carry out routine monitoring and evaluation of food fortification program.

• Train male and female PHOs on food fortification and market surveillance.
• Carry out annual salt iodization monitoring at county level
• Sensitize male and female HCW on the salt iodization monitoring

Output 7
Increased dietary diversity and Bio-fortification of food

Activities
• Sensitize community on increased production, preservation, and consumption of diverse and bio fortified foods using context specific communication channels targeting men and women across different ages and diversities
• Train/Sensitize male and female CHVs on dietary diversity and biofortified foods

3.3.4 KRA 4: Prevention, control and management of diet related non-communicable diseases (DRNCDS) among the population scaled-up

Expected outcome
Prevention, control, and management of DRNCDs improved

Output 1
Good nutrition practices, lifestyle and physical activity in prevention, control, and management of DRNCDs promoted

Activities
• Sensitize community through gender, age, and diversity inclusive community forums (chief barazas, churches, mosques, women groups, youth groups etc.) on healthy diets and physical activity.
• Create awareness among community members of different genders, age, and diversities on nutrition in the prevention, control, and management of DRNCDs using locally available channels e.g., posters, pamphlets, radio, TV, and other social platforms
• Collaborate with other stakeholders to support and participate in health awareness days e.g., world diabetes day (WDD) and WKD,
• Advocate for establishment of gender inclusive wellness programs at facility and community level.
• Carry out nutrition education on importance of physical activity through gender, age, and diversity inclusive community forums

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

Activities
• Carry out gender, age and diversity sensitive nutrition assessment, counselling, and support services to DRNCDs clients in health facilities
• Conduct routine gender and age inclusive nutrition screening for DRNCDs in churches, Huduma Centre and during health awareness days
• Procure and distribute relevant nutrition equipment for NCD clinics
• Collaborate with the clinical team to establish and strengthen existing gender inclusive DRNCDs support groups
• Carry out nutrition education and counselling to male and female DRNCDs clients in the support groups

Output 3
Increased awareness among health care workers on DRNCDs

Activities
- Train male and female health care workers on healthy diets and physical activity
- Conduct CMEs on nutrition management in DRNCDs in health facilities

Output 4
Improved policy and legal environment for nutrition in NCDs

Activities
- Sensitize and disseminate the national guidelines on healthy diets and physical activity to CHMT and SCHMTs
- Adapt existing national standards and regulations on healthy diets, NCDs and physical activities
- Adapt national legislations on advertising, packaging, labelling, and marketing of foods and beverages

Output 5
Improved monitoring and evaluation for diet related NCDs

Activities
- Conduct quarterly support supervision for facilities with NCD clinics to assess nutrition integration
- Monthly submission of reports on DRNCDs
- Integrate gender sensitive nutrition data for DRNCDs during quarterly data review meetings

3.3.5 KRA 5: Clinical nutrition and dietetics in disease management and nutrition in HIV /TB management 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 adapted and implemented

Activities
- Sensitize and disseminate guidelines, strategies and policies on clinical nutrition and dietetics: guidelines for nutritional management of patients in disease and illness; home-based care guidelines for nutrition; guidelines on therapeutic food production units' manual to CHMTs SCHMTs and Facility in charges
- Adapt and disseminate standard operating procedures (SOP) for nutrition and dietetics: protocol on nutrition management in diseases and conditions; inpatient feeding protocol to CHMTs SCHMTs and Facility in charges
- Adapt and disseminate clinical nutrition tools: screening, inter-facility referral, patient feeding monitoring and service quality management tools to CHMTs SCHMTs and Facility in charges

• Adapt and disseminate basic training and patient safety package for clinical nutrition and dietetics to CHMTs SCHMTs and Facility in charges

Output 2
Improved quality of clinical nutrition and dietetics care in management of diseases

Activities
• Train male and female nutritionists on clinical nutrition and dietetics
• Carry out CMEs on clinical nutrition and dietetics at health facility level
• Sponsor male and female nutritionists to be trained on specialization in clinical nutrition and dietetics (oncology, renal, paediatrics, critical care)
• Sponsor male and female nutritionists to be trained on short courses for clinical nutrition and dietetics
• Carry out OJTs, mentorship to frontline health care workers on clinical nutrition and dietetics by the CHMT and SCHMTs
• Advocate for exchange programs to learn best practices in clinical nutrition and dietetics in level 6 health facilities

Output 3
Improved clinical nutrition and dietetics service delivery

Activities
• Sensitize male and female nutritionist and other healthcare workers on nutrition care process.
• Carry out gender, age and diversity sensitive nutrition assessment, counselling, and support (NACS) to all clients in the health facilities
• Refer clients to other service delivery points within the health facility where applicable
• Conduct monthly clinical nutrition data review meetings with sub county teams
• Sensitize health care workers on in-patient feeding protocols and SOPs for Clinical Nutrition and dietetics
• Adapt/develop SOPs for Clinical Nutrition
• Carry out sensitization of SOPs to SCNCs
• Carry out sensitization of clinical nutrition SOPs to all facilities offering in-patient care
• Sensitize HCWs on basic training and patient safety package for clinical nutrition and dietetics
• Assess quality of nutrition care in facilities by County and Sub-County nutrition coordinators
• Advocate for increased resource allocation for clinical nutrition and dietetics at county level targeting key decision makers

Output 4
Supply chain for clinical nutrition and dietetics improved

Activities
• Procure and distribute clinical nutrition assessment equipment and tools to health facilities
• Procure and distribute nutrition therapeutic and supplementary commodities to health facilities
• Procure and distribute enteral and parenteral commodities to health facilities
• Procure and distribute clinical nutrition reporting tools to health facilities

Output 5
Improved food procurement, supply, hygiene, and safety in health care institutions

Activities
- Establish/activate in-patient feeding committees having inpatient care
- Procure and distribute food preparation and feeding equipment for management of special medical conditions
- Establish functional food safety inspection committees in health care institutions

Expected outcome 2: Nutrition in HIV and TB promoted
Reduced impact of HIV-related co-morbidities among people living with HIV through targeted nutrition therapy

Output 1
Improved routine screening for nutrition related problems and referral for all PLHIV and TB patients

Activities
- Train male and female HCWs on Nutrition in HIV and TB using national Guidelines to provide patient-focused nutrition therapy for paediatric patients and adolescents infected with HIV or TB
- Carry out CMEs on nutrition management in HIV and TB in healthcare facilities
- Conduct OJTs, mentorships and support supervisions in Nutrition Assessment, Counselling and Support (NACS) in HIV and TB by county and sub county health management teams
- Hold quarterly technical working group (TWG) meetings with relevant stakeholders on Nutrition in HIV and TB
- Offer comprehensive nutrition assessments, counselling and support in all HIV, TB, MNCH service points to reduce missed opportunities and improve service uptake and retention into care

Output 2
Strengthened maternal infant and young child feeding (MIYCN) in prevention of mother to child transmission (PMTCT) of HIV

Activities
- Carry out continuous updates on MIYCN in PMTCT in reference to the national guidelines to HCWs.
- Carry out nutrition education during PMTCT support group meetings.
- Carry out nutrition assessment among highly exposed infants (HEI) both at the health facility and community level.
- Carry nutrition education to both male and female caregivers of HEI
- Refer and support MAM and SAM HEIs

Output 3
Strengthened nutrition monitoring and evaluation activities in CCCs and TB

Activities
- Conduct quarterly nutrition DQA in CCCs and TB clinics
- Integrate nutrition data from CCC and TB clinics in quarterly data review meetings.

• Link and refer malnourished HIV TB clients to livelihood and social protection programs at community level

Output 4
Strengthened integration of nutrition interventions for home-based care at community level for PLHIVs towards the 90.90.90

Activities
• Adapt a series of small doable actions that enhance dietary diversity and physical exercises at household level for HIV and TB patients
• Sensitize male and female CHVs and other community resource persons targeting both genders across different ages and diversities to promote healthy and sustainable lifestyles at household level
• Disseminate key context-specific nutrition messages that promote positive lifestyles and behaviour for HIV /TB patients
• Conduct outreach, referrals, and linkage systems to involve all community actors and optimize identification and linkage of PLHIV and TB patients with nutrition care and management

3.3.6 KRA 6: Integrated management of acute malnutrition and nutrition in emergencies strengthened

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

Output 1
Policy, standards, and guidelines for the IMAM program adapted and implemented

Activities
• Disseminate guidelines, strategies, treatment protocols and standard operating procedures (SOP) to CHMTs, SCHMTs

Output 2
Capacity enhanced for IMAM Service delivery and programming

Activities
• Train and disseminate IMAM guidelines to male and female healthcare workers.
• Conduct targeted Mentorships, CMEs, and OJTs on IMAM in health facilities
• Scale up facilities offering IMAM services
• Print and distribute BCC materials for IMAM program
• Support the necessary training based on emerging evidence and continuous capacity-building on IMAM
• Carry out nutrition assessment for children under IMAM program in health facilities
• Carry out nutrition education and counselling for male and female caregivers for children under IMAM program
• Carry out nutrition support for children under the IMAM program

Output 3
Strengthened IMAM active case findings and referrals

Activities
- Sensitize male and female CHVs on IMAM
- Carry out community screening of children under five years and refer MAM and SAM cases to link health facilities
- Refer MAM and SAM cases from facility to community for continuous monitoring

Output 4
IMAM commodity supply chain strengthened at county level

Activities
- Procure and distribute nutrition IMAM commodities
- Conduct quarterly nutrition commodity end-user supply monitoring.
- Train male and female healthcare workers on logistic management information system (LMIS) for IMAM program
- Reprint and distribute nutrition data capture and reporting tools for IMAM program

Output 5
IMAM programme performance monitored, and quality of services improved

Activities
- Conduct quarterly nutrition support supervision for IMAM interventions
- Support quarterly nutrition data and quality audits for IMAM program
- Conduct joint multidisciplinary support supervision using the HiNi OJT
- Monitor adherence to IMAM programme SOPs, guidelines and protocols by health and nutrition workforce by CHMT and SCHMT
- Conduct IMAM programme performance reviews – cure, defaulter, death, coverage (linkage with M&E)
- Promote appropriate documentation of related research, best practices, and learning

Output 6
Strengthened partnerships including public–private partnership (PPP) to improve access and coverage of IMAM services and linkages with other interventions

Activities
- Use available mechanisms for coordination of IMAM to link IMAM services with other programmes (WASH, livelihood, social protection, and food security).
- Advocate for Public Private Partnership in the implementation of IMAM.

Expected outcome 2: Nutrition in emergencies strengthened
Improved multi-level and multisectoral capacity for risk preparedness, reduction, and mitigation against impact of disasters on population's nutrition and health

Output 1
Strengthened enabling environment, coordination and partnerships for integrated preparedness and response initiatives to improve nutrition in emergencies

Activities
- Disseminate policy and guidelines on nutrition in emergencies to key decision makers, CHMT and SCHMT.

• Advocate for inclusion of gender sensitive nutrition interventions in the agenda in the emergency, preparedness, and response.
• Map key stakeholders who are involved in nutrition emergency.
• Participate in disaster management response teams at county and sub county levels
• Establish and activate nutrition task force for emergencies
• Hold quarterly task force meetings for nutrition in emergency

Output 2
Strengthened preparedness capacity for the nutrition sector

Activities
• Train male and female HCW on MIYCN-E
• Sensitize male and female CHVs on MIYCN-E
• Train male and female HCWs on IMAM surge kit
• Carry out continuous nutrition messaging targeting the vulnerable groups (PLW, Children under 2 years, people with pre-existing conditions, elderly, OVCs etc) and the entire population
• Participate in joint planning and implementation meetings with other sectors on integrated preparedness and risk reduction in nutrition
• Conduct joint resource mobilization activities with other sectors on integrated preparedness and risk reduction
• Adapt and implement of IMAM surge kit
• Participate in stakeholders on disaster risk reduction
• Adapt national SOPs for emergency response; finalize guidelines on linkage of nutrition with livelihood programmes

Output 3
Improved access to timely multi-sectoral high-impact interventions to populations affected by emergencies to prevent deterioration of nutritional status and avert excess morbidity and mortality

Activities
• Procure contingency commodities for emergency response
• Develop/review county nutrition disaster preparedness and response plan
• Develop county and sub county nutrition contingency plans
• Carry out gender, age and diversity sensitive nutrition assessment during emergencies using the MIYCN-E rapid assessment tools to adapt response to the context
• Disseminate nutrition assessment findings to stakeholders for decision making
• Activate emergency coordination for nutrition response monitoring
• Optimize gender responsive nutrition service delivery approaches including outreach services in hard-to-reach areas, affected urban areas
• Ensure access to high-impact nutrition interventions in emergencies

3.3.7 KRA 7: Promote and scale up nutrition in nutrition sensitive sectors (Agriculture, Education in ECDE, Wash & Social protection)

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

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

Activities
- Hold joint strategic planning meetings with MoH, MoALF&C, MoW, MoE and other stakeholders for nutrition-sensitive agricultural production
- Carry out joint sensitization fora for stakeholders on Agri- nutrition in collaboration with Agriculture
- Carry out joint sensitization fora for stakeholders and disseminate food and nutrition security policy in collaboration with Agriculture
- Hold joint feedback sessions with MoH, MoALF&C, MoW, MoE and other stakeholders
- Participate in Agriculture sector stakeholder's coordination fora

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

Activities
- Sensitize male and female extension workers and CHVs on diversified food production strategies, processing, preservation, and storage
- Sensitize community on diversified food production strategies, processing, preservation, and storage targeting men and women across different ages and diversities
- Establish kitchen garden sites at selected health facilities to act as demonstration sites
- Advocate for establishment of kitchen garden and rearing of small livestock at household level

Output 3
Utilization/ consumption of safe, diverse, and nutritious food promoted

Activities
- Sensitize stakeholders in agriculture and health on food composition tables for decision making
- Carry out community trainings and demonstrations on food utilization through gender, age, and diversity inclusive community fora (farmer to farmer groups, mother to mother, father to father groups)
- Sensitize community on food safety and hygiene along the value chain using context specific communication channels targeting men and women across different ages and diversities
- Sensitize stakeholders on food safety and hygiene along the value chain
- Sensitize local food processors on blending initiatives including fortification along the value chain
- Carry out community trainings and demonstrations on energy saving technologies through gender, age, and diversity inclusive community fora (farmer to farmer groups, mother to mother, father to father groups)
- Carry out community trainings and demonstrations on meal planning through gender, age, and diversity inclusive community fora (farmer to farmer groups, mother to mother, father to father groups)
- Adapt and disseminate gender, age and diversity responsive Social behaviour Change and Communication (SBCC) strategy for increased consumption of nutritious foods and improved dietary diversity (including fortified foods)

• Advocate for nutrition sensitive agricultural production
• Sensitize decision makers in the agriculture department and stakeholders on nutrition sensitive agriculture food systems

Output 4
Strengthened joint Monitoring and Evaluation in Agri-nutrition

Activities
• Carry out joint quarterly support supervision of Agri-nutrition activities with MOA
• Carry out quarterly submission of reports

Expected Outcome 2: WASH
Nutrition integrated into WASH policies, strategies, plans and programmes

Output 1
Optimal WASH practices promoted

Activities
• Carry out awareness/promote use of potable water /water treatment and safe water storage in the health facilities, schools and households through gender, age, and diversity inclusive community forum during nutrition sessions
• Carry out awareness/promote hand washing at critical times in the health facilities, schools and households through gender, age, and diversity inclusive community forums during nutrition sessions
• Carry out awareness/ promote food safety and hygiene in the health facilities, schools and households through gender, age, and diversity inclusive community forums during nutrition sessions
• Carry out awareness /promote environmental hygiene in the health facilities, schools and households through gender, age, and diversity inclusive community forums during nutrition sessions, including special needs related to menstrual hygiene
• Carry out awareness /promote household waste management in the health facilities, schools and households through gender, age, and diversity inclusive community forums during nutrition sessions
• Carry out awareness /promote proper latrine use and proper disposal of diapers/sanitary pads in the health facilities, schools and households through gender, age, and diversity inclusive community forums during nutrition sessions

Output 2
Collaboration with relevant stakeholders on WASH strengthened

Activities
• Hold joint strategic planning meetings with WASH stakeholders
• Advocate for protection of water sources and regular water treatment quality checks
• Participate in WASH stakeholder's coordination forum
• Participate in celebration of WASH related thematic days celebrations (world water day, latrine day)

Output 3
Strengthened joint Monitoring and Evaluation in WASH activities

Activities

- Carry out joint quarterly support supervision of WASH activities with public health department
- Carry out quarterly submission of integrated WASH and nutrition intervention reports

Expected Outcome 3: Nutrition in the education sector strengthened

Nutrition mainstreamed in education sector policies, strategies, and action plans.

Output 1

Capacity of ECDE teachers on Nutrition Assessment, Vitamin A supplementation, deworming and referrals improved

Activities

- Sensitize male and female ECDE teachers on nutrition assessments, Vitamin A supplementation and deworming in schools
- Carry out bi-annual Vitamin A supplementation and deworming in ECDE centres in collaboration with teachers
- Conduct bi-monthly nutritional status assessments in ECDEs in collaboration with ECDE teachers
- Carry out referrals of sick and malnourished children to link health facilities

Output 2

Policies, strategies, standards and guidelines on nutrition and physical activity in schools and other learning institutions adapted and implemented

Activities

- Sensitize and disseminate the School Feeding programme guidelines to County and Sub county Education managers
- Sensitize and disseminate the School Feeding programme guidelines to ECDE head teachers and teachers
- Develop and disseminate menus for the ECDEs schools in collaboration with ECDE teachers
- Advocate for establishment of school kitchen gardens in schools in collaboration with the department of agriculture
- Advocate for support of the School feeding programmes to the County key decision makers (Education, Health, Agriculture, & County Assembly)
- Participate in ECDEs stakeholder's coordination forums

Output 3

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

Activities

- Sensitize stakeholders including, curriculum support officers, food service providers and handlers, Parent–Teacher Associations (PTA) on healthy and safe food environment.
- Advocate for improved access to safe and enough water, and adequate WASH services in schools and other learning institutions

Output 4

Strengthened joint Monitoring and Evaluation in integrated Nutrition School activities

Activities
• Carry out joint quarterly support supervision of integrated Nutrition School activities with MOE
• Carry out quarterly submission of reports

Expected Outcome 4: Nutrition in social protection programmes promoted
Integration of nutrition in social protection programmes strengthened

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

Activities
• Hold joint planning meetings with social services and other relevant stakeholders
• Advocate for inclusion in nutrition indicators into social services programmes
• Advocate for social safety nets in times of crisis
• Participate in social services coordination mechanisms
• Conduct a situation analysis on status of nutrition and health for the vulnerable groups together with the stakeholders
• Adapt and disseminate targeting criteria for nutrition in social protection programmes; cash transfers, hunger safety nets, and others to CHMT, SCHMT and other health care workers

Output 2
Nutrition education and promotion into social services programmes and Child Care Institutions (CCIs) promoted

Activities
• Sensitize (a) the public and b) management of institutions of vulnerable persons and correction facilities including social services staffs on nutrition for vulnerable groups (elderly homes and street children homes)
• Sensitize male and female HCWs on nutrition for vulnerable groups
• Carry out nutrition education & counselling targeting the vulnerable groups in collaboration with social services and agriculture

Output 3
Strengthened joint monitoring and evaluation of integrated nutrition social services activities

Activities
• Carry out joint quarterly support supervision of integrated nutrition social services activities with county department of social services
• Carry out quarterly submission of reports

3.3.8 KRA 8: Sectoral and multisectoral nutrition governance, coordination, legal/regulatory frameworks, leadership and management Nutrition Information Systems, learning and research strengthened

Expected Outcome 1
Efficient and effective nutrition governance, coordination, and legal frameworks in place

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

Activities
- Map all nutrition partners and stakeholders from both public and private sectors within the County
- Establish a multi sectoral platform (MSP) for nutrition
- Conduct bi-annual MSP meetings as per TOR
- Conduct quarterly County nutrition technical forums as per TOR
- Conduct quarterly Sub-County nutrition technical forums as per TOR
- Conduct quarterly review meetings for school health and nutrition programs

Output 2
Strengthened mechanisms for nutrition policy adoption and dissemination

Activities
- Adapt and disseminate relevant nutrition policies and guidelines in the multi-sectoral platforms, CHMT, SCHMT
- Participate in annual nutrition standards and regulation summit with relevant actors

Output 3
Enhance management skills of nutrition staff

Activities
- Train male and female nutrition officers on senior management course
- Train male and female nutrition staff on strategic leadership and development program

Expected Outcome 2: Sectoral and multisectoral Nutrition Information Systems, learning and research strengthened
Sectoral and multisectoral nutrition information systems, learning and research strengthened

Output 1
Quality gender sensitive nutrition data generated for evidence-based programming

Activities
- Conduct quarterly data review meetings for nutrition performance
- Conduct quarterly feedback meetings at facility and community level
- Conduct bi-annual nutrition data quality audit/assessment
- Procure and distribute adequate nutrition M & E tools for all health facilities
- Carryout mentorship, OJT and CMES for health workers of both genders on nutrition data reporting
- Sensitize CHMT, SCHMT on the nutrition score card
- Conduct gender integrated nutrition SMART survey
- Conduct periodic sentinel surveillance
- Conduct gender integrated MIYCN KAP survey
- Conduct nutrition capacity assessment including capacity to mainstream gender in nutrition interventions
- Disseminate survey and assessment findings for decision making

Output 2
Nutrition sector plans developed, implementation progress monitored and reviewed to inform program planning and adjustments

Activities
- Develop gender responsive nutrition annual work plan (AWP)
- Conduct mid-term and end term review of nutrition AWP & CNAP and undertake relevant corrective actions
- Develop the 2nd generation gender responsive Nakuru CNAP
- Develop and disseminate gender integrated annual nutrition reports

Output 3
Improved decision making through research evidence

Activities
- Advocate for research in nutrition among nutrition staff going for further studies
- Partner with academic institutions to conduct implementation/ operational research to address county specific nutrition gaps
- Support participation of nutrition staff in county, national knowledge sharing forums such as symposiums, conferences, workshops, meetings
- Participate in forums for dissemination of research findings and information sharing
- Promote knowledge sharing through publication of nutrition research findings
- Establish research repository for nutrition and dietetics

3.3.9 KRA 9: Advocacy, communication, and social mobilization (ACSM) strengthened

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

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

Activities
- Conduct high level nutrition advocacy forum with the governor, county assembly and other leaders
- Engage male and female nutrition champions to advocate for prioritization of nutrition at all levels
- Develop and submit proposals for funding of nutrition activities
- Advocate for employment of male and female nutrition officers to key county decision makers

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

Activities
- Advocate for relevant sectors to support establishment of multisectoral nutrition platforms

• Advocate for adequate financial resources for sustained and quality nutrition services including domestic resource mobilization and budgetary allocation for nutrition commodities, equipment, and reporting tools
• Participate in county planning process ensuring nutrition representation and mainstreaming nutrition in the national and county plans.

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

Activities
• Train male and female nutrition staff on gender responsive nutrition advocacy to better package information for the community
• Train media personalities of different genders, age, and diversities on gender responsive nutrition advocacy to improve coverage of nutrition issues

Output 4
Enhanced and sustained multisectoral collaboration in ACSM

Activities
• Sensitize County leadership and other stakeholders on CNAP to support implementation
• Develop and disseminate a gender responsive county advocacy, communication, and social mobilization plan
• Advocate for lactation stations in workplaces among stakeholders in public and private sectors

Output 5
Evidence-based gender responsive nutrition advocacy and knowledge management promoted

Activities
• Create awareness for nutrition interventions through media platforms
• Develop/adapt and disseminate gender transformative nutrition IEC/BCC materials
• Document and disseminate lessons learnt and best practices in nutrition
• Document and share human interest stories related to nutrition

Output 6
Community engagement in nutrition strengthened

Activities
• Participate in commemoration of nutrition related health days (World breastfeeding week, diabetes day, hypertension days, prematurity day, Malezi bora weeks)
• Participate in community dialogue days, mainstream nutrition agenda to enhance feedback mechanisms
• Conduct annual roadshows to promote nutrition intervention awareness among the public/population targeting men and women, boys and girls across different ages and diversities
• Advocate through the county leadership for billboards with gender transformative nutrition messages strategically displayed in the county

3.3.10 KRA 10: Supply chain management for nutrition commodities and equipment strengthened

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

Output 1
Improved capacity of health care workers to manage nutrition commodities

Activities
- Train male and female nutritionists and other healthcare workers on quantification, forecasting and supply chain management of nutrition commodities
- Train male and female health workers on nutrition LMIS
- Participate in commodity security TWG meetings and medical therapeutic committees at county and sub-county level
- Conduct joint commodity support supervision with county and sub county health management teams
- Advocate for improved storage facilities for nutrition commodities

Output 2
Improved availability of nutrition commodities, equipment, resources, and management of supply chain

Activities
- Procure and distribute nutrition commodities (enteral, parenteral, therapeutic, supplementary feeds, IFAS, MNPs, Vitamin A, dewormers)
- Conduct a gaps assessment for nutrition equipment and tools
- Procure and distribute gender and age-appropriate nutrition equipment's based on evidence from the gap analysis
- Procure and distribute nutrition reporting tools (data collection and summary tools)

Output 3
Quality of all nutrition commodities and equipment ensured

Activities
- Develop/Adapt national SOPs for nutrition commodities and equipment for each level of care
- Procure and distribute Clinical Nutrition Assessment equipment and tools
- Request for and follow up on repair and maintenance of nutrition equipment through collaboration with the medical engineering department
- Collaborate with the food safety division and regulatory bodies to ensure good quality of nutrition commodities and equipment
- Conduct nutrition commodity data quality audits and data review meetings
- Conduct joint support supervision and end user monitoring of nutrition commodities

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 Nakuru CNAP will evolve as the county assesses data gathered through monitoring.

Monitoring and evaluation will systematically track the progress of suggested interventions, and assess the effectiveness, efficiency, relevance, and sustainability of these interventions. Monitoring will involve ongoing, routine collection of information about a programs activity to measure progress toward results. The generated information will inform the implementers, decision makers and various stakeholders as to whether the nutrition program is on track, and when and where modifications may be needed. Regular monitoring will identify challenges and successes with an aim of evidence-driven decisions.

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 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, trainings, and M&E coordination

4.2 Background and context

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

4.3 Purpose of the MEAL plan

The Nakuru 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
- Client/Patient outcomes (behaviour change, morbidity)
- Clients Access to services
- Quality of health services
- Impact of interventions
- Lessons learnt and best practices

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

In an effort to ensure gender integration at all levels of the Nakuru CNAP, all data collected, analysed, and reported on will be disaggregated by gender and age to provide information and address the impact of any gender issues and relations including benefits from the nutrition programming between men and women.

Sex disaggregated data well analysed as well as monitoring will help detect any negative impact of nutrition programming or issues in relation to gender. Similarly, positive influences and outcomes from the interventions supporting gender equality for improved nutrition and health outcomes shall be documented and learned from to improve and optimize interventions. Other measures that will be put in place to mainstream gender in the MEAL plan will include:

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

4.4 Logic model

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

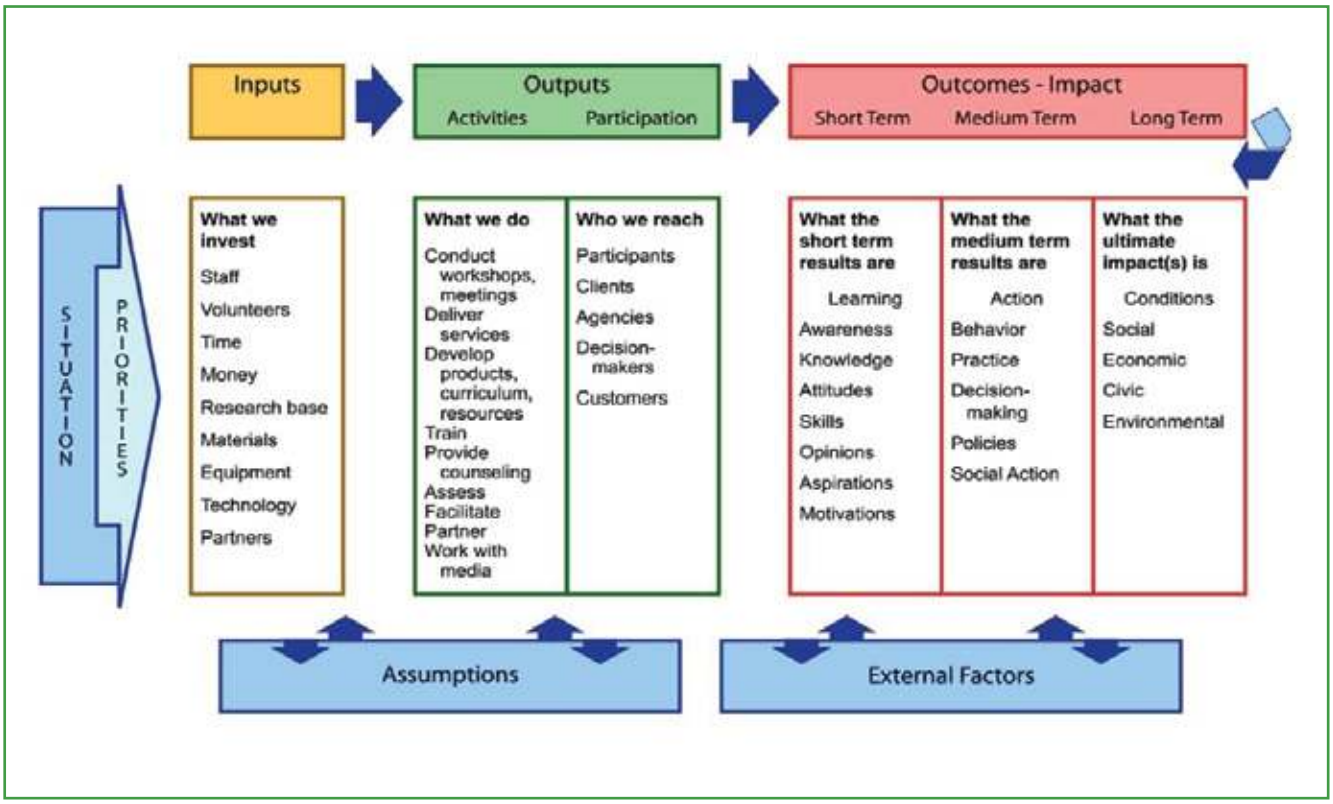

Figure 4: Monitoring and evaluation logical framework

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

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

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

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

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

Assumptions: Assumptions are made on the inputs and outputs, where a certain activity or intervention is assumed to result in a change in behaviour, attitude, or practice.

External factors come into play on the outcomes, given that for an outcome to be achieved, a lot of external factors, including political support, climate changes, disasters etc, which could have a direct impact of achievement of set outcomes.

Table 6: Nakuru CNAP Monitoring and evaluation logical framework

<table>
<tr><td>IMPACT</td><td colspan="3">1. Reduced stunting in children under 5by 40% (WHA Target 2012) by 2025.
2. Reduced and maintained childhood wasting to less than 5% (WHA 2021 Target) by 2025.
3. No increase in childhood overweight (children under 5 years of age) (WHA 2021 Target) by 2025.
4. Improved survival of children below the age of 5 by 25%.
5. Reduced deaths due to NCDs by 33%.
6. Increased rate of exclusive breastfeeding in the first six months to at least 50% by 2025 (WHA Target 2012).
7. Reduced proportion of the population who are overweight by 25%.
8. Improved Educational attainment of the female household population by 40%.
9. Reduced anaemia in women of reproductive age (pregnant and non-pregnant) by 50% by 2025, WHA 2012 Targets.</td></tr>
<tr><td>OUTCOMES</td><td>Outcome 1. Reduction in undernutrition:
- Increased proportion of children less than six months exclusively breastfed
- Reduce low birth weight by 20%</td><td>Outcome 2. Reduction of micronutrient deficiencies
- Improved Vitamin A coverage
- Improved deworming coverage
- Increase the proportion of pregnant women consuming iron and folate as per guidelines by 25%
- Increased consumption of Zinc supplements for children with diarrhoea
- Improve dietary quality and micronutrient adequacy in both women and young children</td><td>Outcome 3. Reduction in overnutrition
- Reduced proportion of adults with overweight and obesity
- Reduced proportion of diet related NCDs</td></tr>
<tr><td>OUTPUTS</td><td colspan="3">1. Maternal, Infant, Young Child Nutrition (MIYCN) scaled up
2. Nutrition of older children and adolescents promoted
3. Prevention, control and management of Micronutrient Deficiencies scaled-up
4. Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) in the life course scaled-up
5. Clinical nutrition and dietetics in disease management including HIV and TB strengthened
6. Integrated management of malnutrition and nutrition in emergencies strengthened
7. Promote and scale up nutrition in nutrition sensitive sectors (Agriculture, Education (ECDE), WASH and social protection)
8. Sectoral and multi-sectoral nutrition governance, coordination and legal/regulatory frameworks, nutrition information systems, learning and research strengthened
9. Advocacy, Communication and Social Mobilization (ACSM) strengthened
10. Supply chain management for nutrition commodities and equipment's strengthened</td></tr>
<tr><td rowspan="5">INPUTS</td><td colspan="2">1. Organization of service delivery for nutrition;</td><td>6. Nutrition Financing;</td></tr>
<tr><td colspan="2">2. Human Resource for Nutrition;</td><td>7. Nutrition research;</td></tr>
<tr><td colspan="2">3. Nutrition infrastructure;</td><td>8. Nutrition leadership;</td></tr>
<tr><td colspan="2">4. Nutrition products and Technology including micronutrient supplements, anthropometric equipment, among others;</td><td>9. Financial, human, physical and social capital;</td></tr>
<tr><td colspan="3">5. Nutrition Information;</td></tr>
</table>

4.5 Monitoring process

To achieve a robust monitoring system, effective policies, tools, processes, and systems should be in place and disseminated. The collection, tracking and analysing of data thus making implementation effective to guide decision making. The critical elements to be monitored are resources (inputs); service statistics; service coverage/outcomes; client/patient outcomes (behaviour change, morbidity); investment outputs; access to services; and impact assessment.

The key monitoring processes as outlined in Figure 5 will involve:

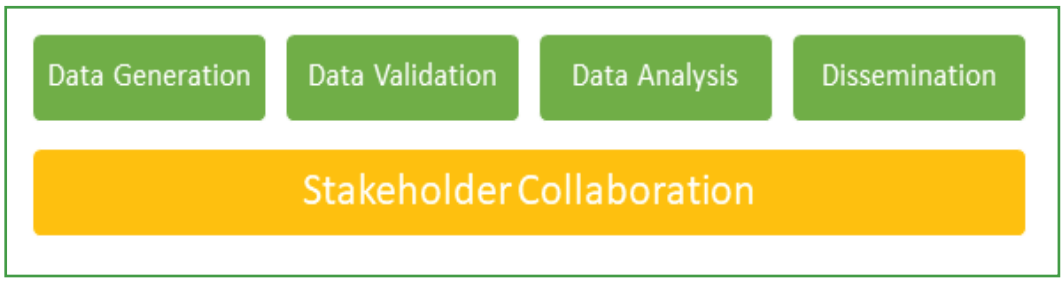

Figure 5: Monitoring processes

Data generation

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

Data validation

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

Data analysis

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

Information dissemination

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

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 7: 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 Nakuru 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 Nakuru 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 Nakuru CNAP are met.

Evaluation criteria

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

Relevance: The extent to which the objectives of the CNAP correspond to population needs including the vulnerable groups. It also includes an assessment of the responsiveness considering changes and shifts caused by external factors.

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

Effectiveness: The extent to which the 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 termina-

4.8 MEAL team

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

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

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

4.9 Critical assumptions

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

4.10 Indicators and information sources

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

Expected Results

Table 8: 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)	27.6% 35.6%	KDHS 2014 GBD 2017 https://vizhub.healthdata.org/lbd/cgf	22.1%	16.6%	Every 2 years
Reduce and maintain childhood wasting to less than 5% (WHA 2021 Target) by 2025	Percentage of children under five years who are wasted (low weight for height).	4.5% 3%	KDHS 2014 GBD 2017 https://vizhub.healthdata.org/lbd/cgf	3.5%	3%	Every 2 years
	Percentage of children under five years who are under-weight (low weight for age)	10.2% 11%	KDHS 2014 GBD 2017 https://vizhub.healthdata.org/lbd/cgf	9.7%	9.2%	Every 2 years
No increase in childhood overweight (children under 5 years of age) (WHA 2021 Target) by 2025	Percentage of children less than 5 years who are overweight (high weight for height->2SD)	5.7%	KDHS 2014	5%	4.5%	Every 5 years
Improved survival of children below the age of 5 by 25%	Infant mortality rate	26.8/1,000 live births	GBD 2017 https://vizhub.healthdata.org/lbd/under5	23.5/1,000 live births	20.1/1,000 live births	Every 3 years
	Under-5 mortality rate	34.5/1,000 live births	GBD 2017 https://vizhub.healthdata.org/lbd/under5	30.2/1,000 live births	25.9/1,000 live births	Every 3 years
	Neonatal mortality rate	16.2/1,000 live births	GBD 2017 https://vizhub.healthdata.org/lbd/under5	14.2/1,000 live births	12.5/1,000 live births	Every 3 years
Reduction of deaths due to NCDs by 33%	NCD mortality rate (18-59 years) (per 100,000)		WHO NCD Progress Monitor, Kenya Vital Statistics Report			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)	41.4%	GBD 2017 https://vizhub.healthdata.org/lbd/ebf	60%	80%	Every 3 years
Reduction by 25% of the proportion of the population who are overweight	Prevalence of overweight in the population	22%	GBD 2017 https://vizhub.healthdata.org/lbd/dbm	19.3%	16.5%	Every 3 years
Educational attainment of the female household population improved by 20% by 2025	Percentage of women who have completed at least twelve years of schooling	37%	KHPC 2019	40.7%	44.4%	Every 5 years
	Average years of education for female 15-49 years	9.4	GBD 2017	10.3	11.3	Every 3 years
Reduce anaemia in women of reproductive age (pregnant and non-pregnant) by 50% by 2025, WHA 2012 Targets.	Estimates of anaemia prevalence in pregnant women	46.1%***	KMNS 2011	25%	20%	Every 5 Years
Improved micronutrient consumption	Percentage of households consuming salt with any iodine	100%	KDHS 2014	100%	100%	Every 5 Years
	Percentage of children 6-59 months given vitamin A supplements in last 6 month	73.6%	KDHS 2014	80%	85%	Every 5 years
	Prevalence of ZINC deficiency among preschool children aged below 59 months	83%***	KNMS 2017	50%	40%	Every 5 Years

IMPACT/OUTCOME	Indicator	Baseline	Baseline Data Source	Mid-term Target (2022)	End-Term target (2025)	Frequency of data collection
Improved female empowerment for better nutrition decision making	Participation of women in household decision making index (Kenya Women's Empowerment Index)	29%** 40%** Urban 22%** Rural	Women's Empowerment Index for Kenyan Women and Girls Survey 2020	35% 50% 30%	45% 60% 40%	Every 5 years
Improved social protection	Proportion of Population Covered By At Least One Social Protection Benefit, By Sex (%)	32.3%	SDG Indicator dashboard https://data.unwomen.org/data-portal/sdg?tab=map 2016	40%	50%	Every 5 years
Improved water and sanitation	Proportion of households with access to safe water	61.1%	County statistical abstract 2015	68.7%	76.4%	Every 5 years
	Proportion of schools in the rural areas with basic water services**	72%	UNICEF 2019 https://data.unicef.org/topic/water-and-sanitation/wash-in-schools/	80%	85%	Every 3 years
	Proportion of schools in the rural areas with basic sanitation services**	50%	UNICEF 2019 https://data.unicef.org/topic/water-and-sanitation/wash-in-schools/	60%	75%	Every 3 years
	Proportion of schools in the rural areas with basic hygiene services**	2%	UNICEF 2019 https://data.unicef.org/topic/water-and-sanitation/wash-in-schools/	10%	15%	Every 3 years
Improved water and sanitation	Proportion of households with access to improved sanitation	64.7%	County statistical abstract 2015	72.8%	80.9%	Every 5 years
Food and nutrition security improved	Prevalence of Severe Food Insecurity in The Adult Population (%)	31.8%	SDG Indicator dashboard 2016 https://data.unwomen.org/data-portal/sdg?tab=map	28.6	25.4%	Every 5 years
Agriculture (283,652 number of farming households)	Dominant land cover (agriculture)	36.1%	County Statistical Abstract 2015	43%	45%	Every 5 years

***Data for the greater Rift valley region ** National level data

Table 9: Annual indicators per nutrition objectives

Target	Indicator	Baseline	Baseline Year/data source	Yr. 1	Yr. 2	Yr. 3	Yr. 4	Yr. 5
REDUCTION IN UNDERNUTRITION: WASTING, STUNTING, UNDERWEIGHT								
Increased proportion of children less than six months exclusively breastfed	Percentage of children 0-6 months visiting facilities exclusively breastfed.	86%	KHIS 2019	86.5%	87%	87.5%	88%	88.5%
	Percentage of infants that were breastfed within one hour after delivery.	91.5%	KHIS 2019	92%	92.5%	93%	93.5%	94%
Reduce low birth weight by 20%	Percentage of children <5years who are underweight	4.1%	KHIS 2019	3.9%	3.8%	3.6%	3.5%	3.3%
	Percentage of new-borns in the facilities, with low birth weight	5.5%	KHIS 2019	5.3%	5.1%	4.8%	4.6%	4.4%
	Proportion of children under 5 attending CWC who are underweight	1.5%	KHIS 2019	1.4%	1.4%	1.3%	1.3%	1.2%

Target	Indicator	Baseline	Baseline Year/data source	Yr. 1	Yr. 2	Yr. 3	Yr. 4	Yr. 5
REDUCTION OF MICRONUTRIENT DEFICIENCIES								
Improved Vitamin A coverage	Percentage of children (6-59 months) receiving VAS twice annually (100,000 IU for children 6-12 months and 200,000 IU for children > 12 months).	48.8%	KHIS 2019	56%	63.2%	70.4%	77.6%	85%
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) twice annually	17.9%	KHIS 2019	20%	30%	40%	50%	60%
	Proportion of school-aged children (6-14 years) dewormed	71.2%	KHIS 2019	73%	76%	79%	82%	85%
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	80.9%	KHIS 2019	82%	85%	87%	90%	92%
Increased consumption of Zinc supplements for children with diarrhoea	Percentage of children under five with diarrhoea treated with Zinc & ORS	96.2%	KHIS 2019	97%	97.5%	98%	98.5%	99%
Improve dietary quality and micronutrient adequacy among children	Minimum dietary diversity among children 6-23 months	41%**	KDHS 2014	45%	50%	55%	60%	65%
	Proportion of children 6-23 months, percentage fed on minimum acceptable diet (four or more food groups)	22%**	KDHS 2014	30%	35%	40%	45%	50%
REDUCTION IN OVERNUTRITION AND DIET RELATED NON-COMMUNICABLE DISEASES								
Reduced proportion of adults with overweight and obesity	Prevalence of overweight among female adults	31.3%	KDHS 2014	28%	25%	23%	20%	18%
	Prevalence of obesity among adults	7.2%	KDHS 2014	7%	6.8%	6.6%	6.4%	6.2%
Reduced proportion of diet related NCDs	Prevalence of Hypertension	12.8%***	KDHS 2014	12%	11%	10%	9%	8%

****Data for former Rift Valley Region* ** *National Level Data*

Output indicators

Table 10: KRA 01: Maternal, Infant, Young Child Nutrition (MIYCN) scaled up

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
BFHI strengthened in level IV and V health facilities	Number of male and female HCW trained on BFHI from implementing health facilities	0	2019	Activity reports	Annually	60	60	60	60	
	Number of facilities assessed for baseline data.	0	2019	Activity reports	Bi-annual	8	9	0	0	0
	Number of facilities assessed continuously	0	2019	Activity reports	Quarterly	17	17	17	17	17
	Number of facilities assessed externally on BFHI.	0	2019	Activity reports	Every 3 Years			2	3	4

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened BFCI in level III, II and I.	Number of male and female HCWs trained n BFCI	xx	2019	Activity reports	Annually	60	60	60	60	60
	Number of BFCI committees established	xx	2019	Activity reports	Every 5 Years	5	10	10	10	10
	Number of community units assessed	21	2019	Activity reports	Annually	5	10	10	10	10
	Number of male and female CHVs trained on C-BFCI	225	2019	Activity reports	Annually	200	400	400	400	400
	Number of CUs assessed	0	2019	Activity reports	Quarterly	5	10	10	10	10
	Number of CUs externally assessed on BFCI	0	2019	Activity reports	Every 3 Years	0	0	10	10	10
	Number of MTMSGs formed	25	2019	Activity reports	Annually	100	200	200	200	200
	Number of facilities reporting monthly	144	2019	Activity reports	Monthly	144	144	144	144	144
GMP Strengthened	Number of male and female HCW trained on growth monitoring standards.	0	2019	Activity reports	Bi-annual	0	60	60	60	60
Workplace support for breastfeeding mothers promoted	Number of male and female members of the informal sector sensitized on workplace support for breastfeeding	0	2019	Activity reports	Bi-annual	0	45	45	0	45
	Number of male and female key influencers engaged.	0	2019	Activity reports	Annually	11	11	11	11	11
	Number of lactation rooms/breastfeeding corners established	0	2019	Activity reports	Every 2 Years	0	16	0	36	0
Strengthened implementation of BMS Act, 2012.	Number of male and female members of the private sector sensitized on BMS Act	0	2019	Activity reports	Annually	30	30	30	30	30
	Number of male and female HCW trained on BMS implementation.	0	2019	Activity reports	Annually	0	60	60	60	60
	Number of male and female PHOs, nutritionists and police officers trained on enforcement of BMS Act.	0	2019	Activity reports	Annually	0	60	60	60	60

Table 11: KRA 02: Nutrition of older children and adolescents promoted

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Increased consumption and marketing of healthy foods for older children and adolescents	Number male and female stakeholders sensitized on promotion and marketing of healthy foods within schools	0	2019	Nutrition Program Reports	Quarterly	100	100	100	100	100
	Number of male and female older children and adolescents reached with healthy diet messages	0	2019	Nutrition Program Reports	Quarterly	1000	1000	1000	1000	1000

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Stakeholders capacity built on healthy diets and physical activity	Proportion of male and female household members sensitized on healthy diets and physical activity			Nutrition Program Reports	Quarterly	0.3	0.4	0.5	0.6	>60%
	Proportion of School health programmes integrated with healthy diets and physical activity messages			Nutrition Program Reports	Bi-annual	100%	100%	100%	100%	100%
Sensitize communities and increase diversity of food production in kitchen gardens.	Proportion of households producing diverse foods			Nutrition and Education Program Reports	Bi-annual	30%	40%	50%	60%	>60%

Table 12: KRA 03: Prevention, control and management of micronutrient deficiencies scaled-up

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened micronutrient supplementation among targeted groups for increased coverage	Proportion of adolescent girls who received any WIFS.	87.8	2019	NI Institutional Support Grant Baseline Survey	Annually	88	90	90	90	90
	Proportion of adolescent girls who received the recommended dose of WIFS.	37.8	2019	NI Institutional Support Grant Baseline Survey	Annually	45	50	55	60	65
	Proportion of boys and girls 6-59 months supplemented with MNPs.	No data	2019	KHIS	Annually	20%	30%	40%	50%	60%
Promoted uptake of micronutrient supplementation through context specific SBCC strategies	Number of road shows/radio talks and targeted gender inclusive youth activities conducted.	No data		Activity Report	Annually	0	11	11	11	11
Strengthened capacity of HCW on prevention, control and management of micronutrient deficiencies.	Number of male and female HCW trained on VAS	350	2018	Activity Report	Every 2 Years	0	350	0	350	0
	Number of male and female HCW trained on IFAS.	0	2019	Activity Report	Every 2 Years	200	0	200	0	200
	Number of male and female teachers trained on WIFS.	0	2019	Activity Report	Every 2 Years		920		920	
	Number of male and female HCWs trained on MNPs.	0	2019	Activity Report	Annually	0	350	350	350	350
	Number of male and female CHVs sensitized on micronutrients.	No data	2019	Activity Report	Annually	300	300	300	300	300
Promoted compliance, production and consumption of fortified foods.	Number of male and female millers trained on food fortification and the food fortification strategy	No data	2019	Activity Report	Every 3 Years	120	0	0	120	0
	Proportion of industries complying with the food fortification standards.	No data	2019	Activity Report	Monthly	60%	70%	80%	85%	90%
	Number of HCW, including PHOs trained on food fortification and food fortification strategy	22	2019	Activity Report	Annually	66	66	66	66	66
	Proportion of samples tested for fortification, found to meet fortification standards	No data	2019	Activity Report	Every 2 Years	70%	75%	80%	85%	90%
Enhanced uptake of diversified and biofortified foods.	Number of male and female CHVs trained on diversified and biofortified foods	No data		Activity Report	Annually	300	300	300	300	300

Table 13: KRA 04: Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) in the life course scaled-up

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Good nutrition practices, lifestyle and physical activity promoted to prevent, control and manage DRNCDs	Number of male and female community members sensitized through community groups / forums on healthy diets and physical activity by SCNCs	No Data	2019	Nutrition Activity Report	Annually	500	500	500	500	500
	Number of awareness sessions on DRNCDs through locally available channels by SCNCs	No Data	2019	Nutrition Activity Report	Bi-annual	22	22	22	22	22
	Number of male and female persons screened during campaigns in churches, health awareness days etc	No Data	2019	Nutrition Activity Report	Annually	2000	2000	2000	2000	2000
Strengthened nutrition services at the NCD clinics	Proportion of male and female clients visiting the NCD clinics receiving nutrition assessment and counselling	No data	2020	Nutrition program Reports and NCD program reports	Quarterly	70%	75%	80%	85%	90%
	Proportion of facilities reporting no stock out of anthropometric equipment	No Data	2020	Supervision reports	Quarterly	80%	85%	90%	95%	95%
	Number of DRNCDs support groups established	0	2019	Nutrition Activity Report	Annually	11	11	11	11	11
	Number of male and female health care workers trained on healthy diets and physical activity	No data	2019	Nutrition Activity Report	Every 2 Years	0	60	0	60	0
Strengthened monitoring and evaluation for DRNCDs	Number of nutrition integrated NCD data review meetings	No data	2019	Nutrition Activity Report	Quarterly	44	44	44	44	44

Table 14: KRA 05: Clinical nutrition and dietetics in disease management including HIV and TB strengthened

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened capacity of Nutritionists on Clinical Nutrition and Dietetics in disease management	Number of male and female of nutritionist trained on clinical nutrition and dietetics	0	2019	Nutrition activity report	Annually	0	30	30	0	0
	Number of male and female nutritionist trained on specialization on clinical nutrition and dietetics	No data	2019	Nutrition activity report	Every 2 Years	0	1	0	1	0
	Number of male and female nutritionist trained on short courses under clinical nutrition and dietetics	No data	2019	Nutrition activity report	Annually	0	2	2	2	2

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened Clinical Nutrition and Dietetics Service Delivery.	Number of male and female HCWs sensitized on nutrition care process	No data	2019	Nutrition activity report	Bi-annual	0	1348	1348	1348	1348
	Proportion of clients assessed referred from nutrition to other service delivery points	No data	2019	Nutrition activity report	Monthly	50%	60%	70%	75%	80%
	Number of bi-annual review meetings done for clinical nutrition and dietetics	No data	2019	Nutrition activity report	Bi-annual	2	2	2	2	2
	Proportion of facilities with SOPs for clinical nutrition and dietetics	No data	2019	Supervision reports	Quarterly	50%	60%	70%	80%	85%
Strengthened supply chain for Clinical Nutrition and Dietetics	Proportion of facilities with nutrition therapeutic and supplementary commodities	No data	2019	Supervision reports	Quarterly	50%	60%	70%	80%	85%
	Proportion of facilities offering inpatient services with enteral and parental commodities	No data	2019	Supervision reports	Quarterly	50%	60%	70%	80%	85%
Strengthened procurement system for food supply	Number of in-patient feeding committees established	5	2019	Nutrition activity report	Annually		0	0	0	0
Strengthened technical capacity of healthcare workers to offer optimal Nutritional care in HIV and TB services.	Number of male and female HCWs trained on nutrition in HIV and TB management	0	2019	Nutrition activity report	Annually	0	30	0	30	0
Strengthened MIYCN in PMTCT	Number of subcounty reports on nutrition assessment of HEIs	No data	2019	Nutrition activity report	Quarterly	44	44	44	44	44
	Number of male and female HCW receiving nutrition education with HEIs	No data	2019	Nutrition activity report	Bi-annual	40	40	40	40	40
	Proportion of MAM and SAM HEIs referred for nutritional support	No data	2019	Nutrition Program Reports	Quarterly	60%	65%	70%	75%	80%

Table 15: KRA 06: Integrated management of malnutrition and nutrition in emergencies strengthened

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened enabling environment for nutrition emergency preparedness and response	Emergency key stakeholders mapping done.	No	2019	Activity reports	Annually	Yes	Yes	Yes	Yes	Yes
	Nutrition task force established and operational	No	2019	Activity reports	Every 5 Years	Yes	Yes	Yes	Yes	Yes
Strengthened capacity of HCW in nutrition emergencies.	Number of male and female HCW trained on MIYCN-E	0	2019	Activity reports	Bi-annual	0	50	50	50	50
	Number of male and female CHV sensitized on MIYCN-E	0	2019	Activity reports	Bi-annual	0	4400	4400	4400	4400
	Number of male and female HCW trained on IMAM surge Kit	0	2019	Activity reports	Annually	0	35	35	35	35

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened nutrition preparedness and response for emergencies	Number of sub-counties with contingency plans in nutrition.		2019	Activity reports	Annually	4	8	10	11	11
	Nutrition assessments done during emergencies using the MIYCN-E rapid assessment tools.	No	2019	Activity reports	Annually	Yes	Yes	Yes	Yes	Yes
Strengthened capacity of healthcare workers on IMAM	Number of male and female HCWs trained on IMAM	0	2019	Nutrition activity Report	Annually	0	60	0	60	0
	Number of facilities offering IMAM services	No data	2019	Nutrition activity Report	Annually	674	674	674	674	674
Strengthened IMAM active case findings and referrals.	Number of male and female CHVs sensitized in IMAM	No data	2019	Nutrition activity Report	Every 2 Years	0	550	0	550	0
	Number of sub counties reports, on screened and referred MAM and SAM cases in the community	No data	2019	Nutrition activity Report	Quarterly	44	44	44	44	44
	Proportion of reported MAM and SAM cases, referred from facility to the community	No data	2019	Nutrition activity Report	Quarterly	60%	70%	75%	80%	85%
Strengthened Nutrition care for IMAM.	Number of sub counties reports on children assessed under IMAM program	No data	2019	Nutrition activity Report	Quarterly	44	44	44	44	44
	Proportion of male and female children supported under IMAM program, provided with nutrition support	No data	2019	Nutrition activity Report	Quarterly	70%	75%	80%	85%	90%
Strengthened nutrition commodity supply chain	Proportion of facilities offering IMAM services reporting no stockout of IMAM commodities	No data	2019	Supervision reports	Quarterly	80%	855	85%	90%	90%

Table 16: KRA 07: Promote and scale up nutrition in nutrition sensitive sectors (Agriculture, Education (ECDE, WASH and social protection)

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Joint planning and implementation with agriculture sector and its stakeholders advocated for	Number of joint planning meetings with agriculture sector conducted	0	2019/20	Nutrition and agriculture program reports	Annually	1	1	1	1	1
Availability and access of safe and nutritious food promoted	Number of male and female extension workers and CHVs sensitized, on diversified food production strategies, processing, preservation and storage	No	2019	Nutrition and agriculture program reports	Quarterly	200	200	200	200	200
	Number of male and female community members sensitized on diversified food production strategies, processing, preservation and storage	No Data	2019	Nutrition and agriculture program reports	Quarterly	1000	1000	1000	1000	1000
	Proportion of health facilities with kitchen garden sites established	No data	2019	Nutrition and agriculture program reports	Bi-annual	50%	60%	70%	75%	80%
	Proportion of households with kitchen gardens	No data	2019	Nutrition and agriculture program reports	Bi-annual	30%	40%	50%	60%	65%

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened utilization/ consumption of safe, diverse and nutritious food	Number of male and female stakeholders in agriculture and nutrition sensitized on food composition tables	No data	2019	Nutrition and agriculture program reports	Annually	50	50	50	50	50
	Number of male and female community members sensitized on food safety	No data	2019	Nutrition and agriculture program reports	Bi-annual	100	100	100	100	100
	Number of local food processors sensitization on fortification and value chain	No data	2019	Nutrition and agriculture program reports	Bi-annual	50	50	50	50	50
	Number of male and female community members sensitized on energy saving technologies	No data	2019	Nutrition and agriculture program reports	Quarterly	110	110	110	110	110
Advocated joint planning with public Health and other stakeholders	Number of joint planning meeting with public health program held	0	2019	Nutrition program reports	Quarterly	1	1	1	1	1
Strengthened capacity of ECDE teachers on nutrition assessment, VAS, Deworming and referrals	Proportion of male and female children assessed for their nutrition status	No Data	2019	Nutrition and ECDE program reports	Monthly	30%	40%	50%	60%	70%
	Proportion of sick and malnourished children referred	No Data	2019	Nutrition and ECDE program reports	Monthly	40%	50%	60%	70%	80%
Strengthened policy environment on existing guidelines for School Feeding programmes	Number of male and female ECDE headteachers and teachers sensitized on the school feeding program	No Data	2019	Nutrition and ECDE program reports	Quarterly	30%	40%	50%	60%	70%
	Proportion of ECDE schools with menus	No Data	2019	Nutrition and ECDE program reports	Quarterly	30%	40%	50%	60%	70%
	Proportion of schools with kitchen gardens	No Data	2019	Nutrition and Education program reports	Bi-annual	20%	30%	40%	50%	60%
Increased joint planning with social services and its stakeholders	Number of joint planning meeting held with social services	No Data	2019	Nutrition and social protection program reports	Quarterly	1	1	1	1	1
	Proportion of social service programmes with nutrition indicators	No Data	2019	Nutrition and social protection program reports	Quarterly	40%	50%	60%	70%	80%
	Situation analysis on status of nutrition and health for the vulnerable groups conducted jointly	No	2019	Nutrition and social protection program reports	Every 3 Years	No	Yes	No	No	No
Integrated nutrition education and promotion into social services programmes and Child Care Institutions (CCIs)	Number of male and female social protection stakeholders sensitized on nutrition for vulnerable groups	0	2019	Nutrition and social protection program reports	Quarterly	50	0	50	0	50
	Proportion of vulnerable groups educated and counselled on nutrition	No Data	2019	Nutrition and social protection program reports	Quarterly	1	1	1	1	1

Table 17: KRA 08: Sectoral and multi-sectoral nutrition governance, coordination and legal/regulatory frameworks, nutrition information systems, learning and research strengthened

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened and diversified partnerships in nutrition	Nutrition partner mapping undertaken	No	2019/20	County Partner database	Annually	Yes	Yes	Yes	Yes	Yes
	Nutrition Multi sectoral platform (MSP)established and operational	No	2019/20	Nutrition program reports	Annually	Yes	Yes	Yes	Yes	Yes
	Number of quarterly county nutrition technical forums conducted	1	2019/20	Nutrition program reports	Quarterly	4	4	4	4	4
	Number of quarterly sub-county nutrition technical forums conducted	2	2019/20	Nutrition program reports	Quarterly	44	44	44	44	44
Strengthened mechanisms for nutrition policy adaption and dissemination	Number of Nutrition Policies and guidelines adapted and disseminated	3	2019/20	Reports	Annually	3	3	3	3	3
Improved quality of nutrition data collection, analysis and dissemination	Number of data review meetings for nutrition performance held	0	2019/20	Reports	Quarterly	4	4	4	4	4
	Number of nutrition DQA conducted	1	2019/20	DQA reports	Bi-annual	2	2	2	2	2
	Proportion of health facilities reporting no stock out of nutrition M&E tools	No Data	2019/20	Sub-county reports	Bi-annual	80%	85%	90%	95%	100%
	SMART survey conducted	No	2019/20	Survey report	Every 3 Years	No	Yes	No	No	No
	MIYCN KAP surveys conducted	No	2019/20	Survey report	Every 5 Years	No	No	No	Yes	No
	Nutrition capacity assessment conducted	Yes	2018/19	Assessment report	Every 2 Years	No	Yes	No	No	Yes
Monitored implementation of CNAP and AWP and evaluate impact of nutrition interventions to inform program planning and adjustments	Annual workplans for nutrition developed guided by the CNAP	0	2019/20	Nutrition AWP	Annually	1	1	1	1	1
	Nutrition AWP reviews conducted	NA	2019/20	Review report	Bi-annual	2	2	2	2	2
	Midterm review of CNAP conducted	No	2020/21	CNAP	Every 5 Years	No	No	Yes	No	No
Nutrition related research within the county promoted	Number of researches in nutrition done	NR	2019/20	Research proposals	Annually	0	1	1	1	1
	Number of MOUs initiated with academic institutions to conduct operational research	NR	2019/20	Draft MOU	Annually	0	1	0	1	0
	Number of male and female nutrition staff supported to attend conferences	4	2019/20	Activity report	Annually	2	5	5	5	5

Table 18: KRA 09: Advocacy, Communication and Social Mobilization (ACSM) strengthened

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Strengthened capacity for nutrition advocacy at county level	Number of high-level advocacy forums conducted with the governor, county assembly, other county leaders	1	2018	Nutrition program reports	Every 2 Years	1	0	1	0	1
	Number of male and female nutrition champions identified	0	2019	Nutrition program reports	Annually	1	2	2	2	2
	Number of male and female key influencers, policy makers, role models, and champions across different ages and diversities, sensitized on nutrition across the life cycle	0	2019	Nutrition program	Annually	10	10	10	10	10
	Number of nutrition proposals developed and submitted for funding considerations	3	2019	Nutrition program reports	Annually	3	5	5	5	5
Advocated employment of nutrition officers to key county decision makers	Number of male and female nutrition officers employed	0	2019	HR Reports	Annually	0	24	0	30	0
Improved advocacy capacity for nutrition	Number of male and female nutritionists trained on advocacy	0	2019	Activity report	Every 3 Years	0	100	0	0	100
	Number of male and female media personalities trained on gender responsive nutrition advocacy	ND	2019	Activity report	Every 2 Years	0	25	0	0	25
Enhanced multisectoral collaboration in ACSM	Number of male and female leaders and stakeholders sensitized on the CNAP	NA	2019	Activity report	Every 2 Years	30	30	0	0	0
	ACSM plan developed and utilized	No	2019	ACSM plan	Every 5 Years	No	Yes	Yes	Yes	Yes
	Number of lactation centres established	0	2019	Reports	Annually	1	1	1	1	1
Strengthened nutrition communication at county level	Number of media awareness programs on nutrition	3	2019	Activity report	Monthly	12	18	24	24	24
	Number of nutrition related human interest stories documented	ND	2019	Documented stories	Annually	1	2	2	2	2
Strengthened community engagement and participation in nutrition agenda	Number of nutrition related health days commemorated	3	2019	Activity report	Annually	4	5	5	5	5
	Number of dialogue days with nutrition agenda conducted	NR	2019	CHS reports	Monthly	249	498	498	498	132

Table 19: KRA 10: Supply chain management for nutrition commodities and equipment strengthened

Expected Output	Key Performance Indicators	Data	Year	Source of Data	Periodicity	2020/21	2021/22	2022/23	2023/24	2024/25
Improved capacity of health care workers to manage nutrition commodities	Number of male and female nutritionists and health workers trained on quantification, forecasting and supply chain management	No Data	2019	Nutrition Program Reports	Every 2 Years	0	50	100	0	100
	Number of male and female health workers trained on Nutrition LMIS	No Data	2019	Nutrition Program Reports	Every 2 Years	0	50	100	0	100
	Number of Commodity, Security and TWG meetings held	4	2019	Report	Quarterly	4	4	4	4	4
Strengthened availability of nutrition commodities, equipment and tools	Proportion of facilities with quarterly nutrition needs of nutrition commodities met	No Data	2019	Delivery notes	Quarterly	50	60	70	80	90
	Proportion of facilities with SOPs on Nutrition equipment	0	2019	Supervision reports	Every 5 Years	60%	65%	70%	75%	80%

4.11 Implementation plan

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

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

Actors	Roles and responsibilities
Nutrition Sensitive Sectors	• Monitoring and reporting on progress towards implementation of key activities that fall within their mandates in line with jointly agreed indicators • Participating in high level M&E activities at the county • Supporting surveys and evaluations needed to assess shared impact of joint interventions
Implementing partners and agencies	• Aligning all their M&E activities to realize the goals of this plan as well as the institutional M&E goals articulated in sectoral, programmatic, and county specific M&E Plans • Routine monitoring and evaluating their activities • Using existing systems/developing M&E sub systems that utilize existing structures at all levels of the health information system • Utilizing the data collected for decision making within the institution
Development Partners	• Providing substantive technical and financial support to ensure that the systems are functional. • Ensuring that their reporting requirements and formats are in line with the indicators outlined in the M&E framework. • Synchronizing efforts with existing development partners and stakeholder efforts based on an agreed upon one county-level M&E system. • Utilizing reports generated in decision making, advocacy and engaging with other partners for resource mobilization.
Health Facilities	• Ensuring that data collected, and reports generated are disseminated and used by the implementors to monitor trends in supply of basic inputs, routine activities, and progress made. • Using this data in making decisions on priority activities to improve access and quality of service delivery.
Community Health Units	• Identifying and notifying the health authority of all health and demographic events including M&E that occurs in the community • Generating reports through community main actors e.g. the CHWs, teachers and religious leaders through a well-developed reporting guideline Community Health Information System (CHIS)

4.12 Calendar of key M&E activities

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

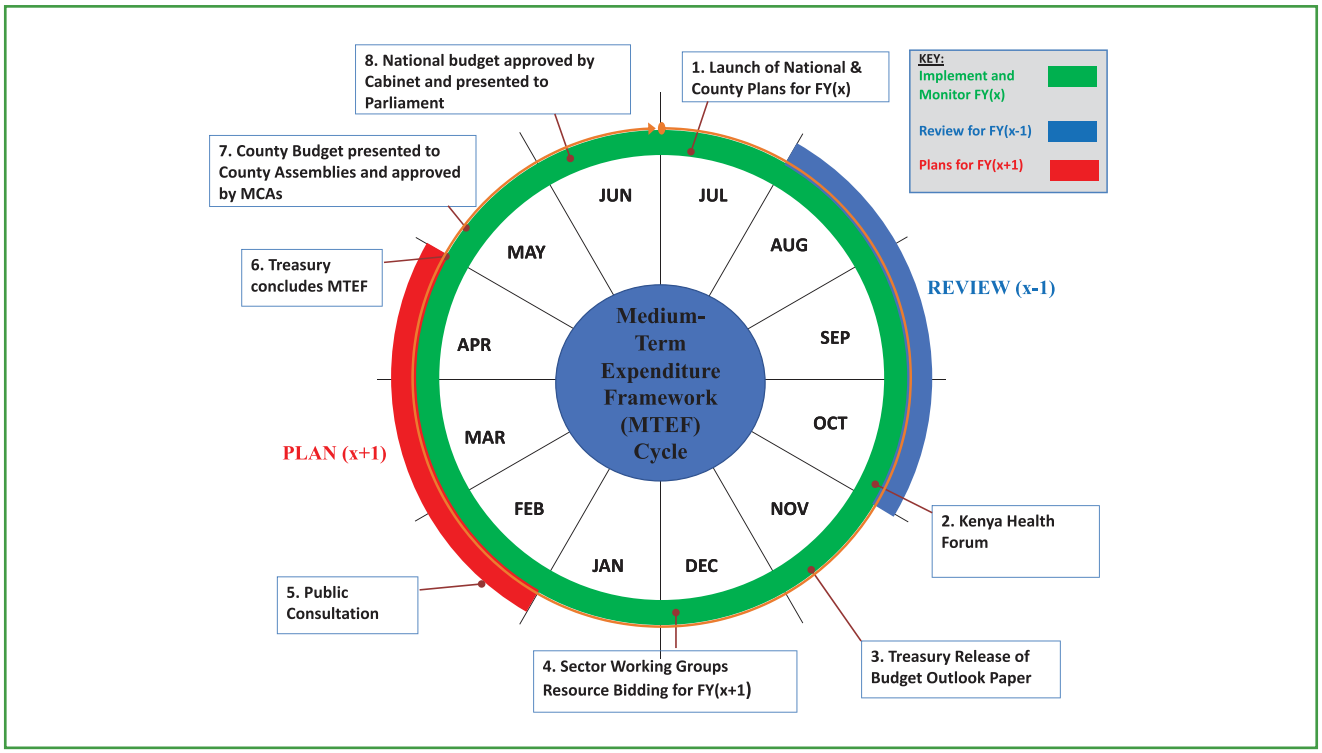

Figure 6: National health sector accountability cycle

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 2022/23 to measure progress of its implementation and hence facilitate necessary amendments.

4.13 Implementation of the Nakuru CNAP

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

5 RESOURCE REQUIREMENTS

5.1 Introduction

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

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

This is a process that allocates costs of inputs based on each intervention and activity with an aim of achieving set goals /results. It attempts to identify what causes the cost to change (cost drivers). All costs of activities are traced and attached to the intervention or service for which the activities are performed.

The chapter describes in detail the level of resource requirements for the strategic plan period, the available resources and the gap between what is anticipated and what is required.

5.2 Costing approach

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

The ABC uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve Strategic plan targets. ABC is a process that allocates costs of inputs based on each activity, it attempts to identify what causes the cost to change (cost drivers); All costs of activities are traced to the product or service for which the activities are performed. The premise of the methodology under the ABC approach will be as follow; (i)The activities require **inputs,** such as labour, conference hall etc.; (ii) These inputs are required in certain **quantities,** and with certain **frequencies;** (iii) It is the product of the **unit cost,** the **quantity,** and the **frequency** of the input that gave the **total input cost;** (iv) The sum of all the input costs gave the **Activity Cost**. These were added up to arrive at the **Output Cost,** the **Objective Cost,** and **eventually the budget.**

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

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

The CNAP was costed using the Activity Based Costing (ABC) approach. The ABC uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve planned targets for the financial years of 2020/21 – 2024/25.

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

The KRAs provided targets to be achieved within the plan period and the corresponding inputs to support attainment of the targets. Based on the targets and unit costs for the inputs, the costs for the strategic plan were computed.

According to the Activity Based Costing, to fully actualize the strategic plan, KSh. 2.6 billion is required as shown in the figure below. Further annual breakdown of cost requirement (s) is also presented.

5.4 Resource requirements

According to the costing estimates, the County department of health requires an investment worth KSh.2.6 billion for nutrition over the plan period. This further has been disaggregated by KRAs as shown in the table below.

Table 21: Resource requirements

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 01: Maternal, Infant, Young Child Nutrition (MIYCN) scaled up	13,259,575	19,443,500	29,128,000	28,827,000	24,177,500	114,835,575
KRA 02: Nutrition of older children and adolescents promoted	2,538,500	7,089,500	7,531,500	6,131,500	3,227,000	26,518,000
KRA 03: Prevention, control, and management of Micronutrient Deficiencies scaled-up	6,862,899	14,898,651	8,733,150	14,735,650	8,962,650	54,193,000
KRA 04: Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) in the life course scaled-up	440,400	75,400	480,400	75,400	480,400	1,552,000
KRA 05: Clinical nutrition and dietetics in disease management including HIV and TB strengthened	88,313,336	91,132,176	88,545,336	90,957,176	88,808,336	447,756,360
KRA 06: Integrated management of malnutrition and nutrition in emergencies strengthened	13,188,800	25,516,800	22,153,300	24,821,800	21,907,300	107,588,000
KRA 07: Promote and scale up nutrition in nutrition sensitive sectors (Agriculture, Education (ECDE), WASH and social protection)	25,303,050	32,806,950	26,567,550	31,544,450	26,836,050	143,058,050
KRA 08: Sectoral and multi-sectoral nutrition governance, coordination and legal/regulatory frameworks, nutrition information systems, learning and research strengthened	7,922,200	11,674,200	7,786,700	10,406,800	15,658,000	53,447,900
KRA 09: Advocacy, Communication and Social Mobilization (ACSM) strengthened	1,120,000	1,806,500	664,000	1,120,000	1,806,500	6,517,000
KRA 10: Supply chain management for nutrition commodities and equipment's strengthened	318,353,756	321,411,696	318,778,256	320,979,696	318,778,256	1,598,301,660
Grand Total	**477,302,516**	**525,855,373**	**510,368,192**	**529,599,472**	**510,641,992**	**2,553,767,545**

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

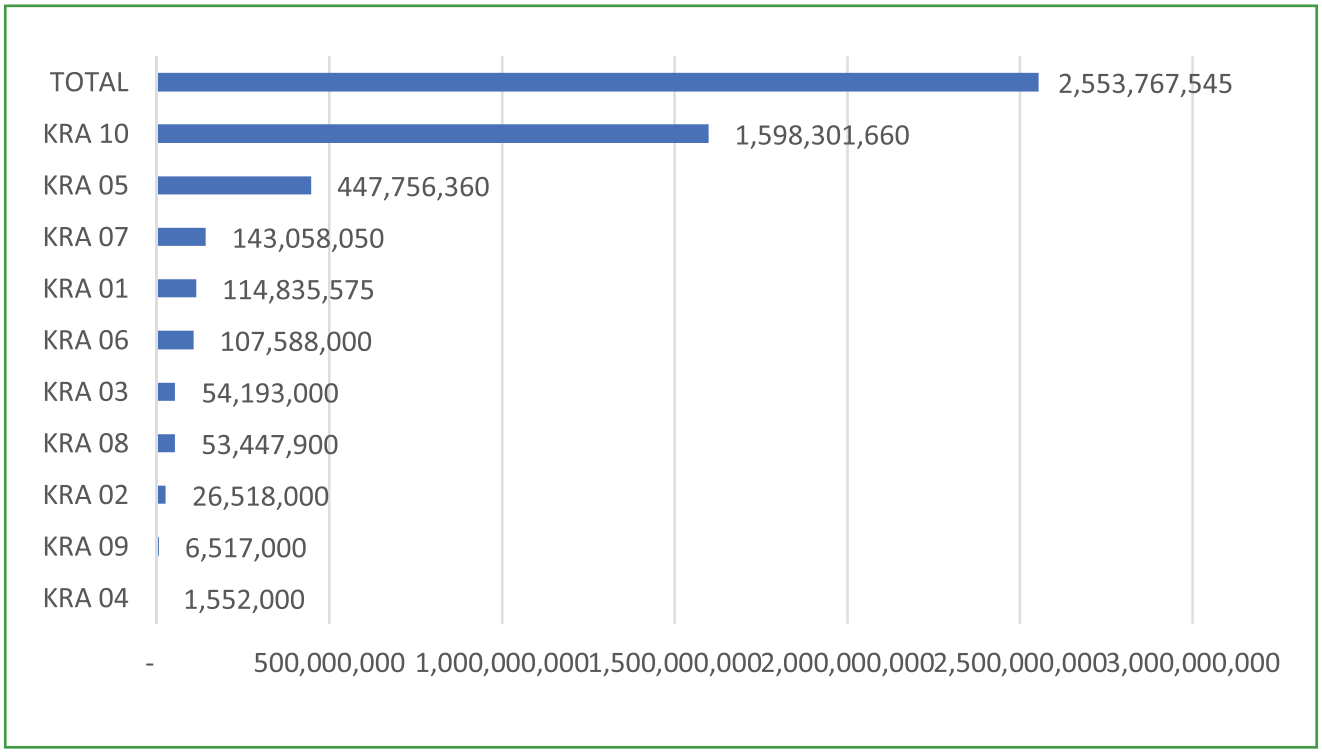

Figure 7: Total cost requirements (2020/21 – 2024/25)

Analysis of the cost requirements shows that 63% of the funds will be required to cater for KRA on Supply chain management for nutrition commodities and equipment's strengthened; KRA on Clinical nutrition and dietetics in disease management including HIV and TB strengthened will require 18% while KRA on Promote and scale up nutrition in nutrition sensitive sectors (Agriculture, Education(ECDE),WASH and social protection) will require 6%.

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 stakeholders and the respective resource for Nutrition.
- Identification, appointment and accreditation of eminent persons in the community as resource mobilization goodwill ambassadors
- Capacity and Demand Management: Optimize resource utilization by prioritizing high value work with available resource capacity
- Resource Utilization: Ensure that the right resources are available to support the strategic goals
- Progress and Time Tracking: Ensure that progress can be tracked, which can be especially valuable when using time tracking. Compare planned effort vs. actual effort to improve estimates and better understand where your resources are truly spending their time.

5.5.2 Strategies to ensure efficiency in resource utilization

- Planning for utilization of the allocated resources
- Continuous monitoring of impact process indicators
- Periodically evaluate objectives, to find out if they have been achieved as planned
- Ownership and commitment to continue on the part of the stakeholders
- Ensure that the steering committee is active and delivering on their mandate by supporting their efforts.

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7 APPENDICES

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

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 01: Maternal, Infant, Young Child Nutrition (MIYCN) scaled up	**13,259,575**	**19,443,500**	**29,128,000**	**28,827,000**	**24,177,500**	**114,835,575**
Adopt and customize complementary feeding strategy specific to Nakuru County.	-	290,000	-	-	-	290,000
Carry out external BFCI assessment.	-	-	5,850,000	5,850,000	5,850,000	17,550,000
Carry out external BFHI assessment.	-	-	3,315,000	3,315,000	3,315,000	9,945,000
Carry out continuous self-assessments at community level on BFCI	857,250	857,250	857,250	857,250	857,250	4,286,250
Carry out continuous self-assessments of the facilities on BFHI	612,000	612,000	612,000	612,000	612,000	3,060,000
Carry out facility baseline assessment for BFHI.	391,000	391,000	-	-	-	782,000
Carry out mentorship and OJT on BFHI by CHMT and SCHMT	-	155,550	155,550	155,550	155,550	622,200
Carry out monthly MTMSG meetings at community level	-	-	-	-	-	-
Carry out monthly submission and verification of MIYCN reports.	-	-	-	-	-	-
Carry out quarterly data quality audits for MIYCN services.	-	-	-	-	-	-
Carry out support supervision for MIYCN services.	-	-	-	-	-	-
Carry out targeted home visits by CHVs	-	-	-	-	-	-
Print and distribute monitoring and reporting tools for BFCI.	-	-	-	-	-	-
Print and distribute reporting tools for GMP	-	-	-	-	-	-
Sensitize and disseminate MIYCN policies/guidelines to CHMT and SCHMT and facility in-charges.	979,200	104,200	979,200	104,200	979,200	3,146,000
Sensitize CHMT and SCHMT on the new WHO growth standards.	-	-	-	-	-	-
Train male and female CHVs on CBFCI	1,458,500	2,917,000	2,917,000	2,917,000	2,917,000	13,126,500
Train male and female HCW on BFCI	3,280,000	3,280,000	3,280,000	3,280,000	3,280,000	16,400,000
Print and distribute monitoring and reporting tools for BFHI	-	-	-	-	-	-
Advocate for oversight, monitoring and enforcement of Breast Milk Substitute (BMS) Act, 2012	61,500	-	-	61,500	-	123,000
Sensitize CHMT, SCHMT and facility health management team on BFHI.	160,000	160,000	-	160,000	-	480,000
Train male and female HCWs on BFHI	2,408,000	2,408,000	2,408,000	2,408,000	-	9,632,000
Establish gender, age, and diversity inclusive BFHI committees in implementing health facilities	-	-	-	-	-	-
Carry out continuous health facility CMEs on BFHI	-	-	-	-	-	-
Sensitize CHMT, SCHMT and health facility in charges on BFCI	86,500	86,500	86,500	86,500	4,000	350,000
Establish gender, age, and diversity inclusive BFCI committees at community unit level	168,750	337,500	337,500	337,500	337,500	1,518,750
Carry out gender integrated BFCI baseline assessment at community unit level	428,625	857,250	857,250	857,250	857,250	3,857,625
Carry out mentorship and OJT to HCWs on BFCI by CHMT and SCHMT	411,750	411,750	411,750	411,750	411,750	2,058,750
Conduct BFCI stakeholder sensitization in selected implementing sub counties	198,000	396,000	396,000	396,000	396,000	1,782,000
Conduct bi-monthly CMSG meetings in selected implementing community units	450,000	900,000	900,000	900,000	900,000	4,050,000
Carry out mapping of households for establishment of mother-to-mother support groups (MTMSG) in selected implementing community units			2,460,000			2,460,000
Carry out quarterly Sub-County data review meetings for MIYCN interventions.	-	-	-	-	-	-
Train male and female HCWs on the new WHO growth standards	-	824,000	824,000	824,000	824,000	3,296,000
Carry out CMEs at health facility level on GMP	-	-	-	-	-	-
Procure and distribute anthropometric equipment to maternal health clinic	-	-	-	-	-	-
Sensitize CHMT and SCHMT on implementation framework for securing a friendly breastfeeding environment at workplace	175,500	175,500	-	-	-	351,000
Train/sensitize male and female health care workers on implementation framework for securing a friendly breastfeeding environment at workplace	399,500	799,000	799,000	799,000	799,000	3,595,500
Sensitize male and female CHVs and the community on implementation framework for securing a friendly breastfeeding environment at workplace using effective communication channels	252,000	504,000	504,000	504,000	504,000	2,268,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 01: Maternal, Infant, Young Child Nutrition (MIYCN) scaled up	**13,259,575**	**19,443,500**	**29,128,000**	**28,827,000**	**24,177,500**	**114,835,575**
Sensitize key stakeholders in formal and informal sectors on implementation framework for securing a friendly breastfeeding environment at workplace	-	112,500	112,500	-	112,500	337,500
Carry out CMEs at health facility level on implementation framework for securing a friendly breastfeeding environment at workplace	-	-	-	-	-	-
Establish lactation rooms/breastfeeding corners in health facilities	-	975,000	-	2,925,000	-	3,900,000
Sensitize CHMT and SCHMT on BMS Act 2012.	-	-	-	-	-	-
Sensitize the private sector on BMS Act 2012.	75,000	75,000	75,000	75,000	75,000	375,000
Train/sensitize HCWs on the BMS implementation framework	-	824,000	824,000	824,000	824,000	3,296,000
Train PHOs, nutritionists, Police officers on monitoring and enforcement of the BMS Act	-	824,000	-	-	-	824,000
Carry out continuous monitoring, enforcement, and reporting of BMS Act,2012	-	-	-	-	-	-
Identify and engage male and female key influencers across different ages and diversities in MIYCN activities and promote increased engagement of men by sensitizing them on their important role in promoting and supporting optimal uptake of MIYCN practices.	-	-	-	-	-	-
Advocate for adaptation of Health Act, 2017, Workplace support for breastfeeding at County level in both public and private workplaces	240,000	-	-	-	-	240,000
Collaborate with print and electronic media to scale up gender transformative MIYCN messaging at all levels	166,500	166,500	166,500	166,500	166,500	832,500
KRA 02: Nutrition of older children and adolescents promoted	**2,538,500**	**7,089,500**	**7,531,500**	**6,131,500**	**3,227,000**	**26,518,000**
Create awareness on healthy diets to the older children and adolescents of both genders through school clubs, out of school youth groups on marketing and promotions within the school; sufficient safe and nutritious foods in school	-	-	286,000	-	-	286,000
Sensitize and disseminate the relevant policies for older children and adolescents to the School Managers, County and Sub-County Health Management Teams	105,000	4,762,500	4,312,500	3,150,000	900,000	13,230,000
Train key stakeholders on healthy diets and physical activity for older children and adolescents	-	-	-	-	-	-
Control marketing of unhealthy foods for older children and adolescents within the school environment	219,000	-	-	219,000	-	438,000
Identify and sensitize male and female key influencers, policy makers, role models, and nutrition champions across different ages and diversities on nutrition for older children and adolescents	124,500	-	-	115,500	-	240,000
Sensitize school stakeholders on marketing and promotions of healthy foods within the school: sufficient safe and nutritious foods in school	-	-	-	-	-	-
Sensitize households on healthy diets and physical activity using context-specific communication channels in both rural and urban setups targeting men and women, boys, and girls	-	-	286,000	-	-	286,000
Integrate messaging on healthy diets and physical activity in the school health programme targeting older children and adolescents	-	-	-	-	-	-
Collaborate with MoALF&C on establishment of diverse food production (crops, livestock, insects, and fisheries) by households	-	237,000	557,000	557,000	237,000	1,588,000
Promote collaboration with other sector interventions to promote good nutrition of older child and adolescent (MoE, MOALF&C, MoH, Industry, Finance, Gender, Sports, and social protection) and the private sector	-	-	-	-	-	-
Carry out joint quarterly support supervision of nutrition activities targeting the older children and adolescents by CHMT and SCHMT	990,000	990,000	990,000	990,000	990,000	4,950,000
Carry out quarterly submission of gender, age disaggregated reports on interventions carried out for older children and adolescents	1,100,000	1,100,000	1,100,000	1,100,000	1,100,000	5,500,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 03: Prevention, control, and management of Micronutrient Deficiencies scaled-up	**6,862,899**	**14,898,651**	**8,733,150**	**14,735,650**	**8,962,650**	**54,193,000**
Adapt, print, and distribute gender transformative BCC materials on micronutrients.	-	83,750	83,750	83,750	83,750	335,000
Carry out biannual Vitamin A supplementation for both boys and girls 6-59 months in health facilities, ECDs, outreaches and door to door visits	1,542,000	1,542,000	1,542,000	1,542,000	1,542,000	7,710,000
Carry out Iron and folic acid supplementation of pregnant women.	-	-	-	-	-	-
Carry out supportive supervision for micronutrient program by CHMT and SCHMT.	3,161,400	3,161,400	3,161,400	3,161,400	3,161,400	15,807,000
Carry out weekly iron and folic acid supplementation for adolescent girls in schools.	-	-	-	-	-	-
Procure and distribute micronutrient supplements (Vitamin A, dewormers, IFAS, MNPs and Zinc).	-	-	-	-	-	-
Sensitize and disseminate micronutrient policies and guidelines to CHMT and SCHMT and MOE. (Vitamin A, IFAS, WIFs, MNPs, Food Fortification)	369,500	-	-	369,500	-	739,000
Sensitize and disseminate the food fortification strategy to CHMT and SCHMT	-	229,500	-	-	229,500	459,000
Sensitize and disseminate the National Food Fortification Strategy to small and medium scale millers	200,999	303,001	-	-	-	504,000
Sensitize male and female CHVs on IFAS, MNPs, Vitamin A and Dewormers	443,000	443,000	443,000	443,000	443,000	2,215,000
Carry out health talks in facilities on IFAS, Vitamin A, dewormers and MNPs supplementation targeting male and female caregivers and other clients	-	-	-	-	-	-
Carry out MNP supplementation for both boys and girls 6-23 months as per national guidelines	-	-	-	-	-	-
Incorporate micronutrients program in the quarterly data review meetings	-	-	-	-	-	-
Print and distribute micronutrient monitoring and reporting tools to health facilities.	42,000	42,000	42,000	42,000	42,000	210,000
Carry out roadshows, radio talks targeting community members of different genders, age, and diversities to pass micronutrient messages	-	275,000	275,000	275,000	275,000	1,100,000
Train male and female HCWs on Vitamin A supplementation using the national guidelines	-	2,669,000	-	2,669,000	-	5,338,000
Train male and female HCWs on IFAS using the national guidelines	-	1,012,500	-	1,012,500	-	2,025,000
Train male and female teachers on weekly iron folic supplementation (WIFS)	-	1,670,500	-	1,670,500	-	3,341,000
Train male and female HCWs on MNPs using the national guidelines	-	1,202,000	1,202,000	1,202,000	1,202,000	4,808,000
Train small and medium scale millers of both gender on food fortification	219,000	219,000	219,000	219,000	219,000	1,095,000
Carry out routine market and industry level surveillance of fortified foods to increase compliance with fortification standards by public health officers.	-	-	-	-	-	-
Carry out routine monitoring and evaluation of food fortification program	-	880,000	880,000	880,000	880,000	3,520,000
Train male and female PHOs on food fortification and market surveillance.	171,000	171,000	171,000	171,000	171,000	855,000
Carry out annual salt iodization monitoring at County level	-	110,000	-	110,000	-	220,000
Sensitize male and female HCW on the salt iodization monitoring	-	171,000	-	171,000	-	342,000
Sensitize community on increased production, preservation, and consumption of diverse and bio fortified foods using context specific communication channels targeting men and women across different ages and diversities	280,000	280,000	280,000	280,000	280,000	1,400,000
Train/sensitize male and female CHVs on dietary diversity and bio-fortified foods.	434,000	434,000	434,000	434,000	434,000	2,170,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 04: Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) in the life course scaled-up	**440,400**	**75,400**	**480,400**	**75,400**	**480,400**	**1,552,000**
Collaborate with other stakeholders to support and participate in health awareness days e.g., WDD and WKD,	23,400	23,400	23,400	23,400	23,400	117,000
Monthly submission of reports on DRNCDs	-	-	-	-	-	-
Sensitize and disseminate the national guidelines on healthy diets and physical activity to CHMT and SCHMTs	-	-	-	-	-	-
Train male and female healthcare workers on healthy diets and physical activity	-	-	-	-	-	-
Sensitize community through gender, age, and diversity inclusive community forums (chief barazas, churches, mosques, women groups, youth groups etc.) on healthy diets and physical activity	-	-	-	-	-	-
Create awareness among community members of different genders, age, and diversities on nutrition in the prevention, control, and management of DRNCDs using locally available channels e.g., posters, pamphlets, radio, TV, and other social platforms	-	-	-	-	-	-
Carry out gender, age and diversity sensitive nutrition assessment, counselling, and support services to DRNCDs clients in health facilities	-	-	-	-	-	-
Conduct routine gender and age inclusive nutrition screening for DRNCDs in churches, Huduma Centre and during health awareness days	12,000	12,000	12,000	12,000	12,000	60,000
Procure and distribute relevant nutrition equipment for NCD clinics	-	-	-	-	-	-
Collaborate with the clinical team to establish and strengthen existing gender inclusive DRNCDs support groups	-	40,000	40,000	40,000	40,000	160,000
Carry out nutrition education and counselling to male and female DRNCDs clients in the support groups	-	-	-	-	-	-
Conduct CMEs on nutrition management in DRNCDs in health facilities	-	-	-	-	-	-
Advocate for establishment of gender inclusive wellness programs at facility and community level.	-	-	-	-	-	-
Carry out nutrition education on importance of physical activity through gender, age, and diversity inclusive community forums	-	-	-	-	-	-
Adapt existing national standards and regulations on healthy diets, NCDs and physical activities	180,000	-	180,000	-	180,000	540,000
Adapt national legislations on advertising, packaging, labelling, and marketing of foods and beverages	225,000	-	225,000	-	225,000	675,000
Conduct quarterly support supervision for facilities with DRNCDs clinics to assess nutrition integration	-	-	-	-	-	-
Integrate gender sensitive nutrition data for DRNCDs during quarterly data review meetings	-	-	-	-	-	-
KRA 05: Clinical nutrition and dietetics in disease management including HIV and TB strengthened	**88,313,336**	**91,132,176**	**88,545,336**	**90,957,176**	**88,808,336**	**447,756,360**
Adapt/develop SOPs for Clinical Nutrition	-	-	-	-	-	-
Carry nutrition education to both male and female caregivers of HEI	-	-	-	-	-	-
Carry out CMEs on Clinical Nutrition and Dietetics at health facility level.	-	-	-	-	-	-
carry out CMEs on Nutrition management in HIV and TB at healthcare facilities.	-	-	-	-	-	-
Carry out continuous updates on MIYCN in PMTCT in reference to the National guidelines to HCWs.	-	-	-	-	-	-
Carry out sensitization of clinical nutrition SOPs to all facilities offering in-patient care	-	-	-	-	-	-
Hold quarterly gender sensitive TWG meetings with relevant stakeholders on Nutrition in HIV and TB	300,000	300,000	300,000	300,000	300,000	1,500,000
link and refer malnourished HIV TB clients to livelihood and social protection programs at community level	-	-	-	-	-	-
Procure and distribute food preparation and feeding equipment for management of special medical conditions	53,000	53,000	53,000	53,000	53,000	265,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 05: Clinical nutrition and dietetics in disease management including HIV and TB strengthened	**88,313,336**	**91,132,176**	**88,545,336**	**90,957,176**	**88,808,336**	**447,756,360**
Refer and support MAM and SAM HEIs	-	-	-	-	-	-
Adapt and disseminate standard operating procedures (SOP) for nutrition and dietetics: protocol on nutrition management in diseases and conditions; inpatient feeding protocol to CHMTs SCHMTs and Facility in charges	-	263,000	-	263,000	-	526,000
Adapt and disseminate clinical nutrition tools: screening, inter-facility referral, patient feeding monitoring and service quality management tools to CHMTs SCHMTs and Facility in charges	736,000	-	736,000	-	736,000	2,208,000
Adapt and disseminate basic training and patient safety package for clinical nutrition and dietetics to CHMTs SCHMTs and Facility in charges	88,000	175,000	-	-	263,000	526,000
Sensitize HCWs on basic training and patient safety package for clinical nutrition and dietetics	-	-	-	-	-	-
Establish food safety inspection committees in the institutions	-	-	-	-	-	-
Disseminate key context-specific nutrition messages that promote positive lifestyles and behaviour for HIV /TB patients	-	-	-	-	-	-
Conduct outreach, referrals, and linkage systems to involve all community actors and optimize identification and linkage of PLHIV and TB patients with nutrition care and management	-	-	-	-	-	-
Sensitize and disseminate guidelines, strategies and policies on clinical nutrition and dietetics: guidelines for nutritional management of patients in disease and illness; home-based care guidelines for nutrition; guidelines on therapeutic food production units' manual to CHMTs SCHMTs and Facility in charges	734,500	-	734,500	-	734,500	2,203,500
Train male and female nutritionists on Clinical Nutrition and Dietetics	-	888,000	-	888,000	-	1,776,000
Sponsor male and female nutritionists to be trained on specialization in Clinical Nutrition and Dietetics (Oncology, Renal, Paediatrics, Critical Care)	-	200,000	200,000	200,000	200,000	800,000
Sponsor male and female nutritionists to be trained on Short courses for Clinical Nutrition and Dietetics	-	120,000	120,000	120,000	120,000	480,000
Carry out OJTs, Mentorship to frontline health care workers on Clinical nutrition and dietetics by the CHMT and SCHMTs	-	30,000	-	30,000	-	60,000
Advocate for exchange programs to learn best practices in Clinical Nutrition and Dietetics in level 6 health facilities	-	50,400	-	50,400	-	100,800
Sensitize male and female nutritionist and other healthcare workers on Nutrition Care Process.	-	-	-	-	-	-
Carry out gender, age and diversity sensitive nutrition assessment, counselling, and support (NACS) to all clients in the health facilities	-	-	-	-	-	-
Refer clients to other service delivery points within the health facility where applicable	-	-	-	-	-	-
Conduct monthly Clinical Nutrition Data Review meetings with Sub-County teams	-	-	-	-	-	-
Carry out sensitization of SOPs to SCNCs	-	-	-	-	-	-
Assess quality of nutrition care in facilities by County and Sub-County nutrition coordinators	712,800	712,800	712,800	712,800	712,800	3,564,000
Advocate for increased resource allocation for clinical nutrition and dietetics at County level targeting key decision makers	-	-	-	-	-	-
Procure and distribute Clinical Nutrition Assessment equipment and tools to health facilities	-	1,341,440	-	1,341,440	-	2,682,880
Procure and distribute nutrition therapeutic and supplementary commodities to health facilities	74,777,600	74,777,600	74,777,600	74,777,600	74,777,600	373,888,000
Procure and distribute enteral and parenteral commodities to health facilities	6,556,436	6,556,436	6,556,436	6,556,436	6,556,436	32,782,180
Procure and distribute clinical nutrition reporting tools to health facilities	500,000	500,000	500,000	500,000	500,000	2,500,000
Establish/activate in-patient feeding committees having inpatient care	-	-	-	-	-	-

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 05: Clinical nutrition and dietetics in disease management including HIV and TB strengthened	**88,313,336**	**91,132,176**	**88,545,336**	**90,957,176**	**88,808,336**	**447,756,360**
Train male and female HCWs on Nutrition in HIV and TB using national Guidelines to provide patient-focused nutrition therapy for paediatric patients and adolescents infected with HIV or TB	-	1,309,500	-	1,309,500	-	2,619,000
Conduct OJTs, Mentorships, and support supervisions in Nutrition Assessment, Counselling and Support (NACS) in HIV and TB by County and Sub-County health management teams	75,000	75,000	75,000	75,000	75,000	375,000
Offer comprehensive nutrition assessments, counselling and support in all HIV, TB, MNCH service points to reduce missed opportunities and improve service uptake and retention into care	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	6,500,000
Carry out nutrition education during PMTCT support group meetings	-	-	-	-	-	-
Carry out nutrition assessment among highly exposed infants (HEI) both at the health facility and community level.	-	-	-	-	-	-
Conduct quarterly nutrition DQA in CCCs and TB clinics	10,000	10,000	10,000	10,000	10,000	50,000
Integrate nutrition data from CCC and TB clinics in quarterly data review meetings	25,000	25,000	25,000	25,000	25,000	125,000
Adapt a series of small doable actions that enhance dietary diversity and physical exercises at household level for HIV and TB patients						-
initiate integrated kitchen gardens at household level using different technologies etc.	2,445,000	2,445,000	2,445,000	2,445,000	2,445,000	12,225,000
KRA 06: Integrated management of malnutrition and nutrition in emergencies strengthened	**13,188,800**	**25,516,800**	**22,153,300**	**24,821,800**	**21,907,300**	**107,588,000**
Advocate for inclusion of nutrition agenda in the emergency, preparedness, and response.	-	-	-	-	-	-
Carry out continuous gender responsive nutrition messaging targeting the vulnerable groups (PLW, Children under 2 years, people with pre-existing conditions, elderly, OVCs etc.) and the entire population	-	-	-	-	-	-
Carry out nutrition education and counselling for male and female caregivers for children under IMAM program	-	-	-	-	-	-
Conduct joint multidisciplinary support supervision using the HiNi OJT	-	-	-	-	-	-
Conduct quarterly nutrition commodity end-user supply monitoring.	-	-	-	-	-	-
Conduct targeted Mentorships, CMEs, and OJTs on IMAM in health facilities	180,000	180,000	180,000	180,000	180,000	900,000
Disseminate nutrition assessment findings to stakeholders for decision making	157,500	157,500	157,500	157,500	157,500	787,500
Establish and activate nutrition task force for emergencies	38,500	-	-	-	-	38,500
Map key stakeholders who are involved in nutrition emergency.	768,000	768,000	768,000	768,000	768,000	3,840,000
Participate in disaster management response teams at County and Sub-County levels	-	-	-	-	-	-
Procure contingency commodities for emergency response	-	-	-	-	-	-
Refer MAM and SAM cases from facility to community for continuous monitoring	-	-	-	-	-	-
Scale up facilities offering IMAM services	-	-	-	-	-	-
Sensitize male and female CHVs on IMAM	-	165,000	-	165,000	-	330,000
Sensitize male and female CHVs on MIYCN-E.	-	5,808,000	5,808,000	5,808,000	5,808,000	23,232,000
Train and disseminate IMAM guidelines to male and female healthcare workers.	-	679,500	-	679,500	-	1,359,000
Disseminate policy and guidelines on nutrition in emergencies to key decision makers, CHMT and SCHMT	-	421,000	-	421,000	-	842,000
Hold quarterly task force meetings for nutrition in emergency	92,400	92,400	92,400	92,400	92,400	462,000
Train male and female HCWs on MIYCN-E	-	2,025,000	2,025,000	2,025,000	2,025,000	8,100,000
Train male and female HCWs on IMAM surge kit.	-	900,000	900,000	900,000	900,000	3,600,000
Participate in joint planning and implementation meetings with other sectors on integrated preparedness and risk reduction	135,000	135,000	135,000	135,000	135,000	675,000
Conduct joint resource mobilization activities with other sectors on integrated preparedness and risk reduction	135,000	135,000	135,000	135,000	135,000	675,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 06: Integrated management of malnutrition and nutrition in emergencies strengthened	**13,188,800**	**25,516,800**	**22,153,300**	**24,821,800**	**21,907,300**	**107,588,000**
Adapt and implement of IMAM surge kit	-	288,000	-	288,000	-	576,000
Participate in stakeholders on disaster risk reduction	246,000	-	246,000	-	-	492,000
Adapt national SOPs for emergency response; finalize guidelines on linkage of nutrition with livelihood programmes	-	-	-	-	-	-
Develop/review County nutrition disaster preparedness and response plan	-	140,000	-	-	-	140,000
Develop County and Sub-County nutrition contingency plans	-	270,000	270,000	270,000	270,000	1,080,000
Carry out gender, age and diversity sensitive nutrition assessment during emergencies using the MIYCN-E rapid assessment tools to adapt response to the context	330,000	330,000	330,000	330,000	330,000	1,650,000
Activate emergency coordination for nutrition response monitoring	-	105,000	-	-	-	105,000
Optimize gender responsive nutrition service delivery approaches including outreach services in hard-to-reach areas, affected urban areas	1,230,000	1,230,000	1,230,000	1,230,000	1,230,000	6,150,000
Ensure access to high-impact nutrition interventions in emergencies	135,000	135,000	135,000	135,000	135,000	675,000
Disseminate guidelines, strategies, treatment protocols and standard operating procedures (SOP) to CHMTs, SCHMTs	-	126,000	-	126,000	-	252,000
Print and distribute IEC materials for IMAM program	-	450,000	-	-	-	450,000
Support the necessary training based on emerging evidence and continuous capacity-building on IMAM	1,930,500	1,930,500	1,930,500	1,930,500	1,930,500	9,652,500
Carry out community screening of children under five years and refer MAM and SAM cases to link health facilities	-	-	-	-	-	-
Carry out nutrition assessment for children under IMAM program in health facilities	-	-	-	-	-	-
Carry out nutrition support for children under the IMAM program	-	-	-	-	-	-
Procure and distribute nutrition IMAM commodities	920,000	920,000	920,000	920,000	920,000	4,600,000
Train male and female healthcare workers on LMIS for IMAM program.	-	1,309,500	-	1,309,500	-	2,619,000
Reprint and distribute nutrition data capture and reporting tools for IMAM program	-	200,000	-	200,000	-	400,000
Conduct quarterly Nutrition support supervision for IMAM interventions	-	-	-	-	-	-
Support quarterly nutrition data and quality audits for IMAM program	-	-	-	-	-	-
Monitor adherence to IMAM programme SOPs, guidelines and protocols by health and nutrition workforce by CHMT and SCHMT	410,000	410,000	410,000	410,000	410,000	2,050,000
Conduct IMAM programme performance reviews – cure, defaulter, death, coverage (linkage with M&E)	4,502,400	4,502,400	4,502,400	4,502,400	4,502,400	22,512,000
Promote appropriate documentation of related research, best practices, and learning	876,000	876,000	876,000	876,000	876,000	4,380,000
Use available mechanisms for coordination of IMAM to link IMAM services with other programmes (WASH, livelihood, Social protection, and food security).	-	828,000	-	828,000	-	1,656,000
Advocate for Public Private Partnership in the implementation of IMAM	1,102,500	-	1,102,500	-	1,102,500	3,307,500
KRA 07: Promote and scale up nutrition in nutrition sensitive sectors (Agriculture, Education (ECDE), WASH and social protection)	**25,303,050**	**32,806,950**	**26,567,550**	**31,544,450**	**26,836,050**	**143,058,050**
Advocate for establishment of school kitchen gardens in collaboration with the schools and agriculture	1,400,600	1,400,600	1,400,600	1,400,600	1,400,600	7,003,000
Advocate for inclusion in nutrition indicators into social services programmes	-	-	-	-	-	-
Advocate for protection of water sources and regular water treatment quality checks	525,000	525,000	525,000	525,000	525,000	2,625,000
Advocate for social safety nets in times of crisis	-	-	-	-	-	-
Advocate for support of the School feeding programmes to the County key decision makers (Education, Health, Agriculture, & County Assembly)	-	-	495,000	-	-	495,000
Carry out bi-annual Vitamin A supplementation and deworming in schools in collaboration with ECDE teachers	-	-	-	-	-	-

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 07: Promote and scale up nutrition in nutrition sensitive sectors (Agriculture, Education (ECDE), WASH and social protection)	**25,303,050**	**32,806,950**	**26,567,550**	**31,544,450**	**26,836,050**	**143,058,050**
Carry out joint quarterly support supervision of WASH activities	363,000	363,000	363,000	363,000	363,000	1,815,000
Carry out joint sensitization fora for stakeholders and disseminate food and nutrition security policy in collaboration with Agriculture	-	-	-	-	-	-
Carry out joint sensitization fora for stakeholders on Agri- nutrition in collaboration with Agriculture	-	-	-	-	-	-
Carry out quarterly submission of reports	-	-	-	-	-	-
Carry out referrals of sick and malnourished children to link health facilities	-	-	-	-	-	-
Conduct bi-monthly nutritional status assessments in ECDEs in collaboration with ECDE teachers	-	-	-	-	-	-
Hold joint planning meetings	-	-	-	-	-	-
Hold joint planning meetings with WASH stakeholders	-	-	-	-	-	-
Hold joint planning meetings with Social services and other relevant stakeholders	-	-	-	-	-	-
Participate in Agriculture sector stakeholders' coordination fora	-	-	-	-	-	-
Participate in ECDEs stakeholders' coordination fora	-	-	-	-	-	-
Participate in WASH stakeholders' coordination fora	-	-	-	-	-	-
Sensitize and disseminate the School Feeding programme guidelines to County and subcounty education managers	-	122,500	-	122,500	-	245,000
Sensitize and disseminate the School Feeding programme guidelines to ECDE headteachers and teachers	7,304,400	7,304,400	7,304,400	7,304,400	7,304,400	36,522,000
Sensitize stakeholders in Agriculture and health on food composition tables for decision making	85,000	-	-	-	-	85,000
Sensitize the local food processors on blending initiatives including fortification along the value chain	40,000	40,000	40,000	40,000	40,000	200,000
Sensitize the male and female extension workers and CHVs on diversified food production strategies, processing, preservation, and storage	2,238,500	2,238,500	2,238,500	2,238,500	2,238,500	11,192,500
Sensitize decision makers in the agriculture department and stakeholders on nutrition sensitive agriculture food systems	244,000	244,000	244,000	244,000	-	976,000
Hold joint feedback sessions with MoH, MoALF&C, MoW, MoE and other stakeholders	-	-	-	-	-	-
Sensitize community on diversified food production strategies, processing, preservation, and storage targeting men and women across different ages and diversities	1,000	1,000	1,000	93,000	93,000	189,000
Establish Kitchen garden sites at selected health facilities to act as demonstration sites	-	645,500	645,500	-	-	1,291,000
Advocate for establishment of Kitchen garden and rearing of small livestock at household level	-	-	-	276,000	276,000	552,000
Carry out community trainings and demonstrations on food utilization through gender, age, and diversity inclusive community fora (farmer to farmer groups, mother to mother, father to father groups)	-	510,000	510,000	510,000	510,000	2,040,000
Sensitize community on food safety and hygiene along the value chain using context specific communication channels targeting men and women across different ages and diversities	-	-	-	-	-	-
Sensitize the stakeholders on food safety and hygiene along the value chain	-	-	-	-	-	-
Carry out community trainings and demonstrations on energy saving technologies through gender, age, and diversity inclusive community fora (farmer to farmer groups, mother to mother, father to father groups	808,250	808,250	808,250	808,250	808,250	4,041,250
Carry out community trainings and demonstrations on meal planning through gender, age, and diversity inclusive community fora (farmer to farmer groups, mother to mother, father to father groups)	1,000	-	-	-	-	1,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 07: Promote and scale up nutrition in nutrition sensitive sectors (Agriculture, Education (ECDE), WASH and social protection)	**25,303,050**	**32,806,950**	**26,567,550**	**31,544,450**	**26,836,050**	**143,058,050**
Adapt and disseminate gender, age and diversity SBCC strategy for increased consumption of nutritious foods and improved dietary diversity (including fortified foods)	807,200	-	507,200	-	807,200	2,121,600
Advocate for nutrition sensitive agricultural production	-	-	-	-	-	-
Carry out joint quarterly support supervision of agri-nutrition activities with MOA	418,000	418,000	418,000	418,000	418,000	2,090,000
Carry out awareness/promote use of potable water /water treatment and safe water storage in the health facilities, schools and households through gender, age, and diversity inclusive community forum during nutrition sessions	1,884,000	8,184,000	1,884,000	8,184,000	1,884,000	22,020,000
Carry out awareness/promote hand washing at critical times in the health facilities, schools and households through gender, age, and diversity inclusive community forums during nutrition sessions	-	-	-	-	-	-
Carry out awareness on food safety and hygiene in the health facilities, schools, and households through gender inclusive community for a	-	-	-	-	-	-
Carry out awareness /promote environmental hygiene in the health facilities, schools and households through gender, age, and diversity inclusive community forums during nutrition sessions	-	-	-	-	-	-
Carry out awareness /promote household waste management in the health facilities, schools and households through gender, age, and diversity inclusive community forums during nutrition sessions	-	-	-	-	-	-
Carry out awareness /promote proper latrine use and proper disposal of diapers/sanitary pads in the health facilities, schools and households through gender, age, and diversity inclusive community forums during nutrition sessions	712,000	712,000	712,000	712,000	712,000	3,560,000
Participate in celebration of WASH related thematic days celebrations (world water day, latrine day)	1,980,000	1,980,000	1,980,000	1,980,000	1,980,000	9,900,000
Carry out joint quarterly support supervision of WASH activities with public health department	-	-	-	-	-	-
Carry out quarterly submission of integrated WASH and nutrition intervention reports						-
Sensitize male and female ECDE teachers on nutrition assessments, Vitamin A supplementation and deworming in schools	4,939,200	4,939,200	4,939,200	4,939,200	4,939,200	24,696,000
Develop and disseminate menus for the ECDEs schools in collaboration with ECDE teachers	-	-	-	-	-	-
Sensitize stakeholders including, curriculum support officers, food service providers & handlers, PTA on healthy and safe food environment	165,900	-	165,900	-	165,900	497,700
Advocate for improved access to safe and sufficient water, and adequate WASH services in schools and other learning institutions	450,000	450,000	450,000	450,000	450,000	2,250,000
Carry out joint quarterly support supervision of Integrated Nutrition School activities with MOE	363,000	363,000	363,000	363,000	363,000	1,815,000
Participate in social services coordination mechanisms	-	-	-	-	-	-
Conduct a situation analysis on status of nutrition and health for the vulnerable groups together with the stakeholders	-	50,000	-	-	50,000	100,000
Adapt and disseminate targeting criteria for nutrition in social protection programmes; cash transfers, hunger safety nets, and others to CHMT, SCHMT and other health care workers	-	935,000	-	-	935,000	1,870,000
Sensitize (a) the public and b) management of institutions of vulnerable persons and correction facilities including social services staffs on nutrition for vulnerable groups (elderly and street children homes)	105,000	105,000	105,000	105,000	105,000	525,000
Sensitize male and female HCWs on nutrition for vulnerable groups	105,000	105,000	105,000	105,000	105,000	525,000
Carry out nutrition education & counselling targeting the vulnerable groups in collaboration with social services and agriculture	-	-	-	-	-	-
Carry out joint quarterly support supervision of integrated nutrition social services activities with County department of social services	363,000	363,000	363,000	363,000	363,000	1,815,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 08: Sectoral and multi-sectoral nutrition governance, coordination and legal/regulatory frameworks, nutrition information systems, learning and research strengthened	**7,922,200**	**11,674,200**	**7,786,700**	**10,406,800**	**15,658,000**	**53,447,900**
Adapt and disseminate relevant nutrition policies and guidelines in the multi-sectoral platforms, CHMT, SCHMT	-	-	-	-	-	-
Conduct bi-annual nutrition data quality audit/assessment	1,020,000	1,020,000	1,020,000	1,020,000	1,020,000	5,100,000
Conduct midterm and end term review of nutrition AWP and undertake relevant corrective actions	410,000	410,000	410,000	410,000	410,000	2,050,000
Conduct quarterly data review meetings for nutrition performance	-	-	-	-	-	-
Conduct quarterly feedback meetings at facility and community level	396,000	396,000	396,000	396,000	396,000	1,980,000
Conduct quarterly review meetings for school health and nutrition programs	552,000	552,000	552,000	552,000	552,000	2,760,000
Disseminate survey and assessment findings for decision making	-	-	-	-	-	-
Establish a multi sectoral platform (MSP) for nutrition	135,500	-	-	-	-	135,500
Partner with academic institutions to conduct implementation/ operational research to address county specific nutrition gaps	-	25,000	-	25,000	-	50,000
Procure and distribute adequate nutrition M & E tools for all health facilities	-	-	-	-	-	-
Sensitize CHMT, SCHMT on the nutrition score card	-	168,400	-	-	168,400	336,800
Train male and female nutrition staff on strategic leadership and development program	627,000	627,000	627,000	627,000	627,000	3,135,000
Map all nutrition partners and stakeholders from both public and private sectors within the County	-	-	-	-	-	-
Conduct bi-annual MSP meetings as per TOR	271,000	271,000	271,000	271,000	271,000	1,355,000
Conduct quarterly County nutrition technical forums as per TOR	554,000	554,000	554,000	554,000	554,000	2,770,000
Conduct quarterly Sub-County nutrition technical forums as per TOR	352,000	352,000	352,000	352,000	352,000	1,760,000
Participate in annual nutrition standards and regulation summit with relevant actors	832,000	832,000	832,000	832,000	832,000	4,160,000
Train male and female nutrition officers on senior management course	440,000	440,000	440,000	440,000	440,000	2,200,000
Carryout mentorship, OJT and CMES for health workers of both genders on nutrition data reporting	144,000	144,000	144,000	144,000	144,000	720,000
Conduct gender integrated nutrition SMART survey	-	1,681,200	-	-	-	1,681,200
Conduct gender integrated MIYCN KAP survey	-	-	-	2,595,100	-	2,595,100
Conduct periodic sentinel surveillance	1,023,000	1,023,000	1,023,000	1,023,000	1,023,000	5,115,000
Conduct nutrition capacity assessment including capacity to mainstream gender in nutrition interventions	-	1,502,900	-	-	1,502,900	3,005,800
Develop gender responsive nutrition annual work plan (AWP)	205,000	205,000	205,000	205,000	205,000	1,025,000
Develop the 2nd generation gender responsive Nakuru CNAP	-	-	-	-	5,690,000	5,690,000
Develop and disseminate gender integrated annual nutrition reports	445,000	445,000	445,000	445,000	445,000	2,225,000
Advocate for research in nutrition among nutrition staff going for further studies	-	-	-	-	-	-
Support participation of nutrition staff in County, national knowledge sharing forums such as symposiums, conferences, workshops, meetings	215,200	725,200	215,200	215,200	725,200	2,096,000
Participate in forums for dissemination of research findings and information sharing	188,000	188,000	188,000	188,000	188,000	940,000
Promote knowledge sharing through publication of nutrition research findings	112,500	112,500	112,500	112,500	112,500	562,500
Establish research repository for nutrition and dietetics	-	-	-	-	-	-

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 09: Advocacy, Communication and Social Mobilization (ACSM) strengthened	**1,120,000**	**1,806,500**	**664,000**	**1,120,000**	**1,806,500**	**6,517,000**
Conduct high level nutrition advocacy forum with the governor, County assembly and other leaders	-	-	-	-	-	-
Create awareness for nutrition interventions through media platforms	350,000	350,000	350,000	350,000	350,000	1,750,000
Develop and submit proposals for funding of nutrition activities	51,000	51,000	51,000	51,000	51,000	255,000
Document and disseminate lessons learnt and best practices in nutrition	-	-	-	-	-	-
Document and share human interest stories related to nutrition	-	-	-	-	-	-
Participate in Commemoration of nutrition related health days (World breastfeeding week, diabetes day, hypertension days, prematurity day, Malezi bora weeks)	-	-	-	-	-	-
Participate in community dialogue days, mainstream nutrition agenda to enhance feedback mechanisms	-	232,500	-	-	232,500	465,000
Sensitize County leadership and other stakeholders on CNAP to support implementation	-	105,000	-	-	105,000	210,000
Engage male and female nutrition champions to advocate for prioritization of nutrition at all levels	500	500	500	500	500	2,500
Advocate for employment of male and female nutrition officers to key County decision makers	-	-	-	-	-	-
Advocate for relevant sectors to support establishment of multisectoral nutrition platforms	456,000	-	-	456,000	-	912,000
Advocate for adequate financial resources for sustained and quality nutrition services including domestic resource mobilization and budgetary allocation for nutrition commodities, equipment, and reporting tools	-	-	-	-	-	-
Participate in County planning process ensuring nutrition representation and mainstreaming nutrition in the national and County plans.	262,500	262,500	262,500	262,500	262,500	1,312,500
Train male and female nutrition staff on gender responsive nutrition advocacy to better package information for the community	-	240,000	-	-	240,000	480,000
Train media personalities of different genders, age, and diversities on gender responsive nutrition advocacy to improve coverage of nutrition issues	-	240,000	-	-	240,000	480,000
Develop and disseminate a gender responsive County advocacy, communication, and social mobilization plan	-	85,000	-	-	85,000	170,000
Advocate for lactation stations in workplaces among stakeholders in public and private sectors	-	-	-	-	-	-
Develop/adapt and disseminate gender transformative nutrition IEC/BCC materials	-	-	-	-	-	-
Conduct annual roadshows to promote nutrition intervention awareness among the public/population targeting men and women, boys and girls across different ages and diversities	-	40,000	-	-	40,000	80,000
Advocate through the County leadership for billboards with gender transformative nutrition messages strategically displayed in the County	-	200,000	-	-	200,000	400,000
KRA 10: Supply chain management for nutrition commodities and equipment's strengthened	**318,353,756**	**321,411,696**	**318,778,256**	**320,979,696**	**318,778,256**	**1,598,301,660**
Advocate for improved storage facilities for nutrition commodities	-	-	-	-	-	-
Conduct a gaps assessment for nutrition equipment and tools	500	-	-	500	-	1,000
Participate in commodity security TWG meetings and medical therapeutic committees at County and Sub-County level	-	-	-	-	-	-
Procure and distribute Clinical Nutrition Assessment equipment and tools	-	1,341,440	-	1,341,440	-	2,682,880
Train male and female health workers on nutrition LMIS	-	-	-	-	-	-
Train male and female nutritionists and other healthcare workers on quantification and forecasting and supply chain management of nutrition commodities	-	425,000	425,000	-	425,000	1,275,000
Conduct joint commodity support supervision with County and Sub-County health management teams	1,710,000	1,710,000	1,710,000	1,710,000	1,710,000	8,550,000

Key Result Areas	2020/21	2021/22	2022/23	2023/24	2024/25	Total
KRA 10: Supply chain management for nutrition commodities and equipment's strengthened	**318,353,756**	**321,411,696**	**318,778,256**	**320,979,696**	**318,778,256**	**1,598,301,660**
Procure and distribute nutrition commodities (enteral, parenteral, therapeutic, supplementary feeds, IFAS, MNPs, Vitamin A, dewormers)	314,866,876	314,866,876	314,866,876	314,866,876	314,866,876	1,574,334,380
Procure and distribute gender and age-appropriate nutrition equipment's based on evidence from the gap analysis	5,500	5,500	5,500	5,500	5,500	27,500
Procure and distribute nutrition reporting tools (data collection and summary tools)	280,000	1,572,000	280,000	1,564,500	280,000	3,976,500
Develop/Adapt national SOPs for nutrition commodities and equipment for each level of care	-	-	-	-	-	-
Request for and follow up on repair and maintenance of nutrition equipment through collaboration with the medical engineering department	-	-	-	-	-	-
Collaborate with the food safety division and regulatory bodies to ensure good quality of nutrition commodities and equipment	672,000	672,000	672,000	672,000	672,000	3,360,000
Conduct nutrition commodity data quality audits and data review meetings	432,000	432,000	432,000	432,000	432,000	2,160,000
Conduct joint support supervision and end user monitoring of nutrition commodities	386,880	386,880	386,880	386,880	386,880	1,934,400
Grand Total	**477,302,516**	**525,855,373**	**510,368,192**	**529,599,472**	**510,641,992**	**2,553,767,545**

Appendix B: List of key contributors

NAME	TITLE	ORGANIZATION
Anne Odhiambo	MoA - Agri-Nutrition	County Government of Nakuru
Anne Owido	Nutritionist	County Government of Nakuru
Caroline Kenduiwa	Nakuru West SC Nutritionist	County Government of Nakuru
Christine Kihara	County Nutrition Coordinator	County Government of Nakuru
Christine Makena	Senior Project Officer	Nutrition International
Dr. Alice Gichobi	County Pharmacist	County Government of Nakuru
Dr. Benedict Osore	Director - Administration & Planning	County Government of Nakuru
Dr. Solomon Sirma	Chief Officer - Medical Services	County Government of Nakuru
Dr. Toromo Kochei	County Partners Coordinator	County Government of Nakuru
Dr. Wainaina Daniel	Director - Medical Services	County Government of Nakuru
Dr. Z. Gichuki Kariuki	County Executive Committee Member – Health Services	County Government of Nakuru
Elizabeth Kiptoo	Director - Public Health & Sanitation	County Government of Nakuru
Elizabeth Njambi	Nutritionist - Nakuru Level V	County Government of Nakuru
Esther Achar	Nutritionist	AFYA Uzazi
Evaline Koech	Nutritionist Nakuru PGH	County Government of Nakuru
Evangeline Nginya	County Programme Coordinator	Nutrition International
Fredrick Oscar	Director - Agriculture & Fisheries	County Government of Nakuru
Gerald Kinyua	P.O - Monitoring and Reporting	Nutrition International
Gerald Maina	County Preventive & Promotive Health Coordinator	County Government of Nakuru
Jacinta Lukania	Nutritionist – Subukia Sub-County	County Government of Nakuru
Jackline Kangongo	County Human Resource Manager	County Government of Nakuru
James Mburu	Nutritionist	County Government of Nakuru
James Oyieko	Program Officer MNCHN.	AFYA Uzazi
Jessica Musisi	County Health Administrator	County Government of Nakuru
John Mwangi	Nutritionist	County Government of Nakuru
Lillian K. Marita	Nutritionist PGH Annex	County Government of Nakuru
Lisa Boiywo	Nutrition Department In-charge Nakuru Level V	County Government of Nakuru
Luke Kiptoon	County Health Records Information Officer	County Government of Nakuru
Rita Ochola	County Community Strategy Focal Person	County Government of Nakuru
Samuel Kingori	Chief Officer – Public Health and Sanitation	County Government of Nakuru
Selina Nkatha	Director - Gender	County Government of Nakuru
Shelmith Mucoki	PAO	County Government of Nakuru
Stellamous Muthoka	Nutritionist – COD Human Nutrition Department	Egerton University
Virginia Njenga	Chief Nursing Officer	County Government of Nakuru
Winnie Kerewo	Nutritionist - Rongai Sub-County	County Government of Nakuru