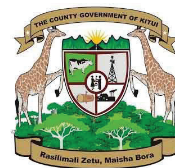
COUNTY GOVERNMENT OF KITUI



County Ministry of Health and Sanitation

County Nutrition Action Plan

2019-2023

Kuya kuseo ni kumina kutina

The financial contribution of DFID-UK through UNICEF's Maternal & Child Nutrition Programme II and USAID's through Health and Nutrition Program plus in the development of this County Nutrition Action Plan is gratefully acknowledged.

Table of Contents

List of Abbreviations and Acronyms iii

Forward iv

Preface v

Acknowledgement vi

Executive summary vii

CHAPTER 1: INTRODUCTION 1

1.1 Background information 1

1.2 Demographic profile 2

1.3 Health Facility Distribution Per Level and Ownership 2

1.4 National policy and legal framework for CNAP 3

1.5 Trends in Health and nutrition situation in Kitui County 4

1.6 Human resource for health and nutrition 5

1.7 constraints in health and nutrition in Kitui County 5

CHAPTER 2: COUNTY NUTRITION ACTION PLAN (CNAP) FRAMEWORK 6

2.1 Introduction 6

2.2 Rationale for the development of Kitui County Nutrition Action Plan 6

2.3 KCNAP Overall Objective/Purpose 7

2.4 KCNAP development process 8

2.5 Target Audience for KCNAP 9

3 CHAPTER 3: KEY RESULT AREAS (KRAs), STRATEGIES AND INTERVENTIONS 10

3.1 KRA 1 - Strengthened care practices and services for improved maternal, newborn, infant and young child nutrition (MNIYCN) 10

3.2 KRA 2: Prevention, control and management of micronutrient deficiencies scaled up 11

3.3 KRA 3: Prevention, Control and management of Non Communicable and other Diet Related Diseases Strengthened (DRNCDs) 12

3.4 KRA 4: Integrated Management of Acute Malnutrition (IMAM) strengthened with a sub-section of Nutrition in emergencies 13

3.5 KRA 5: Nutrition in HIV and TB promoted 15

3.6 KRA 6: Food and Nutrition Security in Agriculture and Livestock Scaled up 16

3.7 KRA 7: Nutrition in the health sector strengthened 18

3.8 KRA 8: Nutrition in Education and Early Childhood Development promoted 18

3.9 KRA 9: Nutrition in Water, Sanitation and Hygiene (WASH) Sector promoted 19

3.10 KRA 10: Nutrition in Social Protection programmes promoted. 20

3.11 KRA 11: Sectoral and Multi Sectoral Nutrition Information Systems, Learning and Research Strengthened 21

3.12 KRA 12: Advocacy, Communication and Social Mobilization (ACSM) Strengthened 22

3.13 KRA 13: Supply Chain Management for Nutrition Commodities and Equipment Strengthened 24

4.0 CHAPTER 4: MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL) FRAMEWORK 25
4.1 Introduction....25
4.2 COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK (CRAF)....26
4.3 KCNAP Monitoring Process....27
4.4 Data Review and Performance Monitoring Processes....27
4.5 KCNAP Evaluation Process....28
4.6 KCNAP Learning Process....29
4.7 Cost of MEAL 30

5.0 CHAPTER 5: CNAP RESOURCE MOBILIZATION AND COSTING FRAMEWORK....31
5.1 Introduction....31
5.2 Costing Approach of the KCNAP 31
5.3 Resource needs for implementing Kitui County Nutrition Action Plan 31
5.4. Funding Opportunities and Sustainability Plan for the KCNAP 33

List of Table

Table 1: Population Distribution per Cohort 2
Table 2: Population Projection Per Sub County.... 2
Table 3 : Health Facility Distribution per level and ownership.... 3
Table 4: Health Facility Distribution by Sub County 3
Table 5: Human Resource for Health and Nutrition 5
Table 6: The cost–benefit ratios of different nutrition intervention programmes....7
Table 7: Kitui County Nutrition Action Plan KRAs 8
Table 8: MEAL Explained....25
Table 9: Kitui Nutrition Targets for 2022/23 26
Table 10: Summary of resource need by KRA for Kitui County Nutrition Action Plan 2019-2023....32

List of Figures

Figure 1: Kitui County Map 1
Figure 2: Malnutrition Trends in Kitui....4
Figure 3: Childhood Diseases in Kitui....4
Figure 4: KCNAP development process....8
Figure 5: SAM (Inpatient Admissions and Out Patient Admissions) 14

List of Abbreviations and Acronyms

KNAP	*Kenya Nutrition Action Plan. CNAP – County Nutrition action plan.*
KCNAP	*Kitui County Nutrition Action Plan. KNBS – Kenya National Bureau of statistics.*
CHSSP	*County Health Sector Strategic plan. FBO – Faith Based organization*
SUN	*Scaling Up Nutrition Movement. WHA – world Health Assembly.*
SDGs	*Sustainable Development Goals.*
ICN2	*Second International Conference on Nutrition. UHC – Universal Health Care.*
SMART	*Specific Measurable Achievable Results oriented and time bound. USD – US dollar.*
KDHS	*Kenya Demographic and Health survey. NHPPLUS-Nutrition and Health Program plus UNICEF – United Nations Children's Fund.*
DALYs	*Disability Adjusted Life Years*
DRNCD	*Diet-Related Non Communicable Diseases WASH – Water and Sanitation Hygiene*
KRAs	*Key Result Areas*
ACSM	*Advocacy, Communication and social mobilization. BFCI – Baby Friendly Community Initiative.*
MNIYCN	*Maternal, Newborn, Infant and Young Child Nutrition. NGOs – Non Governmental organizations.*
KABP	*Knowledge, Attitude, Behavior and Practices. IMAM – Integrated management of acute malnutrition. HIV – Human Immunodeficiency Virus.*
TB	*Tuberculosis.*
PLHIV	*People Living with HIV.*
CIDP	*County Integrated Development Plan SBCC - Social Behavior Change Communication AWPs – Annual Work Plans*
IQ	*Intelligence Quotient*
HGSFP	*Home-grown School feeding programme ECDE - early childhood development and education LRA – Long Rains Assessment*
NFNSP	*National Food and Nutrition Security Policy*
NFNSP-IF	*National Food and Nutrition Security Policy Implementation Framework ASAL – Arid and Semi-Arid Lands*
NHIF	*National Hospital Insurance Fund KCHIC – Kitui County Health Insurance Cover M&E - - Monitoring and Evaluation*
SDP	*Service delivery Point.*
NDMA	*National Drought Management authority. LMIS - Logistics Management Information System. KHIBS - Kenya Household Income and Budget Survey NIS - -Nutrition Information System.*
KNCDF	*Kenya Nutrition Capacity Development Framework. KEMSA – Kenya Medical Supplies Agency*
KEPH	*Kenya Essential Package for Health. EMMS - Essential Medicines & Medical Supplies. MOH – Ministry of Health.*
MEAL	*Monitoring, Evaluation, Accountability and Learning. CRAF - Common Results and Accountability Framework.*
AMNRs	*Annual multi-sectoral and multi-stakeholder nutrition reviews. MTR – Mid-term Review.*
ETR	*End-term Review.*
NIMES	*National integrated monitoring and evaluation systems. CIMES - County integrated monitoring and evaluation systems.*

Foreword

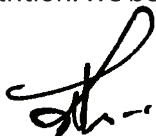
Kenya is a signatory to several nutrition-related global agreements and mechanisms including the Scaling Up Nutrition (SUN) movement, the World Health Assembly (WHA) 2025 nutrition targets, the Sustainable Development Goals (SDGs), the United Nations (UN) Decade of Action on Nutrition (2016–2025), and the 2nd International Conference on Nutrition, Declaration and Plan of Action. The agreements lay down the foundation for addressing the immediate, underlying and basic causes of malnutrition including expanding the political, economic, social and technological space for nutrition actions. The 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 government is committed to creating an enabling environment for citizens to realize these rights as evidenced in the Vision 2030, Kenya Health Policy (2014–2030) and the National Food and Nutrition Security Policy, 2012.

The Kenya Health Policy (KHP) and the National Food and Nutrition Security Policy (NFNSP) outline some of the key measures the government will put in place for realization of the Vision 2030. This is to be achieved through supporting the provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans. The government's commitment to providing a high quality of life to all its citizens was further affirmed by the declaration of His Excellency President Uhuru Kenyatta of the big four agenda in 2017. Among the priorities of this agenda is having universal health coverage by 2022.

Nationally, several pieces of legislation covering key aspects of nutrition interventions have been enacted; for example, in addressing micronutrients deficiency, salt iodization and mandatory fortification of vegetable fats and oil and packaged wheat and maize flours. Additionally, the breastmilk substitute (regulation and control act) 2012 and Article 71 and 72 of the Health Act 2017 provide for promotion, protection and support of breastfeeding.

The Kitui CIDP (2018-2022) has prioritized access to clean and sufficient water for domestic and commercial use including a Health Insurance Scheme to ensure that catastrophic out-of-pocket expenditures are significantly reduced, to lessen the health burden of the vulnerable groups in the County. Additionally, the Kitui HSSP (2018-2022) has anchored the priorities of the national health sector including the drive to achieve the Universal Health Coverage (UHC) spearheaded by the President under his Big Four Agenda. Health is one of her Excellency Kitui County Governor Charity Kaluki Ngilu's manifesto, with commitments to improving access to health care to Kitui people.

The Kitui County Nutrition Action Plan (KCNAP) 2019–2023 is in cognizant of nutrition challenges especially stunting which according to the 2014 Kenya Demographic and Health Survey was reported as 45.8%. In addition, other MIYCN challenges have been reported in KABP surveys notably poor dietary diversity. The main objective of the KCNAP is to accelerate and scale up efforts towards the elimination of malnutrition in Kitui County in line with Kenya's Vision 2030 and Sustainable Development Goals, focusing on specific achievements by 2022. The KCNAP focuses on three areas of intervention namely: nutrition specific, nutrition sensitive and enabling environment, putting emphasis on the need for strengthening Multisectoral collaboration in addressing malnutrition. We believe this four-year plan will contribute to achieving the Kenya Development Agenda.



Dr. Richard Muthoka,
Chief officer,
Ministry of Health and Sanitation,
Kitui County.

Preface

Quality health care forms the foundation for a nation's accelerated overall national development agenda. Vision 2030 envisages Kenya as a globally competitive middle-income country by 2030. To realize this dream, the health sector must institutionalize its planning processes in order to operate efficiently and cohesively. To this effect, the President in November 2017 made a declaration to include the provision of quality and affordable health care as part of the government's 'Big Four' agenda for the 2017–2022 medium-term plan (MTP) period. The Ministry of Health is taking the lead in implementing the President's action plan on universal health coverage and food and nutrition security.

In Kitui County, health is the Second Pillar in the Governor's manifesto. This is being realized through; opening health facilities in under- served areas, increased staffing including nutritionists, expansion of health facilities including the opening of specialized units and procurement of medical equipment to improve the quality of healthcare in the County. The Governor also rolled out Kitui County Health Insurance cover (K-CHIC). This programme is complementing other health insurance covers and leading to reduction of high out- of- pocket expenditure on health in the County. KCHIC, allows beneficiaries to access all health services offered in public hospitals within the County at no extra fee.

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, with an emerging triple burden of malnutrition, where undernutrition (underweight, stunting and wasting), overweight and obesity and micronutrient deficiencies are on the increase in addition to the burden of Non-Communicable Diseases (NCDs) (Kenya Demographic and Health Survey (KDHS), 2014).

The KCNAP 2019-2023 applies a Multi and cross sectoral approach in addressing the social determinants of malnutrition in a sustainable way. This is done while ensuring that optimal nutrition is attained for all County residents. Attaining this noble goal is possible through the alignment and definition of roles and responsibilities of the different actors. Cognizance and prominence is given to the fact that addressing the triple burden of malnutrition requires a wider reach beyond the health sector.

The KCNAP 2019–2023 is the first action plan that follows the implementation of the first National Nutrition Action Plan 2012–2017 and builds on the success, limitations and opportunities of the past five years' plan. Drawing from lessons learnt from the previous National Nutrition Action Plan 2012-2017, the KCNAP has been developed through a stepwise consultative process). A series of dedicated meetings and workshop were held with key Nutrition Actors under County Government leadership during the entire development process.

The KCNAP will provide a critical catalyst for enhancing accountability, Multisectoral collaboration and coordination, linking national and county actions. The KCNAP is also aligned to County CIDP, HSSP and the KNAP's results matrix. Key priorities to be implemented during the four years from 2019 to 2023 have been identified. It is our expectation that in working together, the overall objectives of the KCNAP will be achieved.

Acknowledgement

The development of the Kitui County Nutrition Action Plan (KCNAP) could not have been successful without the concerted effort of various players who worked tirelessly, and ensured that the plan for the period 2019- 2023 was adequately informed and finalized within the desired time. The plan was formulated through a consultative process involving the County Ministry of Health and Sanitation, and relevant stakeholders. It seeks to address the triple burden of malnutrition in Kitui County, characterized by (i) the coexistence of under nutrition as manifested by stunting, wasting, underweight and low birthweight; (ii) micronutrient deficiencies; and (iii) overweight, obesity and diet-related non-communicable diseases (DRNCD).

Kitui County Ministry of Health and Sanitation takes this opportunity to thank everyone who participated in the development of this plan through their technical and financial support.

Special thanks goes to the National MOH's Division of Nutrition and County Ministry of Health's Division of Nutrition and Immunization for the overall leadership and technical support. Further, we express sincere gratitude to Department for International Development (DFID), the United Nations Children's Fund (UNICEF) Kenya, Nutrition Health Program Plus (NHPplus) and World Vision Kenya (WVK) for their technical and financial support.

The contributions of the following Ministries and Government Agencies in the development of the KCNAP by infusing nutrition sensitive aspects and enabling environment is also highly appreciated: Education, Labour (Children's Department), Agriculture, Water and Livestock Development and National Drought Management (NDMA).

I call upon stakeholders engaged in Nutrition specific and Nutrition sensitive interventions, to join hands in utilizing this action plan in the implementation of their programs in an effort to eradicate malnutrition in all its forms from Kitui County.

Dr. Allan Owino
County Director of Health

Executive summary

Kitui County Nutrition Action Plan (KNAP) 2019–2023 is an evidence-based five-year strategic action plan that seeks to address malnutrition in the county in all its forms. It is a Costed Action Plan for the implementation of the Kenya Food and Nutrition Security Policy (FNSP) and borrows a lot from County Integrated Development Plan, County Health Sector Strategic Plan and Sector Annual Works Plans. The Kenya Vision 2030, the Big Four Agenda, together with the overall global health and nutrition agenda within the framework of the constitution and legal framework, formed the over-arching guidance for the development of KCNAP. The plan promotes cross-sectoral collaboration to address the social determinants of malnutrition sustainably. The overall expected result of the KCNAP is a malnutrition free Kitui County.

The KCNAP development process was driven by county government through the County Ministry of Health and Sanitation, the Nutrition Sub Sector. The process involved wide consultation with all key stakeholders including: county government line ministries, development partners and donor agencies, and the private sector. The process was evidence-informed through desktop literature review of KHIS, Nutrition SMART surveys, Knowledge Attitude Practice and Behaviour (KAPB) Survey, Kenya Demographic Health Survey, Nutrition Capacity Assessment and other health and nutrition research. A review of the stated documents indicated substantial reduction in the prevalence of malnutrition among children under five years, improved breastfeeding practices, improved policy environment and capacity to deliver nutrition services which points to improved collaboration among key stakeholders driven by government leadership. However, the review also noted key challenges including: a delay in the establishment of coordination mechanisms as stipulated in the Food and Nutrition Security Policy (FSNP), weak linkage with other sectors, inadequate monitoring and evaluation of nutrition interventions, limited funds allocation from the government for nutrition interventions and inadequate funding for research to generate evidence.

The main audience for the KCNAP is policy makers, planners, nutrition managers and officers at all levels, academia, development partners, donors, Non-Government Organizations (NGOs), civil society organizations (CSOs), faith-based organizations (FBOs) and the private sector. The document will also help the public at large to understand what the county government is doing to ensure optimal nutrition for her citizens, and what they can do individually to contribute to improved nutrition.

This KCNAP has been organized into five chapters as follows: Chapter 1, the introduction, discusses the global, regional and national frameworks under which the KCNAP is anchored. A comprehensive nutrition situation trend analysis is presented in Chapter 2, while Chapter 3 presents the key results areas, strategic objectives, key strategies and interventions and the expected outcomes. Chapters 4 and 5 present the Monitoring, Evaluation, Accountability and Learning (MEAL) Framework respectively and Resources needed for KCNAP implementation.

Further, the KCNAP is organized into three categories of result areas with corresponding interventions. These include nutrition-specific, nutrition-sensitive and enabling environment as listed below:

Nutrition Specific Key Result Areas

KRA 1: Maternal, newborn, infant and young child nutrition (MNIYCN) scaled up

KRA 2: Prevention, control and management of micronutrient deficiencies scaled up

KRA 3: Prevention, control and management of non-communicable and other diet related diseases strengthened

KRA 4: Integrated management of acute malnutrition (IMAM) strengthened with a sub-section of Nutrition in emergencies

KRA 5: Nutrition in HIV and TB promoted

Nutrition Sensitive Key Results Areas

KRA 6: Food and nutrition security in agriculture and livestock scaled up

KRA 7: Nutrition in the health sector strengthened

KRA 8: Nutrition in education and early childhood development promoted

KRA 9: Nutrition in water, sanitation and hygiene (WASH) sector promoted

KRA 10: Nutrition in social protection programs promoted

Enabling Environment (Cross Cutting) Key Result Areas

KRA 11: Sectoral and multi sectoral nutrition information systems, learning and research strengthened KRA 12: Advocacy, communication and social mobilization (ACSM) strengthened

KRA 13: Supply chain management for nutrition commodities and equipment strengthened

The total cost to achieve the 13 key results over the next four years will be KES 38.3 billion (US$ 379.9 million)

Table 1 presents annual estimated budget requirements.

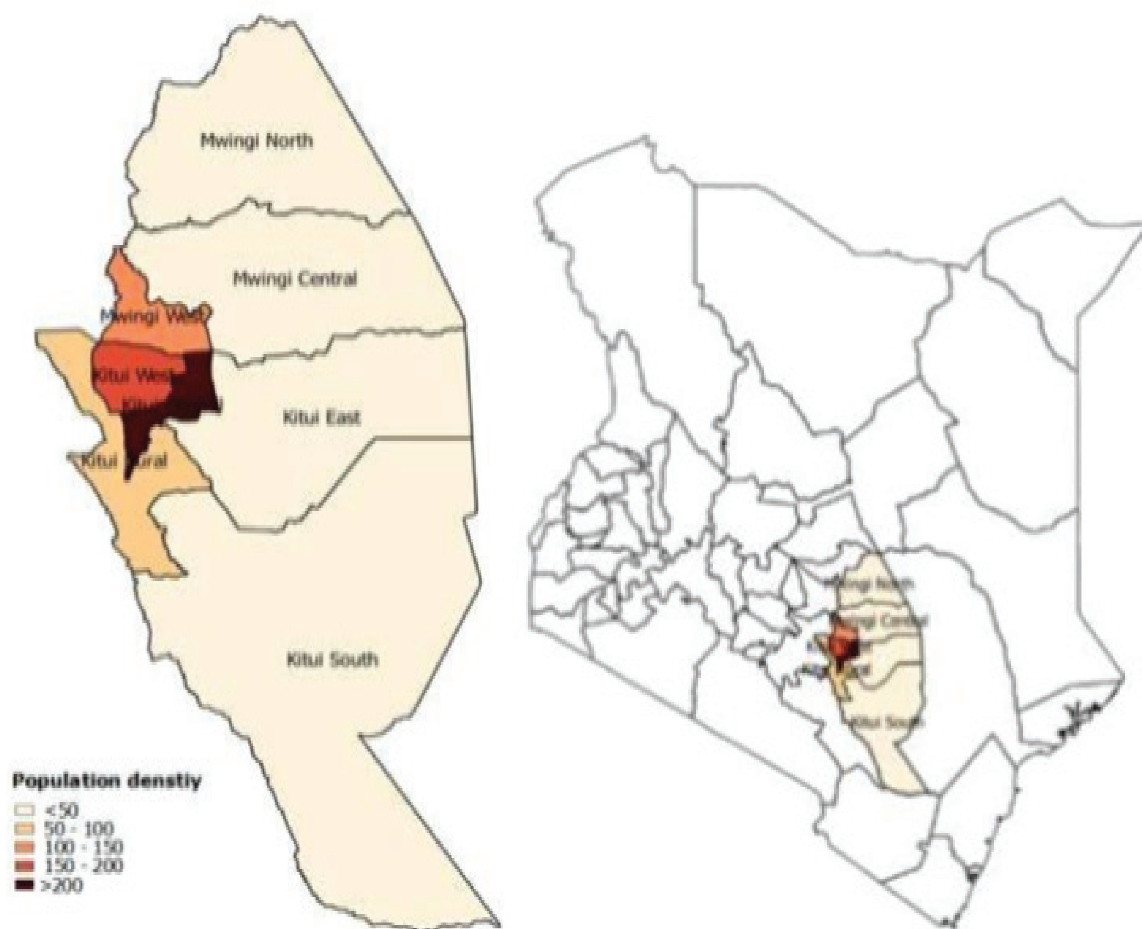
	KCNAP Estimated Annual Budget				**Total Cost**	
Financial Year	2019/2020	2020/21	2021/2022	2022/23	Total KSH	Total USD
Estimated Budget	238,353,562	267,290,011	328,648,292	244,442,779	1,082,747,219	

CHAPTER 1: INTRODUCTION

1.1 Background information

Kitui County is located 170Km to the South East of Nairobi City. It covers an area of about 30,496 km2. It borders Machakos and Makueni Counties to the West, Tana River County to the East, Taita-Taveta County to the South, and Embu and Tharaka- Nithi Counties to the North. The County has eight sub counties namely; Kitui Central, Kitui South, Kitui East, Kitui Rural, Kitui West, Mwingi North, Mwingi West and Mwingi Central with 40 Wards and 247 villages. It is the seventh largest County in Kenya.

Figure 1: Kitui County Map



Source: Kitui County annual Development plan

1.2 Demographic profile

Kitui County has an estimated population projection of 1,131,289 people (KNBS Population 2009).The Male to female ratio is 47.2:52.8.The County has a large population of dependents'; 54% being children, adolescents and the elderly .

Table 1: Population Distribution per Cohort

Population Cohort	%	2019	2020	2021	2022	2023
Total Population		1,131,289	1,141,593	1,152,052	1,162,666	1,173,435
Female	52.8	597,321	602,761	608,283	613,888	619,574
Male	47.2	533,968	538,832	543,769	548,778	553,861
<1 Year	3.2	36,201	36,531	36,866	37,205	37,550
<5 Years	16.0	181,006	182,655	184,328	186,027	187,750
5-14 Year	31.0	350,700	353,894	357,136	360,426	363,765
15-24 population	19.6	221,733	223,752	225,802	227,883	229,993
25-59 population	26.4	298,660	301,381	304,142	306,944	309,787
60 + population	6.9	78,059	78,770	79,492	80,224	80,967
Women of Reproductive Age	23.0	260,196	262,566	264,972	267,413	269,890
Expected Pregnant Women	3.9	44,120	44,522	44,930	45,344	45,764
Estimated Deliveries	3.9	44,120	44,522	44,930	45,344	45,764
Estimated Live Births	3.6	41,292	41,668	42,050	42,437	42,830

Source: CHSSP 2018-2022

Table 2: Population Projection Per Sub County

Sub County	2019	2020	2021	2022	2023
Kitui Central	138,314	139,574	140,834	142,113	143,411
Kitui West	119,016	120,100	121,184	122,286	123,406
Kitui rural	115,407	116,458	117,509	118,576	119,659
Kitui East	143,037	144,340	145,743	147,167	148,612
Kitui South	185,493	187,182	189,001	190,847	192,719
Mwingi West	115,925	116,981	118,037	119,111	120,203
Mwingi Central	157,741	159,178	159,202	159,226	159,250
Mwingi North	156,356	157,780	159,204	160,650	162,118
County Total	**1,131,289**	**1,141,593**	**1,150,714**	**1,159,976**	**1,169,378**

Source: CHSSP 2018-2022

1.3 Health Facility Distribution Per Level and Ownership

Kitui County has a total 384 health facilities which include Public, Private, Faith Based, and 247 Community Health Units.

Table 3: Health Facility Distribution per level and ownership

Row Labels	Faith Based Facilities	Ministry of Health	Private based Facilities	Public Institution – Academic	Grand Total
Basic Health Centre	4	56	8	0	68
Dispensary	20	213	0	3	236
Medical Clinic	1	0	54	0	55
Nursing and Maternity Home	0	0	5	0	5
Primary care hospitals	2	14	4	0	20
Grand Total	**27**	**283**	**71**	**3**	**384**

Source: KHIS and KMHFL

Table 4: Health Facility Distribution by Sub County

Facility Type	2018		
Sub- County	**Hospitals**	**Health Centre**	**Dispensaries**
Kitui Central	2	4	33
Kitui East	2	8	23
Kitui Rural	1	7	20
Kitui South	3	8	33
Kitui West	1	7	18
Mwingi Central	2	8	31
Mwingi North	2	8	24
Mwingi West	1	6	34
Total	**14**	**56**	**217**

Source: KHIS and KMHFL

1.4 National policy and legal framework for CNAP

Kenya is a state party to several nutrition-related global agreements and mechanisms including the Scaling Up Nutrition (SUN) movement, the World Health Assembly (WHA) 2025 nutrition targets, the Sustainable Development Goals (SDGs), the UN International Decade on Food and Nutrition, and the ICN2 Declaration and Plan of Action. These frameworks laid down the foundation for addressing the immediate, underlying and basic causes of malnutrition including expanding the political, economic, social and technological space for nutrition actions.

The Nutrition Sector Planning in Kenya is guided by Vision 2030, which is the long-term development plan for the country and the overall global health and nutrition agenda. These are entrenched within the Constitution of Kenya 2010 under the Bill of Rights as follows: -

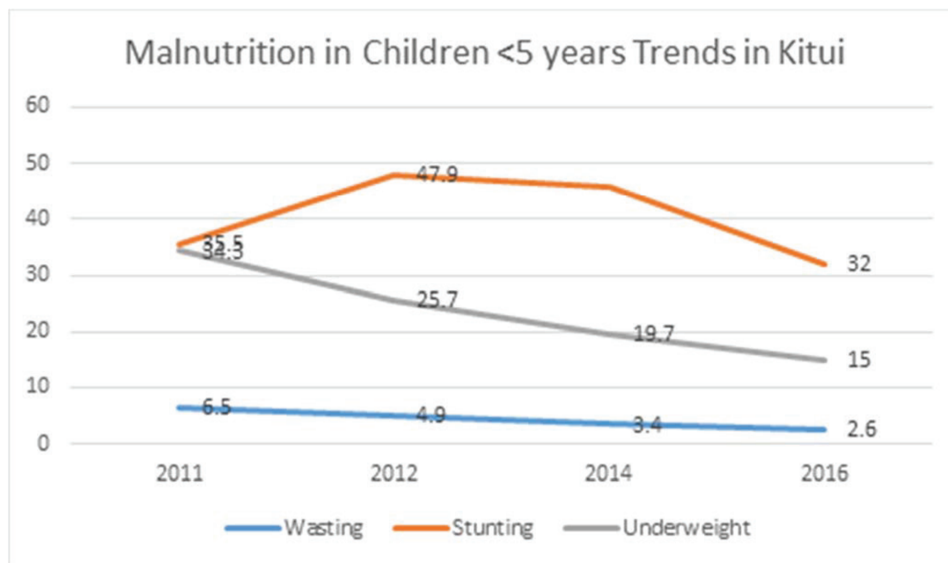
1. Article 43 (1) (c) – the right of every Kenyan to be free from hunger and the right to adequate food of acceptable quality;
2. Article 53 (l) (c) – the right of every child to basic nutrition, shelter and health care; and
3. Article 21 – establishes the progressive realization of social and economic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

In addition, the Big Four Agenda, which is the new focus for the government that ends in 2022, where universal health coverage (UHC), food, and nutrition security form part of the four pillars. Nutrition-related actions in the UHC (2018–2022) include: investing in preventive and promotive services; increased budgetary allocation to public health programmes and nutrition; supervision and monitoring of rational use of commodities; and commitment to work with enabler ministries for nutrition.

1.5 Trends in Health and nutrition situation in Kitui County

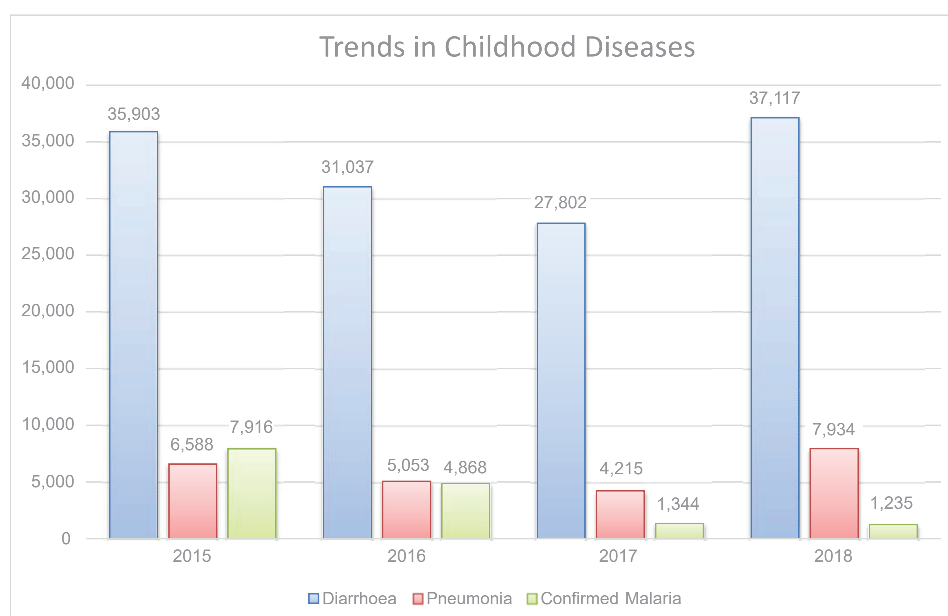
Malnutrition (both under and over-nutrition) is a problem of public interest in the County as if affects various elements of the human life cycle. Under-nutrition is majorly experienced by children under-fives with stunting levels remaining quite high. According to SMART Surveys conducted in the County and KDHS 2014, a worrying trend is illustrated with about one in every two children being too short for their age (stunting). The same population has shown steady decrease in both wasting and underweight. The high levels of chronic malnutrition are attributable to poor dietary diversity, poor child care practices and other underlying causes of malnutrition.

Figure 2: Malnutrition Trends in Kitui



Source: SMART Survey and KDHS

Figure 3: Childhood Diseases in Kitui



Source: KHIS2

The incidences of diarrheal diseases reduced from 35,903 in 2015 to 31,037 in 2016 which further dropped to 27,802 in 2017 with an upside surge of 37,117 in 2018. Similar trend is observed for pneumonia. However, there is a gradual reduction in the prevalence of confirmed malaria cases.

1.6 Human resource for health and nutrition

Currently, Kitui County has 1555 Human Resource for Health and Nutrition which falls short of the 3068 required to effectively and efficiently provide quality Health and nutrition services in the County

Table 5: Human Resource for Health and Nutrition

S/NO	CADRE	Available	What is Required	Gap
1	CLINICAL OFFICER	180	298	118
2	HEALTH RECORDS OFFICER	64	200	136
3	NURSE	839	1270	431
4	LABORATORY SCIENTIST	142	291	149
5	NUTRITIONIST	42	98	56
6	PHARMACEUTICAL TECHNOLOGIST/PHARMACIST	73	252	179
7	MEDICAL DOCTOR	108	386	278
8	MEDICAL SOCIAL WORKER	11	14	3
9	PUBLIC HEALTH OFFICER	96	259	163
TOTAL		**1555**	**3068**	**1513**

Source: KHSS Plan 2018-2022

1.7 Constraints in health and nutrition in Kitui County

In the recent past, the County has witnessed tremendous progress towards the achievement of the governments' big four agenda and the vision 2030 due to the integrated efforts put in place by all the health and nutrition actors. However, there are a number of bottlenecks that hinders the smooth attainment of the desired results as outlined below;

- Inadequate production and consumption of livestock products
- High incidence of animal and crop pest and diseases
- Low mainstreaming of Agri-nutrition practices among partners
- Low household purchasing power
- Weak farmer-extension-research linkages
- Insufficient information on key nutrition best practices
- Poor practices in food safety and hygiene
- Inadequate safe water supply
- Poor health seeking behaviour and religious beliefs (e.g. resistance in attendance to health facilities for treatment, immunization)
- Long walking distances to health facilities
- Weak community level structures
- Inadequate human resource across Sectors
- Inadequate funding to nutrition interventions across sectors

CHAPTER 2: COUNTY NUTRITION ACTION PLAN (CNAP) FRAMEWORK

2.1 Introduction

This chapter seeks to highlight the county's vision and mission for nutrition service delivery. It also strives to provide the rationale for the KCNAP while stating the objectives. Additionally, the chapter demonstrates the overall road map undertaken in the development process. This process sought contributions, inputs and the participation of nutrition specific and sensitive sectors and players. Such inclusivity was meant to constructively harness the inherent knowledge and capacities existing within the various players in comprehensively, addressing the challenge of malnutrition as illustrated in the UNICEF's conceptual framework of malnutrition.

Vision: Malnutrition free Kitui County.

Mission: To reduce all forms of malnutrition in Kitui County using well-coordinated multi-sectoral and community-centered approaches for optimal health of all residents for county's economic growth.

2.2 Rationale for the development of Kitui County Nutrition Action Plan

Implementation of nutrition service in Kitui County has in the past five years been guided by the National Nutrition Action Plan 2012-2017. The National Action Plan was developed to accelerate and scale up efforts towards elimination of malnutrition as a problem of public health significance in Kenya and led implementation of nutrition interventions Nationally and Countywide. While Kitui County did not contextualize and write her own Nutrition Action Plan, this planning cycle presented the County with the opportunity to develop a County Specific Nutrition Action Plan to guide actions and interventions on Nutrition. The development is guided by the Kenya Nutrition Action plan 2018-2022 and will serve the period 2019 - 2023. The three basic rationales for the action plan are:

(a) The health consequences – Good nutrition status leads to a healthier population and enhanced quality of life;

(b) Economic consequences –Good nutrition and health is the foundation for rapid economic growth; and

(c) The ethical argument – Optimal nutrition is a human right.

There is overwhelming evidence that improving nutrition contributes to economic productivity, development, poverty reduction, school performance, improving physical work and mental capacities. Improving nutrition is tremendous value for money as it reduces the costs related to lost productivity and health care expenditures. Globally, it is estimated that each dollar spent on nutrition delivers between USD8 and USD138, which is a cost–benefit ratio of around 1:17, similar to that of infrastructure development like roads, railways and electricity.

Table 6: The cost–benefit ratios of different nutrition intervention programmes

Nutrition intervention programs	Cost-benefit USD	Cost- Benefit Ratio
Breastfeeding promotion in health facilities	5-67	1:13
Integrated child care programs	9-16	1:1.8
Iodine supplementation(women)	15-520	1:35
Vitamin A supplementation (children <6years)	4-43	1.:11
Iron fortification (per capita)	176-200	1:1.4
Iron supplementation (per pregnant woman)	6-14	1.23

Source: The World Bank, Why invest in nutrition?

A cost–benefit analysis conducted in Kenya in 2016 by UNICEF, the World Bank and the Ministry of Health reported that every USD1 invested in scaling up high-impact nutrition interventions has the potential return of USD22, higher than the global estimates of USD16–18. The study was done to help guide the selection of the most cost-effective interventions as well as strategies for scaling up a package of interventions tailored to Kenya's specific needs, as done in the KNAP which is mirrored in the Kitui County Nutrition Action Plan (KCNAP). The study considered high-impact nutrition-specific interventions that largely rely on typical health sector delivery mechanisms. There are 11 high-impact interventions that have been prioritized in the KCNAP. Nationally, it is estimated that the costs and benefits of implementing these 11 critical nutrition-specific interventions will avert more than 455,000 disability adjusted life years (DALYs) annually, save over 5,000 lives, and avert more than 700,000 cases of stunting among children under five.

The KCNAP addresses the triple burden of malnutrition in Kitui, characterized by (i) the coexistence of under nutrition as manifested by stunting, wasting, underweight and low birthweight; (ii) micronutrient deficiencies; and (iii) overweight and obesity and diet-related non- communicable diseases (DRNCD) and low physical activity. All three forms of malnutrition occur within individuals, households and populations throughout the life course – during pregnancy, and among children, adolescents, adults and older persons throughout the county at different levels of public health significance. Addressing all forms of malnutrition at all three levels of causation (immediate, underlying and basic) will simultaneously increase the effectiveness and efficiency of investments of time, energy and resources to improve nutrition. Triple-duty actions have the potential to improve nutrition outcomes across the spectrum of malnutrition, through integrated initiatives, policies and programmes. The potential for triple-duty actions emerges from the shared drivers behind different forms of malnutrition, and from shared platforms that can be used to address these various forms. Examples of shared platforms for delivering triple- duty actions include health systems, agriculture and food security systems, education systems, social protection systems, WASH systems and nutrition-sensitive policies, strategies and programmes.

2.3 KCNAP Overall Objective/Purpose

The objective of the KCNAP is to accelerate and scale up efforts towards the elimination of malnutrition in Kitui County in line with Kenya's Vision 2030 and sustainable development goals, focusing on specific achievements by 2022. The KCNAP purpose is also aligned with the County Health Sector Strategic Plan (CHSSP) strategic objectives. The expected result or desired change for the KCNAP is that 'all county residents achieve optimal nutrition for a healthier and better quality of life and improved productivity for the County's accelerated social and economic growth.

In order to effectively develop an all-inclusive KCNAP that seeks to address the pertinent nutrition issues in the county, a review of the national nutrition action plan's 19 Key Result Areas (KRAs) was done. The aim was to narrow down to the most relevant and context specific KRAs. The KRAs are categorized into three parts namely; i) Nutrition specific, ii) Nutrition sensitive and iii) enabling environment. From the review, a total of 13 KRAs were selected and adopted as shown in the table below;

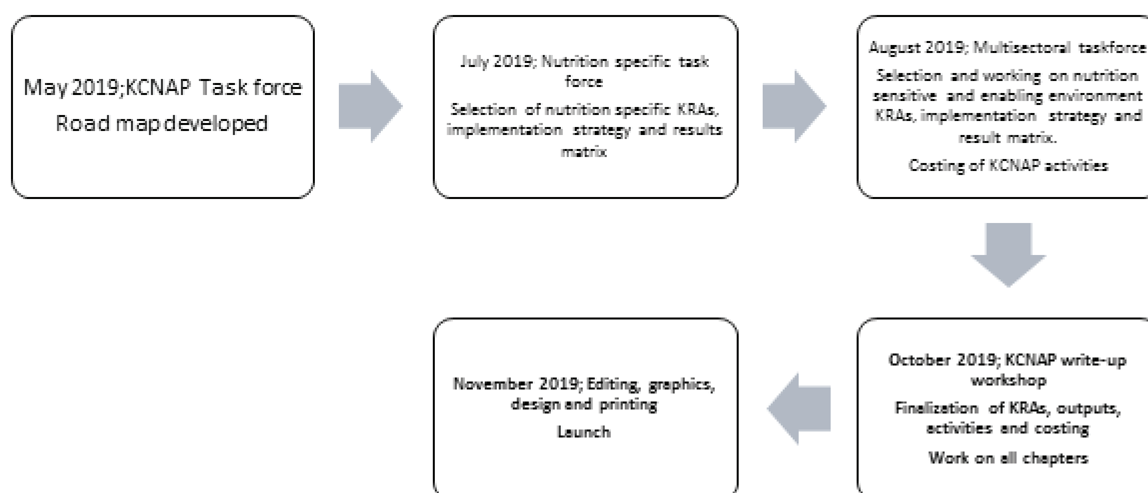
Table 7: Kitui County Nutrition Action Plan KRAs

Category of KRAs	Selected and Adopted KRAs
1. Nutrition Specific	KRA 1: Maternal, newborn, infant and young child nutrition (MNIYCN) scaled up KRA 2: Prevention, control and management of micronutrient deficiencies scaled up KRA 3: Prevention, control and management of non-communicable and other diet related diseases strengthened KRA 4: Integrated management of acute malnutrition (IMAM) strengthened with a sub-section of Nutrition in emergencies KRA 5: Nutrition in HIV and TB promoted
2. Nutrition Sensitive	KRA 6: Food and nutrition security in agriculture and livestock scaled up KRA 7: Nutrition in the health sector strengthened KRA 8: Nutrition in education and early childhood development promoted KRA 9: Nutrition in water, sanitation and hygiene (WASH) sector promoted KRA 10: Nutrition in social protection programs promoted
3.Enabling Environment	KRA 11: Sectoral and multi sectoral nutrition information systems, learning and research strengthened KRA 12: Advocacy, communication and social mobilization (ACSM) strengthened KRA 13: Supply chain management for nutrition commodities and equipment strengthened.

2.4 KCNAP development process

The KCNAP 2019–2023 is the first action plan that follows the implementation of the first National Nutrition Action Plan 2012–2017 and builds on the success, limitations and opportunities of the past programming. Drawing from lessons learnt from the previous National Nutrition Action Plan 2012-2017, the KCNAP has been developed through a consultative process and stepwise as shown in the figure below;

Figure 4: KCNAP development process



2.5 Target Audience for KCNAP

The target audience includes health care planners, policy and decision makers at national, County, Sub County and ward level. This document also targets nutrition sensitive sectors, nutrition workforce, and managers at all levels, donors, development partners, NGOs, civil society and faith based organizations, the private sectors, academia and research institutions, media and the community at large. This will enable them understand what the County Government is doing to ensure optimal nutrition for all residents and what they can do individually or collaboratively to contribute to the overall efforts.

CHAPTER 3:
KEY RESULT AREAS (KRAs), STRATEGIES AND INTERVENTIONS

3.1 KRA 1 - Strengthened care practices and services for improved maternal, newborn, infant and young child nutrition (MNIYCN)

Context

Optimal maternal nutrition is crucial for the health and development of both the foetus and the mother. It has further been shown to have an impact on birth outcomes, with better nourished mothers having increased chances of delivering healthier infants. Maternal malnutrition increases the risk of poor pregnancy outcomes including obstructed Labour, premature or low-birthweight babies and post-partum hemorrhage. Severe anaemia during pregnancy is linked to increased mortality at Labour. Optimal infant and young child feeding practices– which include early initiation of breastfeeding, exclusive breastfeeding for the first six months of life and continued breastfeeding up to two years or beyond in addition to timely introduction of adequate, appropriate and safe complementary foods are crucial to ensure good physical and mental development and also contribute to long-term health benefits. Substantial research has confirmed that breastfeeding improves the health, development and survival of infants, children and mothers. The Lancet series 2013 showed that improving breastfeeding practices could prevent up to 13% deaths and when combined with optimal complementary feeding could avert up to 19% preventable deaths. In the new Lancet series of 2016 it is proven that breastfeeding would avert up to 823,000 under five deaths and would prevent 20,000 cases of cancer among mothers annually in low middle income countries. Additionally, breastfeeding would reduce hospitalization by half of diarrhoea episodes (54 percent) and one third of respiratory infections (32%) cases hospitalized. Further, breastfeeding would reduce hospital admissions of all diarrhoea and respiratory infection by 72% and 57% respectively. Longer breastfeeding is associated with a 13 per cent reduction in the likelihood of overweight and/or prevalence of obesity and a 35 per cent reduction in the incidence of type 2 diabetes.

Investing in the early years, the first 1,000 days of life (from conception to child's second birthday) is critical for child survival, growth and development. It is the period when the physiological needs of both the mother and child are at their highest and the child is highly dependent on the mother for nutrition and other needs. Efforts to improve the nutrition status of mothers during this first 1000 days' window of opportunity is critical.

As per the Kitui county Knowledge, attitude, behavior and practices (KABP) survey done in October 2017, 73.3% of children 0-23 months had a timely initiation to breastfeeding while 75.6% of children aged 0-5 months were exclusively breastfed. Minimum dietary diversity, minimum meal frequency and minimum acceptable diet for children 6-23months was at 32.8%, 59.3% and 22.0% respectively. Reportedly, 7.6% of children had pre-lacteals. Breastfeeding practices revealed high levels of breastfeeding initiation and exclusive breastfeeding, low use of pre-lacteals. The report showed considerably good frequency in child feeding but with diets of low acceptability.

Expected Outcome; Strengthened care practices and services for improved maternal, new born, infant and young child nutrition (MNIYCN)

Output 1.1 Increased proportion of women of reproductive age (15–49 years) and caregivers who practise optimal behaviours for improved nutrition of maternal and young children under five years

Strategies

1. Strengthen delivery of MNIYCN services
2. Scale up advocacy, communication, social mobilization and resource mobilization
3. Technical capacity development for delivery of quality MNIYCN services

Interventions

1. Capacity building of health provider on MNIYCN
2. Roll out of BFCI approaches
3. Support documentation of MNIYCN processes

Output 1.2: MNIYCN policy environment at all levels improved

Strategies

1. Scale up advocacy, communication, social mobilization and resource mobilization

Interventions

1. Advocate for MIYCN targeting policy and decision makers, implementers and the community.
2. Capacity building for program staff and implementers in evidence based programing for MIYCN

Output 1.3: Enhanced capacity for implementation of MNIYCN activities at all levels

Strategies

1. Technical capacity development for delivery and documentation of MNIYCN services

Interventions

1. Enhanced county capacity in MNIYCN documentation.

3.2 KRA 2: Prevention, control and management of micronutrient deficiencies scaled up

Context

The nutrition situation in kitui county is poor as per the recent KABP and KDHS data. The KABP survey showed that the proportion of households with minimum dietary diversity was 28.1% and anaemia prevalence among pregnant women stood at 36%.

Micronutrient deficiencies in Kitui county is aggravated by unreliable rainfall patterns ,general lack of water for subsistence agriculture, and low mainstreaming of Agri-nutrition practices among partners that has led to low dietary diversity. In addition, limited knowledge on food fortification and insufficient information on key nutrition practices has resulted in minimal consumption of micronutrient rich diets.

Expected Outcome

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

Output 2.1: Strengthened routine micronutrient supplementation (vitamin A, iron and folate and micronutrient powders) for targeted groups

Strategies

Strengthen health and community systems for delivery of micronutrient supplementation

Interventions

1. Capacity building on micronutrient supplementation
2. Support community structures for integrated micronutrient supplementation
3. Procurement of micronutrient supplements

Output 2.2: Increased dietary diversity and consumption of fortified foods

Strategies

Promote uptake of diversified, and fortified foods

Interventions

1. Capacity building on diversification of diets and bio-fortification
2. Strengthen compliance and consumption of fortified foods

Output 2.3: Integrated public health measures with micronutrient deficiency prevention and control interventions promoted

Strategy

Support implementation of policies on food fortification standards and procedures

Interventions

1. Capacity development on food fortification, standards and procedures
2. Routine assessment on quality of fortified foods at the community level
3. Enforcement of the food fortification guidelines

3.3 KRA 3: Prevention, Control and management of Non Communicable and other Diet Related Diseases Strengthened (DRNCDs)

Context

The world's biggest killer NCDs are mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes. The world's premature death burden stands at 86% resulting in economic losses of USD dollars of 7 trillion over the next 15years.

In Kitui County, the estimated prevalence of cardiovascular disease stands at 48.3% (KHIS 2019). The risk factors contributing to the rise in NCDs are largely preventable by enabling health systems to respond efficiently and effectively to the health care needs of people. To reduce NCD preventable and avoidable burden of morbidity, mortality and disability a series of strategies and interventions with related outputs will be implemented. Generally, there is a need to support behavior change communication initiatives in the county among all cohorts.

Expected Outcome

Reduced incidences and severity of complications related to DRNCDs

Output 3.1: Established mechanisms to raise the priority accorded to nutrition therapy for prevention and management of NCDs

Strategy

Integrate nutrition agenda for prevention and control of NCDs across all government and private sectors

Intervention

1. Capacity development of health service providers on NCDs prevention, control and management
2. Raise community awareness on NCDs prevention and control
3. Active case finding at all service delivery points

4. Quality and timely provision of nutrition therapy in

Output 3.2: Behaviour change communication strategies developed and implemented to promote primary and secondary prevention of diet- related risk factors for non-communicable diseases

Strategy

Strengthened behavior change communication on DRNCDs

Interventions

1. Capacity building on social behavior change on DRNCDs
2. Awareness creation on DRNCDs
3. Formation and strengthening of community support group

Output 3.3: Improved monitoring and evaluation for diet-related diseases and NCDs

Strategy

Strengthen monitoring of DRNCDs trends in the County

Interventions

1. Regular data review for DRNCDs
2. Provision of data capture and reporting tools
3. Capacity building on DRNCDs data management
4. Assessment on DRNCDs occurrence

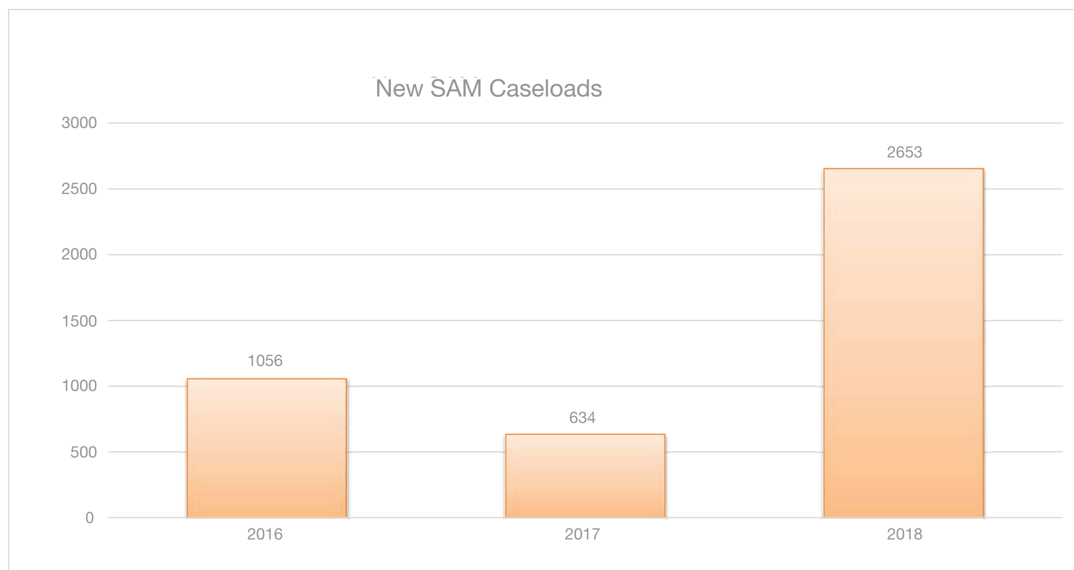
3.4 KRA 4: Integrated Management of Acute Malnutrition (IMAM) strengthened with a sub-section of Nutrition in emergencies

Context

Acute malnutrition results from inadequate dietary intake and/or disease as the two immediate causes. A deadly vicious cycle is often created between acute malnutrition and infection, whereby acutely malnourished children are predisposed to infection, and vice versa. Children with acute malnutrition are at a five to nine times higher risk of death when compared to well-nourished children. Reducing child mortality and improving maternal health depend heavily on reducing malnutrition. While focusing on the management of acute malnutrition, integrated management of acute malnutrition interventions should ensure continuum of care along the spectrum of nutritional status through strong linkages with programmes that focus on preventive and promotive services like supplementation, breastfeeding, complementary feeding, and hygiene and food safety, among others.

The Kitui county context presents a scenario of disparities in the two livelihood zones; marginal and mixed farming. Marginal farming areas located in the Northern, Eastern an Southern parts of the County have significantly higher cases of malnutrition compared to the mixed marginal farming parts found in the western and central parts of the County. KDHS 2014 reported wasting rates of 3.4% for children below five years while Standard Monitoring and Assessments of Relief and Transitions (SMART) survey conducted in 2016 indicated a wasting prevalence of 2.6%. The two methodologies although different provide a picture of wasting rates (global acute malnutrition) that's below 5%. This is classified as normal as per WHO standards. However, a review of absolute numbers highlights significantly high caseloads of acutely malnourished children admitted into health facilities for management.

Figure 5: SAM (Inpatient Admissions and Out Patient Admissions)



Source: KHIS

As illustrated in the figure above, the caseloads show significance variation in admissions across the years which can be associated to; seasonality, availability of supplies, an increase in the number of facilities admitting, managing and reporting on cases of severe and moderate acute malnutrition. Currently, the county has 145 health facilities admitting and managing severely malnourished cases. To achieve the desired outcome a series of strategies and interventions with related outputs have been prioritized for implementation over the plan period.

Expected Outcome: Increased coverage of integrated management of acute malnutrition (IMAM) services Output 4.1: Policy, standards and guidelines for the IMAM programme disseminated and implemented Strategies

Dissemination of IMAM policies, standards and guidelines

Intervention

1. Promote IMAM policy and guidelines utilization

Output 4.2: Scaled-up access to delivering IMAM services in the county

Strategies

Enhance full coverage of IMAM services starting with the hotspot areas which have high caseloads of acute malnutrition and rolling over to other areas

Interventions

1. Scale up of IMAM services

Output 4.3: IMAM program performance monitored, and quality of services improved

Strategies

Institute approaches/measures to monitor the performance and quality of services provided by the IMAM program

Intervention

1. Capacity building for quality IMAM program
2. Enhancing the quality of IMAM services

Output 4.4: Strengthened partnerships and linkages to improve access and coverage of IMAM services.

Strategies
Cross linkage of IMAM services with other programmes (WASH, social protection, food security)

Interventions;
1. Promoting partnerships and coordination in IMAM services delivery
2. Emergency and response preparedness actions

Output 4.5: Innovative approaches to improve IMAM quality and coverage implemented

Strategies
Effective use of available approaches and, where appropriate, develop innovative ways to improve the quality and coverage of IMAM services.

Interventions
1. Use of innovative approaches to improve the delivery of IMAM services

Output 4.6: Enhanced early case identification through community mobilization and referral

Strategies
Strengthen capacity for improved screening and referral of acute malnutrition at community and health facilities

Interventions;
1. Promoting early detection and referral of IMAM cases

Output 4.7: Improved utilization of IMAM data for informed decision making, service delivery and programming

Strategies
Data utilization for evidence-based decision making regarding IMAM

Interventions
1. Capacity development for health workers
2. IMAM program performance, documentation and review

Output 4.8: Strengthened implementation of recovery interventions to enhance resilience

Strategies
Mainstreaming nutrition in resilience programmes

Interventions
1. IMAM program linkage to livelihood support programs
2. Emergency nutrition linkage to early warning and contingency plans.

3.5 KRA 5: Nutrition in HIV and TB promoted

Context
The prevalence of HIV in Kitui is 4.5% against the national 4.8%. There are only 113 comprehensive care clinics (CCC) in the county and there is a need to open up more to increased HIV surveillance and screening. The situation is worsened by inadequate and inconsistent supply of nutrition commodities in HIV/ TB management.

Malnutrition is common among the HIV and TB clients since nutrition therapy with individualized counselling is critical in overall treatment. The screened TB cases in 2017/2018 were 102,533 where by 2,222 people were new admissions - a situation indicating compromised immunity among the Kitui population. In addition to that, holistic HIV/TB preventive and care services can only be offered in Kitui county Referral Hospital, Mwingi level 4 Hospital and Migwani level 4 hospitals.

Expected Outcome

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

Output 5.1: Improved access and demand to quality nutrition services by PLHIV and TB patients

Strategy

Enhance health system to provide patient-focused nutrition therapies

Interventions

1. Capacity building of health workforce on HIV & TB Nutrition therapies
2. Scale up nutrition screening among PLHIV & TB patients at all service points
3. Raise community awareness on nutrition services in HIV & TB patients
4. Strengthen management of nutrition therapeutic commodities in HIV and TB
5. Strengthen community linkages for nutrition interventions including home based care

3.6 KRA 6: Food and Nutrition Security in Agriculture and Livestock Scaled up

Context

According to the County Integrated Development Plan (CIDP) 2018-2022, the economy of the county is mainly dependent on agriculture, which contributes to rural employment, food production and rural incomes. The level of food self-sufficiency in the county is 51%. However, approximately 10 percent of the entire population is absolutely food insecure. The sector plays a major role by contributing about 87.3% of income earned by the rural population. The main food crops grown in the county include cereals such as maize, sorghum, and millet; pulses such as green grams (Ndengu), cowpeas and pigeon peas; root crops such as cassava, sweet potatoes and arrow roots; industrial crops such as cotton, sisal and sunflower, and horticultural crops represented mainly by fruits such as mangoes, pawpaw, and watermelons as well as vegetables such as tomatoes, kales, onions and bullet chilies. County crops are mainly grown as sources of food and income and production is mainly dependent on rain. Rainfall in the county is not only inadequate but erratic thus necessitating the use of irrigation to augment food production.

The entire food system from production to consumption has an influence on the nutritional status of a population. Challenges in food production, storage, processing, marketing, consumer demand, preference and preparation, consequently result in dietary inadequacy that leads to nutritional problems at household level.

Markets play a critical role in increasing access to safe and nutritious foods. Challenges, however, exist in weak market structures and there are opportunities to improve the marketing channels to provide well-defined outlets and markets. Food quality and safety along the value chain is critical to good health and nutrition outcomes. In the recent past, for example, there have been cases of aflatoxin poisoning owing to poor storage of food including during post-harvest. Recurring market disruptions due to inter community conflicts especially in the areas bordering Tana River and Garissa Counties. Poor sanitation and handling of street food leads to increased diarrhoea diseases. Improvements in food access, safety, quality control and utilization of local foods will lead to more diverse diets, improved consumer health and nutrition and ultimately lead to enhanced food security and good nutrition among the population.

Opportunities exist in strengthening Agri-nutrition capacity at policy, programming and community levels. Decision makers require knowledge and skills on how agriculture impacts on nutrition outcomes in the county. Agriculture programmes need to integrate nutrition interventions at all stages of implementation. Household capacities on proper food preparation, utilization, storage and consumption need to be built to enhance the

nutritional outcomes of the household members. Furthermore, diversification and promotion of drought tolerant crops and preservation of locally available green vegetables will be promoted.

The County Ministry of Health and Sanitation will collaborate with the County Ministry of Agriculture, Water and Livestock Development to support food systems to improve access to safe and nutritious foods. The two county ministries will also partner with their respective State Department counterparts. To achieve the desired outcome a series of strategies and interventions with related outputs will be prioritized for implementation over the plan period (2019 to 2022).

Expected Outcome:

Reduced malnutrition rates in the county through strengthened linkages between nutrition, agriculture and food security actors.

Output 6.1: Strengthened sustainable and inclusive food systems that are diverse, productive and profitable for improved nutrition

Strategies

Advocate for joint planning with nutrition-sensitive sectors

Interventions

1. Collaborative planning on County Nutrition Activities.
2. Promotion and Capacity building on importance of linkages between nutrition and food security.
3. Conduct research on value chain weak areas

Output 6.2: Improved access to safe and nutritious foods along the food value chain

Strategies

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

Intervention

1. Support collaboration between public and private stakeholders on food safety and quality through capacity assessments.
2. Promote uptake of food processing, preservation and storage technologies.

Output 6.3: Consumption of diverse, safe and nutritious foods promoted.

Strategy

Promote increased consumption of safe, diverse, nutritious foods

Intervention

1. Promote consumption and utilization of locally available, safe and nutritious foods.
2. Enforce food safety initiatives, regulations and standards.
3. Develop Social Behavior Change Communication (SBCC) strategy for increased consumption of nutritious foods and improved dietary diversity.

Output 6.4: Strengthened Agri-Nutrition capacities and coordination

Strategy

Contribute to strengthening of Agri-Nutrition capacities and coordination at county and sub county levels

Interventions

1. Facilitate Agri Nutrition coordination structures.

Output 6.5: Production of safe, diverse and nutritious foods promoted

Strategy

Promote increased production of safe, diverse, nutritious foods

Interventions

1. Sensitization on diversified food production technologies.

3.7 KRA 7: Nutrition in the health sector strengthened

Context

Nutrition forms an integral part of the larger Kitui county health system. It has an elaborate representation from level one service delivery points to the county level where policy and regulations are implemented. It is key in promoting the general health and wellbeing of the population and cuts across all cohorts. Its agenda includes; directions for addressing both under and over nutrition in children, women and general community to reverse the increasing problem of DRNCDs.

By ensuring good nutrition, the county will be assured of attaining the highest possible standards of health for its residents. The three basic rationale for the nutrition action plan are; the health consequences-improved health status leading to a healthier population and enhanced quality of life; economic consequences- improved nutrition and health is the foundation for rapid economic growth; and the Ethical argument-optimal nutrition is a human right.

Leveraging the health budget at the county level remains critical for nutrition in health. Implementation of strategies and interventions with related outputs will result in achieving the desired outcome.

Expected Outcome

Nutrition mainstreamed in health policies, strategies and action plans

Output 7.1: Nutrition articulated in health policy documents and represented in health sector policy development forums

Strategy

Mainstream nutrition in County policy, planning and strategy documents

Interventions

1. Advocate for inclusion of nutrition interventions in County AWPs
2. Enhance integration of nutrition interventions in health sector
3. Inclusion of nutrition agenda in community health forum
4. Strengthen monitoring, evaluation, research, accountability and learning of nutrition interventions within health sector

3.8 KRA 8: Nutrition in Education and Early Childhood Development promoted

Context

Good nutrition is essential to realize the learning potential of children and maximize returns on educational investments. Good nutrition combined with child stimulation through play and physical activity promotes optimal brain development.

Undernourished children in early childhood have lower performance in Intelligence Quotient (IQ) and other tests. In addition, poor child nutrition is associated with poor school enrolment, low attendance and high school dropout. Nutrition education in schools is known to foster healthy eating habits in the children themselves and in their families in the short and longer terms. School meals ensure children are well nourished and healthy and are able to learn. Home-grown school feeding programmes (HGSFP) are implemented in select sub-counties

within Kitui County. However, not all schools offer school meals supported by the government, and there is inadequate integration of nutrition in the school curriculum. It is evident that nutrition and health outcomes are directly related to the level of education of the mother. According to the 2014 KDHS, the nutritional status of children whose mothers have completed primary school was almost one and a half times better than those who have no education or did not complete primary school. Mothers who have completed secondary education or more were three times less likely to have malnourished children. In Kitui, there is about an equal enrolment of girls and boys in primary and early childhood development and education (ECDE). According to schools' basic education statistics booklet 2014 Kitui county had a total of 1827 ECDE centers (1518 public and 308 privates). Similarly, enrolment in these ECDE stands at 50,398 boys and 47,937 girls representing an 87.2% enrollment rate. According to Kitui county long rain assessment (LRA) 2019 report, enrollment for the girls in ECDE centers reduced by 3.3% and 0.6% for boys. To achieve the desired outcome a series of strategies and interventions with related outputs will be prioritized for implementation over the plan period.

Expected Outcome

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

Output 8.1 Policies, strategies, standards and guidelines on nutrition and physical activity in schools and other learning institutions developed and promoted

Strategies

1. Improved school curriculum to reinforce and promote nutrition and physical activities.
2. Integrate nutrition and physical activities in curricular and co-curricular frameworks

Interventions

1. Promote integration of nutrition in schools' curriculum, guidelines and policies
2. Advocacy on inclusion of physical activities and Agri-nutrition activities in the school curriculum. Output

8.2: Nutrition services enhanced within learning institutions

Strategies

Promote capacity for nutrition assessment in schools and other learning institutions

Interventions

1. Promote uptake and implementation of nutrition services within the learning institutions (Capacity building stakeholders on nutrition assessment and referrals.

Output 8.3: Healthy and safe food environment promoted in learning institutions

Strategies

Promote healthy and safe food environment in schools and other learning institutions

Interventions

Promoting food safety in schools

3.9 KRA 9: Nutrition in Water, Sanitation and Hygiene (WASH) Sector promoted

Context

Access to safe drinking water, sanitation and hygiene (WASH) services is an important contributor to healthy communities while positively impacting on nutrition. WASH related conditions such as diarrhea, intestinal parasite infections and environmental enteropathy can adversely affect the child's nutritional status. Hand washing with soap and water at critical times has been shown to reduce the risk of diarrhea in the general population by 42–44 per cent. In addition, treatment and safe storage of drinking water in the household

reduces the risk of diarrheal diseases by 30–40 per cent while safe disposal of faeces reduces the risk by 30 per cent or more. Kenya is committed to an upscale of WASH under SDG 6 on achieving universal and equitable access to safe and affordable drinking water, access to adequate and equitable sanitation and hygiene and an end to open defecation for all. The 2016 Water Act, the 2017 National Water Policy, the 2017 Sanitation Bill on Environmental Sanitation and Hygiene Policy and its 2016–2020 Action Plan, and the Open Defecation Free campaign for 2016–2020 have been hampered by lack of capacity to implement and adoption to county integrated development and action plans. The National Food and Nutrition Security Policy (NFNSP) and National Food and Nutrition Security Policy Implementation Framework (NFNSP-IF) mainstream WASH into their situational analysis and proposed thematic interventions in food security, schools and emergency response.

Kitui County falls in ASAL and experiences low and unreliable rainfall. Both surface and groundwater resources are limited. The county water demand is estimated to be 35,998m3 per day against a supply of 15,400m3 per day resulting into a water supply deficit of 20,598m3 per day. The county therefore experiences water scarcity in most periods of the year. Majority of the people in the county have to travel long distances in search of scarce water resources. Access to safe and affordable water is estimated to be 39%. 35.5% treated drinking water by boiling, 59.1% applied chroline, 35.5% households had hand washing facilities, with 32.3% being utilized and 12.8% had both soap and water.96% of households have latrines.

Expected Outcome

Nutrition integrated into WASH policies, strategies, plans and programmes

OUTPUT 9.1: Improved access to safe and adequate WASH services.

Strategy

Promote provision of sanitary facilities and safe drinking water to the community

Intervention

1. Advocate for provision of adequate potable water and safe storage facilities in households, community water points and institutions.
2. Advocate for construction and proper use of sanitation facilities at the community and household levels
3. Promote monitoring of the trends on WASH-related diseases
4. Promote integration of sanitation and nutrition activities
5. Capacity building of health service providers on sanitation and nutrition
6. Raise awareness on WASH at the community level

Output 9.2: Collaboration with relevant stakeholders on WASH strengthened

Strategy

Strengthen mechanisms for collaboration and promote participation of stakeholders in WASH forums

Interventions

1. Promote joint resource mobilization for integrated WASH and nutrition activities
2. Promote coordination of WASH activities

3.10 KRA 10: Nutrition in Social Protection programmes promoted.

Context

Social protection policies and programmes hold eminence potential for improving the nutrition situation of vulnerable populations. To ensure that these policies holistically combat malnutrition, a nutrition sensitive approach needs to be employed in the design and implementation. Social protection affects nutrition by;

(a) Improving dietary quality

(b) Increasing income and improving access to quality services.

Kitui County is implementing social safety net programmes that have a direct impact on nutrition. These are; cash transfers (Orphans and Vulnerable Children Cash transfers, Older persons' cash transfer), Food Commodities Support (school feeding and emergency relief) safe motherhood vouchers and hospital insurance covers (NHIF and KCHIC). The County piloted the Nutrition Improvements through Cash and Health Education (NICHE) project which infused nutrition sensitivity into social protection. Results showed remarkable improvements in child feeding practices, hygiene and sanitation and maternal nutrition. Scaling up this approach has the potential to further improve key aspects of child and maternal nutrition especially amongst the vulnerable households with a trickle effect to the wider population.

Expected Outcome

Integration of nutrition in social protection programmes strengthened.

Output 10.1: Nutrition promoted and linkages enhanced in social protection programmes including in crisis

Strategy

Incorporate explicit nutrition objectives, target criteria and indicators in policies and strategies to enhance the positive impact of social protection interventions on nutrition.

Interventions

1. Promote Mainstreaming of nutrition in Social Protection Policy and Strategy
2. To create indicators for Nutrition Sensitive Social Protection and establish evidence based data on the Nutrition status of the vulnerable groups.
3. Establish mechanism for Scaling up Nutrition sensitive social safety nets in times of crises/emergencies

Output 10.2: Resources for nutrition in social protection programmes mobilized

Strategy

Mobilize resources for social protection that address the nutrition needs of vulnerable groups

Interventions

1. Mobilize financial resources for nutrition interventions in social protection programmes.
2. Advocate for Transparency and Accountability on nutrition sensitive interventions in social protection programmes

Output 10.3: Strengthened advocacy, communication and social mobilization for social protection

Strategy

Integrate nutrition education and promotion into social protection interventions

Interventions

1. Build the capacity of Policy makers and implementers on Nutrition Sensitive Social Protection.

3.11 KRA 11: Sectoral and Multi Sectoral Nutrition Information Systems, Learning and Research Strengthened

Context

A nutrition M&E system is critical in tracking the progress and outcome of KCNAP implementation, for it plays a key role in informing programme improvement, adjustment and decisions for nutrition stakeholders in the County. The County's Ministry of Health and Sanitation aims at improving the nutrition M&E system that would strive to link various partners to nutrition information. The system will assist to collect, collate and analyze surveillance and service delivery data from various SDP in the county. M&E aims at integrating the national platforms such as Kenya Health Information software (KHIS), NDMA early warning system, seasonal assessments and Kenya Demographic Health Surveys (KDHS) and Logistics Management Information System (LMIS).

Routine data are collected monthly and reported in KHIS, while other nutrition outcome and impact indicators are monitored through the Kenya Demographic and Health Survey (KDHS) and Kenya Household Income and Budget Survey (KHIBS). Other nutrition data are periodically collected for monitoring purposes through small scale surveys such as integrated nutrition SMART surveys and MNIYCN KAP assessments, sentinel surveillance, food security assessments.

Expected Outcome

Sectoral and Multisectoral nutrition information systems, learning and research strengthened.

Output 11.1: Nutrition sector plans progress reviewed

Strategies: Sectoral and Multisectoral nutrition information systems, learning and research strengthened

Interventions

1. Develop, review and disseminate of County nutrition sector plans and reports.

Output 11.2: Strengthened nutrition sector capacity in Nutrition Information System (NIS) and evidence-based decision-making

Strategies: Improve capacity for quality nutrition data collection, analysis and dissemination

Interventions

1. Develop and capacity build stakeholders on nutrition information system
2. Conduct M&E capacity needs assessment and action plan for findings
3. Develop customized nutrition M&E data collection and reporting tools

Output 11.3: Enhanced multi sectoral linkages result in improved nutrition information efficiencies and cost-effectiveness

Strategies

Mainstream nutrition M&E in the relevant sector information systems and technical working groups

Intervention

1. Strengthen Nutrition Coordination platforms for effective monitoring, evaluation and learning among county stakeholders.

3.12 KRA 12: Advocacy, Communication and Social Mobilization (ACSM) Strengthened

Context

Advocacy is an important key result area if a good nutrition outcome is to be achieved in the country. The result area aims to ensure improved and strengthened governance, capacity to deliver, increased awareness, increased demand and adoption of nutrition services and practices at all levels within the country. The Lancet series in 2013 provided evidence that if a country was to implement all the 12 High-impact nutrition interventions to scale; this would only result in a 30 per cent reduction in stunting. The remaining 70 per cent reduction can only be achieved if other sectors that contribute to this outcome take up their role. This key results area aims to ensure that advocacy and communication is strengthened among the nutrition-specific and nutrition-sensitive actors to achieve the good nutrition outcome.

Several gains have been made in advocacy, and this has resulted in an increased visibility for nutrition in Kenya. Kenya is a signatory and a member of the Scaling up Nutrition movement, it has unveiled a framework for ending drought emergencies and the government has recognized food and nutrition security as one of its key priority areas for the next five years. In addition, the country now has a nutrition financial tracking tool that is unique and the first of its kind in Kenya. With this tool, policy makers will become aware of where funding for

nutrition is and using these information efforts can be made to advocate for targeted actions to have a positive impact on nutrition outcomes.

Despite the various gains on advocacy, gaps still exist. Human resource numbers and the capacity for advocacy have persistently been identified as a gap during capacity assessments at national and county level. Other identified gaps are weak community engagement, weak

community participation and weak feedback mechanisms that result in poor or weak social accountability. National and county budget analysis indicates that nutrition is underfunded; therefore, advocacy is required to lobby for nutrition positioning at national and county levels and increased financial allocation. Currently, a huge share of funding even for nutrition actions goes towards curative actions in nutrition. There is evidence that nutrition-sensitive actions have a big role to play if we are to improve the nutrition indicators. This requires advocacy actions to have line sectors mainstream nutrition in their policies and actions. The objectives and strategies of these key result areas aim to address these gaps. To achieve the desired outcome a series of strategies and interventions with related outputs will be prioritized for implementation over the plan period.

Expected Outcome

Enhanced political commitment and continued prioritization of nutrition in county agenda.

Output 12.1: Political commitment and prioritization of nutrition

Strategies

High-level advocacy for national and county governments

Interventions

1. Hold high-level policy makers' sensitization forums for nutrition.
2. Develop and implement county advocacy, communication and social mobilization plans

Output 12.2: Enhanced and sustained multi-sectoral collaboration, social accountability and financial resources allocated across relevant sectors at county and sub county levels.

Strategies

Enhanced multi-sectoral collaborations for enhanced nutrition service delivery in social accountability and financial resources allocations.

Intervention:

1. Advocate for relevant sectors to support establishment of multi-sectoral nutrition platforms
2. Advocate for adequate financial resources for sustained and quality nutrition services including domestic resource mobilization.

Output 12.3: Increased nutrition capacity in advocacy and documentation.

Strategy

Building capacity for nutrition advocacy and documentation at county and sub-county levels.

Intervention:

1. Capacity building on nutrition advocacy and documentation Output 12.4: Community engagement in nutrition strengthened Strategy

Strengthen community engagement, participation and feedback mechanisms for nutrition services and decision making processes

Interventions

1. Capacity development of community on nutrition resilience and accountability

3.13 KRA 13: Supply Chain Management for Nutrition Commodities and Equipment Strengthened

Context

Nutrition commodities and equipment are a key component for prevention and management of malnutrition along the life course. At national level, the main objective has been to ensure uninterrupted supply by facilitating integration into a single more effective and efficient Government led supply chain system with KEMSA as the key warehousing and distribution agency of nutrition commodities directly to the health facilities. The need for continuous supply of adequate and good quality nutrition commodities and equipment is paramount to the success of the treatment of these conditions and the success of UHC agenda. An increased scope of commodities is also necessary to support the reviewed Kenya Essential Package for Health (KEPH) that focuses on responsiveness to the population needs especially expanding to coverage for more non-communicable diseases. Advocacy for expansion of Essential Medicines & Medical Supplies (EMMS) lists to incorporate new commodities, e.g., nutrition commodities for chronic diseases such as cancer, is critical. An important aspect that determines the scale of procurement is the cyclical emergencies and disasters that increases the caseloads of children affected by malnutrition, consequently increasing the requirements for key products necessary in treatment and management of malnutrition.

Procurement of nutrition commodities is predominantly done by the KEMSA which is a state corporation under the Ministry of Health established under the KEMSA Act 2013. There are, however, limitations in the full range and quality of commodities that KEMSA is currently able to stockpile. The mandate of the authority is to procure, warehouse and distribute nutrition commodities to facilities.

On the other hand, Counties (read Kitui) are supposed to forecast, quantify and procure commodities from KEMSA. The ability of the county to undertake this role effectively has been hampered by capacity issues at health facilities. At the advent of the Logistics Management Information System (LMIS), Kitui County had 75 health facilities forecasting, ordering and procuring nutrition commodities through the platform to KEMSA. These numbers have since increased to 145 signifying expansion and more reach of children with the essential commodities. However, the management of supplies and inherently poor forecasting has often led to under or oversupply of commodities at facilities. Varying capacity exists across the county which needs to be reinforced and supports to ultimately have a better system and responsive system.

Currently, the county receives nutrition commodities mainly from the MOH, NHPplus, Global Fund, and UNICEF.

To achieve the desired outcome a series of strategies and interventions with related outputs will be prioritized for implementation over the plan period.

Output 13.1: Increased government budget allocation for nutrition commodities/allied tools and enhanced quality of nutrition commodities

Strategies

1. Advocate for increased government budget allocation for nutrition commodities and allied tool
2. Optimize functioning of County Nutrition Commodity management structures Interventions
3. Capacity building on effective nutrition commodity management.

CHAPTER 4: MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL) FRAMEWORK

4.1 Introduction

The monitoring, evaluation, accountability and learning (MEAL) framework will facilitate tracking and evaluation of performance of set targets, as well as serving as an accountability and learning framework for the various nutrition stakeholders. In addition to supporting results and financial tracking, the MEAL framework will also provide a mechanism for county, national and, where relevant, global and regional reporting; thereby aligning partners to a common approach to reporting. The KCNAP elaborates required investments to strengthen the nutrition system and scale up coverage of nutritional interventions, to attain set nutrition objectives. The MEAL framework further provides a summary of select results and indicators that will be mutually tracked and reported on by all sectors responsible for the implementation of KCNAP. The summary is referred to as the Common Results and Accountability Framework (CRAF). Table 8 explains key MEAL terms.

Table 8: MEAL Explained

THE MEAL	Definitions
Monitoring	The routine monitoring of project resources, activities and results, and analysis of the information to guide project implementation.
Evaluation	The periodic (midterm, final) assessment and analysis of an existing strategy/action plan
Accountability	Transparency of processes: planning, execution, and reporting
Learning	The process through which information is generated from M&E is reflected upon and intentionally used to continuously improve the ability of an action plan/strategy to achieve results

The KCNAP M&E system will therefore ensure

1. Continued progress monitoring, reporting through regular and systematic tracking of the progress of implementation of the KCNAP.
2. Alignment of stakeholders' resources and actions to strengthen nutrition interventions.
3. Evidence-based decision making through ensuring timely availability of good-quality evidence that is effectively disseminated.
4. Constructive evidence-based policy dialogue to facilitate evidence-informed decision making
5. That operational research capacity is strengthened to generate evidence to inform decision making.
6. Documentation of lessons learnt in KCNAP implementation to promote learning, institutional memory and linking of nutrition programmes with research and training.

4.2 Common Results and Accountability Framework (CRAF)

KCNAP has identified results expected upon full implementation of the action plan, together with indicators that will measure the progress of achievement of the strategies outlined. Important to note is a set of key indicators and targets that are referred to as the CRAF that have been agreed upon. The CRAF uses a logical results framework process at three levels (impacts, outcome and output results). Kitui County has identified and selected 17 nutrition targets that constitute the CRAF and if achieved will contribute significantly to the desired change. Table 9 details the baseline data, and mid- and end-term target as well as the sources for these indicators. The largely impact targets are derived from three sources: The World Health Assembly (WHA) six targets for 2025; the global Non-Communicable Diseases (NCD) nine voluntary 2025 targets and the National Food and Nutrition Security Policy Implementation (NFNSP-IF) results matrix.

Table 9: Kitui Nutrition Targets for 2022/23

No.	KNAP expected results (Global targets used where applicable)	Indicator	Baseline 2019	Data Source	Target 2023	Framework for targets
1	Reduce the prevalence of stunting among children under five years by 40% (estimated reduction by county is 32%)	Prevalence of stunting in children 0-59 months (%)	45.8%	KDHS	31.1%	WHA Target 1 NFNSP-IF
2	Reduce the prevalence of anaemia in women of reproductive age by 30%	Prevalence of anaemia in women 15-49 years (%)	27%	KDHS	17%	WHA Target 2 NFNSP-IF
3	Reduce the prevalence of low birthweight by 30%	Prevalence of low birth weight of 2.5kg and below (%)	8%	KDHS	5%	WHA Target 2 NFNSP-IF
4	Increase the rate of exclusive breastfeeding in the first six months by 20% and above (Estimated increase by county is 10%)	Prevalence of exclusive breastfeeding in children 0-6 months (%)	75.6% (KABP 2017)	KABP	83%	WHA Target 2 NFNSP-IF
5	Maintain childhood wasting at less than 4%	Prevalence of wasting (W/H<2SD) in children 0- 59 months (%)	2.6% (SMART 2016)	SMART	<2.6%	SMART
6	Reduce childhood underweight by 30%	<2sd W/A in children 0-59 months	15.0% (SMART 2016)	SMART	10.5%	SMART
7	Maintain proportion of deaths at below 3% for MAM and 10% for SAM	Proportion (%) of discharges from treatment program who have died children for MAM and SAM)	0.2% MAM	DHIS2	<0.2% MAM	NFNSP-IF
			1.7% SAM	DHIS2	<1.7% SAM	NFNSP-IF
8	Reduced Anemia in children 6-59 months	Prevalence of anemia in children 0-59 months	26%	DHIS	18%	KNAP
9	Reduce anaemia in pregnant women by 40% or more	Prevalence of anaemia in pregnant women (%)	36%	KNMS	20%	NFNSP-IF
10	Reduce anaemia in adolescent girls by 30%	Prevalence of anaemia in girls15-19 years (%)	21%	KNMS	15%	KNAP
11	Reduce folic acid deficiency among non-pregnant women by 50%	Proportion of non-pregnant women with folic acid deficiency (%)	39%	KNMS	20%	NFSNP-IF

No.	KNAP expected results (Global targets used where applicable)	Indicator	Baseline 2019	Data Source	Target 2023	Framework for targets
12	Reduce vitamin A deficiency in children by 50%	Prevalence of VAD in children 0-59 months (%)	9%	KNMS	4%	NFSNP-IF
13	Reduce iodine deficiency among children <5 years by over 50%	Prevalence of iodine deficiency in children <5 years (%)	22%	KNMS	<10%	NFSNP-IF
14	Reduce iodine deficiency among non- pregnant women by over 50%	Prevalence of iodine deficiency in non-pregnant women (%)	26%	KNMS	<10%	NFSNP-IF
15	Reduce prevalence of zinc deficiency in pre-school children by 20%	Prevalence of zinc deficiency in children <5 years (%)	83%	KNMS	66.4%	NFSNP-IF
16	Reduce prevalence of zinc deficiency among pregnant women by 20%	Prevalence of zinc deficiency among pregnant women (%)	60%	KNMS	48%	NFSNP-IF

Monitoring of the KCNAP will require the use of data from multiple data sources, strong Multisectoral collaboration, stakeholder involvement and strong political support.

4.3 KCNAP Monitoring Process

The KCNAP overall progress review will be conducted at midterm and end term. Further, closer monitoring of implementation of the KCNAP will be done through regular progress review (quarterly and annually) of the annual plans developed to implement KCNAP. During implementation, performance and progress of annual plans will be monitored quarterly and annually, while the overall progress review will be conducted at midterm and end term through both quantitative and qualitative assessments. The monitoring and evaluation logical framework will guide this process, through monitoring of the inputs against outputs, outcomes and impacts.

4.4 Data Review and Performance Monitoring Processes

The data review and performance monitoring processes are useful for documenting lessons learnt and measures of success during the implementation of the KCNAP. There will be a transparent system of joint periodic data and performance reviews that will involve key health stakeholders. All data review, performance monitoring and evaluations processes will produce targeted and actionable recommendations. Programme-specific reviews will be linked to the overall health sector review in terms of timing and methodology while contributing to the sector performance.

All the nutrition planning entities and M&E will be required to maintain a recommendation implementation tracking plan which will keep track of review and evaluation recommendations, agreed follow-up actions, and record the status of these actions. A comprehensive and inclusive feedback mechanism will enhance accountability. These processes will be elaborated in the M&E framework and guidelines.

Quarterly Reporting

Monitoring of annual work plans will be carried out through quarterly and biannual reporting from routine data collection, like the HIS, nutrition scorecard, and feedback from coordinating structures which provide opportunities for the adjustment of activities. These data will be presented in the performance review reports that will be prepared both at the county and sub-county levels by various sectors. These review reports will outline the performance against the targets set for the said period. Recommendations from previous reports will be discussed, together with prevailing implementation challenges, by the county health management teams together with the nutrition focal person, and stakeholders at county and sub- county levels.

Annual Reporting

Annual multi-sectorial and multi-stakeholder nutrition reviews (AMNRs) will need to be established. The common results and accountability framework(CRAF) and financial tracking tools will be used to show stakeholders the progress made, the challenges faced and what still needs to be done. The AMNRs will make recommendations on how those challenges will be resolved, indicating timelines and who will be accountable. Progress on implementation of the recommendations will need to be tabled at the next annual multi-sectorial nutrition review. Key outputs of this annual process will be realized at county and sub- county levels as follows:

County Annual Nutrition Sector Report

The county report will be prepared through a consultative process by all the various ministries involved in nutrition, and nutrition stakeholders. This will document the progress made, challenges faced and recommendations for the following year. Best practices will also be documented and shared for mutual learning. This report will feed into the various ministries annual reports to be shared to senior management at county level for endorsement and use, and to the various stakeholders including county health management teams for feedback and use. The dissemination will be through meetings, workshops, emails and county website.

Sub-County Nutrition Sector Report

The report will be developed by the sub- county nutrition stakeholders through a consultative process with all nutrition stakeholders and presented at sub- County Annual Health Review forum. This report will document the overall progress made by the sub- counties against the targets set for the year. This will be collected from ward level and aggregated to the sub-county level. It will include challenges encountered during the period under review, recommendations and priorities for the following year. Best practices will also be documented for shared learning.

4.5 KCNAP Evaluation Process

Evaluating implementation of the KCNAP is intended to determine whether or not the interventions suggested achieved the expected results. The evaluation will provide credible evidence on the performance of the KCNAP and document what worked and did not work. Beyond answering the evaluation questions, it will test the effectiveness of the suggested interventions, against practices in the region with similar challenges. A midterm review and an end evaluation will be undertaken to determine the extent to which the objectives of the action plan are met. Trends will be assessed, together with the results of the various assessments and surveys across the different indicator domains – inputs/processes; outputs; outcomes and expected results.

Mid -term review

A midterm review (MTR) will be done in 2020 that will review the progress made in the two years of implementation and recommend adjustments in strategy or review of expected targets when deemed necessary. This will assess progress made towards the realization of the KCNAP objectives. The midterm review will coincide with the annual work plan review for year three. It will also be aligned to the county health sector strategic plan midterm review. It will cover all the targets mentioned in the plan, including targets for outcome and impact indicators. The results will be used to adjust the KCNAP strategies, priorities and targets.

End term evaluation

The end-term review (ETR) will be done in 2022 to evaluate the overall performance of the KCNAP and use lessons learnt to develop the subsequent KCNAP and review the final achievements of the sector against what had been planned. It will involve a comprehensive analysis of progress and performance for the whole period of the plan.

Evaluation Criteria

To carry out an effective evaluation, there is a need for clear evaluation questions, which answer/ respond to the appropriate policy questions. To establish the type of questions, a theory of change has been developed, describing the results chain, for formulating hypotheses to be tested by the evaluation, and for selecting performance indicators. Evaluation criteria will highlight the following aspects of the interventions:

1. Effectiveness

2. Efficiency
3. Sustainability
4. Relevance
5. Impact
6. Gender
7. Human Rights

KCNAP has clearly set outputs, outcomes and results that are expected to be realized with its implementation. The activities listed herein target a population in need of nutrition services at all levels of service provision. With proper mechanisms for monitoring implementation, the logical flow of activities is meant to ensure that services are rendered as stipulate. This therefore calls for openness in the planning, execution and reporting processes. The planning should be sensitive to other sector inputs and points of joint implementation in an effort to inadvertently maximize on program synergies. Involvement of county, sub county, facility and community level service providers will be part of enshrining transparency and ownership of results. Where services and activities involve community members, then appropriate use of structures and mechanisms to foster community's uptake of services.

Review of progress will involve all key players especially at key stages like annual and midterm periods. Reference will be made to the common results and accountability framework to ensure uniformity of thought.

4.6 KCNAP Learning Process

The learning process of the KCNAP will follow an adaptive management cycle approach, which involves improving outcomes through learning. Assessment of the problems facing nutrition have been outlined in the situation analysis and strategies and interventions outlined to address the issues. This is followed by the actual implementation, and monitoring of the inputs, outputs, outcomes, achieved and evaluation against the expected results, adjusting accordingly. Figure …… indicates the learning cycle involved.

Learning will involve assessing what works well or does not work well in a particular context, which aspects have more influence on the achievement of results, which strategies can be replicated, among others.

For the KCNAP, the following initiatives will guide learning:

1. Compare results across time to determine which ones contribute to achieving the mission and expected results.
2. Facilitation of both formal and informal learning and reflection meetings of all stakeholders, by sharing learning experiences (positive and negative) with partners, communities and other stakeholders, in response to their needs. This will strengthen accountability and transparency.
3. Documentation of processes and reports (paper based, photos, videos, etc.); and appropriate storage (filing – electronic, paper based) of MEAL outputs to keep learning within the organization even when key staff leave.
4. Mentoring of staff with a focus on specific issues or identified needs and helping individuals reflect and question existing practice.
5. Formulation and adaptation of training courses in response to feedback.
6. Development of innovative tools for a robust MEAL.

Institutional Arrangement for M&E

Kenya is implementing National integrated monitoring and evaluation systems (NIMES) and County integrated evaluation system (SIMES) which tracks all government programmes. Kitui County has an Established monitoring and evaluation unit within the MOH. This was informed by the constitution of Kenya, The County Government Act (2012) and the public financial management act (2012) It is also anchored on the county integrated development plan Kitui county.

The function of this unit is to ensure that Data is regularly collected during and after implementation of projects/ programs as outlined in the ministry's strategic plans and Annual Work Plans. It also assesses the capacity of the Health sector to undertake effective M&E

Role of national and county government in implementation of CNAP

The national government formulates nutrition policies and guidelines, supervisory and technical support. It also monitors implementation at the county level. Both governments do advocacy and resource mobilization for nutrition activities.

Data Management for Nutrition M&E

A nutrition M&E system is critical in tracking the progress and outcome of KCNAP implementation, for it plays a key role in informing programme improvement, adjustment and decisions for nutrition stakeholders in the county. M&E aims at integrating the national platforms such as Kenya Health Information software (KHIS), NDMA early warning system, seasonal assessments and Kenya Demographic Health Surveys (KDHS) and Logistics Management Information System (LMIS).

To support health and nutrition system strengthening the department of health is implementing the national health and nutrition policies and guidelines. Routine data are collected monthly and reported in KHIS, while other nutrition outcome and impact indicators are monitored through the Kenya Demographic and Health Survey (KDHS) and Kenya Household Income and Budget Survey (KHIBS). Other nutrition data are periodically collected for monitoring purposes through small scale surveys such as integrated nutrition SMART surveys and MNIYCN KAP assessments, sentinel surveillance, food security assessments.

Research

Implementation research aims to promote the systematic uptake of research findings and other evidence based practices into routine practices. However, in Kitui County, there is limited support and uptake of health and nutrition related research findings.

Limitation of the data source

1. Lack of consistent and recent data from nutrition surveys-KABP survey 2013.
2. A number of Nutrition indicators have not been captured in the KHIS.
3. Lack of county data portal for quick access to nutrition data.
4. Knowledge gap in access to the available data sources like KHIS.
5. Weak data quality checks in the county.

4.7 Cost of MEAL

Kitui county MEAL should be allocated 10% of the total KCNAP budget. In KCNAP, costing has been done on assessments baselines, routine monitoring, ongoing reflections and learning and periodic evaluations.

CHAPTER 5:
CNAP RESOURCE MOBILIZATION AND COSTING FRAMEWORK

5. 1 Introduction

Ideally Kitui county health system should be able to mobilize both financial and non-financial resources geared towards sustaining its health and nutrition service delivery demands from its population. However, this has not been the case since the nutrition department has continuously been receiving minimal funding alongside other departments in the county ministry of health.

Costing of nutrition services is key in that; it will assist in comprehending the cost involved in holistic quality nutrition service provision for the county population; it will also inform budgeting and planning in the department, ministry and county as a whole thus help in understanding the scale of the financial requirements and decide prioritization of areas of resource allocation, it will also point out areas of advocacy for resources from the government and health and nutrition partners for enhanced service delivery in contribution to the national health and nutrition goals and targets.

5.2 Costing Approach of the KCNAP

In this particular KCNAP, a result based costing that emphasizes on results more than spending has been employed. The amount of money needed to effect the KCNAP has been done by estimating the cost of all the activities necessary to achieve each of the expected outputs in each key result areas (KRAs) for the next 5 years. All activities with inputs require costing where by all inputs are required in certain quantities and with certain frequencies. The sum total of all input costs gives the activity cost, then the activities are added to arrive and the output cost, KRA cost and finally the cost of the KCNAP.

5.3 Resource needs for Implementing Kitui County Nutrition Action Plan

The total cost to achieve the 13 key results areas outlined in the KCNAP from 2019 to 2023 will be 938,148,219. Different KRAs have got different financial needs ranging from KRA_ with the lowest costing to KRA _ with the highest costing. (Analyze KRAs costing from the costing table to e attached below.) Detailed financial resources requirement by each KRA by output and activity is provided in Appendix no_ below.

Table 10: Summary of resource need by KRA for Kitui County Nutrition Action Plan 2019-2023

Category of intervention	KEY RESULT AREAS	2019/2020	2020/21	2021/2022	2022/23	Total KSH	Total USD
Nutrition Specific	KRA 1. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up	56,253,500	57,856,500	55,462,500	57,044,500	226,617,000	
	KRA 2: Prevention, control and management of micronutrient deficiencies scaled up	7,486,650	9,975,050	7,465,050	10,412,250	35,339,000	
	KRA 3: Prevention, control and management of non-communicable and other diet related diseases strengthened	18,749,960	29,610,000	59,148,600	24,595,046	132,103,606	
	KRA 4: Integrated management of acute malnutrition (IMAM) strengthened with a sub-section of Nutrition in emergencies	36,629,160	42,832,840	73,178,760	46,505,640	199,146,400	
	KRA 5: Nutrition in HIV and TB promoted	1,932,923	3,490,846	3,415,846	2,846,538	11,686,153	
Nutrition Sensitive	KRA 6: Food and nutrition security in agriculture and livestock scaled up	21,596,100	11,164,400	11,417,900	15,862,600	60,041,000	
	KRA 7: Nutrition in the health sector strengthened	15,547,500	21,537,900	21,537,900	15,547,500	74,170,800	
	KRA 8: Nutrition in education and early childhood development promoted	2,211,000	9,919,000	5,691,000	4,531,000	22,352,000	
	KRA 9: Nutrition in water, sanitation and hygiene (WASH) sector promoted	1,116,000	6,548,000	1,512,000	1,644,000	10,820,000	
	KRA 10: Nutrition in social protection programmes promoted	47,512,000	31,672,000	44,232,000	30,232,000	153,648,000	
Enabling environment/ Crossing Cutting	KRA 11: Sectoral and multi sectoral nutrition information systems, learning and research strengthened	10,722,560	13,377,960	9,078,040	6,422,640	39,601,200	
	KRA 12: Advocacy, communication and social mobilization (ACSM) strengthened	2,949,625	3,227,875	4,012,575,	2,721,425	12,911,500	
	KRA 13: Supply chain management for nutrition commodities and equipment strengthened	15,646,584	26,077,640	36,508,696	26,077,640	104,310,560	
TOTAL BUDGET TO IMPLEMENT THE CNAP		**238,353,562**	**267,290,011**	**328,648,292**	**244,442,779**	**1,082,747,219**	

5.4 Funding Opportunities and Sustainability Plan for the KCNAP

There is a dire need to mobilize domestic resources to fund full implementation of the KCNAP. It is important to note that Non-governmental organizations, churches and good willed donors play a major role in funding health and nutrition activities on humanitarian grounds to help alleviate human suffering. In the recent past, expenditure on nutrition has been relatively low both nationally and at the county level. Nationally, the total health expenditures for nutrition was KES1 billion (USD11.9 million) and KES1.2 billion (USD12.3 million) in the financial year 2012/13 and 2015/16 respectively.

With the coming of devolution, funding for nutrition can only be prioritized with advocacy playing a major role in pointing out the nutrition gaps and their implications to the population with the aim of having it prioritized for funding. However, it is hoped that the government should be able to fund health and nutrition activities by itself without necessarily sourcing for support from donors and other non-governmental actors.

APPENDIXES

APPENDIX 1: DETAILED FINANCIAL RESOURCES REQUIREMENT AND IMPLEMENTATION PLAN FOR CNAP

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA1: Strengthened care practices and services for improved maternal, new born, infant and young child nutrition (MNIYCN)	1.1 Increased proportion of women of reproductive age (15–49 years) and caregivers who practice optimal behaviors for improved nutrition of maternal and young children under five years	1. Capacity building of health provider on MNIYCN	4,715,000	4,715,000	4,715,000	4,715,000	18,860,000	
		2. Roll out of BFCI/BFHI approaches	32,831,000	32,831,000	32,831,000	32,831,000	131,324,000	
		3. Support Documentation of MNIYCN processes	14,552,500	14,552,500	14,552,500	14,552,500	58,210,000	
	1.2 MNIYCN policy environment at all levels improved	1. Advocate for MIYCN targeting policy and decision makers, implementers and the community.	3,955,000	3955000	3164000	4746000	15,820,000	
		2. Capacity building for program staff and implementers in evidence based programing for MNIYCN	0	102,000	0	0	102,000	
	1.3 Enhanced capacity for implementation of MNIYCN activities at all levels	1. Enhanced county capacity in MNIYCN documentation	200,000	1,701,000	200,000	200,000	2,301,000	
KRA 2: Prevention, control and management of micronutrient deficiencies scaled up	2.1 Strengthened routine micronutrient supplementation (vitamin A, iron and folate and micronutrient powders) for targeted groups	1. Capacity building on micronutrient supplementation	0	2,500,000	0	3,000,000	5,500,000	
		2. Support community structures for integrated micronutrient supplementation	1,800,000	1,800,000	1,800,000	1,800,000	7,200,000	
	2.2 Increased dietary diversity and Consumption of fortified foods	1. Capacity building on diversification of Diets and bio- fortification	54,400	52,800	52,800	-	160,000	
		2. Strengthen compliance and Consumption of fortified foods	50,000	40,000	30,000	30,000	150,000	
	2.3 Integrated public health measures with micronutrient deficiency prevention and control interventions promoted	1. Capacity development on food fortification standards and procedures	5,582,250	5,582,250	5,582,250	5,582,250	22,329,000	

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 3: Prevention, control and management of non-communicable and other diet related diseases strengthened (DRNCDs)	3.1 Established mechanisms to raise the priority accorded to nutrition therapy for prevention and management of NCDs	1. Capacity development of health service providers on NCDs prevention, control and management	1,035,000	2,415,000	1,725,000	1,725,000	6,900,000	
		2. Raise community awareness on NCDs prevention and control	0	0	0	0	0	
		3. Active case finding at all service delivery points	486,400	972,800	2,432,00	1,459,200	4,864,000	
		4. Quality and timely provision of nutrition therapy	0	0	0	0	0	
	3.2 Behaviour change communication strategies developed and implemented to promote primary and secondary prevention of diet-related risk factors for non- communicable diseases	1. Capacity building on social behaviour change on DRNCDs	4,181,600	6,976,00	11,161,600	5,580,800	27,904,000	
		2. Awareness creation on DRNCDs	3,456,000	5,760,000	9,216,000	4,608,000	23,040,000	
		3. Formation and strengthening of community support group	1,177,600	1,766,400	5,888,000	2,944,000	11,776,00	
	3.3 Improved monitoring and evaluation for diet-related diseases and NCDs	1. Regular data review for DRNCDs	2,668,800	5,337,600	7,116,800	2,668,800	17,792,000	
		2. Capacity building on DRNCDs data management	3,738,160	9,345,400	18,690,800	5,607,240	37,381,600	
		3. Assessment on DRNCDs occurrence	2,006,400	4,012,800	5,350,400	2,006.400	13,376,000	
KRA 4: Integrated management of acute malnutrition (IMAM) strengthened	4.1 Policy, standards and guidelines for the IMAM programme disseminated and implemented	1.Promote IMAM policy and guidelines utilization	1,182,720	1971200	3153920	1576960	7,884,800	
		2. Scaled-up access to delivering IMAM services in the county	1,221,120	2,035,200	3,256,320	1,628,160	8,140,800	
	4.2 IMAM program performance monitored, and quality of services improved	1. Capacity building for quality IMAM program	4,002,120	8,004,240	10,672,320	4,002,120	26,680,800	
	4.3 Strengthened partnerships and linkages to improve access and coverage of IMAM services.	1. Promoting partnerships and coordination in IMAM services delivery	2,559,200	4,320,000	6,931,200	3,465,600	17,328,000	
		2. Emergency and response preparedness actions	9,165,600	15,276,00	24,441,600	12,220,800	61,104,000	
	4.4 Strengthened partnerships and linkages to improve access and coverage of IMAM services.	1. Promoting partnerships and coordination in IMAM services delivery	4,332,000	4,332,000	4,332,000	4,332,000	17,328,000	
		2. Emergency and response preparedness actions	8,476,000	8,476,000	8,476,000	8,476,000	33,904,001	
	4.5 Innovative approaches to improve IMAM quality and coverage implemented	1. Use of innovative approaches to improve the delivery of IMAM services	0	2,200,000	1,500,000	1,200,000	4,900,000	
	4.6 Enhanced early case identification through community mobilization and referral	1. Promoting early detection and referral of IMAM cases	2,354,400	2,943,000	2,943,000	3,531,600	11,772,000	
	4.7 Improved utilization of IMAM data for informed decision making, service delivery and programming	1. Capacity Development to health workers	0	3,200,000	2,600,000	1,200,000	7,000,000	
		2. IMAM program performance, documentation and review	300,000	400,000	400,000	400,000	1,500,000	
	4.8 Strengthened implementation of recovery interventions to enhance resilience	1. IMAM program linkage to livelihood support programs	3,036,000	3,036,000	3,036,000	3,036,000	11,424,000	
		2. Emergency nutrition linkage to early warning and contingency plans.	0	1,915,200	1,436,400	1,436,400	4,788,000	

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 5: Nutrition in HIV and TB promoted	5.1: Improved access and demand to quality nutrition services by PLHIV and TB patients	1. Capacity building of health workforce on HIV & TB Nutrition therapies	711023	1422046	1422046	1185038	4,740,153	
		2. Scale up nutrition screening among PLHIV & TB patients at all levels	225000	450000	450000	375000	1,500,000	
		3. Raise community awareness on nutrition services in HIV & TB patients	492900	985800	985800	821500	3,286,000	
		4. Strengthen management of nutrition therapeutic commodities in HIV and TB at all level	279000	558000	558000	465000	1,860,000	
		5. Strengthen community linkages for nutrition interventions including home based care	225,000	75,000	0	0	300,000	
KRA 6: Food and Nutrition Security in Agriculture and Livestock Scaled up	6.1: Strengthened sustainable and inclusive food systems that are diverse, productive and Profitable for improved nutrition	1. Collaborative planning on County Nutrition Activities.	0	0	253500	253500	507,000	
		2. Promotion and Capacity building on importance of linkages between nutrition and food security.	1436400	1436400	1436400	478800	4,788,000	
		3. Conduct research on Value chain weak areas	3900000	0	0	3,900,000	7,800,000	
	6.2: Improved access to safe and nutritious foods along the food value chain	1. Support collaboration between public and private stakeholders on food safety and quality through capacity assessments.	1,124,000	0	0	1,124,000	2,248,000	
		2. Promote uptake of food processing, preservation and storage technologies.	1,100,000	0	0	1,100,000	2,200,000	
	6.3: Consumption of diverse, safe and nutritious foods promoted.	1. Promote Consumption and utilization of locally available, safe and nutritious foods.	4238500	4238500	4238500	4238500	16,954,000	
		2. Develop and review food safety initiatives, regulations, standards and enforcement mechanisms.	4336000	1626000	1626000	3252000	10,840,000	
		3. Develop Social Behavior Change Communication (SBCC) strategy for increased consumption of nutritious foods and	1,500,000	0	0	0	1,500,000	
	6.4: Strengthened Agri-nutrition capacities and coordination	1. Facilitate Agri nutrition coordination structures.	3375000	3375000	3375000	1125000	11,250,000	
	6.5: Production of safe, diverse and nutritious foods promoted	1. Sensitization on diversified food production technologies.	586200	488500	488500	390800	1,954,000	
KRA 7: Nutrition in the health sector strengthened	7.1:Nutrition articulated in health policy documents and represented in health sector policy development forums	1. Advocate for inclusion of nutrition interventions in County AWPs	1,136,000	1,136,000	1,136,000	1,136,000	4,544,000	
		2. Enhance integration of nutrition interventions in health sector	1,996,800	7,987,200	7,987,200	1996800	19,968,000	
		3. Strengthen monitoring, evaluation, research, accountability and learning of nutrition interventions within health sector	12,414,700	12,414,700	12,414,700	12,414,700	49,658,800	

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 8: Nutrition in Education and Early Childhood Development promoted	8.1 Policies, strategies, standards and guidelines on nutrition and physical activity in schools and other learning institutions developed and promoted	1. Promote integration of nutrition in schools' curriculum, guidelines and policies	380,000	380,000	380,000	380,000	1,520,000	
		2. Advocacy on inclusion of physical activities and Agri- nutrition activities in the school curriculum.	400,000	400,000	400,000	400,000	1,600,000	
	8.2 Nutrition services enhanced within learning institutions	1. Promote uptake and implementation of nutrition services within the learning institutions	0	5,800,000	3,480,000	2,320,000	11,600,000	
		2. Capacity building stakeholders on nutrition assessment and referrals.	0	1,908,000	0	0	1,908,000	
	8.3 Healthy and safe food environment promoted in schools and other learning institutions	1. Promoting food safety in schools	1,431,000	1,431,000	1,431,000	1,431,000	5,724,000	
KRA 9: Nutrition in Water, Sanitation and Hygiene (WASH) Sector promoted	9.1 Improved access to safe and adequate WASH services.	1.Advocate for provision of adequate potable water and safe storage facilities in households, community water points and institutions	0	5,300,000	0	0	5,300,000	
		2.Advocate for construction and proper use of sanitation facilities at the community and household levels	360,000	360,000	360,000	360,000	1,440,000	
		3.Integration and Promotion of monitoring of the trends on WASH-related diseases	360,000	360,000	360,000	360,000	1,440,000	
	9.2 Collaboration with relevant stakeholders on WASH strengthened	1. Promote joint resource mobilization for integrated WASH and nutrition activities	396,000	528,000	792,000	924,000	2,640,000	
KRA 10: Nutrition in Social Protection programmes	10.1 Nutrition promoted and linkages enhanced in social protection programmes including in crisis	1.Promote Mainstreaming of nutrition in Social Protection Policy and Strategy	1,738,000	1,738,000	1,738,000	1,738,000	6,952,000	
		2. To create indicators for Nutrition Sensitive Social Protection and Establish evidence based data on the Nutrition status of the vulnerable groups.	4,244,000	4,244,000	4,244,000	4,244,000	16,976,000	
		3. Establish mechanism for Scaling up Nutrition sensitive social safety nets in times of crises/ emergencies	18,780,000	3,340,000	15,900,000	1,900,000	39,920,000	
	10.2 Resources for nutrition in social protection programmes mobilized	1. Mobilize financial resources for nutrition interventions in social protection	17,840,000	17,440,000	17,440,000	17,440,000	70,160,000	
	10.3 Strengthened advocacy communication and social mobilization for social protection	1. Link Nutrition beneficiaries to Cash Transfers and the Health Insurance Schemes (National Hospital Insurance (NHIF & KCHIC)	4,910,000	4,910,000	4,910,000	4,910,000	19,640,000	

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 11: Sectoral and multi sectoral nutrition information systems, learning and research strengthened	11.1: Nutrition sector plans progress reviewed							
	11.2: Strengthened nutrition sector capacity in Nutrition Information System(NIS) and evidence-based decision-making	1. Develop and capacity build stakeholders on nutrition information system	1,387,600	2,081,400	2,081,400	1,387,600	6,938,000	
		2. Conduct M&E capacity needs assessment and action plan for findings	3,923,200	5,884,800	5,884,800	3,923,200	19,616,000	
		3. Develop customized nutrition M&E data collection and reporting tools	3,744,000	3,744,000	0	0	7,488,000	
	11.3: Enhanced multi sectoral linkages result in improved nutrition information efficiencies and cost-effectiveness	1. Strengthen Nutrition Coordination platforms for effective monitoring, evaluation and learning among county stakeholders.	294,960	294,960	196,640	196,640	983,200	
KRA12: Advocacy, Communication and social mobilization (ACSM) strengthened.	12.1 Political commitment and Prioritization of nutrition.	1. Hold high-level policy makers' sensitization forums for nutrition.	1,772,575	1,266,125	1,266,125	759,675	5,064,500	
	12.2 Increased nutrition capacity in advocacy and documentation.	1. Develop and implement county advocacy, communication and social mobilization plans	330,000	550,000	770,000	550,000	2,200,000	
		2. Capacity development of community on nutrition resilience and accountability.	847,050	1,411,750	1,976,450	1,411,750	5,647,000	
KRA 13: Supply chain management for nutrition commodities and	13.1 Increased government budget allocation for nutrition commodities/allied tools and enhanced quality of nutrition commodities	1. Capacity building on effective nutrition commodity management	15,547,584	25,912,640	36,277,696	25,912,640	103,650,560	
		2. Advocacy and lobbying for resource allocation for essential nutrition commodities	99,000	165,000	231,000	165,000	660,000	

APPENDIX 2: MATRIX OF COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK (CRAF) FOR RESULTS-BASED PERFORMANCE MONITORING (KNAP 2019-2022)

Monitoring and Evaluation Matrix per KRAs

Output	Expected results	Indicator	Baseline	Yearly Targets		End term	Means of verification	Lead	Associated
			2019	2020	2021	2022			
KRA 1 - Maternal, Infant and Young Child, older Children and adolescent Nutrition (MIYCN) Promoted									
OUTPUT 1.1 Increased proportion of women of reproductive age (15–49 years) and caregivers who practice optimal behaviors for improved nutrition of maternal and young children under five years	Increased Proportion of mothers and care givers who practice optimal behaviors For improved nutrition of women of reproductive age (15-49 years)	48.0% (Small scale HH monitoring survey by NHPplus)	52.00%	55.00%	58.00%	60%	SMART survey, KABPS	MoH	County partners
	Increased proportion of care givers who practice optimal behaviors for improved nutrition of young children under five years	73.3% (KABP 2017)	76.30%	79.30%	82.30%	83%	KABP, KHIS	MoH	County partners
		Proportion of children 20–23 months of age who are fed breast milk	70.8% (KABP 2017)	73.80%	76.80%	79.80%	KABP, SMART Survey	MoH	County partners
		Proportion of infants 6–8 months of age who receive solid, semi-solid or soft foods	87.4% (KABP 2017)	88.40%	89.40%	90.40%	KABP, SMART Survey	MoH	County partners
		Proportion of children 6–23 months of age who receive foods from 4 or more food groups	32.1% (KABP 2017)	36.10%	39.10%	42.10%	KABP, SMART Survey	MoH	County partners
		Proportion of breastfed and non-breastfed children 6–23 months of age who receive solid, semi-solid, or soft foods number of times or more(but also including milk feeds for non- breastfed children) the minimum	No data				KABPS	MoH	County partners
		Proportion of children 6–23 months of age who receive a minimum acceptable diet (apart from breast milk)	28.1% (KABP 2017)	31.10%	34.10%	37.10%	SMART survey, KABPS	MoH	County partners
		Proportion of children 6–23 months of age who receive an iron-rich food or iron-fortified food that is specially designed for infants and young children, or that is fortified in the home	31.4% (KABP 2017)	34.40%	37.40%	40.40%	SMART survey, KABPS	MoH	County partners
		Proportion of children 0– 23 months of age who are fed with a bottle	36.4% (KABP 2017)	34.40%	32.40%	30.40%	SMART survey, KABPS	MoH	County partners
OUTPUT 1.2: Maternal, Infant and young Child nutrition policy environment at all levels improved	Maternal, Infant and young Child nutrition advocated for at all levels	Proportion of public & private institutions with designated breastfeeding places	No data	15%	20%	25.00%	BFCI self-assessment	MoH	County partners

Output	Expected results	Indicator	Baseline	Yearly Targets		End term	Means of verification	Lead	Associated
			2019	2020	2021	2022			
OUTPUT 1.3: Enhanced capacity for implementation of MNIYCN activities at all levels	Enhanced capacity for implementation of MNIYCN activities at all levels	Proportion of health workers and CHVs trained on MIYCN, BFHI, & BFCI	5%	10%	15%	30% health workers trained on MIYCN:, BFHI:, BFCI:,	Program/ supervision reports, Trainings data base	MoH	County partners
		Proportion of health facilities with minimum required anthropometric & IEC materials	TBD	20%	40%	80% health facilities	Program/ supervision reports,	MoH	County partners
		No. of county/sub county conferences held	TBD	2%	2%	4 conferences	Program/ supervision reports,	MoH	County partners
		No. of county/sub county exchange visits held	TBD	1%	1%	2 exchange visits	Program/ supervision reports,	MoH	County partners
Output 2.1: Strengthened routine micronutrient supplementation (vitamin A, iron and folate and micronutrient powders) for targeted groups	1. Reduced vitamin A deficiency in children 6-59months by 50%.	1.No of children 6-59 months supplemented with vitamin A	80%	5%	5%	5%	KHIS	MoH	County partners
	2.Reduced anaemia in pregnant women by 40% or more	Prevalence of anemia in pregnant women (%)	36%	10%	20%	30%	KDHS 2014	MoH	County partners
		Rates of IFAs supplementation among pregnant women	87.90%	10%	20%	30%		MoH	County partners
	3.Reduced zinc deficiency in preschool children by 40%	No of children with diarrhea treated with zinc	TBD	TBD	TBD		KHIS, SMART SURVEY	MoH	County partners
Output 2.2: Increased dietary diversity and consumption of fortified foods	Increased no of HH with improved dietary diversity	Proportion of HH with minimum dietary diversity	28.10%	15%	20%	25%	KAP SURVEY	MoH	County partners
	Increased no of HH consuming fortified foods	Proportion of HH consuming fortified foods.	87.70%	5%	10%	15%	KAP SURVEY	MoH	County partners
Output 2.3: Integrated public health measures with micronutrient deficiency prevention and control intervention promoted	Capacity of service providers strengthened	Number of service providers trained on micronutrient deficiency prevention and control	TBD	TBD	TBD	TBD	Training Report	MoH	County partners
	Enhanced Surveillance on quality of fortified foods	Number of assessments done on quality of fortified foods	0	1	1	1	Activity Report	MoH	County partners
KRA:3 Prevention, control and management of non-communicable and other diet related diseases strengthened (DRNCD)									
Output 3.1: Established mechanisms to raise the priority accorded to nutrition therapy for prevention and management of NCDs	Capacity of service providers on DRNCD strengthened	Number of service providers trained on DRNCD	TBD	TBD	TBD	TBD	Training reports	MoH	County partners
		Proportion of patients with DRNCD receiving nutrition counselling and support	TBD	TBD	TBD	TBD	OPD Register	MoH	County partners
Output 3.2: Behaviour change communication strategies developed and implemented to promote primary and secondary prevention of diet-related risk factors for non- communicable diseases	Increased community knowledge on healthy diets	Proportion of individuals knowledgeable on healthy diets	TBD	TBD	TBD	TBD	Activity Reports	MoH	County partners
		Number of DRNCD information packages disseminated	TBD	TBD	TBD	TBD	Activity	MoH	County partners
		Number of hospital/ community support groups established for DRNCD patients	TBD	TBD	TBD	TBD	Activity Reports	MoH	County partners
Output 3.3: Improved monitoring and evaluation for diet-related diseases and NCDs	Data capture and Reporting rates on DRNCD improved	Number of meetings held to review DRNCD service delivery data	TBD	TBD	TBD	TBD	Minutes/ Reports	MoH	County partners
		Proportion of health facilities timely reporting on DRNCD	TBD	TBD	TBD	TBD		MoH	County partners

Output	Expected results	Indicator	Baseline	Yearly Targets		End term	Means of verification	Lead	Associated
			2019	2020	2021	2022			
KRA 4: Integrated management of acute malnutrition (IMAM) strengthened with the subsection of nutrition in emergencies									
Output 4.1: Policy, standards and guidelines for the IMAM programme disseminated and implemented	Strengthened capacity of service providers on IMAM policy and guidelines	No of health facilities with capacity for IMAM service delivery	122	TBD	TBD	TBD	KHIS	MoH	County partners
Output 4.2: Scaled-up access to IMAM services in the county	Enhanced access to IMAM services	Proportion of children with acute malnutrition accessing IMAM services	TBD	TBD	TBD	TBD	KHIS	MoH	County partners
Output 4.3: IMAM programme performance monitored, and quality of services improved	Strengthened health system to offer IMAM services	No of health facilities implementing quality IMAM services	144	1%	1%	1%	KHIS	MoH	County partners
	Increased proportion of children with SAM cured	No. of Sub Counties meeting sphere standards (focus on cured)	TBD	TBD	TBD	TBD	KHIS	MoH	County partners
Output 4.4: Strengthened partnerships and linkages to improve access and coverage of IMAM services.	Enhanced nutrition inter- sector linkages i.e. WASH, Social Protection and Food Security	No. of inter sectoral meetings held	0	4	4	4	Reports	MoH	County partners
Output 4.5: Innovative approaches to improve the quality and IMAM quality and coverage implemented	Strengthened capacity to document and share best practices contributing to improved quality and coverage of IMAM services	Proportion of service providers trained to capture and share best practices for replication	0	5%	10%	15%	Reports	MoH	County partners
Output 4.6: Enhanced early case identification through community mobilization and referral	Strengthened capacity for screening and referral of acute malnutrition at community and health facilities	Proportion of malnourished cases admitted to IMAM program	TBD	TBD	TBD	TBD	Reports	MoH	County partners
Output 4.7: Improved utilization of IMAM data for informed decision making, service delivery and programming	Increased IMAM data utilization for evidence-based decision making	Proportion of healthcare workers' capacity build on quality IMAM data capture and reporting	25%	30%	40%	50%	Reports	MoH	County partners
		No of meetings held to review performance of IMAM services	1	4	4	4	Reports	MoH	County partners
Output 4.8: Strengthened implementation of recovery interventions to enhance resilience	Enhanced nutrition sector participation in early warning system review process	Proportion of review meeting on early warning system with inclusion of nutrition agenda	100%	100%	100%	100%	Reports	NDMA / MoH	County partners
	Enhanced integration of HINI to early warning contingency plans and emergency response	Proportion of the population (women of reproductive age and under 5) accessing HINI services during emergencies	TBD	TBD	TBD	TBD	Reports	NDMA / MoH	County partners

Output	Expected results	Indicator	Baseline	Yearly Targets		End term	Means of verification	Lead	Associated
			2019	2020	2021	2022			
KRA 5-Nutrition in HIV and TB promoted									
Output 5.1: Improved access and demand to quality nutrition services by PLHIV and TB patients	Capacity of health care workers on Nutrition in HIV & TB enhanced	Number of healthcare providers trained on Nutrition therapy in HIV & TB	TBD	TBD	TBD	TBD	Training Reports	MoH	Partners
		Proportion of health facilities reporting nutrition screening in HIV/ TB (timely & completeness)	30%	80%	80%	80%	MoH733B/ KHIS	MoH	Partners
		Proportion of health facilities equipped with nutrition screening and assessment equipment	TBD	30%	45%	50%	Program/ supervision reports	MoH	Partners
	Improved supply and management of nutrition commodities for PLHIV and TB Patients	Proportion of health facilities reporting adequate nutrition commodities stocks	100%	100%	100%	100%	Reports	MoH	Partners
		Proportion of health facilities with adequate storage facility	24%	30%	40%	50%			
KRA 6 - Food and Nutrition Security in Agriculture and Livestock Sectors scaled up									
OUTPUT 6.1: Strengthened sustainable and inclusive food systems that are diverse, productive and profitable for improved nutrition	Linkages between nutrition, agriculture and food security strengthened	No of joint strategic meetings/forums held for nutrition-sensitive agricultural production	0	4	4	0	Minutes/ reports	MAWLD	NDMA, Develop-ment partners
		Number of trainings for Agrinutrition stakeholders on early warning systems.	0	8	8	0	Minutes/ reports	MAWLD	NDMA, Develop-ment partners
		Number of trainees on early warning systems	TBD			0	Reports	MAWLD	NDMA, Develop-ment partners
		Number of value chain actors' capacity built.	0	4	4	0	Minutes, Training reports, Attendance lists	MAWLD	NDMA, Develop-ment partners
		Number of surveys conducted across all value chains (Sorghum, Millet, Cowpeas, Green grams, Spinach, Kales, Amaranth, Indigenous Chicken, Beekeeping, Dairy Goat)	0	10	0	10	Survey reports, Survey tools, List of enumerators	MAWLD	NDMA, Develop-ment partners
OUTPUT 6.2: Improved access to safe and nutritious foods along the food value chain	Enhanced capacity of the Households to safe and nutritious food	Number of learning meetings held, field days, demos, ASK shows conducted on Food safety and quality.	0	4	4	0	Minutes, Training reports, Attendance lists	MAWLD	NDMA, Develop-ment partners
		Number of capacity assessments conducted	0	4	4	0	Reports	MAWLD	NDMA, Develop-ment partners

Output	Expected results	Indicator	Baseline	Yearly Targets		End term	Means of verification	Lead	Associated
			2019	2020	2021	2022			
Output 6.3: Consumption of safe, diverse, and nutritious foods promoted	Enhanced capacity of households to consume diversified and nutritious foods	Number of meetings held to sensitize the community on diversified, safe and nutritious foods	0	40	40	0	Reports, Pictures, Work tickets	MAWLD	NDMA, Develop-ment partners
		Proportion of households knowledgeable on diversified and nutritious foods	0	40	40	0	Reports, Pictures, Work tickets	MAWLD	NDMA, Develop-ment partners
		Proportion of households consuming diversified and nutritious foods	20	40	50	60	Reports	MAWLD	NDMA, Develop-ment partners
Output 6.4: Strengthened agri-nutrition capacities and coordination	Capacity of Agri nutrition players strengthened	Number of Agri-nutrition coordination forums held	0	196	196	196	Reports, Forum minutes	MAWLD	NDMA, Develop-ment partners
		Number of learning meetings.	0	18	18	18	Reports, Pictures, Work tickets, Forum minutes	MAWLD	NDMA, Develop-ment partners
		Number of trainings on Agri Nutrition packages held	0	18	0	0	Activity Reports	MAWLD	NDMA, Develop-ment partners
		Number of integration meetings held.	0	18	18	18	Reports, Pictures, Work tickets, Forum minutes	MAWLD	NDMA, Develop-ment partners
Output 6.5: Production of safe, diverse, and nutritious foods promoted	Capacity of food value chain players on production enhanced	Number of community sensitization meetings held	0	40	40	40	Pictures, Attendance list	MAWLD	NDMA, Develop-ment partners
		Number of field days, demos, ASK shows conducted	0	40	40	40	Reports	MAWLD	NDMA, Develop-ment partners
		Number of field days, demos, ASK shows conducted	0	40	40	40	Reports	MAWLD	NDMA, Develop-ment partners
	Increased number of households adopting Good Agriculture Practices in production of diversified nutritious foods	Proportion of households adopting GAP in production of diversified and nutritious foods	20%				Assessment Reports	MAWLD	NDMA, Develop-ment partners
KRA 7: Nutrition in the health sector strengthened									
Output 7.1: Nutrition articulated in health policy documents and represented in health sector policy development forums	Nutrition mainstreamed in health policies, strategies and action plans	Number of AWPs with nutrition interventions incorporated	1	1	1	1	AWPs	MoH	County partners
		Number of advocacy meetings held to discuss integration of nutrition interventions within health sector	1	1	1	4	AWPs	MoH	County partners
	Increased budget allocation to nutrition sub sector in the county health budget	Amount of funds allocated to nutrition line item	2,000,000	5,000,000	10,000,000	20,000,000	County Budget	MoH	County partners
	Proportion of Health facilities offering quality Nutrition services increased	Number of health facilities offering comprehensive quality nutrition services	TBD	TBD	TBD	TBD	TBD	MoH	County partners
	Capacity of health service providers in nutrition service delivery enhanced	Number of Health Workers Capacity build on nutrition service delivery	TBD	TBD	TBD	TBD	TBD	MoH	County partners

Output	Expected results	Indicator	Baseline	Yearly Targets		End term	Means of verification	Lead	Associated
			2019	2020	2021	2022			
KRA 8: Nutrition in education and early childhood development promoted									
Output 8.1: Policies, strategies, standards and guidelines on nutrition and physical activity in schools and other learning institutions promoted	Capacity of education stakeholders on nutrition and physical activity strengthened.	Proportion of education sector players trained on nutrition and physical activity in human development	0	0	1	1	Supervision report	MoE, MoH	Partners
		Proportion of schools adopting good nutrition and physical activities practices	0	25%	50%	75%	Reports	MoE, MoWLD, MoH	Partners
		Proportion of schools with demonstration gardens, small animals and revived 4Kclubs	0	25%	50%	75%	Monitoring report	MoE, MoWLD, MoH	Partners
	Customized school meal guideline developed	Number of school meals guidelines customized	0	25%	50%	75%	Monitoring report	MoE, MoH	Partners
		Proportion of schools adopting the customized school meals guideline	0	25%	59%	75%	Monitoring report	MoH, MoE	Partners
Output 8.2: Nutrition Services enhanced within learning institution	Learning institutions equipped to offer nutrition services	proportion of institutions with nutrition assessment equipment, data capture & reporting tools	10%	20%	40%	60%	Deliver notes, reports	MoH, MoE	Partners
		Proportion of institutions providing nutrition and physical activities	10%	20%	40%	60%	Deliver notes, reports	MoH, MoE	Partners
		Proportion of children in ECDEs assessed on nutrition status	5%	15%	30%	45%	Reports	MoH, MoE	Partners
		Proportion of schools with active referral systems	0	10%	25%	50%	Reports	MoH, MoE	Partners
Output 8.3: Healthy and safe food environment promoted in learning institutions	Capacity of food service providers and handlers enhanced	Proportion of food handlers and food service providers certified	60%	70%	80%	100%	Monitoring report	MoH, MoE	Partners
	WASH services in schools and other learning institutions enhanced	The proportion of schools with access to safe and sufficient water	0	15%	30%	45%	Reports	MoH, MoE	Partners
		Proportion of schools accessing and utilizing Sanitation services.	5%	15%	30%	50%	Reports	MoH, MoE	Partners
KRA 9 - Nutrition in water, sanitation and hygiene (WASH) sector promoted									
Output 9.1: Improved access to safe and adequate WASH services.	Strengthened capacity of health service providers and community on WASH	Number of service providers trained on WASH	TBD	TBD	TBD	TBD	Reports	MoH	Partners
		Number of community WASH sensitization meetings held	TBD	TBD	TBD	TBD	Reports	MoH	Partners
		Proportion of households accessing safe water	39.0%	50%	60%	80%	Reports	MoH	Partners
		Proportion of households accessing and utilizing sanitation facilities	96.0%	100%	100%	100%	Reports	MoH	Partners
		Proportion of households having and utilizing hand washing stations	32%	50%	60%	80%	Report, Checklist and pictures	MoH	Partners

Output	Expected results	Indicator	Baseline	Yearly Targets		End term	Means of verification	Lead	Associated
			2019	2020	2021	2022			
		Number of WASH related incidences reported.	TBD	TBD	TBD	TBD	Register of patients, KHIS	MoH	Partners
		Number of supervisory visits on WASH activities conducted	TBD	160	160	160	Register of patients, KHIS	MoH	Partners
Output 9.2: Collaboration with relevant stakeholders on WASH strengthened	Strengthened coordination of WASH activities	Number of WASH coordination forums conducted	2	4	4	4	Reports/ Minutes	MoH	Partners
	Increased budget allocation to WASH	Number of joint resource mobilization meetings held.	0	4	4	4	Minutes/ Report/ Propo-sals	MoH	Partners
		Amount of funds allocated to WASH activities						MoH	Partners
KRA 10: Nutrition in social protection programs promoted									
Output 10.1: Nutrition promoted and linkages enhanced in social protection programs including in crisis	Capacity of social protection program stakeholders on Nutrition interventions strengthened	Number of Social Protection Policy and Strategy sensitive to nutrition developed	0	1	0	1	Report	MoL & SP, MoH	Partners
		Number of stakeholders trained on mainstreaming of Nutrition in Social Protection Policy and Strategies	0	0	0	1	Report	MoL & SP, MoH	Partners
		Number of Frameworks for capacity building, scaling up nutrition sensitive safety nets, active participation, coordination established	0	Draft	2nd draft	Final	Report	MoL & SP, MoH	Partners
		Number of Database on Nutrition status of the vulnerable groups established	0			95%	Report	MoL & SP, MoH	Partners
Output 10.2: Resources for nutrition in social protection programmes mobilized	Increased Financial resources for nutrition interventions in social protection programmes	Number of Framework for financial resources for nutrition interventions in social protection programmes	0	50% of frame work	Draft	95%	Report	MoL & SP, MoH	Partners
Output 10.3: Strengthened advocacy, communication and social mobilization for social protection	Increased number of vulnerable groups under health insurance schemes (National Hospital Insurance Fund (NHIF) & KCHIC)	Proportion of vulnerable groups under health insurance scheme	15%	30%	45%	75%	Report	MoL & SP, MoH	Partner
KRA 11: Sectoral and multi sectoral nutrition information systems, learning and research strengthened									
Output 11.1: Nutrition sector plans progress reviewed	KCNAP Developed and Implemented	KCNAP Developed and Implemented	0	1	1	1	KCNAP	MOH	County partner
	AWPS in place and in use	Number of meetings held	1	1	1	4	Minutes	MOH	County partner
	AWP reviewed with corrective actions	Number of meetings held	0	4	4	4	Minutes	MOH	County partner
	Develop and disseminate annual reports	Number of report done and disseminated	0	1	1	4	Reports	MOH	County partner

APPENDIX 3: LIST OF PARTICIPANTS IN KCNAP DEVELOPMENT PROCESS

KCNAP STEERING TASK FORCE

Jackson Matheka	MoH
Lydia Mbeti	MoH
Henry Kenga	MoH
Mary Katuto	NHPplus
Humphrey Mosomi	UNICEF
Clement Ogecha	World Vision Kenya

NATIONAL LEVEL TEAM

Janet Ntwiga	UNICEF
Edward Kutondo	UNICEF
Sicily Matu	UNICEF
Leila Akinyi	MoH-DND

WRITING TEAM

Jackson Matheka	MoH
Lydia Mbeti	MoH
Henry Kenga	MoH
Mary Katuto	NHPplus
Humphrey Mosomi	UNICEF
Clement Ogecha	World Vision Kenya
Samuel Mulonzya	MoH
Joshua Kilonzi	MoH
Peter Mwanzia	MoH
Leah Mulwa	MoH
Peninah Lwaya	MoH
Norah Musau	MoH
Silvia Maluki	MoH
Patrick Ngatia	MoH
Franciscah Mumbua	MoH
Leonard S. Mbiu	MoH
Carolyn Wandu	NHPplus
Jacqueline Murithi	NHPplus
Henry Murage	MOAWLD
Roy Aseka	MOAWLD
Sammy Mwenga	MOECDE
Immanuel Kalunda	MOECDE
Daniel Musembi	ML&SP
Job Oweya	NDMA
Pascalia Kaguara	NDMA

COUNTY GOVERNMENT OF KITUI

County Ministry of Health and Sanitation

County Nutrition Action Plan 2019-2023

Kuya kuseo ni kumina kutina