REPUBLIC OF KENYA

NYANDARUA COUNTY GOVERNMENT
PAMOJA TUJIJENGE

NYANDARUA COUNTY NUTRITION ACTION PLAN

2023/2024-2027/2028

INVESTING IN NUTRITION FOR ENHANCED HUMAN CAPITAL DEVELOPMENT IN THE COUNTY

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ABBREVIATIONS AND ACRONYMS

ABC:	Activity-Based Costing
ACSM:	Advocacy, Communication & Social Mobilisation
ANC:	Antenatal Care
AWP:	Annual Work Plan
BCC:	Behaviour Change Communication
BETA:	Bottom-Up Economic Transformation Agenda
BFCI:	Baby Friendly Community Initiative
BFHI:	Baby Friendly Hospital initiative
BMI:	Body Mass Index
BMS:	Breastmilk Substitute
CAO	County Agriculture Officer
CBC:	Competency Based Curriculum
CDs:	County Directors
CDMS:	County Director of Medical Services
CDPH:	County Director of Public Health
CDOH:	County Department of Health
CEC:	County Environment Committee
CECM:	County Executive Committee Member
CEMT:	County Education Management Team
CeREB:	Central Regional Economic Bloc
CFSTC:	County Food Safety Technical Committee
CHAs:	Community Health Assistants
CHC:	Community Health Committee
CHEW:	Community Health Extension Worker
CHMT:	County Health Management Team

CHPs:	Community Health Promoters
CHS:	Community Health Strategy
CHUs:	Community Health Units
CHPs:	Community Health Promoters
CFSTC:	County Food Safety Technical Committee
CLTS:	Community-Led Total Sanitation
CIDP:	County Integrated Development Plan
CME:	Continuous Medical Education
CASCADE:	Catalysing Strengthened Policy Action for Healthy Diets and Resilience
NCNAP:	County Nutrition Action Plan
CNTF:	County Nutrition Technical Forum
Cos:	Chief Officers
COMS:	Chief Officer - Medical Services
COP 27:	United Nations Climate Change Conference Resolution
COPH:	Chief Officer - Public Health
CRAF:	Common Results and Accountability Framework
CSA:	Civil Society Alliance
CSOs:	Civil Society Organisations
CWC:	Child Welfare Clinic
DAC:	Day of the African Child
DAR:	Daily Activity Register
DFWND:	Division of Family Wellness, Nutrition and Dietetics
DQA:	Data Quality Assurance
DRNCDs:	Diet-Related Non-Communicable Diseases
DSA:	Directorate of Social Assistance
EBF:	Exclusive Breastfeeding

ECDE:	Early Childhood Development and Education
FAO:	Food and Agricultural Organisation
FBOs:	Faith-Based Organisations
FGDs:	Focus Group Discussions
FFBS:	Farmer Field and Business School
GAIN:	Global Alliance for Improved Nutrition
GAP:	Good Agricultural Practices
GER:	Gross Enrolment Rate
GIZ:	Deutsche Gesellschaft fur Internationale
GMP:	Growth Monitoring and Promotion
HCWs:	Health Care Workers
HFMC:	Health Facility Management Committee
HIS:	Health Information System
HIV/AIDS:	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HMT:	Hospital Management Team
HRH:	Human Resource for Health
HRIOs:	Health Records and Information Officers
ICT:	Information and Communication Technology
IDD:	Iodine Deficiency Disorder
IDPs:	Internally Displaced Persons
IEC:	Information, Education & Communication
IFAS:	Iron and Folic Acid Supplement
IHRIS:	Integrated Human Resource Information System
IMAM:	Integrated Management of Acute Malnutrition
IMR:	Infant Mortality Rate
IQ:	Intelligent Quotient

JMP:	Joint Monitoring Programme
KAP:	Knowledge, Attitude, and Practices
KDHS:	Kenya Demographic and Health Survey
KEPH:	Kenya Essential Package for Health
KHIS:	Kenya Health Information System
KMTC:	Kenya Medical Training College
KNAP:	Kenya Nutrition Action Plan
KNBS:	Kenya National Bureau of Statistics
KNMS:	Kenya National Micronutrient Survey
KPHC:	Kenya Population and Housing Census
KRAs:	Key Result Areas
LMIS:	Logistics Management and Information System
M&E:	Monitoring and Evaluation
MAM:	Moderate Acute Malnutrition
MCA:	Member of County Assembly
MEAL:	Monitoring, Evaluation, Accountability & Learning
MIYCN:	Maternal Infant and Young Child Nutrition
MIYCN-e:	Maternal Infant and Young Child Nutrition Emergency
MMP:	Multiple Micronutrient Powders
MNDS:	Micronutrient Deficiencies
MNPs:	Micro-Nutrient Powders
MOA:	Ministry of Agriculture
MOE:	Ministry of Education
MOH:	Ministry of Health
MOPC:	Medical Outpatient Clinic
MSP:	Multi-Sectoral Platform

MTMSGs:	Mother-to-Mother Support Groups
MTP-IV:	Mid-Term Plan Four
MUAC:	Mid Upper-Arm Circumference
NACS:	Nutrition Assessment Counselling and Support
NCA:	Nutrition Causal Analysis
NCD:	Non-Communicable Disease
NKCH:	North Kinangop Catholic Hospital
NCNAP:	Nyandarua County Nutrition Action Plan
NER:	Net Enrolment Rate
NI:	Nutrition International
NGOs:	Non-Governmental Organisations
NTF:	Nutrition Technical Forum
NuSePPP:	Nutrition-Sensitive Potato Partnership Project
N4G:	Nutrition for Growth
OJT:	On-Job Training
OPD:	Out-Patient Department
OPCT:	Older Persons Cash Transfer
ORS:	Oral Rehydration Solution
OVCT:	Orphans & Vulnerable Cash Transfer
PD:	Positive Deviance
PDH:	Positive Deviance Hearth
PDI:	Positive Deviance Inquiry
PLHIV:	People Living with HIV
PLW:	Pregnant and Lactating Women
PWSDCT:	Persons with Severe Disabilities Cash Transfer
PPP:	Public-Private Partnership

PWDs:	Persons with Disabilities
QIT:	Quality Improvement Teams
RDQA:	Routine Data Quality Assessment
SAM:	Severe Acute Malnutrition
SBCC:	Social-Behaviour Communication Change
SCAO:	Sub-County Agriculture Officer
SCEMT:	Sub-County Education Management Team
SCHMTs:	Sub-County Health Management Teams
SDGs:	Sustainable Development Goals
SMART:	Standardised Monitoring and Assessment in Relief and Transition
SCNC:	Sub County Nutrition Coordinator
SOPs:	Standard Operating Procedures
STH:	Soil-Transmitted Helminth
SUN:	Scaling Up Nutrition
SWOT:	Strengths, Weaknesses, Opportunities, and Threats
TB:	Tuberculosis
TCA:	Tricarboxylic Acid
TOC:	Theory of Change
TOT:	Trainer of Trainer
TWG:	Technical Working Group
URTI:	Upper Respiratory Tract Infections
UNFSS:	United Nations Food Systems Summit
VAS:	Vitamin A Supplementation
WDD:	World Diabetes Day
WAO:	Ward Agricultural Officer
WASH:	Water, Sanitation & Hygiene

WIFS:	Weekly Iron Folic Supplementation
WFD:	World Food Day
WKD:	World Kidney Day
WHA	World Health Assembly
WHO:	World Health Organisation
WRA:	Women of Reproductive Age
UNICE:	United Nations Children's Education Fund
UNFSS:	United Nations Food Systems Summit
URTI:	Upper Respiratory Tract Infections

DEFINITION OF TECHNICAL TERMS

Exclusive Breastfeeding:	The feeding of a baby only breast milk and not any other foods or liquids (including infant formula or water), except for medications or vitamin and mineral supplements.
Gross Enrolment Ratio:	The ratio of total enrolment, regardless of age, to the population of the age group that officially corresponds to the level of education shown.
Net Enrolment Rate:	The ratio of children of official school age enrolled to the corresponding official school-age population.
PD Hearth:	A community-based and food-based approach that involves caregivers straying from the norm, but in a beneficial way, to raise well-nourished children.
Public-Private Partnerships:	A mechanism for the government to procure and implement public infrastructure and services using the resources and expertise of the private sector.

FOREWORD

Provision of the highest attainable standard of health, freedom from hunger and access to adequate food of acceptable quality are constitutional rights enshrined under Article 43 (1) of the Constitution of Kenya 2010. Nutrition is one of the most critical determinants of health, yet Nyandarua County faces a triple burden of malnutrition in the form of undernutrition, overnutrition and micronutrient deficiencies. According to the Kenya Demographic and Health Survey (2022), stunting among children less than five years old stands at 18 per cent, while overweight and obesity among women is at 56 per cent. Results from the Kenya National Micronutrient Survey 2011 showed that micronutrient deficiencies are rampant.

Nyandarua County Nutrition Action Plan (NCNAP) (2023). ./2024- 2027/2028 is a road map that seeks to address nutrition challenges in the County. It is a comprehensive plan that provides a coordinated implementation of nutrition interventions by the Health Department and other government and non-government actors. The document will guide nutrition-specific and nutrition-sensitive programming in the county in line with H.E Governor (Dr.) Moses N. Badilisha Kiarie's Change Agenda for socio-economic development, wealth creation, and resource mobilisation.

The Plan aligns with county and national policy, legislative documents, and international commitments. At the county level, the NCNAP is aligned with the County Integrated Development Plan (CIDP) 2023-2027, whose vision is "A wealthy, transformed and equitable county that provides quality life to its citizens", and the Central Region Economic Bloc (CeREB) blueprint. Nationally, the plan is aligned with the Kenya Nutrition Action Plan (KNAP) 2018-2022, Kenya Vision 2030, Medium Term Plan Four (MTP-IV) and Bottom-Up Economic Transformative Agenda (BETA). Internationally, the document is aligned with commitments such as the Sustainable Development Goals (SDGs) and Africa Agenda 2063.

Nutrition is a smart investment with the potential to impact human capital development significantly. A cost-benefit analysis conducted in Kenya in 2016 by United Nations Children's Education Fund (UNICEF), the World Bank and the Ministry of Health reported that every $1 invested in scaling up high-impact nutrition interventions has a potential return of $22, higher than the global estimates of $16-18. Therefore, investments outlined in this document are expected to yield high returns. Realising the NCNAP goals will call for concerted efforts by different stakeholders. The Department of Health is committed to providing the requisite leadership for the successful implementation of the plan to ensure that it contributes significantly to the development agenda of our great county

Dr. Z. Kariuki Gichuki
County Executive Committee Member, Department of Health Services

PREFACE

Despite being one of Kenya's bread baskets, Nyandarua County faces many nutrition challenges. Addressing these challenges calls for coordinated and concerted efforts by different stakeholders since the causes of malnutrition are unique and multifaceted. Therefore, the Nyandarua County NCNAP was developed to outline the strategies to address the challenges, identify the required resources, and outline coordination mechanisms.

The document domesticates the KNAP 2018-2022 by contextualising interventions given the unique nature of the county's nutrition landscape. The plan has incorporated priorities in the County Integrated Development Plan (CIDP) 2023-2027 and other policy documents guiding programming for health and nutrition in the county.

The County Department of Health drove the plan's development through a sector-wide approach involving multi-sectoral engagements and intensive broad-ranging consultations. The development process involved departments such as Agriculture, Livestock and Fisheries; Education, Social Services and Gender Affairs; Office of the County Secretary & Head of Public Service (Public Communications); and Finance and Economic Planning. The National Ministry of Education also participated in the exercise since the education system greatly influences learners' nutrition through institutional feeding and formal and informal learning experiences. The Scaling Up Nutrition (SUN) Business Network - Nyandarua Chapter represented the private sector. Further, the process was also supported by the CAtalysing Strengthened policy aCtion for heAlthy Diets and resiliencE (CASCADE) consortium and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), consultants and the Ministry of Health and Professional Standards through the Division of Nutrition and Dietetics.

The document is expected to accelerate efforts to eliminate malnutrition as a significant public health problem by supporting resource mobilisation efforts, promoting efficiency in resource utilisation, and enhancing collaborations for synergy.

Peris Mwangi
Chief Officer, Public Health

Julius Ng'ambi
Chief Officer, Medical Services

ACKNOWLEDGMENTS

The Department of Health Services takes this opportunity to appreciate everyone who participated in the development of the Nyandarua County CNAP 2023/2024–2027/2028. This effort was undertaken under the overall guidance and leadership of the County Executive Committee Member (CECM) for Health, Dr. Kariuki Gichuki. This process would not have been successful without the valuable contributions and total commitment of the technical committee members of the various working groups drawn from both the government and partner organizations.

Developing the NCNAP has been highly participatory, with a dedicated task force heavily relying on the valuable inputs of various stakeholders from different sectors, departments, and organizations. This NCNAP was developed with the support of GAIN and CARE—Kenya through the Catalysing Strengthened Policy Action for Healthy Diets and Resilience (CASCADE) Project and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ).

The stewardship of the Chief Officer of Public Health, Peris Mwangi; the Chief Officer of Medical Services, Mr. Julius Ng'ambi; the former Chief Officer of Public Health, Josphine Muiru; the former Chief Officer of Medical Services, Mr. Charles Nderitu and the Chief Officer of Education, Dr. Pachomius Wambugu, was instrumental in delivering the plan. The invaluable contributions of the Director of Health Administration and Planning, Dr. Martha Mwathi; the former County Director of Public Health, Dr. Joram Muraya; the County Health Management Team (CHMT); the Sub-County Health Management Teams (SCHMTs); and other members of the health staff during the development of the NCNAP are highly acknowledged.

We also appreciate the involvement of the County Department of Education, Children, Gender Affairs, Culture and Social Services; the Department of Agriculture, Livestock and Fisheries; and the Office of the County Secretary through the Directorate of Communication and Public Relations. The participation of the National Ministry of Education, led by Mr. Philip Wambua, the County Director of Education, is highly acknowledged.

Special thanks are extended to the NCNAP development secretariat, led by the County Nutrition Services Coordinator, Mr. Paul Migwi, for coordinating and providing critical input to the process.

Finally, the County Department of Health greatly appreciates Ms. Leila Odhiambo and Mr. Zacharia Muriuki from the Ministry of Health - Division of Nutrition and Dietetics (DND) for their technical support. The consulting team led by Clementina Ngina, Nutrition Expert, and Edgar Okoth, Policy Expert, as well as the CASCADE consortium led by Charles Opiyo, Sheila Odhiambo, Geraldine Nthigah, and Immaculate Nyaugo, provided essential support. The contributions of Mr. Jackson Muchoki and Kevina Wangai of the GIZ-supported Nutrition Sensitive Potato Partnership Project (NuSePPP) during the formative stages of the plan are highly appreciated. The contributions of The Root Cause and Helen Keller International are also recognized and appreciated.

Dr. Gachara Ndegwa
County Director of Medical Services

CHAPTER 1: INTRODUCTION

1.1 Background Information

1.1.1 Location and Size

Nyandarua County is one of the forty-seven (47) counties in Kenya. It is in the former Central Province and covers a total area of 3245.1 km^2, part of which is covered by the Aberdare Range. The county lies in the central part of Kenya between latitude 0°8' North and 0°50' South and between longitude 35° 13' East and 36°42' West. The county headquarters are in Ol'Kalou town, approximately 150 kilometres Northwest of Nairobi. The county is divided into five administrative sub-counties, which double up as constituencies, namely: Ol'Kalou, Kinangop, Kipipiri, Ndaragwa and Ol'joroorok, and further into twenty-five (25) wards. Kinangop is the biggest Sub-County with eight wards. Kipipiri, Ndaragwa and Ol'JoroOrok have four wards each, whereas Ol'Kalou has five. The major urban centres in the county are Ol'Kalou, Njabini, Engineer, and Mairo Inya. Other vibrant centres include Ndunyu Njeru, Miharati and Magumu.

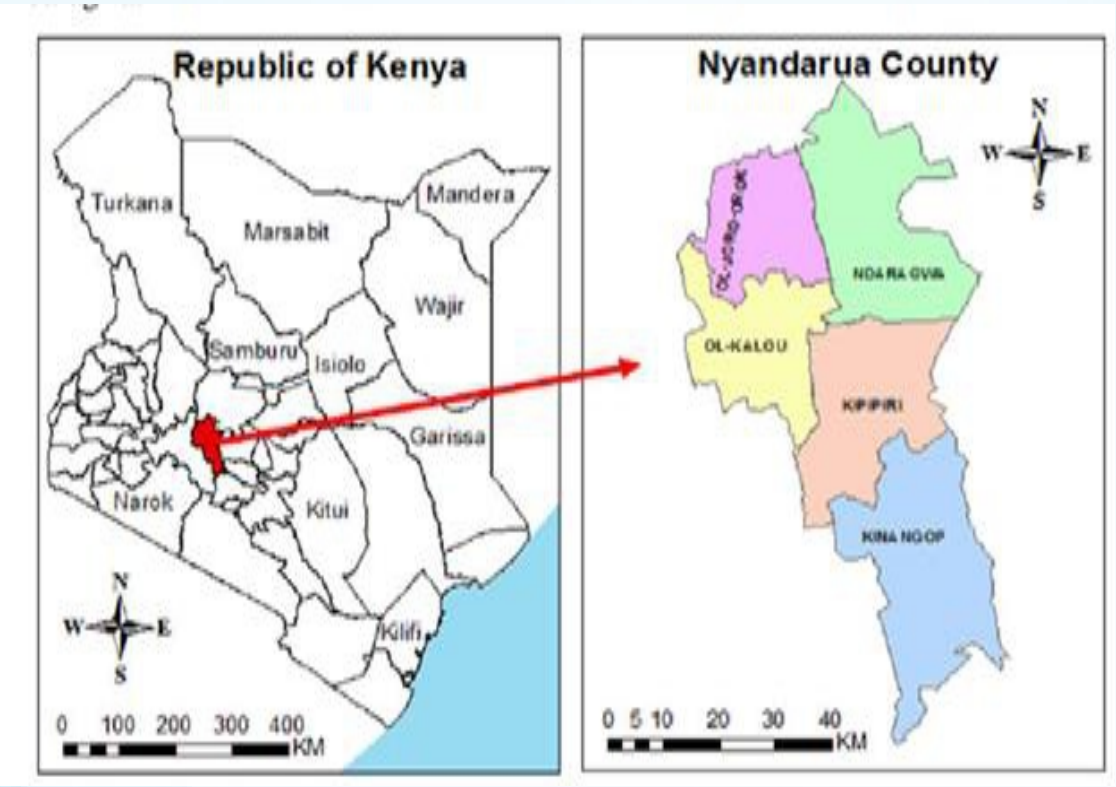

Figure 1: Map of Kenya Showing the Location Of Nyandarua County and Her Constituencies

1.1.2 Socio-Economic Activities

The socio-economic mainstay of Nyandarua is agriculture and related industries, primarily attributed to its favourable climate and abundant natural resources such as fertile soils. The county's main agricultural products include Irish potatoes, cabbages, carrots, peas, flowers, pyrethrum, sugar beet, cereals, poultry and dairy. This unique combination has propelled Nyandarua County to the forefront of agricultural production, making it the leading producer of Irish potatoes, accounting for over a third of the national output. Additionally, it is the second top milk producer nationally, further solidifying its position as a food basket and a strategic county in national food security.

1.1.3 Population Distribution

Due to its location in Central Kenya, the inhabitants are predominantly Kikuyu. They settled in from Kiambu, Murang'a, and Nyeri during and after the colonial era. The Kikuyu account for more than 95 per cent of the county's inhabitants, with other communities accounting for the remaining 5 per cent. The other significant inhabitants include Turkana, Gusii, Luo, and Luhya, who settled there due to intermarriages and employment. These minority communities are spread evenly across the county.

According to the 2019 Kenya Population and Housing Census (KPHC), the total population in the county stood at 638,289, of which 315,022 are males, 323,247 are females, and 20 are intersex persons (Table 1). There are 178,686 households, with an average household size of 4.0 persons per household and a population density of 178 people per square kilometre.

Table 1: County Population per Sub- County and Sex

Sub-County	Male	Female	Intersex	Total
Kinangop	100,884	104,387	9	205,280
Kipipiri	46,113	47,740	2	93,855
Olkalou	70,776	71,697	3	142,479
Oljoroorok	48,752	49,209	4	97,965
Ndaragwa	48,486	50,210	2	98,698
Total	**315,011**	**323,247**	**20**	**638,289**

Source: KPHC Vol II, 2019

1.1.4. Nyandarua Age Cohort Population Pyramid 2019

The county population pyramid shows a broad base concentrated among the population aged below 19 years among the sexes, as illustrated in Figure 2.

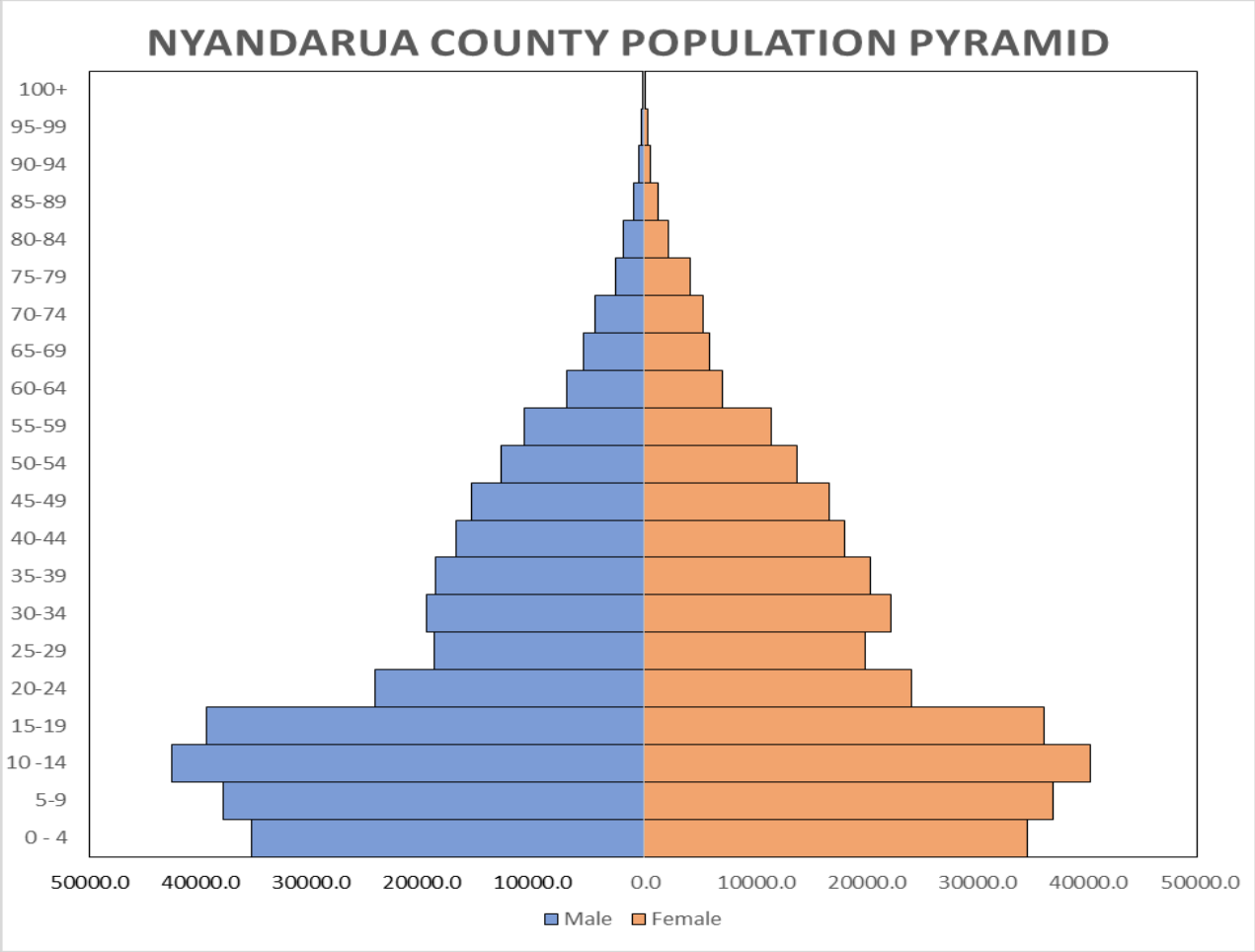

Figure 2:Nyandarua County Population Pyramid

Source: KPHC Vol III, 2019

1.2 Health Access and Infrastructure

The County Health System is structured along four care levels guided by the Kenya Essential Package for Health (KEPH): Level 1—Community Health Services, Level 2 –Dispensaries, Level 3—Health Centres, and Level 4—Primary Hospitals.

Meeting the diverse health needs of the public, there are a total of 216 health facilities distributed across the county. The County Government-owned facilities include 2 Level 4 hospitals (JM Kariuki County Referral Hospital and Engineer County Hospital), 26 health centres and 60 dispensaries. Most of these facilities are accessible and within the WHO-recommended distance of five kilometres. The county is also served by 129 Community Health Units (CHUs) spread across the five sub-counties, as shown in Table 2. 709 healthcare workers serve at the county public facilities. The county government is still hiring more. Ten dispensaries offer newborn and maternity services, ensuring the health of our future generations. The Government health facilities are complemented by nine health facilities owned by Faith-based Organisations (FBOs), including

North Kinangop Catholic Hospital (NKCH), and seventy private health facilities, including Pine Hospital.

Table 2: Health Facilities Distribution Per Sub-County

Sub-County	Hospitals	Health centres	Dispensary	Private	FBO	CHUs
Kinangop	1	6	15	38	5	41
Kipipiri	0	5	11	6	0	20
Olkalou	1	5	14	15	3	27
Oljoroorok	0	5	7	8	1	18
Ndaragwa	0	6	12	11	0	23
Total	**2**	**27**	**60**	**70**	**9**	**129**

1.3 Human Resource for Nutrition in Nyandarua County

Nyandarua County needs to be more adequately staffed to provide clinical and preventive nutrition services within the health facilities and at the community level. More human resource competencies must be required to implement nutrition-specific and nutrition-sensitive interventions to address malnutrition. Additionally, a gap in clinical nutrition specialities is needed to offer services in the specialised units, thus creating a need for training in clinical nutrition as per the human resource norms and standards for the Ministry of Health (Integrated Human Resource Information System (IHRIS) IHRIS, 2019).

As per the Kenya Human Resource for Health (HRH) norms and standards guidelines 2014, Nyandarua County should ideally have 602 nutrition staff for optimum service delivery across the levels of care. However, the reality is starkly different, with only 13 staff members available, leaving a staggering gap of 589. The county staffing situation on nutrition is presented in Table 3, which clearly outlines the staff available, requirements, and gaps across the five sub-counties based on the number of facilities and their level of care.

Table 3: Distribution of Human Resources for Nutrition in Nyandarua County

Sub-County	Nutrition Staff Available	Nutrition Staff Required	Gaps
Kinangop	3	151	148
Ol'Kalou	4	134	130
Kipiriri	2	103	101
Oljororok	2	91	89
Ndaragwa	1	123	122
Total	**13**	**602**	**590**

1.4 Nutrition Situation

1.4.1 National Nutrition Situation

1.4.1.1 Undernutrition (Stunting, Wasting and Underweight)

Malnutrition in childhood and pregnancy has many adverse consequences for child survival and long-term well-being. It also has far-reaching implications on human capital, economic productivity, and overall national development. The consequences of malnutrition should be a significant concern for policy makers at the national and county levels. Kenya is experiencing the triple burden of malnutrition characterised by the co-existence of undernutrition as manifested by stunting, wasting, underweight, micronutrient deficiencies, overweight and obesity, including Diet Related Non-Communicable Diseases (DRNCDs). There has been substantial progress in reducing the prevalence of stunting in children under five, which fell from 26 per cent in 2014 to 18 in 2022. Wasting increased from 4 per cent to 5per cent while overweight decreased from 4 per cent to 3 per cent in the same period. Figure 3 presents national trends in child nutrition status from 1993 to 2023 according to the Kenya Demographic and Health Surveys. Despite the reduced child undernutrition, there are regional disparities, where counties with the lowest stunting rate at 9 per cent (Kisumu and Garissa) while those with the highest are at 37 per cent (Kilifi, West Pokot, and Samburu), a level categorised as very high in public health significance.

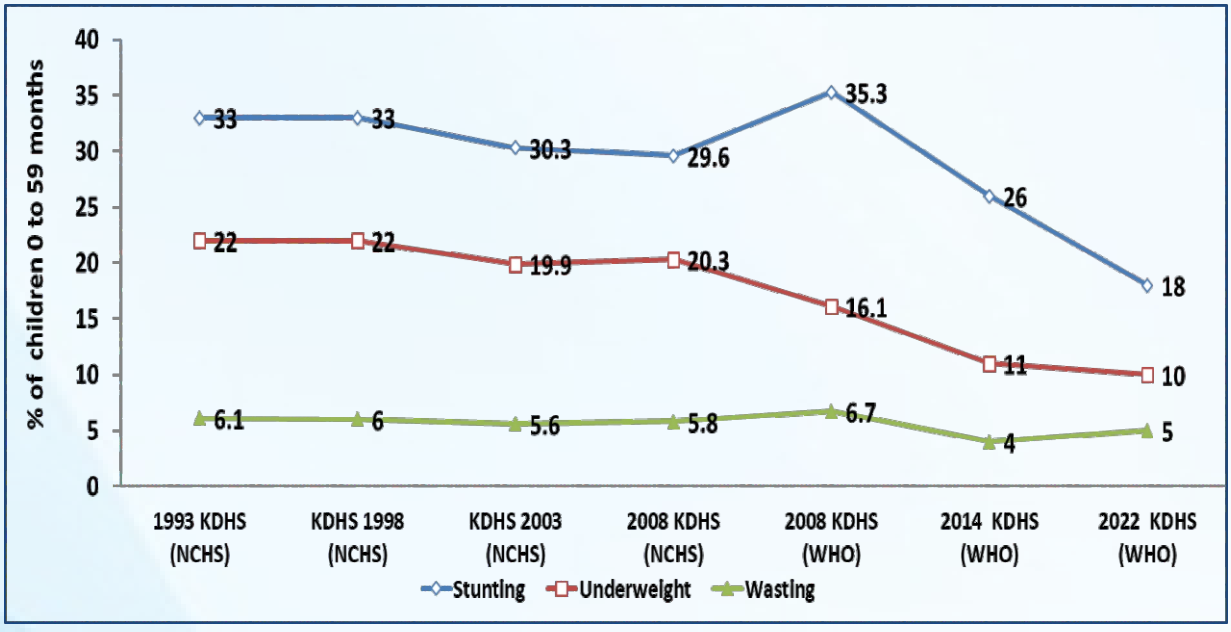

Figure 3: National Nutrition Status of Children Less than Five Years Old (KDHS 1993-2022)

1.4.1.2 Infant and Young Child Feeding

Children have the right to access safe and nutritious food. Nutrition is a universally recognised component of the child's right to enjoyment of the highest attainable standard of health as enshrined in the Constitution of Kenya (2010). Optimal nutrition during the first 1000 days of a child's life is critical because it lowers morbidity and mortality, reduces the risk of chronic disease,

and fosters better overall growth and development. Poor nutrition among infants and young children results primarily from inappropriate feeding practices where the timing, quantity and quality of foods given to infants are often sub-optimal. Exclusive Breast-Feeding (EBF) is recommended during the first six months of life because breast milk contains all the nutrients required for growth, development, and survival. Timely, adequate, appropriate, and safe introduction of complementary foods with continued breastfeeding for two years or beyond is critical at six months when breast milk alone is no longer enough to meet the nutritional requirements of infants and young children. Exclusive breastfeeding rates in Kenya have slightly declined from 61 per cent in 2014 to 60 per cent in 2022, while no data exists for Nyandarua County. Figure 4 presents trends in exclusive breastfeeding rates in Kenya from 1989 to 2022 according to the KDHS.

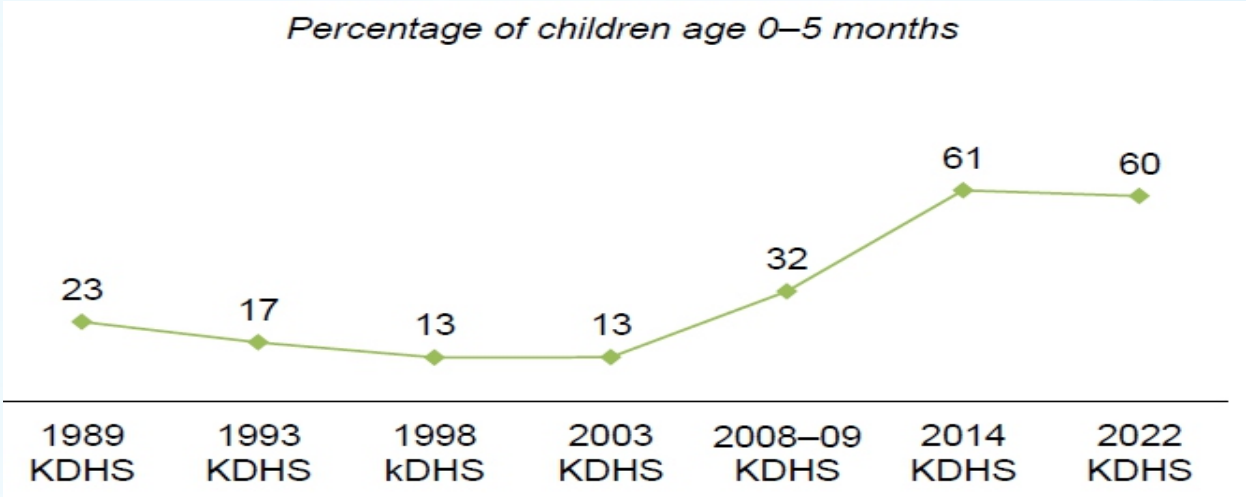

Figure 4: Exclusive Breastfeeding Rates in Kenya (KDHS 2022)

It is recommended that infants be initiated to breastfeeding within one hour after delivery. According to the Lancet series (2016), this can save 22 per cent and 16 per cent of neonatal deaths within the first hour of birth and 48 hours, respectively. In Kenya, trends in early initiation to breastfeeding show slight decrease from 62 per cent in 2014 to 60 per cent in 2022, and bottle feeding from 22 per cent in 2014 to 34 per cent in 2022. This indicates increased infection and reduced breastfeeding duration and breast milk. Figure 5 compares early initiation, exclusive breastfeeding and bottle feeding in 2014 and 2022 health and demographic surveys.

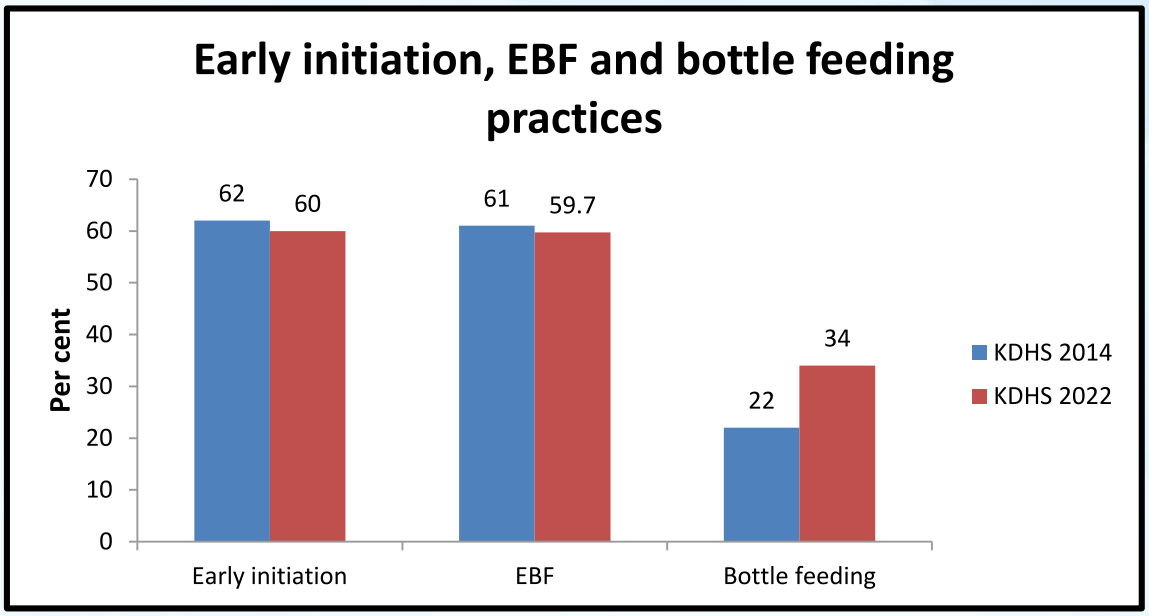

Figure 5: Comparison of Early Initiation, Exclusive Breastfeeding and Bottle Feeding in 2014 and 2022 KDHS

Source: KDHS 2014&2022

Complementary feeding, defined as providing foods in addition to milk when breast milk or milk formula alone is no longer adequate to meet nutritional requirements, generally starts at age 6 months and continues until 23 months. However, breastfeeding may continue beyond this period. This is a developmental period when children must learn to accept healthy foods and beverages and establish long-term dietary patterns. It also coincides with the peak period for the risk of growth faltering and nutrient deficiencies. Inappropriate complementary feeding can result in overweight, Type 2 diabetes and disability in adulthood. Figure 6 shows complementary feeding indicators in 2022 compared with 2014.

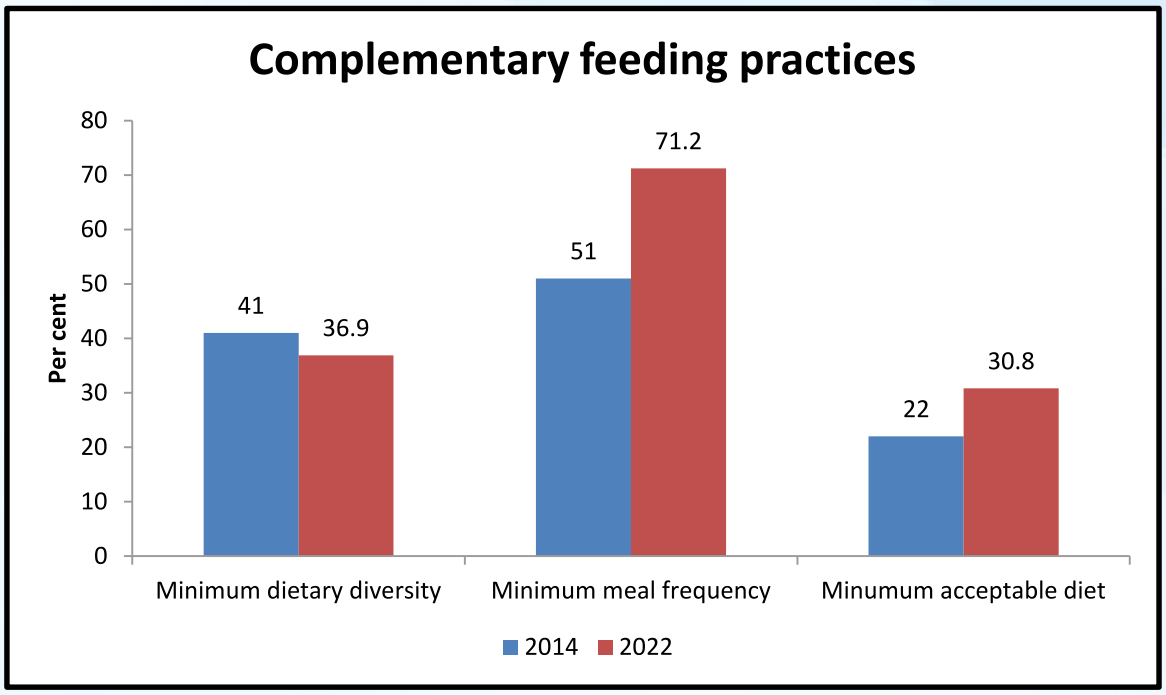

Figure 6: Comparison of Complementary Feeding Indicators

Source: KDHS, 2014 and 2022

1.4.2 County Nutrition Situation

1.4.2.1 Under-Nutrition

Good nutrition is a prerequisite for the county's development and individuals' well-being. Adequate nutrition is critical for children's growth and development, and its importance is articulated in the Constitution of Kenya (2010), which recognises sufficient food and nutrition as a human right (Article 43) and that every child has the right to essential nutrition (Article 53).

Nyandarua County has 76,784 children under the age of five. According to KDHS 2022, child stunting level is at 18 per cent (same as the national prevalence), wasting at 2 per cent and underweight at 4per cent (higher than the national prevalence, which is at 3 per cent). No data shows the spatial distribution of malnutrition in the county. The leading cause of malnutrition in the county is poor maternal, infant, and young child feeding practices. According to national-level data, only 36.9per cent of children aged 6 to 23 months receive adequately diversified diets (KDHS 2022). Stunting peaks at 23 to 35 months when the child's nutrition requirements heavily depend on complementary feeding practices. At this age, a child's care practices are sometimes compromised by the birth of another child when attention is shifted to the younger child.

1.4.2.2 Micronutrient Supplementation and Deworming

Vitamin A Supplementation (VAS)

Vitamin A Supplementation is critical, especially in regions of low uptake of Vitamin A-rich foods. Vitamin A supplementation program in the county has been doing well over the years with a consistent supply of commodities. Routine data indicate that the county surpassed the national target of 80 per cent in 2020 and 2023. The achievement was realised through routine supplementation in static health facilities, mobile outreach services and accelerated activities during the Mother-Child Health and Nutrition Weeks, which are observed biannually. Figure 7 highlights Vitamin A Supplementation coverage in the county since 2020 against the national target. The findings of the population-based survey (KDHS 2022) painted a different picture. The findings indicated that only a paltry 43 per cent of children aged 6 to 59 months received the supplement against a national coverage of 64 per cent. The disparities point to gaps in documentation and reporting and possible double dosing of some children, which can be harmful to their health. Further, the survey indicated that only 4 per cent of the eligible children received Multiple Micronutrient Powders (MMPS).

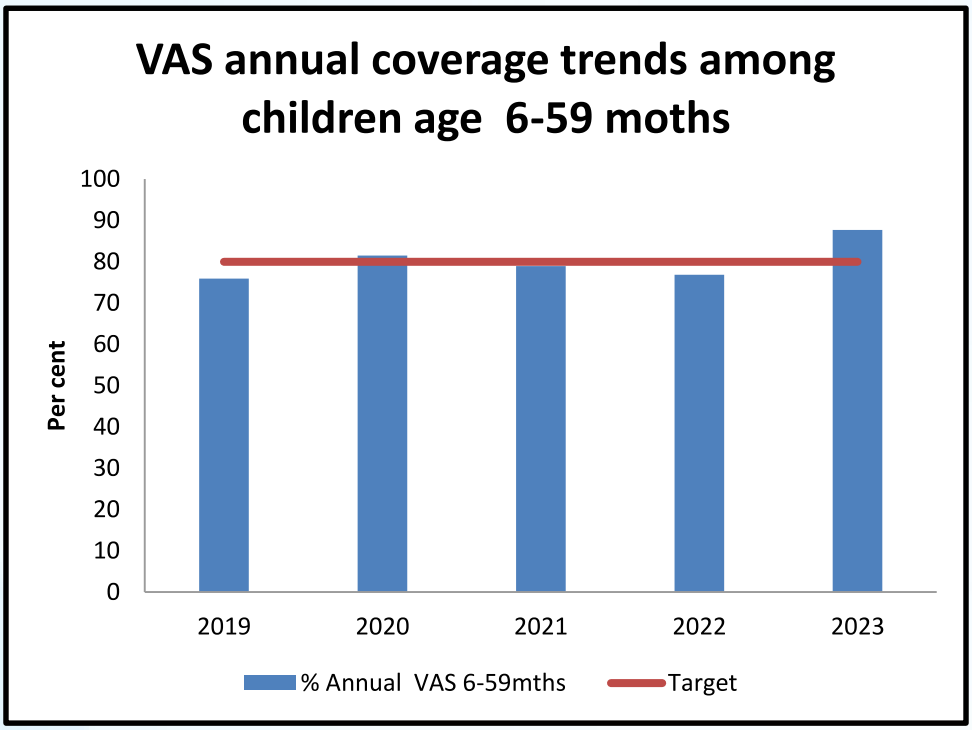

Figure 7: Vitamin A Supplementation (6-59 months) for the Year 2019-2022 in Nyandarua County

Deworming

Soil-Transmitted Helminth (STH) infections are among the most common infections in humans, caused by a group of parasites commonly referred to as worms, which include roundworms, whipworms, and hookworms. Those living in poverty, mostly in developing countries, are more vulnerable to these infections. These can impair nutritional status by causing internal bleeding leading to low absorption of iron, intestinal inflammation and obstruction, diarrhoea, impairment of nutrient intake, digestion and absorption.

Preventive chemotherapy (deworming) is an integral part of a comprehensive package to eliminate morbidity due to STH in at-risk populations. However, long-term solutions to STH infection must address many other factors, including improving Water, Sanitation, and Hygiene (WASH).

As indicated in Figure 8, deworming coverage among children under five has consistently been below the national target of 80 per cent and far below that of VAS. Since the two interventions target the same children, strengthening the programme is necessary to avoid missed opportunities.

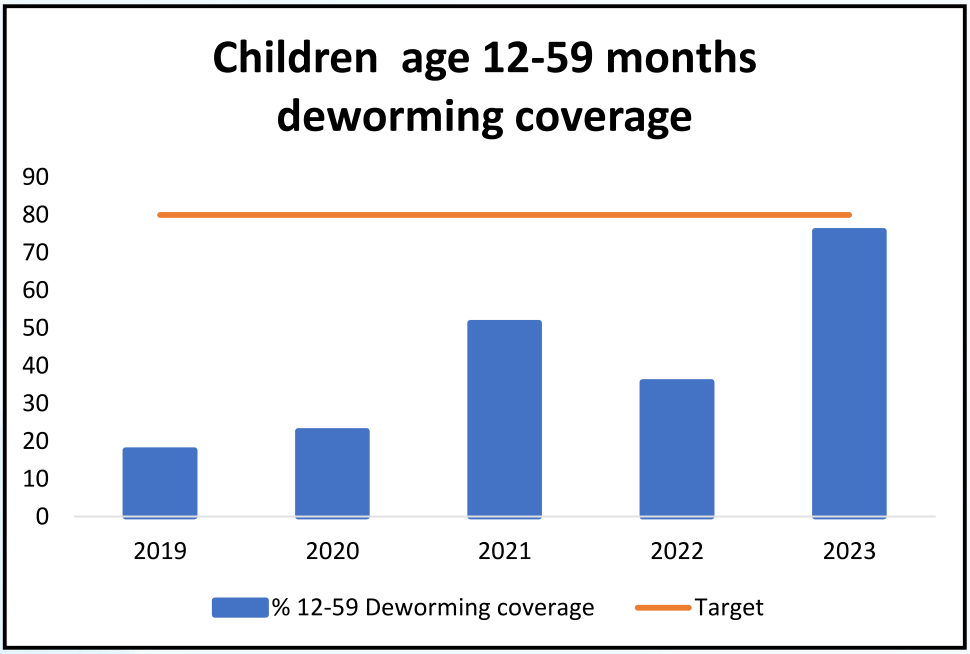

Figure 8:Trends in Deworming Coverage for Children Aged 12-59 Months in Nyandarua County

Iron and Folic Acid Supplementation (IFAS)

In Kenya, the prevalence of anemia among pregnant women stands at 46.1 per cent, with a much higher prevalence in rural pregnant women at 50.8 per cent (MOH, 2011). Nyandarua County is predominantly rural and falls in the most affected category. According to a baseline survey conducted by Nutrition International in January 2020, only 53.6 per cent of pregnant women consumed IFAS for at least 90 days or more. per cent. Sub-optimal knowledge of the benefits of

IFAS was 56.4 per cent, while understanding diarrhoea management using zinc and Oral Rehydration Solution (ORS) was 10.3 per cent.

Routine KHIS data for Nyandarua County indicates that the coverage of issues of IFAS among pregnant women visiting Antenatal Care (ANC) has been below the national target for three consecutive years leading to 2022 (Figure 9). This could be attributed to data documentation gaps and isolated stockouts in health facilities. On the other hand, population-based data from KDHS 2022 showed that 92 per cent of sampled women who had a live birth or stillbirth two years preceding the survey received some iron-containing supplements during their most recent pregnancy. Among women who took some form of iron supplementation, 11 per cent took the iron supplements for 180 days or more, and 44 per cent took the supplements for 90–179 days.

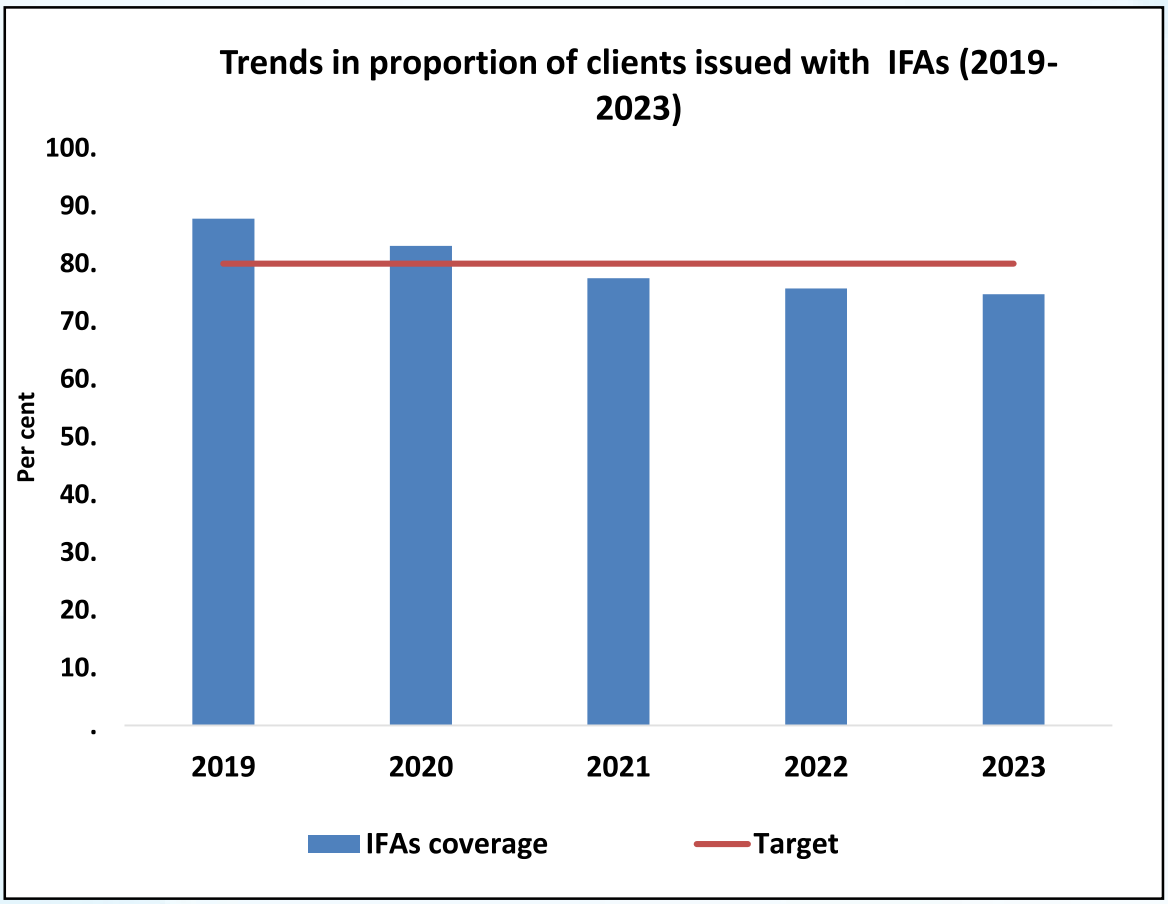

Figure 9: Trends in the Proportion of Children Issued with IFAS (2019-2023)

Source: KHIS

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

Overweight and obesity are risk factors for DRNCDs. Despite the lack of current population-based data on DRNCDs for Nyandarua County, health facility-based data show a high burden of the

diseases. KDHS 2022 report showed that overweight /obesity in the county stood at 56 per cent among women aged 20-49 years (Figure 10) compared to 19 per cent among men. On the other hand, only 3 per cent of women are thin with Body Mass Index (BMI) <18.5) compared to 12 per cent among men.

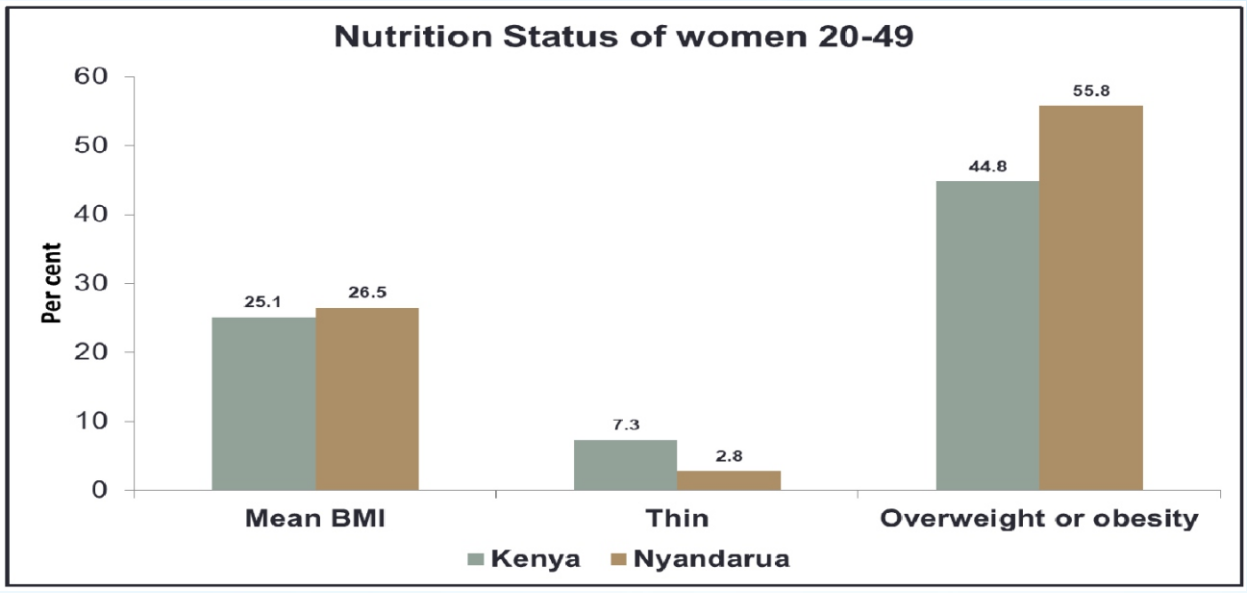

Figure 10: Nutrition Status of Women Aged 20-49 Years (KDHS 2022)

1.4.3 Morbidity and Mortality Trends

Morbidity is the condition of being ill, diseased, or unhealthy. Mortality, on the other hand, is the state of being dead. Ending preventable child deaths can be achieved by providing immediate and exclusive breastfeeding, improving access to skilled health professionals for antenatal and postnatal care, improving access to nutrition and micronutrients, promoting knowledge of danger signs among family members, improving access to WASH, and providing immunisations. According to KDHS 2022, the Infant Mortality Rate (IMR) stood at 36/1000 live births, while the neonatal mortality rate stood at 20/1000 live births.

The topmost communicable disease condition is According to the Lancet series, there is proven scientific evidence that poor early infant feeding practices are related to the increased risk of morbidity for under-fives related to diarrhoea and URTI (Rollins et al., 2016; Victora et al., 2016). For example, sub-optimal breastfeeding would lead to 7-fold and 5-fold increased hospitalisation for diarrhoea and respiratory tract infectious disease, respectively, for under-fives. Nutrition is essential in averting admission due to poor feeding habits.

1.5 Nutrition-Sensitive Sectors

The three main underlying causes of undernutrition are unsuitable or insufficient food intake, poor care practices, and diseases. These are directly or indirectly related to inadequate access to WASH. Nutrition-sensitive sectors provide interventions that address the underlying determinants of

maternal, foetal, and child nutrition and development—food security, adequate caregiving, access to health services, and a safe and hygienic environment.

1.5.1 Water, Sanitation and Hygiene (WASH)

A growing evidence base indicates that the WASH environment can be critical in shaping children's nutritional outcomes and complementary resources, guiding how this integration can happen practically. Safe water use, sanitation amenities, and good hygiene practices can improve dietary outcomes as they address immediate and underlying causes of malnutrition. Lack and inadequate sanitation facilities are particularly strongly correlated with acute malnutrition and stunting. Even when diarrhoea is absent, a faecal-contaminated environment can be linked to chronic undernutrition, which can hinder or reduce the utilisation of essential nutrients. Diarrhoeal diseases lessen the absorption of nutrients by the gut. A quarter of all stunting is attributed to five or more episodes of diarrhoea during the first two years of life. WASH programmes can serve as a key delivery platform for enhancing the coverage and effectiveness of nutrition interventions. Collaboration between the two sectors will ensure WASH programmes are designed to include nutrition-sensitive characteristics to contribute to better nutrition outcomes effectively.

The WHO/UNICEF Joint Monitoring Programme (JMP)for Water Supply, Sanitation, and Hygiene identifies a five-rung sanitation service ladder for monitoring progress towards attaining the SDG targets. According to the KDHS 2022 findings, about 34 percent of the population in Nyandarua County has access to at least essential sanitation services, 13.5 per cent use limited services, and more than half use unimproved services. No case of open defecation was reported.

1.5.2 Agriculture and Food Security

Agriculture and nutrition share a common entry point: "food." Food is a crucial outcome of agricultural activities and, in turn, is a key input into good nutrition. Without agriculture, there is little food or nutrition, but the availability of food from agriculture does not ensure good nutrition. There is a dire need to reinforce the relationship between the two fields of agriculture and nutrition. Agriculture is the backbone of Nyandarua's economy due to the fertile soils and favourable climate. The county is considered Kenya's food basket because of its high production of potatoes, cabbages, carrots, peas, and milk sold in Nairobi and countrywide. While food availability is not a problem, limited dietary diversity still poses a challenge as evidenced by the high percentage of stunting levels at 18 per cent (KDHS 2022). This could be attributed to an overemphasis on agri-business at the expense of agri-nutrition, thus compromising the nutrition status of the people.

The Department of Agriculture promotes sustainable agriculture through capacity building on agricultural productivity, food and nutrition security, value addition, marketing, and extension using the Farmer Field and Business School (FFBS) methodology (integrating nutrition and good agricultural practices) and infrastructural development.

Land ownership in Nyandarua is mainly private, with most owners being small-scale farmers with a few large farms spread across the county. The average holding size per household is 2.5 hectares (ha). With the projected population growth and the predominant cultural practices on inheritance,

the average acreage per household will continue to decrease due to subdivisions. Over 90 per cent of the households owning land have title deeds.

Due to increased population growth in urban areas, there is pressure to subdivide land into high-potential agricultural areas. 55,500 ha have already been affected, thus reducing the average farm holding to 4 ha and 0.8 ha in low and high potential zones, respectively. Available data indicates that the optimum land holdings in both zones are 8.9 ha and 2.0, respectively.

While 57 per cent of the country's land is arable, only 25 per cent is cultivated. In addition to size and fertility, other main challenges include urban sprawl, threatening agricultural land, inadequate service provision in urban settlements, and unplanned settlement growth.

The county is relatively food secure, but nutritional inadequacy is apparent, leading to manifestations of hidden hunger. This can be prevented and reduced through strategies to equally train and engage men and women across different ages and diversities on climate-smart sustainable gardening technologies, rearing of small livestock coupled with irrigation and household used water treatment, enhancing their knowledge on dietary diversification, recipes, and preparation methods, including sustainable income-generating activities. This will go a long way in realising increased food and nutrition security, household purchasing power, enhanced asset-building mechanisms, and access to market and financial facilities.

The Department of Agriculture faces an acute staff shortage precipitated by natural attrition and inadequate staff replacement. Before the advent of devolution, home economists provided extension services on food utilisation and home management. This service has since lost prominence and most home economists have retired. This raises the need to strengthen agri-nutrition to promote nutrition within agricultural programming.

1.5.3 Education

Every child has the right to education, which should be directed towards developing their personality, talents, and mental and physical abilities to their fullest potential. Good nutrition is essential to realising children's learning potential and maximising returns on educational investments. Good nutrition promotes optimal brain development, hence a high Intelligence Quotient (IQ). Poor child nutrition is associated with poor school enrolment, low attendance, and high school dropouts. School nutrition education fosters healthy eating habits in children and their families.

Early Childhood Development and Vocational Training

The education sector has a high potential to improve immediate nutrition outcomes. According to the Constitution of Kenya (2010), only early childhood education and vocational training were devolved. Early childhood education or early learning goes up to year five, and vocational training caters for primary and secondary leavers or graduates.

Nyandarua County has 929 Early Childhood Development and Education (ECDE) centres, 496 public and 433 private. The enrolment stands at 33,953, of which 20,216 are in public centres and 13,737 are in private centres. Of this enrolment, 17,270 are boys, while 16,683 are girls.

The enrolment is approximately 49.49 per cent of the projected target population aged between 3 to 5 years. The Gross Enrolment Rate (GER) is 54.5 per cent, with that of boys being 55.6per cent and that of girls being 53.3 per cent. The Net Enrolment Rate (NER) is 53per cent, with that of boys being 54.2 per cent and that of girls being 51.8 per cent. This indicates that many children need to be enroled in ECDE. There are 1,317 ECDE teachers, indicating a general teacher--to-pupil ratio of 1:26. There are 789 teachers in public centres and 528 teachers in private centres. The average age of attendance in ECDE is two years.

The county is preparing a policy paper on school feeding programmes for early learners through the County Assembly to establish a legal framework. The county has already rolled out school feeding programmes for all the ECDE centres, supplying milk twice a week for over 23,000 children. This is in recognition of the importance of nutrition for our children and its bearing on their growth and development. Progressively, the county plans to introduce a lunch programme besides the supplementary milk for tea breaks. The programme's budgetary implication has been the rollout challenge, inhibiting the noble idea of covering the entire county. This calls for concerted efforts by all the stakeholders and well-wishers to make the plan sustainable and successful.

Primary Education and Post-Basic Education/Training

Primary, secondary, and tertiary education are in the domain of the National Government as per the Constitution of Kenya (2010). School-age children have high nutrition needs due to the growth and development requirements during this stage of life. Adolescence comes with increased dietary requirements to cater to puberty's growth spurt and developmental needs. Children spend most of their time in school, so institutional meals largely determine the sufficiency of nutrients to meet their needs. Students in boarding schools depend on the school meals for their nourishment, while those in day schools take at least one meal in school. School meals are usually funded by contributions from the parents and guardians, supplemented by school projects such as crop and livestock production. Nutritional adequacy of school meals is therefore critical to the health and nutritional status of the learners. Nyandarua County has 107,937 and 5,137 children in day and boarding primary schools respectively. .

Additionally, 39,411 and 24,327 children are in day and boarding secondary schools, respectively. In colleges, there are 4,388-day scholars and 205 boarders. Details of enrolment are presented in Table 4 below.

Marketing unhealthy foods, such as deep-fried wheat-based products and fizzy sugary drinks, in the school environment challenges healthy eating among children. This leads to unhealthy weight gain and inadequate micronutrient intake.

The introduction of the Competency-Based Curriculum (CBC) has placed particular emphasis on nutrition. There has been increased awareness of healthy food choices among the learners, which has the potential to improve eating habits among the learners and the general population.

The Department of Health, in collaboration with the National Ministry of Education, implements the school health programme. Some of the interventions under the programme include sanitation and hygiene improvement, nutrition and health talks, and menstrual hygiene. However, the programme's coordination could be more optimal.

Table 4: Enrolment in Day and Boarding Schools and Colleges in Nyandarua County by Sub-County in 2023

Sub-County	Primary		Secondary		Colleges	
	Day	Boarding	Day	Boarding	Day	Boarding
Wanjohi	10095	0	4430	1796	0	0
Aberdare	5783	177	2136	1743	0	0
Kipipiri	7299	0	2594	1884	411	0
Gathanji	7832	56	3003	153	0	0
North Kinangop	14643	0	6014	5413	0	0
Nyandarua West	7686	4039	3466	2557	2842	0
South Kinangop	22348	382	8635	6044	592	0
Nyandarua Central	12645	317	5050	2076	116	0
Nyandarua North	11266	186	825	1010	427	205
Mirangine	8340	0	3258	1651	0	0
Total	**107937**	**5157**	**39411**	**24327**	**4388**	**205**

1.5.4 Social Protection

Social protection is concerned with preventing, managing, and overcoming situations that adversely affect people's well-being. When these have been taken care of, the beneficiaries are cushioned against hunger, giving them dignity as well.

The youth in Nyandarua County still carry the highest burden of unemployment, leading to low productivity and, hence, high levels of poverty. People experiencing poverty in the county have limited access to basic needs such as food, shelter, clothing, health, water, and education. Most people with low incomes are women, children, and Persons with Disabilities (PWDs). Poverty is most severe amongst young, productive women due to gender inequality, limited access to/and ownership of land, lack of income-generating opportunities, and isolation in essential economic activities and decision-

The pillars that guide social protection through the Directorate of Social Assistance (DSA) are addressing elite capture and making the governance system work for a more equal society, implementing safety net programmes for the disadvantaged segments of the population, supporting jobs and livelihoods, and enhancing human capital development. These pillars cushion the vulnerable in their day-to-day lives.

Social protection is a direct insurance to help the segment of the population that is very vulnerable in the county through the national government program to support older persons with what is commonly known as Older Persons Cash Transfer (OPCT). Other programmes include the Persons with Severe Disability Cash Transfer (PWSDCT) and the Orphans and Vulnerable Cash Transfer (OVCT). Individuals, families, and communities can access good nutrition through these cash transfer programmes and get informational, emotional, esteem, and tangible support. The cash transfers need to be coupled with nutrition education to ensure that their utilisation is sensitive to the needs of the beneficiaries.

The beneficiaries attest to improved household food security, retention of children in schools, access to primary health care, enhanced social support networks, self-esteem, and dignity alongside diversified diets. It is crucial to note that social protection needs to be part of a carefully targeted multi-sectoral approach tailored to reach the most vulnerable and embedded in the broader rural development agenda to ensure coverage of the poorest, disadvantaged, and marginalised populations, which has been factored in this NCNAP.

1.5.5 Gender Mainstreaming

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

Gender roles and responsibilities tend to overburden women and children, leading to limited opportunities to engage in competitive and skilled productive work. Women have less access to use of , and control over productive economic resources, services, and opportunities. Attitudes about or experience of gender-based violence disproportionately affecting women, girls, and children have been observed to have a far-reaching influence on nutrition and health-related outcomes (Nutrition International, 2018).

Nonetheless, women are critical in providing good nutrition as principal caregivers and income earners in their families. Gender equality and economic empowerment of women and girls matter in nutrition because they affect the nutrition determinants, i.e., food security, care practices, and health-seeking behaviour. A disempowered woman needs more income to spend on nutrition. Empowering women is central to tackling malnutrition, with which the effectiveness of nutrition-sensitive programming would be protected.

This NCNAP aligns itself with the Nyandarua CIDP 2023/27, which calls for gender mainstreaming across all policies and programmes implemented in the county. It seeks to promote gender transformation by targeting men and women of different ages and diversities throughout its development, implementation, monitoring, and evaluation process.

1.6 Challenges in Nutrition Programming

Table 5 summarises the challenges facing nutrition programming in the county.

Table 5: Challenges in Nutrition Programming

Category	Challenge
Political	• Inadequate allocation of funds • Increased unemployment • High poverty level in the county • Reducing donor support • Low level of education
Coordination	• Sub-optimal multi-sectoral collaboration • Poor coordination structures and referrals within other relevant departments • No Agri-nutrition desk officer at the Department of Agriculture, Livestock, and Fisheries • Inadequate community units
Harmful Practices	• Increased alcohol and drug abuse • Increased gender-based violence affecting women and girls in their productive and reproductive years, compromising their capacity to be productive workers, earners, and caregivers, thus reinforcing the vicious cycle of poverty and jeopardising food and nutrition security
Capacity	• Inadequate capacity of staff in terms of knowledge and skills • Inadequate space for nutrition activities within the health facilities • Inadequate equipment for nutrition assessment • Inadequate capacity among nutrition and health-related staff on the nexus between gender equality, socio-economic, cultural factors and nutrition including effective gender integration in nutrition – health-related policies and implementation
Disease Burden	• Upsurge of non-communicable diseases • Increasing trend of malnutrition (overnutrition among women)
Knowledge, Attitude and Practices (KAP)	• Sedentary lifestyles behaviour among the population • Poor eating habits among the population significantly, those under five years, adolescents, lactating mothers, and elderly among others • Poor health-seeking behaviour among most community members

	• Ignorance of nutrition issues
Gender	• Inadequate social and gender integration in nutrition assessments, surveys/research to identify social and non-medical factors • Inconsistent collection and use of sex-age disaggregated nutrition data leading to a lack of gender-sensitive information for decision-making and programming
Supply	• Insufficient nutrition commodities • Inadequate tools and equipment
Human Resource	• Inadequate staffing as per the WHO staffing norms & standards

1.6. 1 Strengths, Weaknesses and Opportunities and Threats (SWOT) Analysis in Nutrition Programming

Various strengths, weaknesses, opportunities, and threats related to nutrition programming were also analysed, as shown in Table 6.

Table 6: Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis in Nutrition Programming

Strengths	Weaknesses
• Availability of well-trained nutrition workforce and interns • Existence of well-distributed public health facilities • Well-established KHIS to support routine data management. • Political goodwill and structured governance for nutrition. • Availability of a training institution where a nutrition course is offered at Kenya Medical Training College (KMTC)	• Acute shortage of nutritionists • Erratic supply of nutrition commodities • Inadequate budgetary allocation of funds for nutrition interventions • Inadequate Advocacy Communication Social Mobilisation (ACSM) • Inadequate coverage of community health units • Over-reliance on rain-fed agriculture • High poverty index • Emerging and re-emerging animal/crop pests and diseases decreasing agricultural productivity • Poor environmental management leading to water pollution • Poor road network/ connectivity • Inadequate training and capacity strengthening services for nutrition

• Availability of food safety and wet market bills and policies. • Availability of County Environmental Committee (CEC) • Availability of County Food Safety Technical Committee (CFSTC) • County has a robust health product supply systems and distribution network • Well-organised farmer groups • High literacy levels in the population	• Inadequate nutrition population-based data to inform decision-making • Poor monitoring of nutritionally relevant indicators • Minimal value addition for farm products • Weak multi-sectoral collaboration
Opportunities	**Threats**
• Availability of technical support from Ministry of Health (MOH) • Partnerships including CASCADE • Availability of irrigation technologies and innovations • Potential for Public Private Partnership (PPP) • Digital connectivity • Availability of corporate bodies in the county • Availability of data collection tools • A ready market for farm products • Introduction of irrigation systems • Introduction of climate-resilient crops/livestock, e.g. bees • Well-educated residents in influential positions/ diaspora • Favourable weather conditions for growing diverse nutritious foods and livestock rearing	• Increased cost of living/ inflation • Food insecurity because of climate change • Rising trends of non-communicable and chronic diseases • Epidemics and emergencies • Growing population • Land subdivision and urbanisation reducing arable land • Corruption • Decision-making at the household level being more male based • Influx of Internally Displaced Persons (IDPs) • Changing arable land to real estate • Subdivision of inherited land leading to uneconomical portions for farming • High post-harvest losses • Poor market prices for farm products • Incidences of frost/drought/emerging pest invasion e.g. armyworms and emerging diseases • Rising alcoholism and drug abuse in the community

CHAPTER 2: COUNTY NUTRITION ACTION PLAN FRAMEWORK

2.1 Introduction

The NCNAP aims to significantly reduce malnutrition through comprehensive and sustainable measures. The plan targets malnutrition in all forms and age groups by employing a multi-sectoral approach and fostering cross-sectoral collaboration. The expected outcome of the NCNAP is an overall improvement in the nutritional health of Nyandarua County's population.

Malnutrition is multi-faceted and requires a combined effort from various stakeholders to manage. Good maternal and child nutrition results from determinants at the immediate, underlying and enabling environment levels. Good diets and care are the immediate determinants, while age-appropriate, nutrient-dense foods, age-appropriate feeding and dietary practices determine good nutrition at the underlying level. On the other hand, adequate resources and positive social and cultural norms and actions provide an enabling environment for good maternal and child nutrition (Figure 11). This NCNAP seeks to address the determinants of good nutrition at all levels.

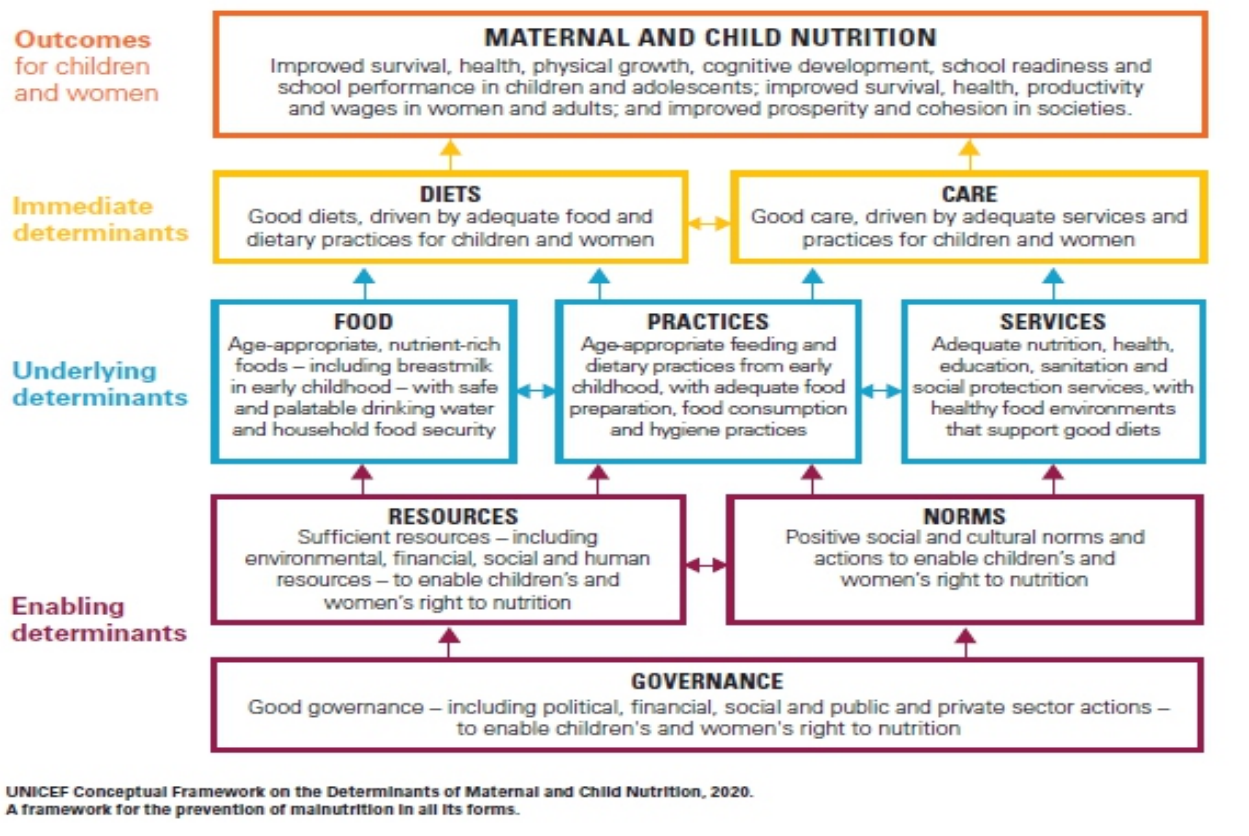

Figure 11: Determinants of Maternal and Child Nutrition (UNICEF, 2020)

2.2 NCNAP Vision, Mission, and Guiding Principles

2.2.1 NCNAP Vision

A well-nourished and prosperous County

2.2.2 NCNAP Mission

To provide quality preventive and curative nutrition services responsive to the needs of the people

2.2.3 Guiding Principles

- **Transparency and Accountability**

The action plan seeks to foster transparency and accountability in its implementation, monitoring, and evaluation. The document will be available to all members of the public in print and electronic media. It apportions responsibility for implementation to different actors and provides for further involvement of other interested players.

- **Responsiveness**

Emphasis is placed on the need to address the people's felt needs. The document provides for adaptability and flexibility to respond to these needs.

- **Respect for Human Rights.**

Respect for human rights is central to the interventions identified in this action plan. Its implementation should not discriminate or harm the service providers or the beneficiaries.

- **Equity, Fairness, and Inclusivity**

Intervention targeting is expected to ensure equity, fairness, and inclusivity. This will ensure that those in greatest need are identified and supported in a manner sensitive to their vulnerability. Moreover, the needs of those at a lesser risk of undernutrition are also taken care of in the spirit of equity.

- **Gender Sensitivity**

Implementing this NCNAP will ensure the representation of both males and females in all activities and programmes. Efforts will be made to ensure that at least one-third of either gender is represented in the implementation arrangements.

2.3 Policy and Legal Framework for the NCNAP

Access to good health and nutrition is a human right. The Constitution of Kenya (2010) provides the highest attainable health standards for the people of Kenya. Articles 43 (1) (c) and 53 (1)(c) guarantee children (and the general population) access to basic standards of health, food, nutrition, and sanitation. The Constitution places the responsibility of implementing nutrition programs under the county governments, so there is a need to develop this NCNAP.

The NCNAP 2022/23 –2026/27 is aligned to local plans such as CIDP, the Governor's change manifesto, Central Region Economic Bloc (CeREB) blueprint, national plans such as Kenya Nutrition Action Plan 2018-2022, Kenya Vision 2030, Medium Term Plan four (MTP-IV) and Bottom-Up Economic Transformative Agenda (BETA), international commitments such as the Sustainable Development Goals (SDGs), Africa Agenda 2063 and United Nations Climate Change Conference Resolution (COP27). As such, the interventions in this document outline the nutrition priorities of Nyandarua County.

The Kenya Nutrition Action Plan (KNAP) provided an umbrella framework and guidance for developing this NCNAP. It has ten key result areas clustered into three thematic areas: nutrition-specific interventions, nutrition-sensitive interventions, and enabling environment key result areas.

2.4 NCNAP Rationale

The NCNAP provides a strategic approach to implementing nutrition services for the next five years, targeting malnutrition in all its forms throughout the cycle. The plan addresses the triple burden of malnutrition, which includes the emerging issues of overweight, obesity, and DRNCDs, as well as child stunting and micronutrient deficiencies.

The NCNAP acknowledges that the risk factors for malnutrition are multi-sectoral and multifactorial, occurring within households and communities. Therefore, effective interventions must be multi-sectoral and address various causative factors. By focusing efforts at the county level, the plan aims to achieve significant impacts at the community level. The plan is aligned with the KNAP 2018–2022 strategic framework, consistent with the roles of the County Government in tackling malnutrition.

2.5 Objectives of the NCNAP

The main objective of this NCNAP is to contribute to the national nutrition agenda by accelerating and scaling up efforts to eliminate malnutrition in Kenya, as envisioned in the KNAP.

The plan has the following specific objectives:

1. To outline the desired nutrition outcomes for improved nutrition for residents of the County.
2. To identify activities to be implemented to attain the desired outcomes.
3. To provide cost estimates for the identified activities and supplies.
4. To provide a framework for monitoring the plan's implementation.

2.6 NCNAP Development Process

This action plan was developed through a consultative process involving multiple stakeholders. The process was informed by the KNAP 2018-2022 and other national and county-level strategic documents, such as the county integrated development plan.

The initiation meeting was held in November 2019, after which the process was temporarily interrupted by the onset of the COVID-19 pandemic. In 2022, the process was re-initiated with online meetings with the support of a consultant. A follow-up meeting was held in Laikipia County, where the planning matrix was populated, and key result areas, strategies, and activities were agreed upon. The third workshop was held in Kwale County with GIZ's support, where the initial draft was developed. The fourth workshop was held in Machakos County with the support of the CASCADE Project to review and update the KRAs. A draft document was then developed in the fifth consultative workshop held in Nyandarua County.

Stakeholders validated the document in a workshop held in Nyandarua County in January 2024.

2.7 Target Audience for NCNAP

The primary audience of this NCNAP is policymakers and service providers implementing nutrition-specific and sensitive interventions, including the partners who work with them. The document is intended for the county's residents, who will be the primary beneficiaries of the planned interventions.

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

3.1 Introduction

The overall expected result or desired change for the NCNAP is to achieve optimal nutrition for the entire population in the county, thus, healthier and better quality of life and improved productivity for accelerated social and economic growth. Ten Key Result Areas (KRAs) have been identified to achieve the expected results. The KRAs are categorised into three focus areas: (a) Nutrition-specific, (b) Nutrition-sensitive, and (c) Enabling environment interventions/ activities that are further costed and presented within an implementation matrix. A summary of the KRAs is presented in Table 7.

Table 7: NCNAP KRAs per Focus Areas

Category of Key Result Areas by Focus Areas	Key Result Areas
Nutrition-specific result areas	1: Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up
	2: Nutrition of older children, adolescents, adults, and older persons promoted
	3: Prevention, control, and management of Micronutrient Deficiencies scaled-up
	4. Prevention, control, and management of DRNCDs in the life course scaled-up
	5: Integrated Management of Acute Malnutrition (IMAM) and nutrition in emergencies strengthened
	6. Clinical nutrition and dietetics in disease management including HIV and TB strengthened
Nutrition-sensitive result areas	7: Nutrition in nutrition-sensitive sectors (Agriculture and Food Security, Education, WASH and Social protection) strengthened
Enabling environment result areas	8: Sectoral and multi-sectoral nutrition governance and advocacy strengthened
	9: Sectoral and multi-sectoral information systems, monitoring, accountability, learning and research for nutrition strengthened
	10: Supply chain management for nutrition commodities and equipment strengthened

3.2 Theory of Change and NCNAP Logic Framework

The "Theory of Change" (ToC) is a specific methodology for planning, participation, and evaluation used to promote social change – in this case, nutrition status improvement. The ToC defines long-term goals, in this case, realising a healthy Nyandarua County free of malnutrition by providing integrated quality health services for men, women, and children of different ages and diversities. It then maps backwards to identify the necessary pre-conditions for achieving the desired outcomes.

It describes and illustrates how and why a desired change is expected to happen in a context. Therefore, the pathway of change for the NCNAP is best defined through the theory of change. The ToC was used to develop a set of result areas. If specific strategies are deployed to implement the prioritised activities, results will be realised to improve the county's nutrition situation. The logic framework outlining the key elements and processes used to integrate "ToC" in the NCNAP development is captured in Figure 12. The expected outcome, output, and priority activities in line with the process logic have been outlined in Section 3.3.

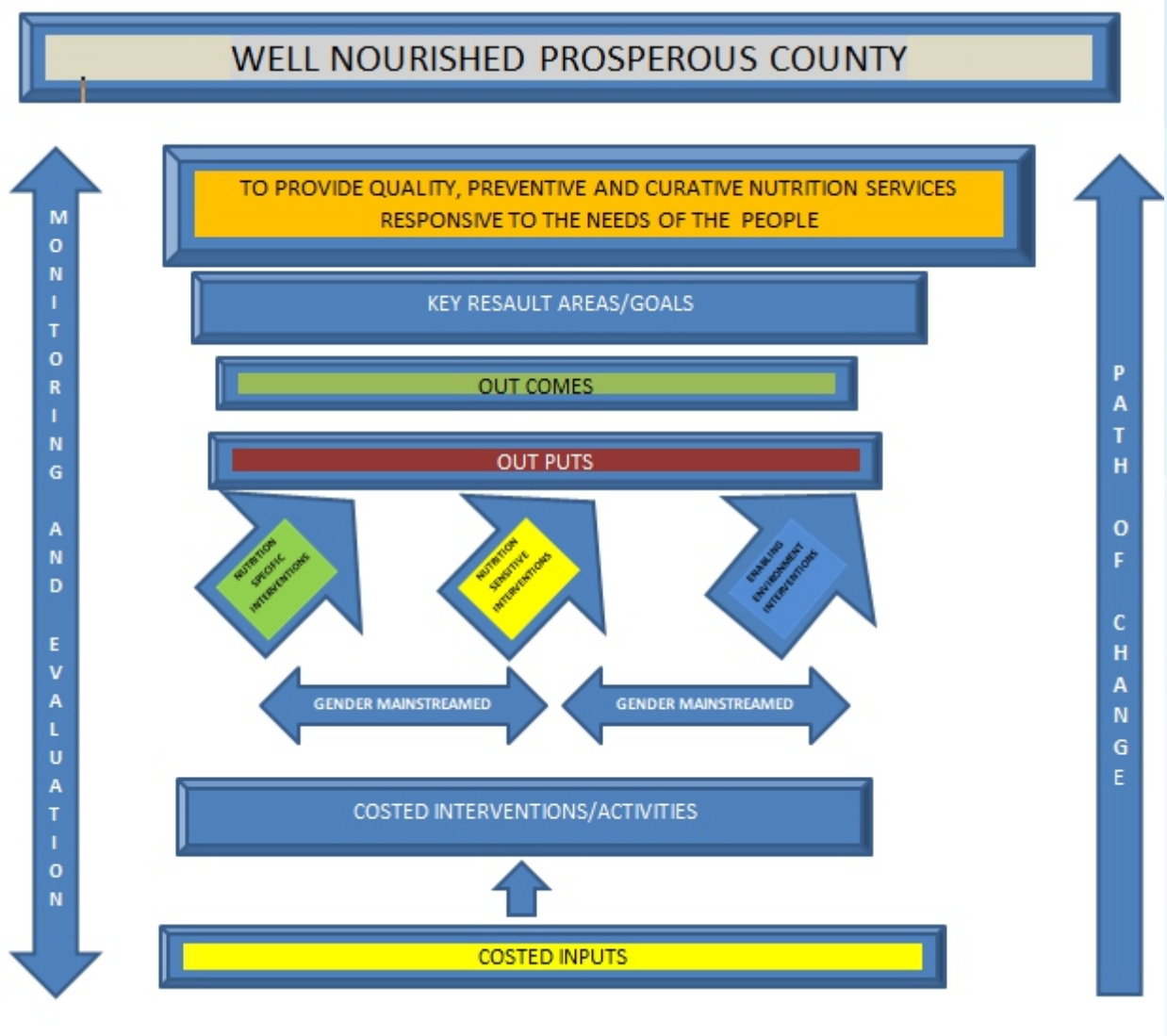

Figure 12: Theory of Change for NCNAP

3.3: The Expected Outcomes, Outputs and Priority Activities

KRA 1: Maternal, Infant, Young Child Nutrition Scaled-up

Expected Outcome: Strengthened care practices and services for improved Maternal, Infant and Young Child Nutrition (MIYCN)	
Expected Outputs	**Interventions/Activities**
1.1 MIYCN policy environment at the county level improved	1. Disseminate the MIYCN policy summary statement to all policymakers (CECMs, Chief Officers (COs), Country Directors (CDs), CHMT, Hospital Management Teams (HMTs) and SCHMTs) 2. Disseminate MIYCN strategy 2023-2028 to all policymakers (CECMs, COs, CDs, CHMT, HMTs, SCHMT, Members of County Assemblies (MCAs))
1.2 Implementation of Baby Friendly Hospital Initiative (BFHI) in health facilities all offering maternity and newborn services promoted and strengthened	1. Sensitise health managers (CHMT, SCHMTs, HMTs) on BFHI 2. Train Health Care Workers (HCWs) in all health facilities offering maternity and newborn services on BFHI 3. Establish BFHI committees or integrate BFHI in the Quality Improvement Teams (QIT) in all health facilities offering maternity services/ Integrate BFHI in quality improvement teams 4. Carry out continuous medical education to all non-clinical staff in all health facilities offering maternity and newborn services on BFHI 5. Conduct baseline BFHI assessment in all health facilities offering maternity and newborn services 6. Conduct Continuous Medical Education (CME) on BFHI in implementing health facilities 7. Conduct continuous quality BFHI assessments in implementing health facilities 8. Supervision of BFHI activities in implementing health facilities 9. Conduct BFHI external assessment in implementing health facilities 10. Provide nutrition education to pregnant mothers, and caregivers during ANC visits 11. Provide nutrition education to lactating mothers at the postnatal ward and the newborn unit 12. Document and report implementation of BFHI

1.3 Implement Baby Friendly Community Initiative (BFCI) in community health units promoted and strengthened	1. Sensitise CECMs, COs, CDs, CHMT and SCHMT on BFCI 2. Sensitise Community Health Committees (CHCs) and Health Facility Management Committees (HFMCs) on BFCI 3. Train health workers on BFCI 4. Train c-BFCI Trainer of Trainers (c-BFCI TOT) 5. Conduct BFCI baseline assessment 6. Train Community Health Promoters (CHPs) on BFCI 7. Map households and form Mother-To-Mother Support Groups (MTMSGs) 8. Conduct nutrition education during mother-to-mother support group meetings 9. Conduct cookery demonstrations during bi-monthly baby-friendly gatherings 10. Conduct continuous BFCI quality improvement self-assessments 11. Conduct BFCI external assessments 12. Carry out support supervision for BFCI at community level by CHMT, SCHMT 13. Document and report implementation of BFCI in CHU's
1.4 Delivery of MIYCN services strengthened	1. Train health care workers on MIYCN 2. Provide nutrition education and counselling at health facilities and community level 3. Sensitise CHPs on MIYCN 4. CHPs communicate key MIYCN messages at the community level
1.5 Strengthened BMS Act, 2012 implementation at county level	1. Sensitise policymakers (CECMs, COs, CDs, CHMT, HMTs, SCHMTs, MCAs) on the Breast Milk Substitutes (BMS) Act,2012 and its regulations of 2021 2. Sensitise the private sector on the BMS Act,2012 3. Train health care workers on the BMS Act,2012 4. Sensitise law enforcers on the BMS Act,2012 5. Sensitise CHPs on the BMS Act,2012 6. Conduct market-level surveillance/monitoring of the BMS Act implementation 7. Document and report violations of the BMS Act

1.6 Workplace support for breastfeeding mothers promoted	1. Sensitise CECMs, COs, CDs, CHMT, SCHMTs and HMTs on implementation framework for securing a breastfeeding-friendly workplace environment 2. Train healthcare workers on the implementation framework for securing a breastfeeding-friendly environment at the workplace 3. Sensitise key stakeholders in public and private institutions on implementation framework for securing a breastfeeding-friendly environment at the workplace 4. Carry out CMEs at the health facility level on implementation framework for securing a breastfeeding-friendly environment at the workplace 5. Establish lactation rooms/ lactation stations in health facilities 6. Advocate for establishing lactation stations in both public and private entities in formal and informal institutions 7. Monitor and document the utilisation of lactation stations
1.7 Strengthened growth monitoring and promotion at the county level	1. Sensitise CHMT, SCHMT and HMT on the new WHO growth standards 2. Train health workers on the new WHO growth standards 3. Carry out CMEs at the health facility level on growth monitoring and promotion 4. Sensitise education managers on growth monitoring and promotion 5. Sensitise CHPs on growth monitoring including family Mid-Upper Arm Circumference (MUAC) 6. CHMT and SCHMT conduct support supervision on growth monitoring 7. Carry out Growth Monitoring and Programming (GMP) in all health facilities offering child welfare services and record in individual child-mother booklet 8. Document and report individual growth indices in the Child Welfare Clinic (CWC) register

KRA 2: Nutrition of Older Children, Adolescents and Older Persons Promoted

Expected Outcome: Increased nutrition awareness and uptake of nutrition services for improved nutritional status of older children (5-9 years), adolescents (10-19) years and older persons	
Expected Output	**Interventions/Activities**
2.1 Improved environment for the development and implementation of policies targeting older children, adolescents, and older persons	1. Advocate Inclusion of policy interventions for older children (5-9 years), adolescents (10-19 years) and older persons in the proposed Nyandarua County nutrition policy 2. Disseminate policy interventions to control the marketing of unhealthy foods in and around learning institutions to CECMs, COs, CDs, CHMT, SCHMT and MCAs 3. Advocate for dissemination of guidelines on healthy diets and Physical Education to the CECMs, COs, CDs, CHMT, SCHMTs and HMTs
2.2 Enhanced capacity of service providers to create awareness of healthy diets and physical activity	1. Sensitise workers on a healthy diet and physical activity guidelines 2. Sensitise CHPs on guidelines on healthy diets and physical activity 3. Train health workers on healthy diets and physical activity 4. Train CHPs on module 8 for nutrition
2.3 Increased awareness of healthy diets and physical activity through life courses in the community	1. Sensitise older children, adolescents, and communities on healthy diets and physical activity 2. Sensitise older persons on healthy diets and physical activity through effective communication channels, e.g. Media, religious institutions, village meetings etc 3. Conduct nutrition screening at the community level 4. Conduct behaviour change communication sessions at the community level 5. Conduct Cooking demonstration sessions for healthy family diets at the community level

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

Expected Outcome: Improved micronutrient status in children, adolescents, women of reproductive age, men, and older persons.	
Expected Output	**Interventions/Activities**
3.1 Policy environment on micronutrient and food fortification strengthened	1. Sensitise all policymakers (CECMs, COs, CDs, CHMT, HMT and SCHMTs) on VAS guidelines, IFAS policy, MNP policy, Food Fortification strategy 2. Develop a county-contextualised nutrition safety policy
3.2 Strengthen the capacity of all the relevant stakeholders (HCW.s,) on Vitamin A supplementation + deworming, IFAS, MNP's, food fortification and dietary diversification	1. Train HCWs on Vitamin A supplementation + deworming 2. Train HCWs on IFAS 3. Train HCWs on MNPs 4. Sensitise CHPs on IFAS, MNPs, Vitamin A and dewormers 5. Sensitise the community on micronutrient supplementation through effective VAS, IFAS, and MNP communication channels to target populations 6. Sensitise HCWs on food fortification 7. Conduct (CMEs targeting health workers on food fortification 8. Sensitise CHPs on food fortification including fortified foods in local markets 9. Conduct nutrition health talks on dietary diversification and biofortification at health facilities
3.3 Uptake of micronutrient supplementation to target audience promoted and strengthened	1. Carry out IFAS supplementation to all pregnant women 2. Carry out VAS supplementation to 6-59 months children 3. Carry out deworming to 12-59 months children 4. Carry out deworming to pregnant women in their 2nd trimester 5. Conduct *Malezi Bora* activities across the County biannually 6. Provide nutrition education and counselling on IFAS to pregnant women at health facility level

	7. Provide nutrition education and counselling on VAS +Deworming to lactating women at health facility level 8. Provide health talks in health facilities on prevention, control, and management of Micronutrient Deficiencies
3.4 Increased uptake of locally available fortified foods	1. Map food manufacturers for food fortification purposes in the county 2. Activate county food safety and fortification committee 3. Carry out community sensitisation on food fortification including fortified food in the market and locally produced fortified foods
3.5 Strengthened monitoring and evaluation of the micronutrient activities in the county	1. Conduct annual salt iodisation monitoring in the county 2. Conduct market-level surveillance on food fortification 3. Conduct support supervision of the micronutrient supplementation activities at the county and sub-county biannually 4. Submission of monthly reports on micronutrient supplementation at the county and sub-county levels to the relevant department. 5. Conduct biannual food safety and fortification review meetings

KRA 4: Prevention, Control, and Management of Diet-Related Non-Communicable Diseases (DRNCDs) in the Life Course Scaled- up

Expected Outcome: To strengthen prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs)	
Expected Outputs	**Interventions/Activities**
4.1 Integration of nutrition therapy in the prevention and control of DRNCDs into policies across all sectors	1. Sensitise stakeholders (CHMT, SCHMT, County Education Management Team (CEMT), Sub-County Education Management Team (SCEMT), County Agriculture Officer (CAO), SCAO) on policies/guidelines on non-communicable diseases, healthy diet and physical activity

	2. Disseminate nutrition SOPs on Diabetes, obesity/overweight, cardiovascular, throat and colon cancers to HCWs for implementation
4.2 Improve skills, competency, knowledge and practices in the prevention, control, and management of DRNCDs	1. Train HCWs on the prevention and management of Diabetes 2. Train HCWs on the prevention and management of cardiovascular diseases 3. Train HCWs on the prevention and management of diet-related cancers 4. Train HCWs on prevention and management of obesity and overweight 5. Conduct CMEs in the health facilities on nutrition in Diabetes 6. Conduct CMEs in the health facilities on nutrition in cardiovascular diseases 7. Conduct CMEs in the health facilities on nutrition in emerging diet-related cancers 8. Conduct CMEs in the health facilities on nutrition in obesity and overweight 9. Sensitise CHPs and the community on healthy diets and physical activities, using effective communication channels 10. Sensitise CHPs and the community on nutrition assessments and messages in Diabetes, cardiovascular and obesity/overweight 11. Sensitise health workers on proper documentation of diabetes, cardiovascular, and obesity /overweight
4.3 Improve community awareness on prevention, control and management of diabetes, cardiovascular diseases, obesity/overweight and diet-related cancers	1. Collaborate with Stakeholders to support and participate in health thematic days; world diabetes day, Hypertensive Day, World Cancer Day and World Kidney Day. 2. Hold podcasts, and radio talk shows on diabetes, cardiovascular, overweight/obesity and emerging diet relating cancers in relation to nutrition. 3. Conduct Nutrition Assessment Counselling Support (NACS) in monthly outreaches 4. Conduct nutrition assessments and counselling in medical camps

4.4 Improve documentation and reporting on DRNCDs	1. Timely submission of Monthly reports on DRNCDs 2. Integrate support supervision on documentation and reporting of nutrition in the Medical Outpatient Clinic (MOPC) and wellness clinics 3. Integrate DRNCDs data with nutrition report during routine data review meeting
4.5 Provision of Quality and appropriate nutrition therapy in prevention, management, and control of DRNCDs	1. Conduct nutrition assessments and counselling for all clients attending MOPC and cancer clinics. 2. Advocate for establishing psychosocial support groups in MOPCs and cancer clinics 3. Conducting routine nutrition education during psychosocial support group meetings 4. Conduct community linkages and referral of DRNCDs in the community and health facilities by CHPs and CHAs 5. Establish wellness clinics

KRA 5: Integrated Management of Acute Malnutrition (IMAM) and Nutrition in Emergencies Strengthened

5.1 Expected Outcome 1: Increased coverage of integrated management of acute malnutrition (IMAM) services	
Expected Outputs	**Intervention/Activities**
5.1.1 Guidelines for Integrated Management of Acute Malnutrition (IMAM) disseminated	1. Disseminate guidelines for Integrated Management of Acute Malnutrition to CHMT, SCHMT and HMT
5.1.2 Capacity on IMAM for HCW's and CHP's and management improved	1. Sensitise CHMTs, SCHMTs and HMTs on SOPs for IMAM 2. Sensitise health care workers on IMAM SOPs 3. Adapt, print and distribute IMAM SOPs to health facilities 4. Train health care workers on Integrated Management of Acute Malnutrition. 5. Sensitise CHPs on IMAM 6. Conduct CMEs to HCWs on IMAM 7. Assess, diagnose, counsel and support all children with acute malnutrition

		8. Follow up children with acute malnutrition by giving Tricarboxylic Acid (TCA)
5.1.3	Monitoring of IMAM implementation strengthened	1. Conduct support supervision on IMAM 2. Carry out referrals of children with acute malnutrition to the health facility by CHP's 3. Carry out IMAM reporting monthly
5.1.4	Capacity to Implement PD Hearth model for management of acute malnutrition supported	1. Sensitise policymakers (CECMs, COs, CDs and MCAs) on PD Hearth 2. Sensitise CHMT, SCHMT and HMTs on PD Hearth guideline 3. Train multi-sectoral service providers on PD Hearth 4. Train CHPs on PD Hearth
5.1.5	PD Hearth model for management of acute malnutrition monitored and reported monthly	1. Conduct baseline assessment of children's nutrition status 2. Conduct support supervision for hearth sessions 3. Document and report on PD Hearth implementation
5.1.6	PD Hearth model for management of acute malnutrition executed	1. Conduct Positive Deviance Inquiry (PDI) 2. Conduct hearth sessions in the community
5.2 Expected Outcome 2: Improved multi-sectoral capacity for risk preparedness, reduction, and mitigation against impact of disasters		
Expected Outputs		**Intervention/Activities**
5.2.1	Strengthened preparedness and response capacity for the nutrition sector	1. Conduct coordination meetings for nutrition in emergencies with partners 2. Incorporate nutrition technical officers in the emergency preparedness and response committees at county, sub-county and facility levels 3. Participate in policy discussions related to post-disaster reviews to influence nutrition consideration 4. Participation in community-level dialogue and recovery initiatives
5.2.2	Preparedness and response capacity of service providers strengthened	1. Develop/review the county nutrition preparedness and response contingency plan and integrate it with the county plan 2. Train health care workers on MIYCN-e 3. Sensitise CHPs on MIYCN-e

5.2.3 Utilisation of data/ information to 5.2.4 Enhance decision-making in emergencies strengthened	1. Conduct MIYCN-e assessment in selected emergency hotspots to adapt the response to the context 2. Disseminate MIYCN-e assessment findings to stakeholders
5.2.5 Roll out a package of high-impact interventions to the affected population	1. Integrate and provide nutrition services during outreach in hard-to-reach and affected areas 2. Provide nutrition education/counselling on high-impact nutrition interventions in emergencies

KRA 6: Clinical Nutrition and Dietetics in Disease Management, Including Human Immunodeficiency Virus **(HIV) (and** Tuberculosis **(TB), Strengthened.**

6.1 Expected Outcome 1: Clinical nutrition and dietetics coverage improved and scaled-up to 80per cent by 2027	
Expected Outputs	**Interventions/Activities**
6.1.1 Technical capacity of healthcare workers in clinical nutrition enhanced	1. Undertake specialised courses for renal, oncology, critical care and paediatric nutritionists 2. Undertake training of health care workers on enteral and parenteral nutrition 3. Create a database for trained personnel on clinical nutrition specialities 4. Benchmark in level V or VI hospital on clinical nutrition practice 5. Carry out CMES on clinical nutrition to health workers 6. Integrate clinical nutrition in support supervision tool for level IV hospitals 7. Train healthcare workers on guidelines on nutrition and dietetics for participants drawn from hospitals and high workload facilities
6.1.2 Adoption and implementation of nutrition and dietetics guidelines, standards, screening, and	1. Disseminate clinical nutrition tools for screening, inter-facility referral and monitoring and service quality management tools to CHMT, SCHMTs and the facility in charge

	assessment tools strengthened	2. Sensitise and disseminate policies and guidelines related to clinical nutrition & dietetics to CHMT, SCHMT, and HMTS 3. Disseminate and implement the national guidelines on inpatient feeding protocols
6.1.3	Integration of nutritional care in disease management scaled-up	1. Carry out NACS) to all individuals seeking health care in all health facilities and refer them appropriately. 2. Adopt clinical nutrition Information, Education and Communication (IEC) materials 3. Distribution of IEC materials to all health facilities 4. Establish clinical nutrition resource centres in level IV facilities 5. Establish a patient feeding committee for all health facilities offering in-patient care. 6. Conduct monthly inpatient feeding committee meetings 7. Assessment of food preparation and storage equipment requirements 8. Conduct continuous support supervision of inpatient feeding in health facilities offering in-patient care
6.1.4	Documentation and reporting on clinical nutrition improved	1. Adopt data capture and reporting tools on clinical nutrition 2. Sensitisation of healthcare workers on clinical nutrition data tools
6.2 Expected Outcome 2: To reduce the impact of HIV/TB co-morbidities among people living with HIV by instituting patient-centric interventions		
6.2.1	Optimise the knowledge and skill sets of healthcare workers in clinical nutrition management in TB and HIV	1. Train healthcare providers on nutrition in TB management 2. Train healthcare providers on nutrition in HIV management 3. Sensitise health care workers on nutrition and HIV counselling cards for focused nutrition therapy and interpersonal counselling for HIV and TB 4. Carry out CMES on nutrition in TB management in health facilities 5. Carry out CMES on nutrition in HIV management in health facilities

6.2.2	Nutrition care process and referral for all PLHIV and TB improved	1. Conduct nutrition screening and assessment to all patients attending comprehensive care clinics and TB clinics 2. Conduct counselling and support to patients diagnosed with PLHIV and TB 3. Adopt/Dissemination of policies and guidelines on the management of HIV to healthcare providers 4. Disseminate the clinical nutrition referral protocol for HIV and TB patients 5. Integrate support supervision on clinical nutrition in the HIV and TB care sites
6.2.3	Strengthened integration of nutrition interventions for home-based care at the community level for PLHIVs towards 95:95:95	1. Train /sensitise CHPs and other community resource persons on good nutrition practices for HIV/TB patients to promote a healthy and sustainable lifestyle at the household level 2. Refer/link malnourished HIV/TB patients from the community to health facilities 3. Refer/link malnourished HIV/TB patients from the community to existing social protection programmes

KRA 7: Nutrition in Nutrition-Sensitive Sectors Strengthened

7.1 Expected Output 1: Linkages between nutrition and agriculture strengthened	
Expected Output	**Interventions/Activities**
7.1.1 Enhanced capacity to produce diverse, safe and nutritious food along the entire value chain	1. Support and participate in training of Ward Agricultural Officer on Agri-nutrition 2. Conduct training on nutrition-sensitive agriculture and food systems for agriculture managers and extension workers 3. Support and participate in the training of Ward Agricultural Officer and lead farmers as TOTs on FFBS+ Nutrition methodology 4. Advocate for recruiting Agri-nutrition officers at the county and sub-county level in collaboration with MOH 5. Advocate for the establishment of an Agri-nutrition desk at the county and sub-county level

7.1.2	Improved production of diverse, safe and nutritious food	1. Establish demonstration farms for the production of diverse nutritious foods 2. Conduct field days at ward levels on the production of safe diverse nutritious foods 3. Promote scaling up value chain crops/small stocks production of safe diverse nutritious foods 4. Promotion of production of bio-fortified food crops 5. Promote integrated kitchen gardens/vegetable gardens within the health facilities to act as demonstration sites in collaboration with the Department of Agriculture 6. Promote integrated kitchen gardens/home gardens within households in collaboration with the Department of Agriculture
7.1.3	Enhanced capacity for food preservation, value addition, storage, Agro-processing	1. Collaborate in sensitisation of transporters, traders and food processors on food safety and nutrient preservation 2. Conduct Nutrition Education sessions for value chain players - Transporters, traders, aggregators, and food processors 3. Participate in training on value addition, preservation, storage and Agro processing 4. Promote sustainable food preservation methods including traditional methods 5. Participate and support farmers during field days at ward levels on the consumption of safe diverse nutritious foods 6. Hold cooking demonstrations with the community units/farmer groups in collaboration with MOH 7. Participate during exhibitions agricultural shows/trade fairs on the consumption of safe, diverse nutritious foods
7.2 Expected Output 2: Nutrition mainstreamed in the education sector		
7.2.1	Nutrition capacity for teachers enhanced	1. Sensitise and disseminate the food and nutrition reference manual to teachers 2. Train teachers on healthy diets and physical activity
7.2.2	Healthy and safe food environment in schools	1. Support the implementation of school meals programmes that promote nutrient-dense foods

	and other learning institutions promoted	2. Advocate for sensitisation of parents towards the provision of safe and healthy foods in schools during school general meetings. 3. Advocate for revival and formation of 4K and young farmers clubs 4. Support and participate in the training of 4K/Young farmers clubs by Agricultural extension officers 5. Advocate for the establishment of school gardens to produce nutritious and diverse foods. 6. Advocate for the rearing of small livestock e.g. rabbits and poultry in schools. 7. Sensitise teachers and college tutors on healthy diets and physical activity guidelines 8. Integrate key messages on healthy diets and physical activity in the learning institutions' health programs 9. Conduct nutrition service delivery in schools (Vitamin A, deworming, assessment and referral) 10. Support the implementation of food and nutrition in the school curriculum
7.3 Expected Output 3: Nutrition integrated into WASH policies, strategies, plans and programmes		
7.3.1	Improved households' water quality and quantity control	1. Sensitise CHPs on safe water and community water sources protection 2. Conduct demonstration on household water treatment techniques to CHPs 3. Sensitise communities on rain harvesting in public *barazas* and other effective communication channels at the community level 4. Sensitise communities on proper human waste disposal through CLTS and the link with nutrition
7.3.2	Establishment and adequate WASH in households promoted	1. Sensitise CHPs on the construction of dish racks, garbage pits and tippy taps 2. Sensitise the community on the construction of dish racks, garbage pits and tippy taps 3. Sensitise CHPs on five critical times for hand washing and proper hand washing technique 4. Sensitise the community on five critical times for hand washing and proper hand washing techniques during dialogue days

	5. Sensitise the community on safe and hygienic practices during food preparation and storage 6. Promote environmental hygiene at household Level 7. Participate in the commemoration of World Hand Washing and Toilet Days.
7.4 Expected Outcome 4: Integration of nutrition in social protection programmes strengthened	
7.4.1 Enhanced awareness of safe and nutritious foods as a component of social protection	1. Support sensitisation for the elderly, OVCs and people with disabilities in Cash transfer programmes on the consumption of nutritious food 2. Advocate for nutrition interventions in social protection programmes 3. Support in sensitisation of the management of institutions of vulnerable persons and correction facilities on optimal nutrition for the institutions.
7.4.2 Nutrition promoted and linkages enhanced in social protection programmes including in crisis	1. Sensitise HCWs and CHPs on the targeting criteria for nutrition in social protection programmes (cash transfers, hunger safety nets, and others). 2. Support sensitisation of stakeholders in social protection programmes on the linkage between social protection and nutrition 3. Conduct a gender-integrated baseline survey/situation analysis on the status of nutrition and health for the vulnerable groups in social protection programmes 4. Advocate for harmonisation of all-inclusive gender, age and diversity responsive nutrition and social protection services for vulnerable groups (PWDs, orphans and vulnerable and the elderly) 5. Scale up social safety nets on nutrition in times of crises targeting vulnerable groups

KRA 8: Sectoral and Multi-sectoral Nutrition Governance and Advocacy Strengthened

Expected Outcome 1: Efficient, effective nutrition governance in place, and enhanced commitment and continued prioritization of nutrition in county agenda	
Expected Output	**Interventions/Activities**
8.1 Improved collaboration among sectoral and multi-sectoral nutrition sectors	1. Map, identify and mobilise stakeholders through a stakeholder's forum 2. Establish a multi-sectoral nutrition platform (CECMs, COs and CDs) for oversight and resource mobilisation for nutrition 3. Form a nutrition technical working group at County and sub-county levels. 4. Hold Monthly Nutrition Technical working group meetings at county and sub-county level 5. Form a multi-sectoral nutrition technical forum at the county level and sub-counties 6. Hold Monthly Nutrition Technical Forum (NTF) meetings at county and sub-county level 7. Hold MSP meetings 8. Disseminate capacity needs assessment findings and use them to develop a Multi-Sectoral Platform (MSP)framework to guide collaboration
8.2 Strengthened partnership and collaboration mechanisms for programme implementation, knowledge sharing and learning at the county level.	1. Adopt and sensitise county policymakers on SUN business strategy to strengthen the public-private partnership 2. Conduct nutrition capacity needs assessment for multi-sectoral partnerships/linkages. 3. Sensitise multi-sectoral stakeholders including the private sector on their role in nutrition. 4. Develop a costed second generation NCNAP
8.3 Enhanced accountability for nutrition resource allocation	1. Conduct nutrition budget analysis and financial tracking on nutrition financing for budget advocacy 2. Sensitisation of MSP on nutrition investment case 3. Sensitise the community to participate in social accountability and demand creation for nutrition through effective community channels

8.4 Policy and legislative environment for nutrition strengthened	1. Develop a county nutrition policy 2. Develop investment case for nutrition
8.5 Nutrition advocacy at political, technical and community level enhanced	1. Identify and train nutrition champions across the multi- sectors on nutrition advocacy 2. Develop the county advocacy and social mobilisation plan to guide nutrition advocacy interventions 3. Develop and sensitise policymakers on nutrition policy briefs 4. Hold consultative meetings on the integration of gender and social inclusion in nutrition programming 5. Develop a media nutrition advocacy kit 6. Sensitise and engage with the media to promote the nutrition agenda at all levels 7. Participate in commemoration of nutrition-related health days (World Diabetes Day, World Kidney Day, World Food Day, Day of the African Child) 8. Conduct nutrition-related health days/events (Breastfeeding week, Nutrition Week, Iodine Deficiency Day, No Obesity Day) 9. Sensitise HCWs, CHPs, and the community on the existing feedback mechanism at all levels
8.6 Management skills of nutrition staff improved	1. Train nutrition officers on senior management course 2. Train nutrition staff on strategic leadership and development program

KRA 9: Sectoral and Multi-sectoral Information Systems, Monitoring, Accountability, Learning and Research for Nutrition Strengthened.

Expected Outcome: Sectoral and multi-sectoral nutrition information systems, learning and research strengthened	
Expected Output	**Interventions/Activities**
9.1 Nutrition Information System Capacity enhanced among HCW's	1. Train HCW on documentation and reporting of nutrition indicators and KHIS 2. Train M&E and nutrition officers on basic data analysis 3. Train staff on nutrition scorecards (nutrition officers, HRIOs, Community services focal persons)

	4. Sensitise CHPs on documentation and reporting of community nutrition indicators (MOH 100, 513 and 514) 5. Train nutritionist and pharmacist on Logistics management information System (LMIS) 6. Conduct integrated support supervision in all health facilities
9.2 Nutrition sector plans (NCNAP; AWP) developed, implementation progress monitored and reviewed to inform program planning and adjustments	1. Conduct a mid-term review of the NCNAP implementation 2. Conduct an end-term review of the NCNAP implementation 3. Prepare annual NCNAP progress reports 4. Conduct annual NCNAP review dissemination meetings 5. Prepare annual nutrition work plans.
9.3 Data quality for M&E systems strengthened	1. Conduct data review meetings on nutrition performance in the sub-counties 2. Conduct feedback meetings on nutrition indicators. 3. Conduct annual nutrition data quality audit/assessment 4. Conduct nutrition feedback meetings at the community unit level
9.4 Quality nutrition data generated for evidence-based programming	1. Carry out nutrition SMART survey 2. Conduct Nutrition Causal Analysis 3. Disseminate survey findings/information to stakeholders 4. Conduct nutrition MIYCN KAP survey 5. Conduct nutrition capacity assessment 6. Develop and disseminate county nutrition profile to stakeholders 7. Develop annual policy briefs in line with the research/surveys conducted to inform decision-making processes 8. Hold consultative meetings with policymakers to disseminate the policy briefs
9.5 Improved decision-making through research	1. Collaborate with the academia to conduct operational research on nutrition to address county specific nutrition gap 2. Conduct workshops to disseminate operational research on nutrition 3. Establish a research repository for nutrition and dietetics

9.6 Improved knowledge sharing and learning on matters nutrition at all levels	1. Conduct county nutrition conferences/symposiums to exchange knowledge and share best practices. 2. Facilitate county actors to participate in symposiums/ conferences to showcase best practices and lessons in the implementation of nutrition interventions.

KRA 10: Supply Chain Management for Nutrition Commodities and Equipment Strengthened

Expected Outcome: Integrated supply chain management of nutrition commodities, equipment and tools strengthened	
Expected Output	**Interventions/Activities**
10.1 Enhance commodity management knowledge and skills for healthcare workers	1. Carry out integrated commodity management training including nutrition commodities for all health facility managers 2. Conduct CME sessions on commodity management to managers and health care workers in all health facilities and at the sub county levels 3. Carry out support supervision for nutrition commodities
10.2 Nutrition supply chain planning improved	1. Integrate nutrition in the annual commodity quantification and forecasting workshop 2. Advocate for adequate funding for nutrition commodities, equipment and tools 3. Procure and distribute nutrition commodities 4. Procure and distribute nutrition equipment and tools 5. Procure and distribute nutrition reporting tools for all programs. 6. Integrate nutrition in commodity utilization reviews
10.3 Availability and functionality of nutrition equipment enhanced	1. Establish nutrition equipment and tools needs for respective health facilities 2. Develop and effect an equipment maintenance and calibration plan for nutrition equipment and tools 3. Sensitise relevant HCWs on the use and maintenance of nutrition equipment 4. Conduct OJT to all health facilities on the use and maintenance of nutrition equipment. 5. Sensitise biomedical engineers on the repair of nutrition equipment.

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

4.1 Introduction

This chapter guides the monitoring, evaluation, accountability, and learning process and how the monitoring process will measure and track the implementation of the NCNAP.

Monitoring and evaluation will track suggested interventions' progress systematically and assess effectiveness, efficiency, relevance, and sustainability. Monitoring will involve ongoing, routine information collection about a programme's activities to measure progress toward results. The generated data will inform the implementers, decision makers and various stakeholders as to whether the implementation is on track and when and where modifications may be needed.

4.2 Background and Context

The NCNAP gives a framework of the expected results, which, if realised, will go a long way in ensuring that the county achieves the nutrition goal as outlined in the global commitments, e.g. **World Health Assembly** (WHA), United Nations Food Systems Summit (UNFSS), Nutrition for Growth (N4G), Sustainable Development Goals (SDGs), as well as the national priorities laid out in the KNAP and Food & Nutrition Security Policy. Furthermore, it defines the priority strategies and interventions/activities necessary to achieve the expected outcomes and the organisational frameworks needed to implement the plan.

4.3 Purpose of the MEAL Plan

The NCNAP MEAL plan seeks to offer strategic information vital for county-level evidence-based development of a Common Results and Accountability Framework (CRAF). The CRAF will create the foundation of one expected results framework that brings together the information from different sectors related to nutrition and other non-state actors, e.g. private sector, Civil Society Organisations (CSOs), Non-Governmental Organisations (NGOs); and external actors, e.g. development partners, and technical partners, resulting in improved efficiency, transparency and accountability.

The previous chapters described the current nutrition situation and strategic interventions. The MEAL plan lays out the specific indicators to track (when, how, and by whom data will be collected), the frequency of submission, and the timelines for the collective programme performance reviews with stakeholders.

Elements to be monitored include:

- Statistics for service delivery
- Service coverage/outcomes
- Client access to services
- Quality of health services
- Impact of interventions

The evaluation plan elaborates on periodic performance reviews/surveys and unique research complementing routine monitoring data knowledge base.

To ensure there is gender inclusivity throughout the NCNAP, all data collected, analysed, and reported on will be disaggregated by gender and age to deliver information and address the impact of any gender issues and relations, including benefits from the nutrition programming between boys, girls, men and women. Sex disaggregated data will be well analysed and monitored to help pinpoint any negative bearing of nutrition programming or problems about gender. Likewise, positive effects and results from the interventions promoting gender equality for enhanced nutrition and health outcomes shall be documented and learned to improve and optimise interventions. Other procedures that will be put up to streamline gender in the MEAL plan will include:

- Development/review of M&E tools and methods to ensure they document gender differences
- Ensuring that terms of reference for reviews and evaluations include gender-related results
- Ensuring that M&E teams (e.g., data collectors and evaluators) include men and women, as diversity can help access different community groups
- Reviewing existing data to identify gender roles, relations, and issues before designing nutrition programming to help set a baseline.
- Hold separate interviews and Focused Group Discussions (FGDs) with women and men across different genders, ages, diversities, and other socio-economic variations.
- Verifiable indicators were included to focus on the benefits of nutrition programming for boys, girls, and women and men.
- Integration of gender-sensitive indicators to point out gender-related changes leading to improved nutrition and related health outcomes over time.

4.4 Logic Model

Monitoring and evaluation of the NCNAP will follow a logical model. examining what it takes to achieve the intended results, linking this with the expected result and the strategies, outputs, and inputs to create a shared understanding of the relationships between the expected results, activities conducted, and resources required, as illustrated in Figure 13.

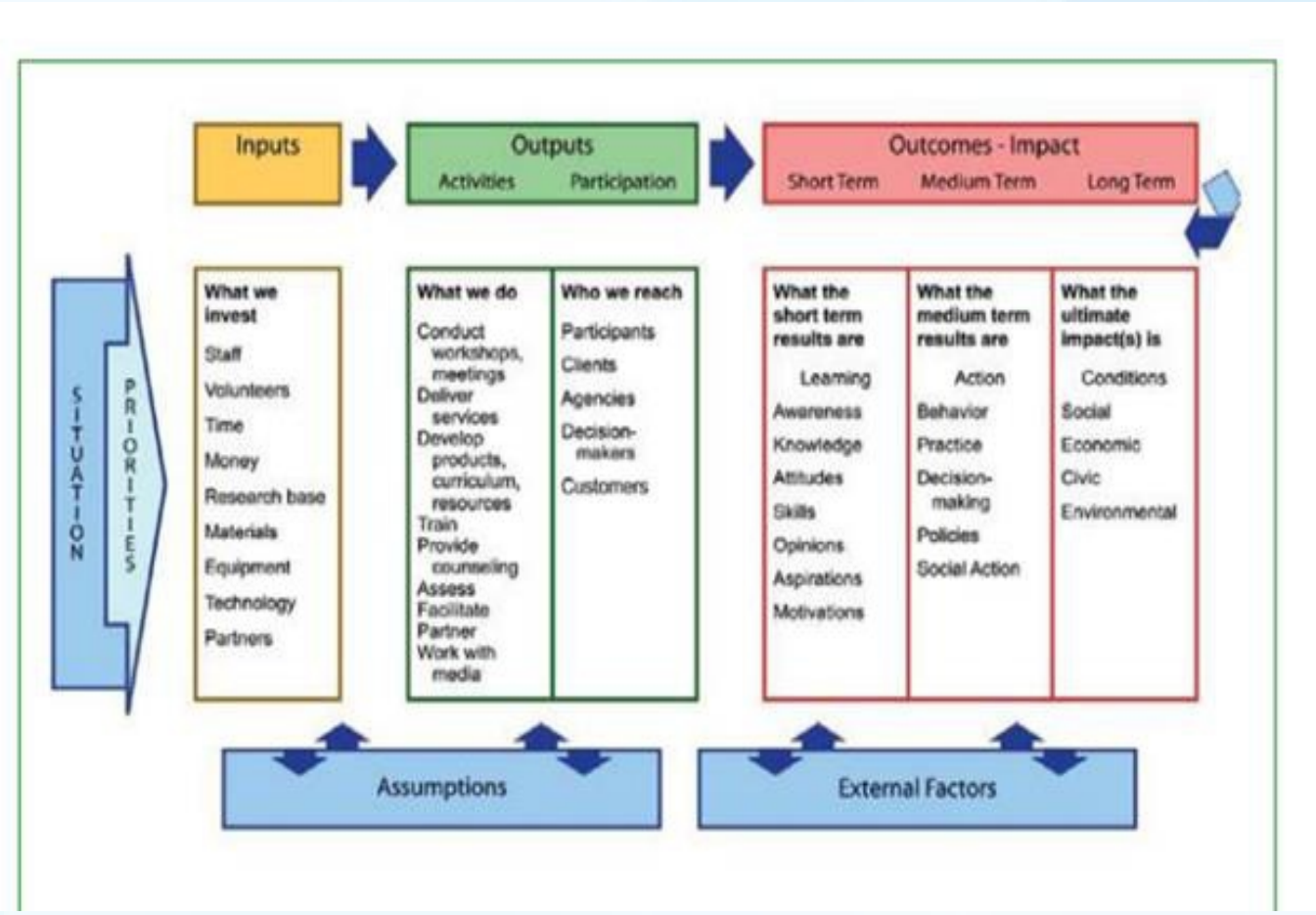

Figure 13: Monitoring and Evaluation of the Logical Framework

Source: (Taylor et al., 2002)

4.5 Monitoring Process

Monitoring and evaluating the NCNAP will follow a logical model, looking at what it takes to achieve intended results, linking this with the expected outcome and with the strategies, outputs and inputs for a shared understanding of the relationships between the expected results, activities conducted, and resources required. The process will be participatory, with stakeholder collaboration starting from data collection through validation, analysis and dissemination of the final report, as shown below.

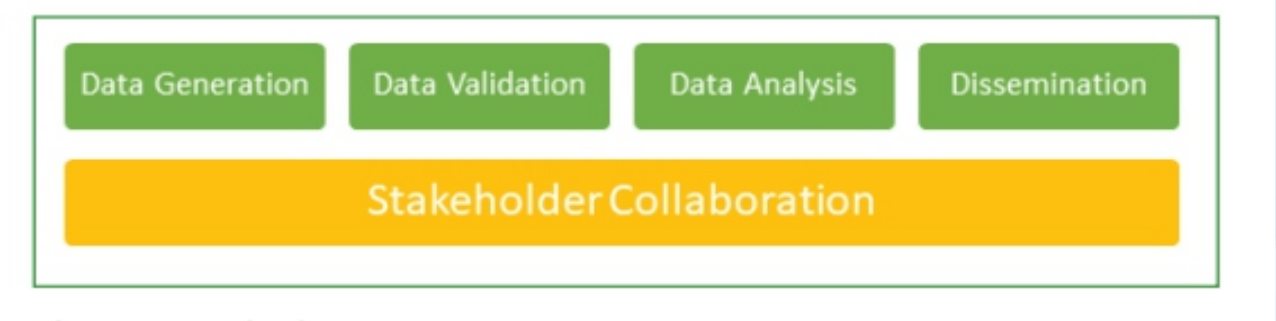

Figure 14: Monitoring Process of Stakeholder Collaboration

4.6 Monitoring NCNAP Performance

Data Generation

Various data types will be collected from different sources to monitor the implementation's progress. These data will be collected through routine surveys, sentinel surveillance, and periodic assessments.

Routine health facility data will be generated using the existing mechanisms and uploaded to the KHIS monthly. Other routine data, such as training activity reports, will be stored in the nutrition program for reference and consolidation. Strong multi-sectoral collaboration with nutrition-sensitive sectors in data generation will be encouraged.

Data flow from the primary source through the levels of aggregation to the national level will be guided by reporting guidelines and SOPs and reach the MOH by agreed timelines for all levels.

Data Validation

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

Data Analysis

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

Information Dissemination

Information products, such as quarterly bulletins, annual performance review reports, and nutrition fact sheets, are developed and routinely disseminated to crucial sector stakeholders and the public.

Evaluation of the NCNAP

The NCNAP will be evaluated midterm after implementation to assess achievements after two years and at the end of the implementation period. The two activities have been factored into the action plan.

4.7. Monitoring, Evaluation, Accountability and Learning (MEAL) Team

The County M&E division will be responsible for overall oversight of M&E activities. The functional linkage of the nutrition programme to the Department of Health and the overall county inter-sectoral government M&E will be through the county M&E and Technical Working Group (**TWG**). To monitor this action plan, the Health Department M&E unit will be responsible for the day-to-day implementation and coordination of the M&E activities. The nutrition unit will share quarterly progress reports with the County Department of Health Services (CDOH) M&E Division, which will take the lead in the joint performance reviews at the national level. The CHMT will prepare the quarterly reports in collaboration with county stakeholders and organise the county quarterly performance review forums. These reports will be shared with the national M&E unit during the annual health forum, which brings together all stakeholders in health to jointly review the performance of the health sector for the year under review. To successfully monitor this action plan, the county will have to strengthen the M&E function by investing in the infrastructure and the human resources for M&E. Technical capacity building for data analysis will be promoted through collaboration with research institutions for training targeting the County M&E staff. Low reporting from other sectors on nutrition-sensitive indicators is still a challenge due to the use of different reporting systems that need to be inter-operational. Therefore, Investment in Health Information System (HIS) infrastructure to facilitate e-reporting is critical. Timely collection and quality assurance of health data will improve with the institutionalisation of a functional team dedicated to this purpose.

4.8 Critical Assumptions

- Sufficient resources and organisational systems will be available to implement the plan.
- Training done throughout the implementation process will lead to knowledge gain and behaviour change.
- Data and information employed in the development and implementation process of the NCNAP are credible, accurate, reliable, and timely.
- Information relayed to community members and various stakeholders will lead to actual change in behaviour and practices.
- The various sectors will embrace this plan and monitor and evaluate their specific action points outlined in this NCNAP.
- Heightened coordination with various stakeholders—other sectors, as well as other programmes in the public and private sectors—will positively influence the outcomes.
- There will be a favourable prevailing evidence-based policy and political environment during the implementation of this NCNAP.
- Investments as inputs will result in desired outputs and outcomes and, eventually, achievement of overall results as outlined in the NCNAP.

Table 8: Impact and Outcome Indicators and Information Sources

Impact/ Outcome	Indicator	Baseline	Baseline Data Source	Mid-term Target (2025)	End-Term Target (2027)	Frequency of Data Collection
Reduce the number of children under five who are stunted by 40per cent (WHA Target 2030) by 2027	The proportion of children under five years stunted (low height for age)	18 per cent	KDHS 2022	15	12	Every two years
Reduce and maintain childhood wasting to less than 5per cent (WHA 2022 Target) by 2027	Percentage of wasted children under five years (low weight for height).	2 per cent	KDHS 2022	2	1	Every two years
Reduce the proportion of underweight children to less than 3 per cent by 2027	Percentage of under-weight under five years (low weight for age)	4 per cent	KDHS 2022	3.5	3	Every two years
No increase in childhood overweight (children under	Percentage of overweight children less than five years	3.1 per cent	KDHS 2022	2.5	2	Every two years

five years of age) (WHA 2022 Target) by 2027	(high weight for height->2SD)					
Improved survival of children below the age of 5	Infant mortality rate	36	KDHS 2022	33	30	Every 5 years
	Neonatal Mortality Rate	20	KDHS 2022	18	16	Every 5 years
	Under-5 mortality rate	45	KDHS 2022	42	39	Every 5 years
Increase the proportion of children exclusively breastfed in the first 6months of life by 2027 to at least 70per cent	Exclusive breastfeeding rate for children under six months (population-based)		KDHS 2022	65	70	Every five years
Reduction by 25per cent of the proportion of the population who are overweight/obese	Prevalence of overweight/obese in women	56 per cent	KDHS 2022	53	50	Every 5 years
	Prevalence of overweight/obese in men	18.6	KDHS 2022	15	12	Every 5 years
Minimum Dietary Diversity for children aged 6-23	Percentage of children 6-23 months of age who	-	MIYCN KAP	42	45	Every 5 years

	consumed foods and beverages from at least five out of eight defined food groups during the previous day					
Minimum meal frequency for children 6-23 months	Percentage of children 6-23 months of age who consumed solid or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more during the previous day	-	MIYCN KAP	75	78	Every 5 years
Minimum acceptable diet 6–23 months	Percentage of children 6–23 months of age who consumed a minimum acceptable diet during the previous day	-	MIYCN KAP	40	43	Every 5 years

Minimum dietary diversity for women (MDD-W)	Percentage of women 15-49 years of age who consumed foods from 5 food groups during the previous day	72	KDHS 2022	75	80	Every 5 years
Reduce anaemia in WRA (pregnant and non-pregnant) by 50 per cent by 2025, WHA 2012 Targets.	Estimates of anaemia prevalence in pregnant women	-	Kenya National Micronutrient Survey (KNMS, 2011	35	30	Every 5 years

NCNAP Implementation Plan by Key Result Area

The implementation plan for the interventions identified under each KRA is detailed in Tables 9 to 19.

Table 9: KRA 1- Scaling up of (MIYCN Implementation Plan

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Disseminate the MIYCN policy summary statement to all policymakers (CECMs, COs, CDs, CHMT, HMTs and SCHMTs)	No. of dissemination meetings held		Nutrition activity reports	5	Annually	1	1	1	1	1
Disseminate MIYCN strategy 2023-2028 to all policymakers (CECMs, COs, CDs, CHMT, HMTs, SCHMT, MCAs)	No. of dissemination meetings held		Nutrition activity reports	5	Quarterly	1	1	1	1	1
Sensitise health managers (CHMT, SCHMTs, HMTs) on BFHI	No. of sensitisation meetings held		Nutrition activity reports	5	Annually	1	1	1	1	1
Train Health Care Workers (HCWs) in all health facilities offering maternity and newborn services on BFHI	No. of training held		Nutrition activity reports	10	Annually	2	2	2	2	2
Establish BFHI committees or integrate BFHI in the QIT in all health facilities offering maternity services/ Integrate BFHI in quality improvement teams	No. of BFHI committees established/integrated		Nutrition activity reports	37	Annually	5	8	8	8	8

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Carry out continuous medical education to all non-clinical staff in all health facilities offering maternity and newborn services on BFHI	No. CMEs carried out to all non-clinical staff		Nutrition activity reports	128	bi-annually	8	30	30	30	30
Conduct baseline BFHI assessment in all health facilities offering maternity and newborn services	No. of baseline assessments carried out		Nutrition activity reports	40	Annually	4	26	10	0	0
Conduct continuous CMEs on BFHI in implementing health facilities	No. of CMEs carried out		Nutrition activity reports	100	Quarterly	20	20	20	20	20
Conduct continuous quality BFHI assessments in implementing health facilities	No. of BFHI self-assessments carried out		Nutrition activity reports	40	Annually	0	4	26	10	0
Supervision of BFHI activities in implementing health facilities	No. of supervision visits carried out		Nutrition activity reports	154	Quarterly	4	30	40	40	40
Conduct BFHI external assessment in implementing health facilities	No. of BFHI external assessments carried out		Nutrition activity reports	40	Annually	0	4	26	10	0
Provide nutrition education to pregnant mothers, and caregivers during ANC visits	Qualitative			0						
Provide nutrition education to	Qualitative			0						

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
lactating mothers at postnatal ward and the newborn unit										
Document and report implementation of BFHI	No. of reports on BFHI implementation		Nutrition activity reports	82	Quarterly	2	20	20	20	20
Sensitise CECMs, COs, CDs, CHMT and SCHMT on BFCI	No. of CECMs, CHMT, SCHMT and other trainings carried		Nutrition activity reports	2	Annually	2	0	0	0	0
Sensitise Community Health Committees (CHCs) and Health Facility Management Committees (HFMCs) on BFCI	No. of sensitisation meetings held		Nutrition activity reports	60	Annually	12	12	12	12	12
Train health workers on BFCI	No. of trainings held		Nutrition activity reports	7	Annually	3	1	1	1	1
Train c-BFCI Trainer of Trainers (c-BFCI TOT)	No. of trainings held		Nutrition activity reports	1	Annually	1	0	0	0	0
Conduct BFCI baseline assessment	No. of BFCI baseline assessments carried		Nutrition activity reports	60	Annually	12	12	12	12	12
Train Community Health Promoters (CHPs) on cBFCI	No. of cBFCI trainings done for CHPs		Nutrition activity reports	60	Annually	12	12	12	12	12
Map households and form Mother-to-Mother Support Groups (MTMSGs)	No. of household mapping exercises		Nutrition activity reports	60	Annually	12	12	12	12	12

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
	carried out									
Conduct nutrition education during mother-to-mother support group meetings	No. of nutrition education sessions conducted		Nutrition activity reports	588	Monthly	12	144	144	144	144
Conduct cookery demonstrations during bi-monthly baby-friendly gatherings	No. of cookery demonstrations carried out		Nutrition activity reports	204	Quarterly	12	48	48	48	48
Conduct continuous BFCI quality improvement self-assessments	No. of BFCI quality assessment		Nutrition activity reports	204	Quarterly	12	48	48	48	48
Conduct BFCI external assessments	No. of BFCI external assessments carried out		Nutrition activity reports	48	Annually	0	12	12	12	12
Carry out support supervision for BFCI at community level by CHMT, SCHMT	No. of supportive supervision visits made		Nutrition activity reports	168	Annually	12	24	36	48	48
Document and report implementation of BFCI in CHU's	No. of BFCI implementation reports prepared		Nutrition activity reports	50	bi-annually	10	10	10	10	10
Train health care workers on MIYCN	No. of MIYCN trainings conducted for health workers		Nutrition activity reports	5	Annually	1	1	1	1	1
Provide nutrition education and	Qualitative			0						

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
counselling at health facilities and community level										
Sensitise CHPs on MIYCN	No. of MIYCN sensitisation meetings held for CHPs		Nutrition activity reports	100	Annually	20	20	20	20	20
CHPs communicate key MIYCN messages at the community level	Qualitative			0						
Sensitise policymakers (CECMs, COs, CDs, CHMT, HMTs, SCHMTs, MCAs) on Breast Milk Substitutes (BMS) Act,2012 and its regulations of 2021	No. of sensitisation meetings held		Nutrition activity reports	2	Annually	2	0	0	0	0
Sensitise the private sector on the BMS Act,2012	No. of sensitisation meetings held		Nutrition activity reports	5	Annually	1	1	1	1	1
Train healthcare workers on BMS Act,2012	No. of trainings on BMS Act done		Nutrition activity reports	2	Annually	1				1
Sensitise law enforcers on the BMS Act,2012	No. of training on BMS Act done		Nutrition activity reports	9	Annually	5	1	1	1	1
Sensitise CHPs on the BMS Act,2012	No. of BMS Act sensitisation meetings held		Nutrition activity reports	189	Annually	20	40	40	40	49

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Conduct market-level surveillance/monitoring of the BMS Act implementation	No. of market-level surveillance/ mmonitoring visits carried out		Nutrition activity reports	125	Annually	25	25	25	25	25
Document and report violations of the BMS Act	No. of reports BMS Act violations reports made		Nutrition activity reports	10	bi-annually	2	2	2	2	2
Sensitise CECMs, COs, CDs, CHMT, SCHMTs and HMTs on implementation framework for securing a breastfeeding-friendly environment at workplaces	No. of sensitisation meetings on implementation framework for securing a breastfeeding-friendly environment at workplaces		Nutrition activity reports	6	Annually	2	1	1	1	1
Train healthcare workers on implementationframework for securing a breastfeeding-friendly environment at the workplaces	No. trainings on implementation framework for securing a breastfeeding-friendly environment at the workplace done		Nutrition activity reports	5	Annually	1	1	1	1	1
Sensitise key stakeholders in public and private institutions on implementation framework for securing a breastfeeding-friendly environment at the	No of sensitisation meetings held for key stakeholders in public and private institutions on implementation framework		Nutrition activity reports	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
workplaces	for securing a breastfeeding-friendly environment at the work places .									
Carry out CMEs at the health facility level on implementation framework for securing a breastfeeding-friendly environment at the workplaces	No. of CMEs carried out on implementation framework for securing a breastfeeding-friendly environment at the workplace done		Nutrition activity reports	100	Quarterly	20	20	20	20	20
Establish lactation rooms/ lactation stations in health facilities	No. of lactation rooms/stations established in health facilities		Nutrition activity reports	25	Annually	5	5	5	5	5
Advocate for the establishment of lactation stations in both public and private entities in formal and informal institutions	No. of advocacy meetings on the establishment of lactation stations in public and private entities held		Nutrition activity reports	10	Annually	2	2	2	2	2
Monitor and document utilisation of lactation stations	No. of reports on utilisation of lactation stations		Nutrition activity reports	40	bi-annually	0	10	10	10	10
Sensitise CHMT, SCHMT and HMT on the new WHO	No. of sensitisation meetings on		Nutrition activity reports	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
growth standards	WHO growth standards sensitisation meetings held									
Train health workers on the new WHO growth standards	No. of trainings on new WHO growth standards held		Nutrition activity reports	5	Annually	1	1	1	1	1
Carry out CMEs at health facility level on growth monitoring and promotion	No. of CME sessions on growth monitoring and promotion held		Nutrition activity reports	100	Quarterly	20	20	20	20	20
Sensitise education managers on growth monitoring and promotion	No. of sensitisation meetings on growth monitoring held for health managers		Nutrition activity reports	25	Annually	5	5	5	5	5
Sensitise CHPs on growth monitoring including family MUAC	No. of sensitisation meetings on growth monitoring (including family MUAC) carried out		Nutrition activity reports	150	Annually	30	30	30	30	30
CHMT and SCHMT conduct support supervision on growth monitoring	No. of supervision sessions on growth monitoring carried out		Nutrition activity reports	100	Quarterly	20	20	20	20	20
Carry out GMP in	Routine			0						

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
all health facilities offering child welfare services and record in individual child-mother booklet										
Document and report individual growth indices in CWC register	Routine			0						

Table 10: KRA 2 - Promoting Older Children and Adolescent Nutrition Implementation Plan

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Advocate Inclusion of policy interventions for older children (5-9 years), adolescents (10-19 years) and older persons in the proposed Nyandarua County food policy	Launching of the Policy control document on the marketing of unhealthy food in and around learning institutions.	0	Launched policy document	1			1			
Disseminate policy interventions on control of the marketing of unhealthy foods in and around learning institutions to CECMs, COs, CDs, CHMT,	Policy control document on the marketing of unhealthy food in and around learning institutions disseminated to CECM, COs, CDs,	0	Nutrition technical reports	1	Every 5 years		1			

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
SCHMT and MCAs	CHMT, SCHMT and MCAs									
Advocate for dissemination of guidelines on healthy diets and physical activity to the CECMs, COs, CDs, CHMT, SCHMTs and HMTs	Guidelines on healthy diets and physical activity disseminated to CECM, Cos, CDs, CHMT, SCHMT and MCAs	0	Nutrition technical reports	1	Every five years		1			
Sensitise workers on guidelines on healthy diets and physical activity	No. of sensitisation done on health workers on guidelines on healthy diets and physical activity	0	Nutrition technical reports	2			1	1		
Sensitise CHPs on guidelines on healthy diets and physical activity	No. of sensitisation sessions done to CHPs on healthy diets and physical activity	0	Nutrition technical reports	4	Annually		2	2		
Train health workers on healthy diets and physical activity	No. of health workers' trainings on guidelines on healthy diets and physical activity done	0	Nutrition technical reports	2	Annually		1	1		
Train CHPs on module 8 for nutrition	No. of trainings for CHPs on healthy diets	0	Nutrition technical reports	2	Annually		1	1		

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
	and physical activity									
Sensitise older children and adolescents and communities on healthy diets and physical activity	No. of sensitisation sessions conducted to the caregivers	0	Nutrition technical reports	5	Annually	1	1	1	1	1
Sensitise older persons on healthy diets and physical activity through effective communication channels, e.g. Media, religious institutions, village meetings etc.	No. of sensitisation sessions conducted	0	Nutrition technical reports	10	Annually	2	4	4	4	4
Conduct nutrition screening at the community level	No. of nutrition screening sessions conducted	0	Nutrition technical reports	16	Annually	0	4	4	4	4
Conduct behaviour change communication sessions at the community level	No. of behaviour change communicatio n sessions conducted	0	Nutrition technical reports	20	Annually	12	12	12	12	12
Conduct Cooking demonstration sessions for healthy family diets at the community	No cooking demonstration conducted	0	Nutrition technical reports	20	Annually	4	4	4	4	4

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
level										

Table 11: KRA 3 - Prevention, Control, and Management of Micronutrient Deficiencies Scaled-up Implementation Plan

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Sensitise policymakers (CECMs, COs, CDs, CHMT, HMT and SCHMTs) on VAS guidelines, IFAS policy, MNP policy, Food Fortification strategy	No. of sensitisation sessions for policymakers (CECMs, COH, CDH, CHMT, HMT and SCHMTs) on VAS guidelines, IFAS policy, MNP policy, Fortification strategy policies and guidelines conducted	0	Nutrition Technical Report	1	Annually	1				
Develop county county-contextualised food safety policy	Contextualise the County food safety policy	-	Nutrition activity reports	1	Every 5 years		1			
Train HCWs on Vitamin A supplementation and deworming	No. of trainings for HCWs on vitamin A supplementation and deworming	0	Nutrition Technical Report	2	Annually	1	1			
Train HCWs on	No. of IFAS	0	Nutrition	2	Every two	1	1			

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
IFAS	trainings for HCWs		Technical Report		years					
Train HCWs on MNPs	No. of HCW trainings on MNPs	0	Nutrition Technical Report	2	Every two years	1	1			
Sensitise CHPs on IFAS, MNPs, Vitamin A and dewormers	No. of CHPs sensitisation sessions on IFAS, MNPs, Vitamin A and dewormers	0	Nutrition Technical Report, meeting minutes	2	Annually	1	1			
Sensitise the community on micronutrient supplementation (VAS, IFAS, MNPs) through effective communication channels to target populations	No. of Community sensitisation meetings	0	Nutrition Technical Report	5	Annually	1	1	1	1	1
Sensitise HCWs on food fortification	Integrated into routine activities - qualitative									
Conduct CMEs targeting health workers on food fortification	No. of CMEs conducted on health workers on fortified food in the market	0	CMEs minutes	20	Quarterly	4	4	4	4	4
Sensitise CHPs on food fortification including fortified foods in local markets	No. of CHPs sensitisation sessions on available fortified foods in local	2	Nutrition Technical Report	2	Annually	1	1			

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
	markets									
Conduct nutrition health talks on dietary diversification and bio fortification at the health facilities	No. of nutrition health talks carried out on dietary diversity and food fortification at the health facilities	0	Micro teaching report	60	Monthly	12	12	12	12	12
Carry out IFAS supplementation to all pregnant women	The proportion of pregnant women supplemented with IFAS	0	MOH 711, Kenya Health Information System (KHIS)	80	Monthly	80	80	80	80	80
Carry out VAS supplementation to 6-59 months children	The proportion of children aged 6-59 months supplemented with Vitamin A and deworming	0	MOH 710, KHIS	80	Monthly	80	80	80	80	80
Carry out deworming to 12-59 months children	The proportion of children aged 6-59 months supplemented with MNPs	0	MOH 711, KHIS	60	Monthly	60	60	60	60	60
Carry out deworming to pregnant women in their 2nd trimester	The proportion of pregnant women in 2nd trimester dewormed	0	Nutrition Technical Report	80	Monthly	80	80	80	80	80
Conduct Malezi Bora Activities	No. of rounds of Malezi	0	Nutrition Technical	10	Bi-annual	2	2	2	2	2

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
across the County bi-annually	Bora activities carried out annually		Report, MOH 711, 710, KHIS							
Provide nutrition education and counselling on IFAS to pregnant women at health facility level	Routine									
Provide nutrition education and counselling on VAS +Deworming to lactating women at the health facility level	Routine - qualitative									
Provide health talks in health facilities on prevention, control, and management of Micronutrient Deficiencies	Routine - qualitative									
Map food manufacturers for purposes of food fortification in the county	No. of mapping sessions for fortified food manufacturers in the county		Nutrition Technical Report	5	Annually	1	1	1	1	1
Activate county food safety and fortification committee	No. of county food safety and fortification meetings		Nutrition Technical Report, meeting minutes	20	Quarterly	4	4	4	4	4

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Carry out community sensitisation on food fortification including fortified food in the market and locally produced fortified foods	Qualitative									
Conduct annual salt iodisation monitoring in the county	No. of salt iodisation monitoring activities carried out		Nutrition activity reports	5	Annually	1	1	1	1	1
Conduct market-level surveillance on food fortification	Qualitative		Nutrition activity reports							
Conduct support supervision of the micronutrient supplementation activities at the county and sub-county biannually	No. of support supervision on the micronutrient supplementation activities conducted at the county and sub county		Nutrition Technical Report	20	Quarterly	4	4	4	4	4
Submission of monthly reports at the micronutrient supplementation on at the county and sub-county levels to the relevant department	No. of reports on micronutrients supplementation on submitted at the county and sub-county levels		Nutrition Technical Report	60	Monthly	12	12	12	12	12

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Conduct biannual food safety and fortification review meetings	No. of Biannual review meetings conducted		Nutrition Technical Report, meeting minutes	3	Annually	1	0	1	0	1

Table 12: KRA 4: Prevention, Control and Management of Diet Related Non-Communicable Diseases (DRNCDs) in the Life Course Scaled-up Implementation Plan

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Sensitise stakeholders (CHMT, SCHMT, CEMT, SCEMT, CAO, SCAO) on policies/guidelines on Diabetes, cardiovascular, non-communicable disease, healthy diet, and physical activity	No. of stakeholders' meetings carried out Diabetes, cardiovascular, non-communicable diseases, healthy diet guidelines and policies to stakeholders (CHMT, SCHMT, CEMT, SCEMT, CAO, SCAO)	0	Nutrition technical reports	5	Every two years	1		1		
Disseminate nutrition SOPs on Diabetes, obesity/overweight, cardiovascular, throat and colon cancers to HCWs for implementation	No nutrition SOPs on diabetes, obesity/overweight, cardiovascular, throat and colon cancers to HCWs disseminated.	0	Nutrition technical reports	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Train HCWs on prevention and management of Diabetes	No. of trainings on prevention and management of diabetes held.	0	Minutes, nutrition technical reports	5	Bi-annual		1			
Train HCWs on the prevention and management of cardiovascular diseases	No. of trainings on prevention and management of cardiovascular diseases held.	0	Minutes, nutrition technical reports	3	Annually	1	1			
Train HCWs on the prevention and management of diet-related cancers	No. of trainings on nutrition in prevention and management of diet-related cancers held	0	Minutes, nutrition technical reports	5	Annually	1	1			
Train HCWs on the prevention and management of obesity and overweight	No. of trainings on nutrition in prevention and management of obesity and overweight held	0	Minutes, nutrition technical reports	5	Annually	1	1			
Conduct CMEs in the health facilities on nutrition in Diabetes	No. of CMEs on nutrition in diabetes held in the health facilities	0	Minutes	20	Quarterly	4	4	4	4	4
Conduct CMEs in health facilities on nutrition in cardiovascular diseases	No. of CMEs held on nutrition in cardiovascular diseases in the health facilities	0	Minutes	60	Quarterly	4	4	4	4	4

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Conduct CMEs in the health facilities on nutrition in emerging diet related cancers	No. of CMEs held on nutrition in diet-related cancers in the health facilities.	0	Minutes	20	Quarterly	4	4	4	4	4
Conduct CMEs in the health facilities on nutrition in obesity and overweight	No. of CMEs held on nutrition in obesity and overweight in the health facilities	0	Minutes	60	quarterly	4	4	4	4	4
Sensitise CHPs and the community on healthy diets and physical activities, using effective communication channels	No. of sensitisation meetings held to CHPs and the community on healthy diets and physical activities using effective communication channels.	0	Minutes, nutrition technical reports	5	Quarterly	4	4	4	4	4
Sensitise CHPs and the community on nutrition assessments and messages in Diabetes, cardiovascular and obesity/overweight	No. of sensitisation meetings held to CHPs and community on NACs in diabetes, cardiovascular diseases and obesity/overweight.	0	Minutes, nutrition technical reports	60	Quarterly	4	4	4	4	4
Sensitise health workers on proper documentation of diabetes,	No. of sensitisation meetings held with health workers on proper documentation of diabetes, cardiovascular and overweight/ obesity	0	Minutes, nutrition technical reports	5	Annually	1	1			

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
cardiovascular, and obesity /overweight										
Collaborate with Stakeholders to support and participate in health thematic days, such as World Diabetes Day, World Hypertensive Day, World Cancer Day, and World Kidney Day.	No. of thematic days supported	0	Nutrition technical reports	20	Annually	1	1	1	1	1
Hold podcasts and radio talk shows on diabetes, cardiovascular disease, overweight/obesity, and emerging diet-related cancers in relation to nutrition.	No. of podcast and radio shows done		Nutrition technical reports		Annually	1	1	1	1	1
Conduct NACs in monthly outreaches	No. of outreaches conducted with NACs		Nutrition technical reports		Quarterly	4	4	4	4	4
Conduct nutrition assessments and counselling in medical camps	No. of medical camps conducted with NACs		Nutrition technical reports		Quarterly	4	4	4	4	4

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Timely submission of Monthly reports on DRNCDs	No. of DRNCDs monthly reports submitted		MOH 740, KHIS		Monthly	2	2	2	2	2
Integrate support supervision on documentation and reporting of nutrition in the MOPC and wellness clinics	No. of supportive supervisions done		Nutrition technical reports		Quarterly	4	4	4	4	4
Integrate DRNCDs data with nutrition report during routine data review meeting	No. of data review meetings held		MOH 740, KHIS		monthly	12	12	12	12	4
Conduct nutrition assessments and counselling for all clients attending MOPC and cancer clinics.	No. of MOPC and cancer clients receiving NACs.		MOH 740, KHIS		monthly	12	12	12	12	12
Advocate for the establishment of psychosocial support groups in MOPCs and cancer clinics	No. of psychosocial support groups established.		Nutrition technical reports		Annually	1	1	1	1	1
Conducting routine nutrition	No. of psychosocial support groups meetings held		Minutes, nutrition		Monthly	12	12	12	12	12

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
education during psychosocial support group meetings			technical reports							
Conduct community linkages and referral of DRNCDs in the community and health facilities by CHPs and CHAs	No. of community linkages and referrals done		Minutes, nutrition technical reports		Monthly	12	12	12	12	12
Establish wellness clinics	No. of wellness clinics established		Minutes, nutrition technical reports		Annually	1	1			

Table 13: KRA 5 - Integrated Management of Acute Malnutrition (IMAM) and Nutrition in Emergencies Strengthened Implementation Plan

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Disseminate guidelines for Integrated Management of Acute Malnutrition to CHMT, SCHMT and HMT	No. of IMAM guidelines dissemination meetings held		Nutrition activity reports	5	Annually	1	1	1	1	1
Train healthcare workers on Integrated Management of Acute	No. of trainings on IMAM carried out for health workers		Nutrition activity reports	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Malnutrition.										
Conduct CMEs to HCWs on IMAM	No. of IMAM CMEs conducted for healthcare workers		Nutrition activity reports	1566	Annually	174	348	348	348	348
Adapt, print, and distribute IMAM SOPs to health facilities			Nutrition activity reports	0						
Sensitise CHMTs, SCHMTs and HMTs on SOPs for IMAM	No. of IMAM SOPs sensitisation sessions for health managers conducted		Nutrition activity reports	2	Annually	1	0	1	0	0
Sensitise health care workers on IMAM SOPs	No. of IMAM SOPS sensitisation sessions conducted for health workers		Nutrition activity reports	20	Annually	4	4	4	4	4
Assess, diagnose, counsel, and support all children with acute malnutrition	Routine -qualitative									
Follow of children with acute malnutrition by giving TCA	Routine-qualitative									
Conduct support supervision on IMAM	No. of IMAM support supervision sessions conducted		Nutrition activity reports	100	Quarterly	20	20	20	20	20
Carry out referrals of children with acute malnutrition to health facility by CHP's	Routine - qualitative									
Carry out IMAM reporting monthly	No. of IMAM reports submitted		KHIS	1800	360	360	360	360	360	360

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Sensitise policy makers (CECMs, COs, CDs, and MCAs) on PD Hearth	No. of PD Hearth sensitisation meetings held for policy makers		Nutrition activity reports	2	Annually	2	0	0	0	0
Sensitise CHMT, SCHMT and HMTs on PD Hearth guideline	No. of PD Hearth sensitisation meetings held for health managers		Nutrition activity reports	3	Annually	3	0	0	0	0
Train multi-sectoral service providers on PD Hearth	No. of multi-sectoral PD Hearth trainings for service providers carried out		Nutrition activity reports	15	Annually	3	3	3	3	3
Train CHPs on PD Hearth	No. of PD Hearth training sessions done for CHPs		Nutrition activity reports	60	Annually	12	12	12	12	12
Conduct baseline assessment of children's nutrition status	No. of baseline nutrition status assessments done		Nutrition activity reports	60	Annually	12	12	12	12	12
Conduct support supervision for hearth sessions	No. of PD Hearth supervision sessions conducted		Nutrition activity reports	720	Annually	144	144	144	144	144
Document and report on PD Hearth implementation	No. of PD Hearth implementation reports prepared		Nutrition activity reports	50	Bi-annual	10	10	10	10	10
Conduct Positive Deviance Inquiry (PDI)	No. of Positive Deviance inquiries done		Nutrition activity reports	60	Annually	12	12	12	12	12
Conduct hearth sessions in the community	No. of hearth sessions conducted in the community		Nutrition activity reports	1440	Annually	288	288	288	288	288

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Conduct coordination meetings for nutrition in emergencies with partners	No. of nutrition coordination meetings conducted		Nutrition activity reports	16	Quarterly	0	4	4	4	4
Incorporate nutrition technical officers in the emergency preparedness and response committees at county, sub county and facility levels	No. of emergency and response committees in which nutrition technical officers have been incorporated		Nutrition activity reports	8	Annually	8	0	0	0	0
Participate in policy discussions related to post-disaster reviews to influence nutrition consideration	Qualitative		Nutrition activity reports							
Participation in community-level dialogue and recovery initiatives	Qualitative		Nutrition activity reports							
Develop/review county nutrition preparedness and response contingency plan and integrate with the county plan	County nutrition preparedness and response plan developed		Nutrition activity reports	1	0	1	0	0	0	0
Train health care workers on MIYCN-e	No. of healthcare workers' MIYCN-e trainings conducted		Nutrition activity reports	4	Annually	0	1	1	1	1
Sensitise CHPs on MIYCN-e	No. of MIYCN-e sensitisation meetings conducted for CHPs		Nutrition activity reports	40		0	10	10	10	10
Conduct MIYCN-e-assessment in selected	No. MIYCN-e assessments conducted in selected emergency hotspots		Nutrition activity reports	20	Annually	0	5	5	5	5

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
emergency hotspots to adapt the response to the context										
Disseminate MIYCN-e-assessment findings to stakeholders	No. of MIYCN-e-assessment dissemination meetings conducted		Nutrition activity reports	4	Annually	0	1	1	1	1
Integrate and provide nutrition services during outreach services in hard-to-reach areas, affected areas	Qualitative		Nutrition activity reports							
Provide nutrition education/counselling on high-impact nutrition interventions in emergencies	Qualitative		Nutrition activity reports							

Table 14: KRA 6 - Clinical Nutrition Strengthened Implementation Plan

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Undertake specialised courses for nutritionists in renal, oncology, critical care, and paediatric nutrition	No. of nutritionists trained on specialised courses		Training reports	2	Annually		1	1		
Undertake training of health care workers on enteral and parenteral nutrition	No. of healthcare workers trained on enteral and parenteral nutrition		Training reports	80	Annually		80			

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Create a database for trained personnel in clinical nutrition specialities	Updated database of nutrition specialists		HR database	2	Annually		1	1		
Benchmark in level V or VI hospital on clinical nutrition practice	No. of benchmarking visits done on clinical nutrition		Benchmarking report	2	Annually		1	1		
Carry out CMES on clinical nutrition to health workers	No. of CMES conducted		CME reports in target facilities	2	Annually		1	1		
Integrate clinical nutrition in support supervision tool for level IV hospitals	Updated supervision tool		Supervision reports	1	Bi-annual	1				
Train healthcare workers on guidelines on nutrition and dietetics for participants drawn from hospitals and high-workload facilities										
Disseminate clinical nutrition tools for screening, inter-facility referral and monitoring and service quality management tools to CHMT, SCHMTs and the facility in charges	Nutrition tools disseminated		Tools register at the County and sub-county levels	4	Annually	1	1	1	1	
Sensitise and disseminate policies and guidelines related to clinical nutrition & dietetics to CHMT, SCHMT, HMTS	No. of policies and guidelines disseminated		Dissemination meetings' reports	20	Annually	4	4	4	4	4
Disseminate and implement the national guidelines on inpatient feeding protocols										

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Carry out nutrition assessment, counselling, and support (NACS) to all individuals seeking health care in all health facilities and refer them appropriately.	No. of Nutrition counselling and support done		Nutrition DAR	20	Quarterly	4	4	4	4	4
Adopt clinical nutrition IEC materials	No. of IEC materials adopted		IEC materials inventory register	1	Annually	1	0	0	0	0
Distribution of IEC materials to all health facilities	No. of IEC materials distributed to health facilities		IEC materials inventory register	1	Annually	0	1	0	0	0
Establish a clinical nutrition Resource Centre in level IV health facilities	No. of level IV health facilities with a Resource Centre established		Resource Centre presence	1	Annually	0	1	0	0	0
Establish a patient feeding committee for all health facilities offering in-patient care.	No. of Inpatient feeding committees established		Appointment letters of members	1	Annually	1	0	0	0	0
Conduct monthly inpatient feeding committee meetings	No. of inpatient feeding committee meetings held		Minutes of meeting	20	Quarterly	4	4	4	4	4
Assessment of food preparation and storage equipment requirements	Nutrition assessment needs done		Nutrition equipment assessment report	1	Annually	1	0	0	0	0
Conduct continuous support supervision of inpatient feeding in health facilities offering in-patient care	No. of support supervisions done		Supervision reports	20	Quarterly	4	4	4	4	4
Adopt data capture and	Data capture and		Nutrition daily	1	Quarterly	1	0	0	0	0

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
reporting tools on clinical nutrition	reporting tools adopted		register							
Sensitisation of healthcare workers on clinical nutrition data tools	Sensitisation meetings held		Sensitisation meeting report	5	Annually	1	1	1	1	1
Train healthcare providers on clinical nutrition in TB management	No. of healthcare workers trained		Training reports	5	Annually	1	1	1	1	1
Train healthcare providers on clinical nutrition in HIV management	No. of healthcare workers trained		Training reports	5	Annually	1	1	1	1	1
Sensitise healthcare workers on nutrition and HIV counselling cards for focused nutrition therapy and interpersonal counselling for HIV and TB	No. of sensitisation sessions carried out		Nutrition activity reports	20	Annually	0	5	5	5	5
Carry out CMES on clinical nutrition in TB management in health facilities	No. of CMEs conducted on clinical nutrition		CMEs reports	20	Quarterly	4	4	4	4	4
Carry out CMES on clinical nutrition in HIV management in health facilities	No. of CMEs conducted on clinical nutrition		CMEs reports	20	Quarterly	4	4	4	4	4
Conduct nutrition screening and assessment of all patients attending comprehensive care clinics and TB clinics	The proportion of patients who have nutrition assessment documented on their records		Patient records	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Conduct counselling and support to patients diagnosed with PLHIV and TB.	No. of clients counselled and supported		Patient records	20	Quarterly	4	4	4	4	4
Adopt/Dissemination of policies and guidelines on management of HIV to health Care providers	No. of policies and guidelines disseminated HIV		Dissemination reports	1	Annually	1	0	0	0	0
Disseminate the clinical nutrition referral protocol for HIV and TB patients	No. of referral protocol for HIV and TB disseminated		Referral protocol in place	1	Annually	1	0	0	0	0
Integrate support supervision on clinical nutrition in the HIV and TB care sites	No. of support supervisions done		Support supervision report	20	Quarterly	4	4	4	4	4
Train /sensitise CHPs and other community resource persons on good nutrition practices for HIV/TB patients to promote healthy and sustainable lifestyles at the household level	No. of CHAs sensitised on good nutrition practices		Sensitisation report	1	Annually	1	0	0	0	0
Refer/link malnourished HIV/TB patients from the community to health facilities	No. of patients referred/ linked to facilities		Linkage/Referral reports	20	Quarterly	4	4	4	4	4
Refer/link malnourished HIV/TB patients from the community to existing social protection programmes	No. of patients referred/ linked to social protection programmed		Linkage/Referral reports	20	Quarterly	4	4	4	4	4

Table 15: KRA 7- Nutrition in Nutrition-sensitive Sectors Promoted (Agriculture, Education, WASH, and Social Protection) Implementation Plan

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Support and participate in training of Ward Agricultural Officer on Agri-nutrition	No. of Supported training of ward agricultural officers and lead farmers on FFBS methodology		Nutrition activity reports	5	Annually	1	1	1	1	1
Conduct training on nutrition sensitive agriculture and food systems for agriculture managers and extension workers	No. of training session conducted		Nutrition activity reports	5	Annually	1	1	1	1	1
Support and participate in the training of Ward Agricultural Officers and lead farmers as TOTs on FFBS+ Nutrition methodology	No. of trainings conducted		Nutrition activity reports	5	Annually	1	1	1	1	1
Advocate for recruitment of Agri-nutrition officers at county and	No. of advocacy letters done on recruitment of ward		Nutrition activity reports	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
sub-county level in collaboration with MOH	agricultural officers.									
Advocate for the establishment of an Agri-nutrition desk at the county and sub-county level	No. of advocacy meetings conducted		Nutrition activity reports	5	Annually	1	1	1	1	1
Establish demonstration farms for the production of diverse nutritious foods	No. of farm demonstrations conducted		Nutrition activity reports	5	Annually	1	1	1	1	1
Conduct farmer field days at ward levels on the production of safe diverse nutritious foods	No. of farmer field days supported on safe, diverse nutritious foods		Nutrition activity reports	20	Quarterly	4	4	4	4	4
Promote scaling up of value chain crops/small stocks production of safe, diverse nutritious foods	No. of meetings held to scale up value chain crops/small stocks		Nutrition activity reports	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Promotion of production of biofortified food crops	No. of meetings to promote production of bi-fortified food crops		Nutrition activity reports	10	Bi-annual	2	2	2	2	2
Promote integrated kitchen garden/vegetable gardens within the health facilities to act as demonstration sites in collaboration with Department of Agriculture.	No. of demonstrations done		Nutrition activity reports	20	Quarterly	4	4	4	4	4
Promote integrated kitchen garden/home gardens within household in collaboration with the Department of Agriculture.	No. of kitchen gardens established		Nutrition activity reports	20	Quarterly	4	4	4	4	4
Collaborate in sensitisation of transporters, traders and food processors on food safety and nutrient	No. of sensitisation meetings		Nutrition activity reports	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
preservation										
Conduct nutrition education sessions for value chain players - Transporters, traders, aggregators, food processors	No. of sessions conducted		Nutrition activity reports	5	Annually	1	1	1	1	1
Participate during training on value addition, preservation, storage and Agro-processing	No. of training sessions participated on value addition, preservation, storage and Agro processing		Nutrition activity reports	10	Bi-annual	2	2	2	2	2
Promote sustainable food preservation methods including traditional methods	No. of demonstration on preservation conducted		Nutrition activity reports	10	Bi-annual	2	2	2	2	2
Advocate for validation of food safety bill and policy	No. of advocacy meetings conducted		Nutrition activity reports	1	Every five years	0	0	0	1	0
Participate and support farmers during field days at	No. of fields days held		Nutrition activity reports	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
ward levels on consumption of safe diverse nutritious foods.										
Hold cooking demonstrations with the community units/farmer groups in collaboration with MOH	No. of cooking demonstrations done		Nutrition activity reports	10	Bi-annual	2	2	2	2	2
Participate during exhibitions agricultural shows/trade fairs on the consumption of safe diverse nutritious foods	No of agricultural shows/trade participated		Nutrition activity reports	5	Annually	1	1	1	1	1
Sensitise and disseminate the food and nutrition reference manual to teachers	No. of sensitisation sessions conducted		Nutrition activity reports	5	Annually	1	1	1	1	1
Train teachers on healthy diets and physical activity	No. of trainings conducted		Nutrition activity reports	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Support the implementation of school meal programmes that promote nutrient-dense foods	No. of schools implementing a feeding program		Nutrition activity reports	5	Annually	1	1	1	1	1
Advocate for sensitisation of parents towards the provision of safe and healthy foods in schools during school general meetings.	No. of meetings held		Nutrition activity reports	5	Annually	1	1	1	1	1
Advocate for revival and formation of 4K and young farmers clubs	No. of schools with 4K and young farmers' clubs		Nutrition activity reports	20	Quarterly	4	4	4	4	4
Support and participate in the training of 4K/Young farmers clubs by Agricultural extension officers	No. of trainings conducted		Nutrition activity reports	20	Quarterly	4	4	4	4	4
Advocate for the establishment of school gardens for the	No. of advocacy meetings conducted		Nutrition activity reports	20	Quarterly	4	4	4	4	4

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
production of nutritious and diverse foods.										
Advocate for the rearing of small livestock e.g. rabbit and poultry in schools.	No. of advocacy meetings conducted		Nutrition activity reports	5	Annually	1	1	1	1	1
Sensitise teachers and college tutors on healthy diets and physical activity guidelines	No. of sensitisation meetings conducted		Nutrition activity reports	5	Annually	1	1	1	1	1
Integrate key messages on healthy diets and physical activity in the learning institutions' health programmes	No. of meetings held		Nutrition activity reports	5	Annually	1	1	1	1	1
Conduct nutrition service delivery in schools (Vitamin A, deworming assessment, and referral)	No. of service delivery sessions conducted		Nutrition activity reports	10	Bi-annual	2	2	2	2	2

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Support implementation of food and nutrition in the school curriculum	No. of Schools supported		Nutrition activity reports	5	Annually	1	1	1	1	1
Sensitise CHPs on safe water and community water source protection	No. of sensitisation conducted		Nutrition activity reports	10	Bi-annual	2	2	2	2	2
Conduct demonstration on household water treatment techniques to CHPs	No. of demonstrations conducted		Nutrition activity reports	10	Bi-annual	2	2	2	2	2
Sensitise communities on rain harvesting in public *barazas* and other effective communication channels at the community level	No. of sensitisation conducted		Nutrition activity reports	20	Quarterly	4	4	4	4	4
Sensitise communities on proper human waste disposal through CLTS and the link	No. of trainings conducted		Nutrition activity reports	10	Bi-annual	2	2	2	2	2

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
with nutrition										
Train CHPs on the construction of dish racks, garbage pits and tippy taps	No. of trainings sessions carried out		Nutrition activity reports		Annually	2	2	2	2	2
Sensitise the community on the construction of dish racks, garbage pits and tippy taps	No. of community sensitisation sessions carried out		Nutrition activity reports		Annually	2	2	2	2	2
Sensitise CHPs at five critical times for hand washing and proper hand washing technique	No. of sensitisation sessions carried out		Nutrition activity reports		Annually	2	2	2	2	2
Sensitise community on safe and hygienic practices during food preparation and storage	No. of sensitisation conducted		Nutrition activity report	10	Bi-annual	2	2	2	2	2

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Promote environmental hygiene at household Level	No. of sensitisation sessions carried out		Nutrition activity reports	20	Biannually	4	4	4	4	4
Participate in the commemoration of World Hand Washingd and Toilet Days.	No. of meetings held		Nutrition activity report	5	Annually	1	1	1	1	1
Support sensitisation for the elderly, OVCs and people with disabilities in Cash transfer programmes on consumption of nutritious food	No. of sensitisation held		Nutrition activity report	20	Quarterly	4	4	4	4	4
Advocate for nutrition interventions in social protection programmes	No. of advocacy meetings held		Nutrition activity report	5	Annually	1	1	1	1	1
Support in sensitisation of the management of institutions of vulnerable persons and	No. of sensitisations held		Nutrition activity report	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
correction facilities on optimal nutrition for the institutions.										
Sensitise male and female HCWs and CHPs to the targeting criteria for nutrition in social protection programmes, cash transfers, hunger safety nets, and other programmes.	No. of sensitisation held		Nutrition activity report	10	Bi-annual	2	2	2	2	2
Support Sensitisation of stakeholders in social protection programmes on the linkage between social protection and nutrition	No. of sensitisation held		Nutrition activity report	20	Quarterly	4	4	4	4	4
Conduct a gender-integrated baseline survey/situation analysis on the status of nutrition and health for the vulnerable	No. of surveys conducted		Nutrition activity report	1	Every five years	0	1	0	0	0

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
groups in social protection programmes										
Advocate for harmonisation of all-inclusive gender, age and diversity-responsive nutrition and social protection services for vulnerable groups (people living with disabilities, orphans and vulnerable and the elderly)	No. of advocacy meetings conducted		Nutrition activity report	5	Annually	1	1	1	1	1
Scale up social safety nets on nutrition in times of crises targeting the vulnerable groups	No. of additional vulnerable people reached (variable)		Nutrition activity reports		Annually					

Table 16 : KRA - 8 Sectoral and Multi-sectoral Nutrition Governance and Advocacy Strengthened Implementation Plan

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Map, identify and mobilise stakeholders through forums	No. of meetings held		Activity reports	10	Bi-annual	2	2	2	2	0
Establish a multi-sectoral nutrition platform (CECMs, COs and CDs) for oversight and resource mobilisation for nutrition	No. of platforms established		Activity reports	1	Every five years	1	0	0	0	0
Form a nutrition technical working group at County and sub-county	Nutrition technical working groups formed at the county and in the five sub-counties		Nutrition activity reports	6	Biannually	0	6	0	0	0
Hold Monthly Nutrition Technical working group meetings at county and sub-county level	No. of nutrition technical working group meetings held		Nutrition activity reports	96	Quarterly	0	24	24	24	24
Form a multi-sectoral nutrition technical forum at the county level and sub-counties	No. of committees established		Nutrition activity reports	1	Every five years	1	0	0	0	0
Hold Monthly Nutrition Technical Forum (NTF) meetings at county and sub-county level	No. of meetings held		Nutrition activity reports	60	Monthly	12	12	12	12	12
Hold MSP meetings	No. of meetings held		Nutrition activity reports	20	Quarterly	4	4	4	4	4

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Disseminate capacity needs assessment findings and use them to develop an MSP framework to guide collaboration	No of meetings		Nutrition activity reports	3	Every two years	1	0	1	0	1
Adopt and sensitise county policymakers on SUN business strategy to strengthen the public-private partnership	No of sensitisation meetings		Nutrition activity reports	20	Quarterly	4	4	4	4	4
Conduct nutrition capacity needs assessment for multi-sectoral partnership/linkages	No. of meetings		Nutrition activity reports	5	Annually	1	1	1	1	1
Sensitise multi-sectoral stakeholders including the private sector on their role in nutrition	No. of meetings		Activity reports	5	Annually	1	1	1	1	1
Develop a costed second generation NCNAP	Copy of the second-generation NCNAP		Second generation NCNAP	1	Every five years	0	0	0	0	1
Conduct nutrition budget analysis and financial tracking on nutrition financing for budget advocacy	Copy of county budget analysis report		County financial report	3	Every two years	1	0	1	0	1
Sensitisation of MSP on nutrition investment case	No. of meetings		Activity reports	5	Annually	1	1	1	1	1
Sensitise the community to participate in social accountability and demand creation for nutrition through effective	No. of community sensitisation sessions conducted		Activity report	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
community channels										
Develop a county nutrition policy	Copy of the county nutrition policy		Technical report	1	Every five years	0	1	0	0	0
Develop investment case for nutrition	Copy of the investment case report		Technical report	1	Every five years	1	0	0	0	0
Identify and train nutrition champions across the multi- sectors on nutrition advocacy	No. of champions trained		List of nutrition champions	1	Every five years	1	0	0	0	0
Develop the county advocacy and social mobilisation plan to guide nutrition advocacy interventions	Copy of the county nutrition advocacy plan developed		Technical report	1	Every five years	1	0	0	0	0
Develop and sensitise policymakers on nutrition policy briefs	Copies of policy briefs and advocacy tools		Technical report	1	Every five years	1	0	0	0	0
Hold consultative meetings on the integration of gender and social inclusion in nutrition programming	No. of advocacy meetings on gender inclusion held		Activity report	5	Annually	1	1	1	1	1
Develop a media nutrition advocacy kit	Copy of media nutrition advocacy kit		Technical report	2	Every five years	0	1	0	0	1
Sensitise and engage with the media to promote the	No. of local media houses sensitised and engaged		Activity report	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
nutrition agenda at all levels										
Participate in commemoration of nutrition-related health days (World Diabetes Day, World Kidney Day, World Food Day, Day of the African Child)	No. of nutrition health days participated		Activity report	20	Quarterly	4	4	4	4	4
Conduct nutrition-related health days/events (Breastfeeding Week, Nutrition Week, Iodine Deficiency Day, No Obesity Day)	No. of nutrition health days conducted		Activity report	5	Annually	1	1	1	1	1
Sensitise HCWs, CHPs, and the community on the existing feedback mechanism at all levels	No. of sensitisation meetings held		Activity report	5	Annually	1	1	1	1	1
Train nutrition officers on senior management course	Number of officers trained in senior management		Nutrition activity reports	12	Annually	2	2	4	2	2
Train nutrition staff on strategic leadership and development programme	Nutrition officers trained in strategic leadership development program		Nutrition activity reports	5	Annually	0	1	1	1	2

Table 17: KRA 9 - Sectoral and Multi-sectoral Information Systems, Monitoring, Accountability, Learning and Research for Nutrition Strengthened Implementation Plan

Interventions/ Activities	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Train HCW on documentation and reporting of nutrition indicators and KHIS	No. of trainings conducted on documentation and reporting of nutrition indication		County training database, Training reports		Every two years	1	0	0	1	0
Train M&E and nutrition officers on basic data analysis	No. of trainings conducted on basic data analysis		County training database, training reports		Every two years	0	1	0	1	0
Train staff on nutrition scorecard (nutrition officers, HRIOs, Community services focal persons)	No. of trainings conducted on a scorecard		County training database		Every three years	0	0	1	0	0
Sensitise CHPs on documentation and reporting of community nutrition indicators (MOH 100, 513 and 514)	No. of sensitisation meetings conducted to community reporting indicators		County training database, Training reports		Every two years	1	0	0	1	0
Train nutritionist and pharmacist on LMIS	No. of trainings conducted		County training database, Training reports		Every two years	1	0	0	1	0
Conduct integrated support supervision in all health facilities	No. of support supervisions conducted		Supervision reports		Bi-annual	1	1	1	1	1

Interventions/ Activities	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Conduct a mid-term review of the NCNAP implementation	The proportion of NCNAP reviewed		Review reports		Every two years	0	0	1	0	0
Conduct an end-term review of the NCNAP implementation	The proportion of NCNAP reviewed		Review nutrition reports		Every five years	0	0	0	0	1
Prepare annual NCNAP progress reports	No. of annual NCNAP progress reports		Annual progress reports		Annually	1	1	1	1	1
Conduct annual NCNAP review dissemination meeting	Proportion of work plan		Annual work plan		Annually	1	1	1	1	1
Prepare annual nutrition work plan	No. of meetings		Annual dissemination reports		Annually	1	1	1	1	1
Conduct data review meetings on nutrition performance in the sub-counties	No. of review meetings on nutrition performance		Health data reports, performance reviews		Bi-annual	2	2	2	2	1
Conduct feedback meetings on nutrition indicators	No. of feedback meetings on nutrition activities		Feedback reports		Annually	1	1	1	1	1
Conduct annual nutrition data quality audit/assessment	No. of audit /assessment reports		Audit reports		Annually	1	1	1	1	1
Conduct nutrition	No. of feedback meetings		Activity reports		Annually	1	1	1	1	1

Interventions/ Activities	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
feedback meetings at the community unit level										
Carry out nutrition SMART survey	No. of surveys		Survey reports		Every five years	0	1	0	0	0
Conduct Nutrition Causal Analysis	No. of surveys carried out		Survey reports	2	Every two years	0	1	0	0	1
Disseminate survey findings/informatio n to stakeholders	No. of dissemination meetings		Survey reports		Every five years	0	1	0		1
Conduct nutrition MIYCN KAP survey	No. of surveys conducted		Survey reports		Every five years	0	0	1	0	0
Conduct a nutrition capacity assessment	No. of surveys conducted		Survey reports		Every five years	0	1	0	0	0
Collaborate with academia to conduct operational research on nutrition to address county-specific nutrition gap	No. of research reports		Research reports		Every five years	0	0	0	1	0
Conduct workshops to disseminate operational research on nutrition	No. of workshops conducted		Workshop reports		Annually	1	1	1	1	1
Develop and disseminate County nutrition profile to stakeholders	No. of the county nutrition profile		County nutrition profile		Every five years	1	0	0	0	0
	No. of dissemination		Activity report	years	years	1	0	0	0	0

Interventions/ Activities	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
	meetings									
Develop annual policy briefs in line with the research/surveys conducted to inform decision-making processes	No. of annual policy briefs		Policy briefs		Every two years	1	0	1	0	0
Hold consultative meetings with policymakers to disseminate the policy briefs	No. of meetings conducted		Meeting reports		Every two years	1	0	0	1	0
Establish a research repository for nutrition and dietetics	No. of research repositories for nutrition and dietetics established		Research repositories		Every five years	0	1	0	0	0
Conduct county nutrition conferences/symposiums for knowledge exchange and sharing of best practices	No. of conferences/symposiums		Conference/symposium reports		Every two years	1	0	0		0
Facilitate county actors to participate in symposiums/ conferences to showcase best practices and lessons in the implementation of nutrition interventions	No. of conferences attended		Nutrition activity reports		Annually	1	1	1	1	1

Table 18: KRA10 - Supply Chain Management for Nutrition Commodities and Equipment Strengthened

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
Carry out integrated commodity management training including for nutrition commodities for all health facility managers	No. of facility managers trained in commodity management		Training report	2	Bi-annual	0	1	0	1	0
Conduct CMES for commodity management to managers and healthcare workers in all health facilities and at the sub-county levels	No. of CMEs conducted		CMEs report	2	Bi-annual	0	1	0	1	0
Carry out support supervision for nutrition commodities within the integrated supervision	No. of health commodity support supervisions done		Supervision report	20	Quarterly	4	4	4	4	4
Integrate nutrition in the annual commodity quantification	Report of annual forecasting and quantification		Forecasting and quantification reports	5	Annually	1	1	1	1	1

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
and forecasting workshop	activities									
Advocate for adequate funding for nutrition commodities, equipment and tools	Increased allocation for nutrition products		Approved budget	5	Annually	1	1	1	1	1
Procure and distribute nutrition commodities	Nutrition products procured and distributed		Delivery notes	20	Quarterly	4	4	4	4	4
Procure and distribute nutrition equipment and tools	No. of Nutrition commodities utilisation review done		Meeting report	10	Bi-annual	2	2	2	2	2
Procure and distribute nutrition reporting tools for all programs.	All Nutrition reporting tools procured and distributed		Review of available tools	5	Annually	1	1	1	1	1
Integrate nutrition in commodity utilisation reviews	Updated quarterly review template to include nutrition performance reporting		Sub-county and County quarterly review reports	5	Annually	1	1	1	1	1
Establish nutrition	Nutrition equipment		Nutrition equipment list	1	Annually	1	0	0	0	0

Expected Outputs	Performance Indicator	Baseline Data	Source of Data	Target	Periodicity	2023/24	2024/25	2025/26	2026/27	2027/28
equipment and tools needs for respective health facilities	needs to be established									
Develop and effect an equipment maintenance and calibration plan for nutrition equipment and tools	Approved equipment maintenance and calibration plan		Approved maintenance plan	5	Annually	1	1	1	1	1
Sensitise relevant HCWs on the use and maintenance of nutrition equipment	No. of biomedical engineers trained		Training database	5	Annually	1	1	1	1	1
Conduct OJT to all health facilities on the use and maintenance of nutrition equipment	No. of health care facilities visited, and OJT conducted on nutrition equipment maintenance		Sub-county and county equipment maintenance report	4	Annually	0	1	1	1	1
Sensitise biomedical engineers on the repair of nutrition equipment.	No. of sensitisation sessions carried out		Nutrition activity reports	3	Annually	0	1	1	1	0

4.9 Implementation Plan

The implementation of the MEAL framework will be spearheaded by the county in collaboration with development partners and stakeholders. This will ensure the successful implementation of the NCNAP. To ensure coordinated, structured, and effective implementation of the NCNAP, the county government will work with partners and the private sector to ensure implementation through:

1. Developing SOPs for managing data, monitoring, evaluation and learning among all stakeholders
2. Improving performance monitoring and review processes
3. Enhancing the sharing of data and use of information for evidence-based decision-making

Roles and Responsibilities of Different Actors in the Implementation of the NCNAP

Different players will have different roles and responsibilities, as outlined in Table 19.

Table 19: Roles and Responsibilities of Different Actors in the Implementation of the NCNAP

Actors	Roles and Responsibilities
Nutrition M&E Staff Members	• Ensuring the overall design of the MEAL plan is technically sound • Working with stakeholders to develop and refine appropriate outputs, outcomes, indicators and targets • Providing technical assistance to create data collection instruments • Helping program staff with data collection (including selection of appropriate methods, sources, enforcement of ethical standards) • Ensuring data quality systems are established • Analysing data and writing up the findings • Aiding program staff to interpret their output and outcome data Promoting use of M&E data to improve program design and implementation • Conducting evaluations or special studies
Management at Programme Level	• Determining what resources, human and financial, should be committed to M&E activities and assess them • Ensuring the content of the M&E plan aligns with the overall vision and direction of the county • Assuring data collected meet the information needs of stakeholders • Tracking progress to confirm staff carry out activities in the M&E

	plan • Improving project design and implementation based on M&E data • Deciding how results will be used and shared • Identifying who needs to see and use the data • Deciding where to focus evaluation efforts • Interpreting and framing results for a different audience
County Department of Health Services	• Providing technical services and coordinating M&E activities • Establishing and equipping robust M&E units aligned to their respective departmental organograms • Providing a dedicated staff team comprised of the entire mix of M&E professionals needed to implement this scope (M&E, officers, Health Record & Information Officers (HRIOs), statisticians, planners, economics, epidemiologists • Coordinating and supervising the implementation of all M&E activities at the county and sub-county and facility levels
Nutrition-sensitive Sectors	• Monitoring and reporting on progress towards implementation of key activities that fall within their mandates in line with jointly agreed indicators • Participating in high-level M&E activities at the county • Supporting surveys and evaluations needed to assess the shared impact of joint interventions
Implementing Partners and Agencies	• Aligning all their M&E activities to realise the goals of this plan as well as the institutional M&E goals articulated in sectoral, programmatic and county-specific M&E Plans • Routine monitoring and evaluating their activities • Using existing systems/developing M&E sub-systems that utilise existing structures at all levels of the health information system • Utilising the data collected for decision making within the institution
Development Partners	• Providing substantive technical and financial support to ensure that the systems are functional • Ensuring that their reporting requirements and formats are in line with the indicators outlined in the M&E framework

	• Synchronising efforts with existing development partners and stakeholders' efforts based on an agreed-upon one county-level M&E system • Utilising reports generated in decision making, advocacy and engaging with other partners for resource mobilisation
Community Health Units	• Ensuring that data collected, and reports generated are disseminated and used by the implementers to monitor trends in supply of basic inputs, routine activities, and progress made • Using this data in deciding priority activities to improve service delivery access and quality

4.10 Calendar of Key M&E Activities

The county will adhere to the health sector accountability cycle, illustrated in Figure 14. This will ensure the alignment of resources and activities to meet the needs of various health sector actors.

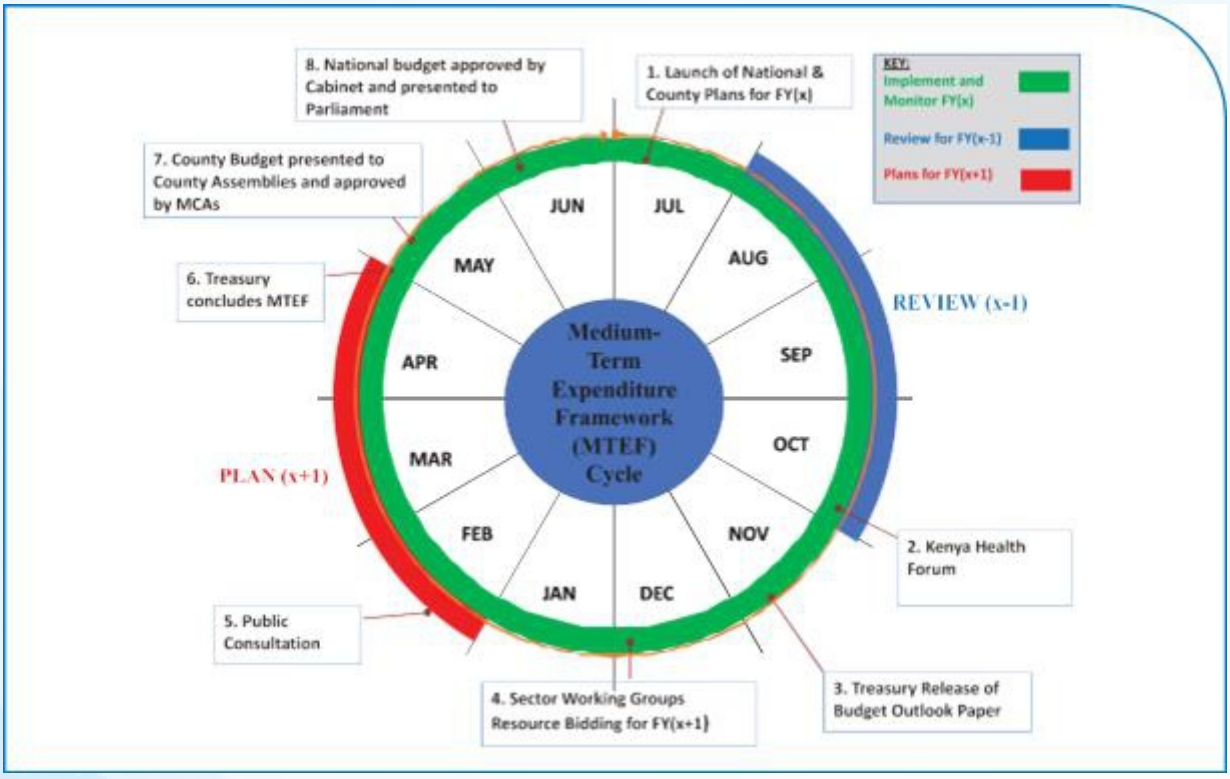

Figure 15: Health Sector Accountability Cycle

4.11 Implementation of the NCNAP

To implement this NCNAP effectively, the nutrition unit and all stakeholders involved will continue to address structural bottlenecks and enhance capacity building within themselves. They will also engage all the stakeholders for their contributions and promote innovativeness, creativity, and professionalism toward realising the action plan.

CHAPTER 5: RESOURCE REQUIREMENTS

5.1 Introduction

A good health system raises adequate revenue for health service delivery, enhances the efficiencies of management of health resources and provides financial protection to people experiencing poverty against catastrophic situations. By understanding how the health systems and services are financed, programs and resources can be better directed to strategically complement the health financing already in place, advocate for the funding of needed health priorities, and aid populations to access available health services. Determining the value of inputs is required to generate a particular output in monetary terms. It involves estimating the quantity of inputs needed for an activity/programme. Costing may also be described as a quantitative process that evaluates a programme's operational (recurrent) and capital costs. The process ensures that the value of resources required to deliver services is cost-effective and affordable. This process allocates input costs based on each intervention and activity to achieve set goals /results. It attempts to identify what causes the price to change (cost drivers). All costs of activities are traced and attached to the intervention or service for which the activities are performed. The chapter describes the level of resource requirements for the strategic plan period, the available resources, and the gap between what is anticipated and what is required.

5.2 Costing Approach

The financial resources needed for the NCNAP were estimated by calculating all the activities necessary to achieve the expected outputs in each KRA. The costing of NCNAP used the Activity-Based Costing (ABC) approach to estimate the total resources needed to implement the action plan for the next five years. The ABC uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve Strategic plan targets. ABC is a process that allocates costs of inputs based on each activity; it attempts to identify what causes the price to change (cost drivers); all costs of activities are traced to the product or service for which the activities are performed.

The premise of the methodology under the ABC approach will be as follows: (i) The activities require inputs, such as labour, conference hall, etc.; (ii) These inputs are required in specific quantities and with specific frequencies; (iii) It is the product of the unit cost, the quantity, and the frequency of the input that gave the total input cost; (iv) The sum of all the input costs gave the Activity Cost. These were added up to arrive at the Output Cost, the Objective Cost, and eventually the budget. The cost over time for all the thematic areas provides essential details that will initiate debate and allow CDOH and development partners to discuss priorities and decide on effective resource allocation for Nutrition.

5.3 Total Resource Requirements (2022/2023-2026/2027)

The ABC approach was used to compute the cost of this plan. This is a bottom-up, input-based approach, indicating the cost of all inputs required to achieve planned targets for the financial years of 2023/24 – 2027/28. The cost for all the KRAs provides essential details that will initiate debate and allow County health management, related sectors, and development partners to discuss priorities to enable them to decide on effective resource allocation. The plan will cost five hundred and fifty-four million, eighty-three

thousand, and two hundred and fifty shillings (Kshs. 554,083,250) over the five years of implementation, as summarised in tables 20 and 21. KRA disaggregates the annual breakdown of cost requirements.

Table 20: Total Resource Requirements per KRA

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
KRA 1: MIYCN **nutrition scaled-up**	Disseminate the MIYCN policy summary statement to all policymakers (CECMs, COs, CDs, CHMT, HMTs and SCHMTs)	200,000	200,000	200,000	200,000	200,000	1,000,000
	Disseminate MIYCN strategy 2023-2027 to all policymakers (CECMs, COs, CDs, CHMT, HMTs, SCHMT, MCAs)	200,000	200,000	200,000	200,000	200,000	1,000,000
	Sensitise health managers (CHMT, SCHMTs, HMTs) on BFHI	200,000	200,000	200,000	200,000	200,000	1,000,000
	Train Health Care Workers (HCWs) in all health facilities offering maternity and newborn services on BFHI	2,114,848	2,114,848	2,114,848	2,114,848	2,114,848	10,574,240
	Establish BFHI committees or integrate BFHI in the Quality Improvement Teams (QIT) in all health facilities offering maternity services/ Integrate BFHI in quality improvement teams	0	0	0	0	0	0
	Carry out continuous medical education to all non-clinical staff in all health facilities offering maternity and newborn services on BFHI	0	0	0	0	0	0
	Conduct baseline BFHI assessment in all health facilities offering maternity and newborn services	662,000	936,000	160,000	0	0	1,758,000
	Conduct continuous CMEs on BFHI in implementing health facilities	0	0	0	0	0	0
	Conduct continuous quality BFHI assessments in implementing health facilities	480,000	192,000	416,000	4,320,000	0	5,408,010
	Supervision of BFHI activities in implementing health facilities	0	0	316,800	316,800	326,400	960,000
	Conduct BFHI external assessment in implementing health facilities	0	0	0	1,156,000	1,734,000	2,890,000
	Provide nutrition education to pregnant mothers, and caregivers during ANC visits	0	0	0	0	0	0

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
	Provide nutrition education to lactating mothers at the postnatal ward and the newborn unit	0	0	0	0	0	0
	Document and report implementation of BFHI	0	0	0	0	0	0
	Sensitise CECMs, COs, CDs, CHMT and SCHMT on BFCI	600,000	0	0	0	0	600,000
	Sensitise Community Health Committees (CHCs) and Health Facility Management Committees (HFMCs) on BFCI	2,268,000	2,268,000	2,268,000	2,268,000	6,750,000	15,822,000
	Train health workers on BFCI	4,125,000	1,375,000	1,375,000	0	0	6,875,000
	Train c-BFCI Trainer of Trainers (c-BFCI TOT)	2,512,000	0	0	0	0	2,512,000
	Conduct BFCI baseline assessment	340,000	0	0	0	0	340,000
	Train Community Health Promoters (CHPs) on cBFCI	2,436,000	0	0	0	0	2,436,000
	Map households and form MTMSGs	360,000	0	0	0	0	360,000
	Conduct nutrition education during mother-to-mother support group meetings	0	0	0	0	0	0
	Conduct cookery demonstrations during bi-monthly baby-friendly gatherings	0	0	0	0	0	0
	Conduct continuous BFCI quality improvement self-assessments	100,000	150,000	150,000	150,000	150,000	700,000
	Conduct BFCI external assessments		370,000	370,000	370,000	370,000	1,480,000
	Carry out support supervision for BFCI at community level by CHMT, SCHMT		400,000	400,000	400,000	400,000	1,600,000
	Document and report implementation of BFCI in CHU's		0	0	0	0	0
	Train health care workers on MIYCN	3,233,750	3,233,750	3,233,750	3,233,750	3,233,750	16,168,750
	Provide nutrition education and counselling at health facilities and community level	0	0	0	0	0	0
	Sensitise CHPs on MIYCN	675,000	675,000	675,000	675,000	675,000	3,375,000
	CHPs communicate key MIYCN messages at the community level	0	0	0	0	0	0
	Sensitise policymakers (CECMs, COs, CDs, CHMT, HMTs, SCHMTs, MCAs) on the Breast Milk Substitutes (BMS) Act,2012 and its regulations of 2021	0	525,000	0	0	0	525,000
	Sensitise the private sector on the BMS Act,2012	270,000	270,000	270,000	270,000	270,000	1,350,000

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
	Train healthcare workers on BMS Act,2012	0	1,581,800	1,581,800	0	0	3,163,600
	Sensitise law enforcers on the BMS Act,2012	0	165,000	165,000	165,000	165,000	660,000
	Sensitse CHPs on the BMS Act,2012	0	120,000	120,000	120,000	120,000	480,000
	Conduct market-level surveillance/monitoring of the BMS Act implementation	0	0	0	0	0	0
	Document and report violations of the BMS Act	0	0	0	0	0	0
	Sensitise CECMs, COs, CDs, CHMT, SCHMTs and HMTs on implementation framework for securing a breastfeeding-friendly environment at workplaces	148,000	148,000	148,000	148,000	148,000	740,000
	Train health care workers on implementation framework for securing a breastfeeding-friendly environment at the workplaces	1,571,400	1,571,400	1,571,400	1,571,400	1,571,400	7,857,000
	Sensitise key stakeholders in public and private institutions on implementation framework for securing a breastfeeding-friendly environment at the workplaces	0	140,000	140,000	140,000	140,000	560,000
	Carry out CMEs at the health facility level on implementation framework for securing a breastfeeding-friendly environment at the workplaces	0	0	0	0	0	0
	Establish lactation rooms/ lactation stations in health facilities	0	0	0	0	0	0
	Advocate for the establishment of lactation stations in both public and private entities in formal and informal institutions	350,000	350,000	350,000	350,000	350,000	1,750,000
	Monitor and document utilisation of lactation stations	0	0	0	0	0	0
	Sensitise CHMT, SCHMT and HMT on the new WHO growth standards	205,000	205,000	205,000	205,000	205,000	1,025,000
	Train health workers on the new WHO growth standards	1,701,000	1,701,000	1,701,000	1,701,000	1,701,000	8,505,000
	Carry out CMEs at health facility level on growth monitoring and promotion	0	0	0	0	0	0
	Sensitise education managers on growth monitoring and promotion	525,000	525,000	525,000	525,000	525,000	2,625,000

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
	Sensitise CHPs on growth monitoring, including family MUAC	310,000	310,000	310,000	310,000	310,000	1,550,000
	CHMT and SCHMT conduct support supervision on growth monitoring	240,000	240,000	240,000	240,000	240,000	1,200,000
	Carry out GMP in all health facilities offering child welfare services and record in individual child-mother booklet	0	0	0	0	0	0
	Document and report individual growth indices in the CWC register	0	0	0	0	0	0
Total Cost for KRA 1							**108,849,600**

Key Result Area	Interventions/Activities	2023/2024	2023/2024	2024/2025	2025/2026	2026/2027	Total
KRA 2: Nutrition of Older Children, Adolescents and older persons promoted	Advocate Inclusion of policy interventions for older children (5-9 years), adolescents (10-19 years) and older persons in the proposed Nyandarua County food policy	0	0	0	0	0	0
	Disseminate policy interventions on control of the marketing of unhealthy foods in and around learning institutions to CECMs, COs, CDs, CHMT, SCHMT and MCAs	0	250,000	0	0	0	250,000
	Advocate for dissemination of guidelines on healthy diets and physical Education to the CECMs, COs, CDs, CHMT, SCHMTs and HMTs	0	250,000	0	0	0	250,000
	Sensitise health workers on guidelines on healthy diets and physical activity	0	251,000	251,000	0	0	502,000
	Sensitisee CHPs on guidelines on healthy diets and physical activity	0	580500	580500	0	0	1161000
	Train health workers on healthy diets and physical activity	0	250,000	0	0	0	250,000
	Train CHPs on module 8 for nutrition	0	1,100,000	0	0	0	1,100,000
	Sensitise older children and adolescents and communities on healthy diets and physical activity	0	0	0	0	0	0

	Sensitise older persons on healthy diets and physical activity through effective communication channels e.g. media, religious institutions, village meetings etc.	0	0	0	0	0	0
	Conduct nutrition screening at the community level	0	0	0	0	0	0
	Conduct behaviour change communication sessions at the community level	150,000	150,000	150,000	150,000	150,000	750,000
	Conduct Cooking demonstration sessions for healthy family diets at the community level	150,000	150,000	150,000	150,000	150,000	750,000
Total cost							**5,013,000**

Key Result Area	Interventions/Activities	2023/2024	2023/2024	2024/2025	2025/2026	2026/2027	Total
KRA 3: Prevention, control, and management of micronutrient deficiencies scaled-up	sensitise all policymakers (CECMs, COs, CDs, CHMT, HMT and SCHMTs) on VAS guidelines, IFAS policy, MNP policy, fortification strategy	135,000	0	0	0	0	135,000
	Train HCWs on Vitamin A supplementation + deworming	2,055,000	2,055,000	0	0	0	4,110,000
	Train HCWs on IFAS	2,055,000	2,055,000	0	0	0	4,110,000
	Train HCWs on MNPs	2,055,000	2,055,000	0	0	0	4,110,000
	Sensitise CHPs on IFAS, MNPs, Vitamin A and Deworming	483,750	483,750	0	0	0	967,500
	Sensitise the community on micronutrient supplementation through effective communication channels on VAS, IFAS, and MNPs to target populations	0	0	0	0	0	0
	Sensitise HCWs on food fortification	0	0	0	0	0	0
	Conduct CMEs targeting health workers on food fortification	0	0	0	0	0	0
	Sensitise CHPs on food fortification including fortified foods in local markets	387,000	387,000	0	0	0	774,000
	Carry out community sensitisation on food fortification, including fortified food in the market and locally produced	0	0	0	0	0	0
	Conduct nutrition health talks on dietary diversification and biofortification at health facilities	0	0	0	0	0	0
	carry out IFAS to all pregnant women	0	0	0	0	0	0
	carry out VAS to 6-59 months children	0	0	0	0	0	0
	carry out deworming to 12-59 months children	0	0	0	0	0	0
	carry out deworming to pregnant women in their 2nd trimester	0	0	0	0	0	0
	Conduct *Malezi Bora* Activities across the county biannually	5,940,000	5,940,000	5,940,000	5,940,000	5,940,000	29,500,000
	Provide nutrition education and counselling on IFAS to pregnant women at health facility level	0	0	0	0	0	0

	Provide nutrition education and counselling on VAS +Deworming to lactating women at health facility level	0	0	0	0	0	0
	Provide health talks in health facilities on prevention, control, and management of Micronutrient Deficiencies	0	0	0	0	0	0
	Conduct annual salt iodisation monitoring in the county	165,000	0	165,000	0	165,000	495,000
	Conduct market-level surveillance on food fortification by public health officers	0	0	0	0	0	0
	Develop a county-contextualised food safety policy	1,925,000	500,000	0	0	0	2,425,000
	Map fortified food manufacturers in the county	0		0	0	0	
	Activate county food safety and fortification committee	200,000	200,000	0	0	0	240,000
	Conduct support supervision of the micronutrient supplementation activities at the county and sub-county biannually	0	0	0	0	0	0
	Submission of monthly reports on micronutrient supplementation at the county and sub-county levels to the relevant department	0	0	0	0	0	0
	Conduct biannual food safety and fortification review meetings	200,000	200,000	200,000	200,000	200,000	1,000,000
	Conduct Routine Data quality assessment (RDQA) on micronutrient supplementation activities	650,000	0	650,000	0	650,000	1,950,000
Total cost							49,816,500

Key Result Areas		Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
KRA 4. Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) in the life course scaled-up		Sensitise stakeholders (CHMT, SCHMT, CEMT, SCEMT, CAO, SCAO) on policies/guidelines on non-communicable disease, healthy diet, and physical activity	176,000	0	176,000	0	0	352,000
		Disseminate nutrition SOPs on Diabetes, obesity/overweight, cardiovascular, throat and colon cancers to HCWs for implementation	0	0	0	0	0	0
		Train HCWs on the prevention and management of Diabetes	750,000	750,000	0	0	0	1,500,000
		Train HCWs on the prevention and management of cardiovascular diseases	750,000	750,000	0	0	0	1,500,000
		Train HCWs on the prevention and management of diet-related cancers	450,000	450,000	0	0	0	900,000
		Train HCWs on the prevention and management of obesity and overweight	450,000	450,000	0	0	0	900,000
		Conduct CMEs in the health facilities on nutrition in Diabetes	0	0	0	0	0	0
		Conduct CMEs in health facilities on nutrition in cardiovascular diseases	0	0	0	0	0	0

		Conduct CMEs in the health facilities on nutrition in emerging diet-related cancers	0	0	0	0	0	0
		Conduct CMEs in the health facilities on nutrition in obesity and overweight	0	0	0	0	0	0
		Sensitise CHPs and the community on healthy diets and physical activities, using effective communication channels	32,000	32,000	32,000	32,000	32,000	160,000
		Sensitise CHPs and the community on nutrition assessments and messages in Diabetes, cardiovascular and obesity/overweight	32,000	32,000	32,000	32,000	32,000	160,000
		Sensitise health workers on proper documentation on diabetes, cardiovascular, and obesity /overweight	250,000	250,000	0	0	0	500,000
		Collaborate with Stakeholders to support and participate in health thematic days, such as World Diabetes Day (WDD), World Hypertensive Day, World Cancer Day, and World Kidney Day.	300,000	300,000	300,000	300,000	300,000	1,500,000
		Hold podcasts and radio talk shows on diabetes, cardiovascular disease, overweight/obesity, and emerging diet-related cancers in relation to nutrition.	80,000	80,000	80,000	80,000	80,000	400,000
		Conduct NACS in monthly outreaches	0	0	0	0	0	0
		Conduct nutrition assessments and counselling in medical camps	0	0	0	0	0	0

		Timely submission of Monthly reports on DRNCDs	0	0	0	0	0	0
		Integrate support supervision on documentation and reporting of nutrition in the MOPC and wellness clinics	0	0	0	0	0	0
		Integrate DRNCDs data with nutrition report during routine data review meeting	0	0	0	0	0	0
		Conduct nutrition assessments and counselling for all clients attending MOPC and cancer clinics.	0	0	0	0	0	0
		Advocate for the establishment of psychosocial support groups in MOPCs and cancer clinics	144,000	144,000	0	0	0	288,000
		Conducting routine nutrition education during psychosocial support group meetings	0	0	0	0	0	0
		Conduct community linkages and referral of DRNCDs in the community and health facilities by CHPs and CHAs	0	0	0	0	0	0
		Establish wellness clinics	1,987,500	1,987,500	0	0	0	3,975,000
Total cost								**12,135,000**

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
KRA 5. Integrated Management of Acute Malnutrition (IMAM) and nutrition emergencies strengthened	Disseminate guidelines for Integrated Management of Acute Malnutrition to CHMT, SCHMT and HMT	300000	300000	300000	300000	300000	1,500,000
	Sensitise CHMTs, SCHMTs and HMTs on SOPs for IMAM	0	0	0	0	0	0
	Sensitise healthcare workers on IMAM SOPs	0	0	0	0	0	0
	Adapt, print, and distribute IMAM SOPs to health facilities	0	0	0	0	0	0
	Train healthcare workers on Integrated Management of Acute Malnutrition.	3,185,000	3,185,000	3,185,000	3,185,000	3,185,000	15,925,000
	Conduct CMEs to health care workers on IMAM	0	0	0	0	0	0
	Assess. dragonise, counsel, and support all children with acute malnutrition	0	0	0	0	0	0
	Follow up children with acute malnutrition by giving TCA	0	0	0	0	0	0
	Conduct support supervision on IMAM	220,000	220,000	220,000	220,000	220,000	1,1000,000
	Carry out referrals of children with acute malnutrition to health facilities by CHP's	0	0	0	0	0	0
	Carry out IMAM reporting on a monthly basis	0	0	0	0	0	0
	Sensitise policymakers (CECMs, COs, CDs & CHMTs) on PD Hearth	200,000	200,000	200,000	200,000	200,000	1,000,000
	Sensitise SCHMT and HMTs on PD Hearth guideline	2,250,000	0	0	0	0	2,250,000
	Train multisectoral service providers on PD Hearth	5,292,000	5,292,000	5,292,000	5,292,000	5,292,000	26,460,000
	Train CHPs on PD Hearth	6,360,000	6,360,000	6,360,000	6,360,000	6,360,000	31,800,000
	Conduct baseline assessment of children's nutrition status	648,000	648,000	648,000	648,000	648,000	3,240,000
	Conduct support supervision for health sessions	576,000	576,000	576,000	576,000	576,000	2,880,000
	Document and report on PD Hearth implementation	0	0	0	0	0	0
	Conduct Positive Deviance Inquiry (PDI)	744,000	744,000	744,000	744,000	744,000	3,720,000
	Conduct hearth sessions in the community	1,152,000	1,152,000	1,152,000	1,152,000	1,152,000	5,760,000
	Develop a county nutrition supply chain contingency plan	0	1,654,800	0	0	0	1,654,800

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
	Conduct coordination meetings for nutrition in emergencies with partners	0	300,000	300,000	300,000	300,000	1,200,000
	Incorporate nutrition technical officers in the emergency preparedness and response committees at county, sub-county and facility levels	0	0	0	0	0	0
	Participate in policy discussions related to post-disaster reviews to influence nutrition consideration	0	0	0	0	0	0
	Participation in community-level dialogue and recovery initiatives	0	0	0	0	0	0
	Develop/review county nutrition preparedness and response contingency plan and integrate it with the county plan	0	0	0	0	0	0
	Train health care workers on MIYCN-e	0	1,919,000	1,919,000	1,919,000	1,919,000	7,677,600
	Sensitise CHPs on MIYCN-e	0	520,000	520,000	520,000	520,000	1,880,000
	Conduct MIYCN-e assessment in selected emergency hotspots to adapt the response to the context	0	100,000	100,000	100,000	100,000	400,000
	Disseminate MIYCN-e assessment findings to stakeholders	0	250,000	250,000	250,000	250,000	1,000,000
	Integrate and provide nutrition services during outreach services in hard-to-reach areas, affected areas	0	0	0	0	0	0
	Provide nutrition education/counselling on high-impact nutrition interventions in emergencies	0	0	0	0	0	0
Total cost							**119,347,400**

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
KRA 6. Clinical nutrition and dietetics in disease management including HIV and TB strengthened	Undertake specialised courses for nutritionists in renal, oncology, critical care, and paediatric nutrition	0	608,000	608,000	0	0	1,216,000
	Undertake CMES for health care workers on enteral and parenteral, oncology, critical care, and paediatrics nutrition	0	1,615,000	0	0	0	1,615,000
	Create a database for trained personnel in clinical nutrition specialities	0	0	0	0	0	0
	Benchmark in level V or VI hospital on clinical nutrition practice	0	170,000	0	0	0	170,000
	Carry out CMES on clinical nutrition to health workers	0	255,000	0	0	0	255,000
	Disseminate clinical nutrition tools for screening, inter-facility referral and monitoring and service quality management tools to CHMT, SCHMTs and the facility in charge	0	120,000	0	0	0	120,000
	Sensitise and disseminate policies and guidelines related to clinical nutrition & dietetics to CHMT, SCHMT, HMTS	0	210000	0	0	0	210000
	Train healthcare workers on guidelines on nutrition and dietetics for participants drawn from hospitals and high-workload facilities	0	600,000	0	0	0	600,000
	Carry out nutrition screening and assessment of all individuals seeking health care in all health facilities and refer them appropriately.	0	0	0	0	0	0
	Carry out nutrition counselling and support for identified cases	0	0	0	0	0	0
	Disseminate and implement the national guidelines on inpatient feeding protocols	0	100000	0	0	0	100000
	Carry out nutrition assessment, counselling, and support (NACS) to all individuals seeking health care in all health facilities and refer them appropriately.	0	0	0	0	0	0
	Adopt clinical nutrition IEC materials	0	0	0	0	0	0

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
	Distribution of IEC materials to all health facilities	0	75,000	0	0	0	75,000
	Establish a clinical nutrition resource centre in level IV facilities	0	20,000	0	0	0	20,000
	Establish a patient feeding committee for all facilities offering in-patient care.	0	0	0	0	0	0
	Conduct monthly inpatient feeding committee meetings	40.000	40.000	40,000	40.000	40.000	200,000
	Assessment of food preparation and storage equipment requirements	0	784,000	0	0	0	784,000
	Conduct continuous support supervision of inpatient feeding in health facilities offering in-patient care	0	0	0	0	0	0
	Adopt data capture and reporting tools on clinical nutrition	0	0	0	0	0	0
	Sensitisation of healthcare workers on nutrition data tools	0	100,000	0	0	0	100,000
	Train healthcare providers on nutrition in TB management	0	0	0	0	0	0
	Train healthcare providers on nutrition in HIV management	0	0	0	0	0	0
	Carry out CMES on nutrition in TB management in health facilities	0	500000	0	0	0	500000
	Carry out CMES on nutrition in HIV management in health facilities	0	0	180000	0	0	180,000
	Conduct nutrition screening and assessment of all patients attending comprehensive care clinics and TB clinics	0	0	0	0	0	0
	Conduct counselling and support to patients diagnosed with nutrition disorders	0	0	0	0	0	0
	Sensitise healthcare workers on nutrition and HIV counselling cards for focused nutrition therapy and interpersonal counselling for HIV and TB	0	200,000	0	0	0	200,000
	Adopt/Dissemination of policies and guidelines on management of HIV to health Care providers	0	0	0	0	0	0

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
	Disseminate the clinical nutrition referral protocol for HIV and TB patients	0	0	0	0	0	0
	Integrate support supervision on clinical nutrition in the HIV and TB care sites	0	0	0	0	0	0
	Conduct nutrition screening and assessment of all patients attending comprehensive care clinics and TB clinics	0	0	0	0	0	0
	Train /sensitise CHPs and other community resource persons on good nutrition practices for HIV/TB patients to promote healthy and sustainable lifestyles at the household level	0	250,000	0	0	0	250,000
	Refer/link malnourished HIV/TB patients from the community to health facilities	0	0	0	0	0	0
	Refer/link malnourished HIV/TB patients from the community to social protection programmes	0	261,000	0	0	0	261,000
Total cost							**6,856,000**

Key result areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
KRA 7: Nutrition in nutrition-sensitive sector strengthened	Support and participate in the training of the Ward Agricultural Officers on Agri-nutrition	2,425,000	0	0	0	0	2,425,000
	Conduct training on nutrition-sensitive agriculture and food systems for agriculture managers and extension workers	6,171,000	0	0	0	0	6,171,000
	Support and participate in the training of Ward Agricultural Officers and lead farmers as TOTs on FFBS+ Nutrition methodology	7,492,000	0	0	0	0	7,492,000
	Advocate for recruitment of Agri-nutrition officers at county and sub-county level in collaboration with MOH	No cost	0	0	0	0	0
	Advocate for the establishment of an Agri-nutrition desk at the county and sub-county level	No cost	0	0	0	0	0

Key result areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
	Establish demonstration farms for the production of diverse nutritious foods	No cost	0	0	0	0	0
	Conduct field days at ward levels on the production of safe, diverse, nutritious foods	3,800,000	3,800,000	3,800,000	3,800,000	3,800,000	19,000,000
	Promote scaling up of value chain crops/small stocks	No cost	0	0	0		0
	Production of safe, diverse, nutritious foods	No cost	0	0	0	0	0
	Promotion of production of biofortified food crops	No cost	0	0	0	0	0
	Promote integrated kitchen gardens/vegetable gardens within the health facilities to act as demonstration sites in collaboration with the Department of Agriculture	No cost	0	0	0	0	0
	Promote integrated kitchen garden/home gardens within households in collaboration with Department of Agriculture personnel	No cost	0	0	0	0	0
	Collaborate in sensitisation of transporters, traders and food processors on food safety and nutrient preservation	0	1,450,000	0	0	0	1,450,000
	Conduct Nutrition Education sessions for value chain players - Transporters, traders, aggregators, food processors	0	1,205,000	0	0	0	1,205,000
	Participate during sensitisation on value addition, preservation, storage and Agro-processing	No cost	0	0	0	0	0
	Promote sustainable food preservation methods including traditional methods	No cost	0	0	0	0	0
	Participate and support farmers during field days at ward levels on the consumption of safe, diverse nutritious foods	No cost	0	0	0	0	0
	Hold cooking demonstrations with the community units/farmer groups in collaboration with MOH	No cost	0	0	0	0	0
	Participate during exhibitions agricultural shows/trade fairs on the consumption of safe, diverse, nutritious foods.	162,500	162,500	162,500	162,500	162,500	812,500

Key result areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
	Sensitise and disseminate the food and nutrition reference manual to teachers	0	1,360,000	0	0	0	1,360,000
	Train teachers on healthy diets and physical activity	0	2,610,000	0	0	0	2,610,000
	Support the implementation of school meals programmes that promote nutrient-dense foods	0	0	0	0	0	0
	Sensitisation of parents towards the provision of safe and healthy foods in schools during school general meetings.	0	0	0	0	0	0
	Advocate for revival and formation of 4K and young farmers clubs.	0	2,700,000	0	0	0	2,700,000
	Support and participate in the training of 4K/Young farmers clubs by Agricultural extension officers	0	0	0	0	0	0
	Advocate for the establishment of school gardens to produce nutritious and diverse foods.	0	0	0	0	0	0
	Sensitisation for the rearing of small livestock e.g. rabbits and poultry in schools.	0	0	0	0	0	0
	Sensitise teachers and college tutors on healthy diets and physical activity guidelines	0	1,688,700	0	0	0	1,688,700
	Integrate key messages on healthy diets and physical activity in the learning institutions' health programmes	0	0	0	0	0	0
	Conduct nutrition service delivery in schools (Vitamin A, deworming, assessment and referral)	0	0	0	0	0	0
	Support the implementation of food and nutrition in the school curriculum	0	0	2,310,000	0	0	2,310,000
	Sensitise CHPs on safe water and community water source protection	0	0	0	0	0	0
	Conduct demonstration on household water treatment techniques to CHPs	0	0	0	0	0	0
	Sensitise communities on rain harvesting in public barazas and other effective communication channels at the community level	0	0	0	0	0	0

Key result areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
	Sensitise communities on proper human waste disposal through CLTS and the link with nutrition	0	0	0	0	0	0
	Sensitise CHPs on the construction of dish racks, garbage pits and tippy taps	0	0	0	0	0	0
	Sensitise the community on the construction of dish racks, garbage pits and tippy taps						
	sensitise CHPs on five critical times for hand washing and proper hand washing technique during dialogue days	0	0	0	0	0	0
	Sensitise the community on five critical times for hand washing and proper hand washing technique during dialogue days	0	0	0	0	0	0
	Sensitise the community on safe and hygienic practices during food preparation and storage	0	0	0	0	0	0
	Promote environmental hygiene in households by	0	0	0	0	0	0
	Participate in the commemoration of World Handwashing and Toilet Days	0	0	0	0	0	0
	Support sensitisation for the elderly, OVCs and Persons with Disabilities in Cash transfer programmes on the consumption of nutritious food	0	0	0	0	0	0
	Advocate for nutrition interventions in social protection programmes	0	0	0	0	0	0
	Support in sensitisation of the management of institutions of vulnerable persons and correction facilities on optimal nutrition for the institutions	0	0	0	0	0	0
	Sensitise HCWs and CHPs to the targeting criteria for nutrition in social protection programmes, cash transfers, hunger safety nets, and other programmes.	0	0	0	0	0	0
	Support Sensitisation of stakeholders in social protection programmes on the linkage between social protection and nutrition	0	0	0	0	0	0
	Conduct a gender-integrated baseline survey/situation analysis on the status of nutrition	0	3,0000,000	0	0	0	3,000,000

Key result areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
	and health for the vulnerable groups in social protection programmes						
	Advocate for harmonisation of all-inclusive gender, age and diversity-responsive nutrition and social protection services for vulnerable groups (people living with disabilities, orphans and vulnerable and the elderly)	0	251,000	0	0	0	251,000
	Scale up social safety nets on nutrition in times of crises, targeting vulnerable groups	0	0	0	0	126,000	126,000
Total cost							**52,601,200**

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Totalthe
KRA 8. Sectoral and multi-sectoral nutrition governance and advocacy strengthened	Map, identify and mobilise stakeholders through stakeholder forum	300,000	300,000	300,000	300,000	300,000	1,500,000
	Establish a multi-sectoral nutrition platform (CECMs, COs and CDs) for oversight and resource mobilisation for nutrition	301,200	0	0	0	0	301,200
	Form a nutrition technical working group at the county and sub- county levels	0	0	0	0	0	0
	Hold monthly nutrition technical working groups at the county and sub-county levels	600,000	600,000	600,000	600,000	600,000	3,000,000
	Form a multisectoral nutrition technical forum at the county and sub-county levels.	486,000	0	0	0	0	486,000
	Hold Monthly Nutrition Technical Forum (NTF) meetings at the county and sub-county levels	600,000	600,000	600,000	600,000	600,000	3,000,000
	Hold MSP meetings	300,000	300,000	300,000	300,000	300,000	1.500,000
	Disseminate capacity needs assessment findings and use them to develop an MSP framework to guide collaboration	0	0	0	0	0	0
	Adopt and sensitise county policymakers on SUN business strategy to strengthen the public-private partnership	0	0	0	0	0	0

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Totalthe
	Conduct nutrition capacity needs assessment for multi-sectoral partnerships/linkages.	375,000	375,000	375,000	375,000	375,000	1,875,000
	Sensitise multi-sectoral stakeholders including the private sector on their role in nutrition.	150,000	150,000	150,000	150,000	150,000	750,000
	Develop a costed second generation NCNAP	-	-	-	-	6,075,000	6,075,000
	Conduct nutrition budget analysis and financial tracking on nutrition financing for budget advocacy	671,220	671,220	671,220	671,220	671,220	3,356,100
	Sensitisation of MSP on nutrition investment case	0	0	0	0	0	0
	Sensitise the community to participate in social accountability and demand creation for nutrition through effective community channels	0	0	0	0	0	0
	Develop a county food and nutrition policy	0	2,000,000	0	0	0	2,000,000
	Develop investment cases for nutrition	1,125,000	0	0	0	0	1,125,000
	Identify and train nutrition champions across the multi- sectors on nutrition advocacy	175,000	0	0	0	0	175,000
	Develop the county advocacy plan to guide nutrition advocacy interventions	1,110,000	0	0	0	0	1,110,000
	Develop and sensitise policymakers on nutrition policy briefs	50,320,000	0	0	0	0	50,320,000
	Hold consultative meetings on the integration of gender and social inclusion in nutrition programming	250,000	250,000	250,000	250,000	250,000	1,250,000
	Develop a media nutrition advocacy kit	0	760,000	0	760,000	-	1,520,000
	Sensitise and engage with the media to promote the nutrition agenda at all levels	0	0	0	0	0	0
	Participate in commemoration of nutrition-related health days (World Diabetes Day WDD, World Kidney Day WKD, World Food Day WFD, Day of the African Child DAC)	0	0	0	0	0	0
	Conduct nutrition-related health days/events (Breastfeeding Week, Nutrition Week, Iodine Deficiency Day, No Obesity Day)	0	0	0	0	0	0

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Totalthe
	Sensitise HCWs, CHPs, and the community on the existing feedback mechanism at all levels	0	0	0	0	0	0
	Train nutrition officers on a senior management course	0	600,000	0	600,000	0	1,200,000
	Train nutrition staff on strategic leadership and development program	600,000	0	600,000	0	0	1,200,000
Total cost							**80,243,300**

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
KRA 9. Sectoral and multi-sectoral information systems, monitoring, accountability, learning and research for nutrition strengthened	Train HCW on documentation and reporting of nutrition indicators and KHIS	450,000	0	0	0	0	450,000
	Train M&E and nutrition officers on basic data analysis	0	0	0	0	390,000	390,000
	Train staff on nutrition scorecard (nutrition officers, HRIOs, Community services focal persons)	0	0	0	1,200,000	0	1,200,000
	Sensitise CHPs on documentation and reporting of community nutrition indicators (MOH 100, 513 and 514)	321,750	0	0	0	0	321,750
	Train nutritionist and pharmacist on LMIS	187,500	0	0	0	0	187,500
	Conduct integrated support supervision in all health facilities	575,250	575,250	575,250	575,250	575,250	2,876,250
	Conduct a mid-term review of the NCNAP implementation	0	0	625,000	0	0	625,000
	Conduct an end-term review of the NCNAP implementation	0	0	0	0	625,000	625,000
	Prepare annual NCNAP progress reports	125,000	125,000	125,000	125,000	125,000	625,000
	Conduct annual NCNAP review dissemination meeting	125,000	125,000	125,000	125,000	125,000	625,000
	Prepare annual nutrition work plan	225,000	225,000	225,000	225,000	225,000	1,125,000
	Conduct data review meetings on nutrition performance in the sub-counties	960,000	960,000	960,000	960,000	960,000	4,800,000
	Conduct feedback meetings on nutrition indicators	0	0	0	0	0	0

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
	Conduct annual nutrition data quality audit/assessment	205,150	205,150	205,150	205,150	205,150	1,025,750
	Conduct nutrition feedback meetings at the community unit level	0	0	0	0	0	0
	Carry out nutrition SMART survey	0	2,500,000	0	0	0	2,500,000
	Conduct nutrition causal analysis	0	2,500,000	0	0	0	2,500,000
	Disseminate survey findings/information to stakeholders	0	250,000	0	0	250,000	500,000
	Conduct nutrition MIYCN KAP survey	0	0	2,500,000	0	0	2,500,000
	Conduct a nutrition capacity assessment	0	2,500,000	0	0	0	2,500,000
	Develop and disseminate County nutrition profile to stakeholders	55,000	0	0	0	0	55,000
	Develop annual policy briefs in line with the research/surveys conducted to inform decision-making processes	50,000	0	50,000	0	0	100,000
	Hold consultative meetings with policymakers to disseminate the policy briefs	224,000	0	0	224,000	0	448,000
	Collaborate with academia to conduct operational research on nutrition to address county-specific nutrition gap	100,000	100,000	100,000	100,000	100,000	500,000
	Conduct workshops to disseminate operational research on nutrition	5,000	5,000	5,000	5,000	5,000	25,000
	Establish a research repository for nutrition and dietetics		50,000	0	0	0	50,000
	Conduct county nutrition conferences/symposiums for knowledge exchange and sharing of best practices	300,000	0	0	300,000	0	600,000
	Facilitate county actors to participate in symposiums/conferences to showcase best practices and lessons in the implementation of nutrition interventions		416,000		416,000		832,000
Total cost							**27,986,250**

Key Result Areas	Interventions/Activities	2023/2024	2024/2025	2025/2026	2026/2027	2027/2028	Total
KRA 10. Supply chain management for nutrition commodities and equipment strengthened	Carry out integrated commodity management training, including for nutrition commodities for all health facility managers	0	1,160000	0	0	0	1,160,000
	Conduct CMES for commodity management to managers and healthcare workers in all health facilities and at the sub-county levels	130,000	130,000	130,000	130,000	130,000	650,000
	Carry out support supervision for nutrition commodities	0	0	0	0	0	0
	Integrate nutrition in the annual commodity quantification and forecasting workshop	0	0	0	0	0	0
	Advocate for adequate funding for nutrition commodities, equipment and tools	0	100,000	0	0	0	100,000
	Procure and distribute nutrition commodities	12,000,000	12,000,000	12,000,000	12,000,000	12,000,000	60,000,000
	Procure and distribute nutrition equipment and tools	0	13,000,000	13,000,000	0	0	26,000,000
	Procure and distribute nutrition reporting tools for all programmes.	0	1,300,000	1,300,000	0	0	2,600,000
	Integrate nutrition in commodity utilisation reviews	25,000	25,000	25,000	25,000	25,000	125,000
	Establish nutrition equipment and tools needs for respective health facilities	0	0	0	0	0	0
	Develop and effect an equipment maintenance and calibration plan for nutrition equipment and tools	0	0	0	0	0	0
	Sensitise relevant healthcare workers on the use and maintenance of nutrition equipment	0	150,000	0	0	0	150,000
	Conduct OJT to all health facilities on the use and maintenance of nutrition equipment	60,000	60,000	60,000	60,000	60,000	300,000
	Sensitise biomedical engineers on the repair of nutrition equipment	0	150,000	0	0	0	150,000
Total Cost							**91,235,000**

Table 21: Summary Costing Table for NCNAP

No	Key Result Area	Cost
1	Maternal, Infant and Young Child Nutrition (MIYCN) scaled-up	108,849,600
2	Nutrition of older children, adolescents, adults and older persons promoted	5,013,000
3	Prevention, control, and management of micronutrient deficiencies scaled-up	49,816,500
4	Prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs) in the life course scaled-up.	12,135,000
5	Integrated Management of Acute Malnutrition (IMAM) and nutrition emergencies strengthened	119,347,400
6	Clinical nutrition and dietetics in disease management including HIV and TB strengthened	6,856,000
7	Nutrition in nutrition-sensitive sectors (Agriculture and Food Security, Education, WASH and social protection) strengthened	52,601,200
8	Sectoral and multi-sectoral nutrition governance and advocacy strengthened.	80,243,300
9	Sectoral and multi-sectoral information systems, monitoring, accountability, learning and research for nutrition strengthened	27,986,250
10	Supply chain management for nutrition commodities and equipment strengthened	91,235,000
Overall Total cost		**554,083,250**

Strategies to Ensure Available Resources are Sustained

- Advocating for consistency and gradual increment of resources allocated for nutrition programming.
- Participating fully in the budget-making process.
- Ensuring that performance reports are disseminated to the relevant stakeholders.
- Prudent and efficient use of allocated resources with accountability at all levels.
- Ring-fencing of the health facilities' revenue streams to enhance maximum utilisation of the funds for improvement.

Strategies to Mobilise Resources from New Sources

- Advocating for a legislative framework in the county assembly for resource mobilisation and allocation.
- Identification of potential stakeholders for the provision of additional resources.
- Advocate for the inclusion of nutrition components in the mandate of existing partners.

Strategies to Ensure Efficiency in Resource Utilisation

- Continuous capacity building on nutrition interventions.
- Integration of nutrition interventions with other interventions, such as integrated outreaches.
- Planning for utilisation of the allocated resources by use of the planning documents.
- Continuous monitoring of impact and process indicators.
- Periodically evaluate objectives to find out if they have been achieved as planned.

ANNEXES

Annex 1: References

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Disclaimer:

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