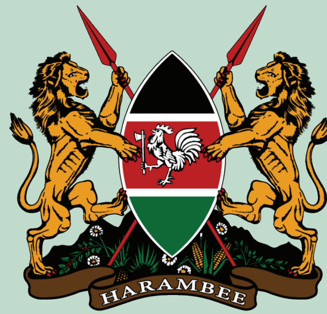


REPUBLIC OF KENYA

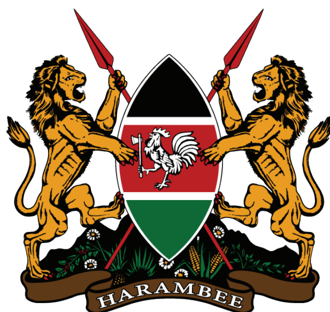
COUNTY GOVERNMENT OF KAJIADO

DEPARTMENT OF HEALTH SERVICES

NUTRITION ACTION PLAN

2016 -2018

Nutrition is key, take up your role. Act Now!



REPUBLIC OF KENYA

COUNTY GOVERNMENT OF KAJIADO

DEPARTMENT OF HEALTH SERVICES

TABLE OF CONTENTS

FOREWORD ______ iii

ACKNOWLEDGMENTS ______ iv

EXECUTIVE SUMMARY ______ v

ACRONYMS AND ABBREVIATIONS ______ vi

CHAPTER I: INTRODUCTION ______ 1

1.1 Background information

1.2 Nutrition Response

1.3 Challenges

1.4 Policy framework and linkage

1.5 Purpose of CNAP

CHAPTER II: COUNTY NUTRITION ACTION PLAN ______ 4

2.1 The strategic objectives

2.2. Implementation matrix

CHAPTER III: MONITORING AND EVALUATION FRAMEWORK ______ 18

3.1 Monitoring and evaluation Matrix

CHAPTER IV: RESOURCE MOBILIZATION FRAMEWORK ______ 24

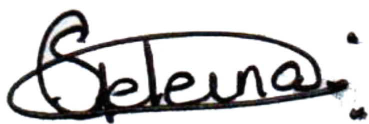
FOREWORD

Good nutrition is one of the key foundations for the development of a healthy and productive workforce with the first 1000 days of an individuals' life being the most critical period. Investing in good nutrition particularly for women and children will be important to achieving the overall developmental goals for Kajiado County.

Kajiado County Government recognizes that a high rate of malnutrition is a threat to achieving Sustainable Development Goals and Vision 2030 and goes against our constitution, which emphasizes on the right to highest standard of health. Reducing the rates of malnutrition in Kajiado is not just a health issue but calls for a multi-sectoral approach whereby different sectors join hands with a common goal. Communities must be empowered to claim their right to good nutrition and guided to play their role towards realizing this right.

Kajiado County Nutrition Action Plan (KCNAP) has aligned to key county strategic documents such as the County Health Strategic and Investment Plan and County Medium Term Expenditure Plans. The solutions to solving nutrition issues are practical and basic; and the KCNAP has outlined a road map for reaching the goal. It provides practical guidance to implementation and a framework for coordinated implementation of proven and cost effective High Impact Nutrition Interventions. This CNAP will facilitate mainstreaming of the nutrition budgeting process into County development plans, and subsequently, allocation of resources to nutrition programs. The County Health Management team shall be directly in charge of coordinating the implementation of the plan at the county level, while the Sub-County Health Management teams (SCHMTs) shall be in charge of the devolved coordination system at the sub-county level, which will feed into the county level coordination unit.

Let us join hands in taking up our roles to scale up nutrition in our county.



Gladys Marima
County Executive Committee member

Fridah N. Tait
Chief Officer

Department of Health Services
County Government of Kajiado

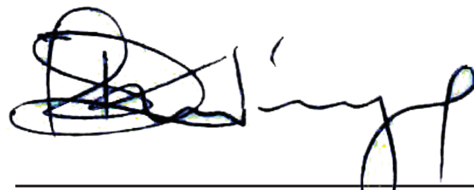
ACKNOWLEDGMENTS

Kajiado County Department of Health through the Nutrition and Dietetics Unit acknowledges the valuable contributions by County Department of Health and partners towards development and finalization of the Kajiado County Nutrition Action Plan. Our gratitude goes to Gladys Marima Executive Committee Member for Health and Fridah Tait Chief Officer of Health for their invaluable technical and moral support and for providing an enabling environment.

Secondly, our gratitude goes to County and Sub County Health Management Teams led by the Director for Health Services and all members of the County Nutrition Technical Forum for taking the initiative and tirelessly supporting the development and finalization of the CNAP. The overall coordination and technical support was led by a team comprising of Ruth Nasinkoi County Nutrition Coordinator; Harriet Namale (UNICEF), Dorcas Amunga (Kenya Red Cross Society), Pauline Kariuki and Esther Komen (Feed the children). To you all thank you for your support and dedication.

We are very grateful to all who generously contributed their finances, time and expertise to make this county nutrition action plan a real time and robust document. The county government highly appreciates financial support from Feed the Children, Kenya Red Cross Society, UNICEF and APHIA PLUS nuru ya bonde that made the development of CNAP possible.

We sincerely appreciate the role played by the National Government specifically the Nutrition and Dietetics Unit in the Ministry of Health in giving the technical team the guidelines on how to make the plan. To everybody who contributed in one way or another in ensuring that the document is ready.



Dr. Ezekiel Kapkoni
County Director for Health Services
Kajiado County

EXECUTIVE SUMMARY

Malnutrition remains one of the key public health problems in Kajiado County; negatively affecting growth, development and survival of the population. Addressing the challenges contributing to malnutrition in the County requires a holistic approach throughout the lifecycle and strong multi-sectoral collaboration. The County Government of Kajiado has recognized that this will only be possible through an integrated multi-agency and multi-sector coordination framework hence the development of this nutrition action plan. The purpose of this CNAP is to provide a framework for coordinated implementation of nutrition interventions, activities and programs by Kajiado County government, stakeholders and partners. It identifies priority areas, key strategies, proposed activities and key partners who will be instrumental in its implementation.

The first chapter provides a preview of the background information concerning the general county profile, nutrition situation in Kajiado County, nutrition response, challenges facing the county, policy framework and highlight how CNAP link with key national and county policy and policy frameworks.

The second chapter introduces the strategic objectives and spells out the priority areas per strategic objectives and the expected outcomes. The chapter gives a snap shot of the key priority areas in nutrition sector in Kajiado County. The chapter also highlights the implementation matrix indicating the output and outcome indicators, respective activities and the responsible persons per each strategic objective.

The third chapter specifies programs/projects to be implemented during the plan period. It also specifies objectively verifiable indicators that will be used to monitor project/program implementation, and sets medium term milestones for impact assessment based on activities in chapter two. It also provides a framework for coordination.

The fourth chapter explains the resource mobilization framework and include strategies for fund raising, asset management, financial management, capital financing and accountability. It also indicates the Kajiado County nutrition sector 3-year budget.

This document is aligned to the National Nutrition Action Plan 11 strategic objectives and County Health Sector Plan priority areas. It clearly, spells out county nutrition sector priority interventions under each of the national strategic objectives and resources needed in order to actualize the plan. The total cost for implementation of the plan over the next three 3 years is estimated at Ksh. 406,336,355.

ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
ACSM	Advocacy Communication and Social Mobilization
AWP	Annual Work Plan
BMS	Breast milk substitutes
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
BMI	Body Mass Index
CDE	County Department of Education
CDH	County Department of Health Services
CIDP	County Integrated Development Plan
CNAP	County Nutrition Action Plan
C4D	Communication for Development
CSG	County Steering Group
CHANIS	Child Health and Nutrition Information System
CHEWs	Community Health Extension Workers
CHMT	County Health Management Committee
CHV	Community Health Volunteer
CHSSP	County Health Sector Strategic Plan
CSO	Civil Society Organization
DOH	Department of Health Services
DHIS	District Health Information System
ECD	Early Childhood Development
HCP	Health Care Providers
HINI	High Impact Nutrition Interventions
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IMAM	Integrated Management of Acute Malnutrition
IYCN	Infant and Young Children Nutrition
KABP	Knowledge Attitude Beliefs and Practice
KAP	Knowledge Attitude and Practice
KCNAP	Kajiado County Nutrition Action Plan

KDHS	Kenya Demographic Health Survey
KRCS	Kenya Red Cross Society
MIYCN	maternal infant and young child nutrition
MOA	Ministry of Agriculture
MOE	Ministry of Education
MOH	Ministry of Health
MOU	Memorandum of Understanding
MUAC	Mid Upper Arm Circumference
NDMA	National Drought Management Authority
NTF	Nutrition Technical Forum
ORS	Oral Rehydration Salts
PLW	pregnant and lactating women
RRI	Rapid Results Initiative
SMART	Standardized Monitoring and Assessment of Relief and Transition
SCHMT	Sub County Health Management Team
SDGs	Sustainable Development Goals
SO	Strategic Objective
SUN	Scaling Up Nutrition
TORs	Terms of Reference
VAS	Vitamin A Supplementation
WESCOORD	Water and Environmental Sanitation Coordination
WRA	Women of Reproductive Age
WHO	World Health Organization

CHAPTER I
INTRODUCTION

1.1 Background information

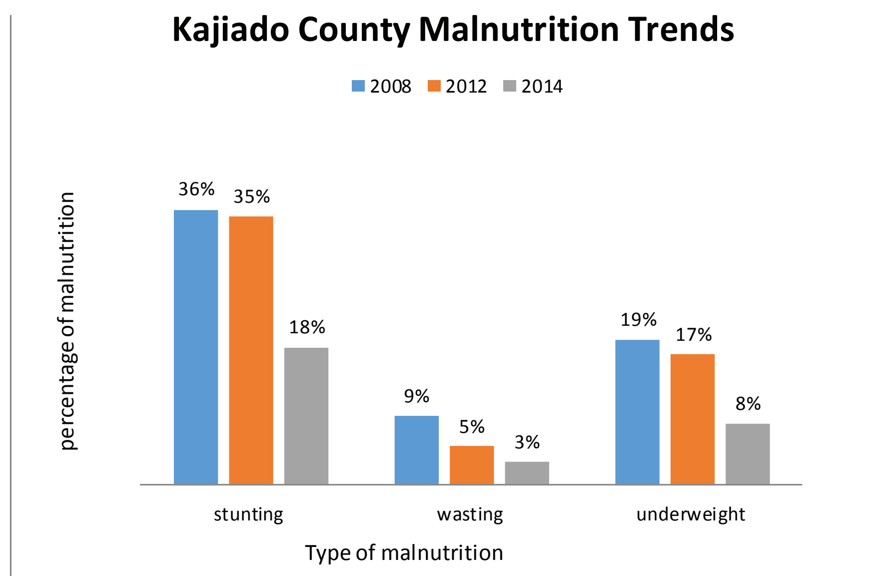
1.1.1. County Profile

Kajiado County is located in the southern part of Kenya and it borders the Republic of Tanzania to the southwest, Taita Taveta County to the south-east, Machakos to the Northeast, Makueni County to the east, Nairobi, Nakuru and Kiambu counties to the North and Narok County to the North West. The region is dry with no continually flowing rivers and is officially designated as a semi-arid region covering an area of 21,903km^2. According to the Kenya National Bureau of Statistics (KNBS) Census report, 2010, the total population was 687,312 (under five population 110,763 and pregnant and lactating population was 41,238) with an annual population growth rate of 3.6%.

1.1.2. Nutrition situation in Kajiado County

Globally more than one third of child deaths are attributable to under-nutrition (WHO 2008). The immediate causes of malnutrition are inadequate food intake and disease while the underlying causes include poor maternal/ childcare practices, household food insecurity, and inadequate health services (WHO 2010). According to the 2014 Kenya Demographic Health Survey (KDHS), the national estimates for malnutrition were as follows: of children aged less than five years, 26% were stunted, 11% were underweight while 4% were wasted and 4% were overweight or obese. On the other hand, the KDHS county specific data for Kajiado County indicates slightly better nutrition status in the county as compared to national estimates. In the county, among children under five years; 18% are stunted, 8% are underweight, and 3% are wasted while 4% are overweight or obese. This current situation can be interpreted as being normal and it is a reduction from the 2012 Standardized Monitoring and Assessment of Relief and Transition (SMART survey results which indicated the following rates: 34.8% stunting, 16.6% underweight and 3% wasting.

Figure 1: Kajiado County malnutrition trends 2008-2014 (source: Kajiado SMART and KDHS)



With regards to Infant and Young Child Nutrition (IYCN) practices, exclusive breastfeeding rates are 44.7% against a target of 80% while the minimum meal frequency was 68.8% (2012 SMART survey). Micronutrients are vital in proper growth development and immune strengthening. Micronutrients of public health concern include Vitamin A, Iron-folate, Zinc and Iodine. In the county, Vitamin A supplementation rates are 46.9% (national targets 80%), iron-folate supplementation during pregnancy 69.9% (national targets 100%). On the other hand, deworming coverage 34.9% (national targets 80%). Cultural practices, poor hygiene and sanitation practices, poor dietary diversity, poor health seeking behaviour and long distance to health facilities contribute to poor nutrition indicators in the county.

While the micronutrient intake and deworming coverage are well below the national targets in Kajiado, it is worth noting that the improvement in other nutrition indicators such as stunting and underweight can be attributed to strengthened nutrition programming, enhanced synergies between nutrition sensitive and nutrition specific stakeholders as well as fairly improved resource allocation for nutrition actions by the county government and partners.

1.2 Nutrition Response

Improving nutritional status and reducing micronutrient deficiencies are integral to achieving Kenya's Vision 2030 and the Sustainable Development Goals (SDGs). These, and meaningful economic development will not happen without continued support to nutrition. Kajiado County has shown strong commitment in tackling malnutrition, particularly through implementation of the 11 High Impact Nutrition Interventions (HINI) at all levels which have been effective in preventing malnutrition and mortality in children. They include: promotion of exclusive breastfeeding for the first six months, timely complementary feeding for infants after the age of six months, improved hygiene practices including hand washing, vitamin A supplementation, multiple micronutrient supplementation, zinc supplementation for diarrhoea management, de-worming, iron-folic acid supplementation for pregnant women, salt iodization, iron fortification of staple foods, prevention and treatment acute malnutrition. Additionally the County recognises the role that multi-sectoral approach plays in improving nutrition actions. Through this, the Department of Health (DOH) has been supportive to the Scaling Up Nutrition (SUN) movement initiatives through participation in advocacy workshops targeting nutrition specific and nutrition sensitive (agriculture and food security; social safety nets; early child development; maternal mental health; women's empowerment; child protection; schooling; water, sanitation, and hygiene; health as well as family planning services) actors as well as joint work planning. Resource availability will enable the county to scale-up evidence-based HINI.

1.3 Challenges

Limited human and institutional capacity: The County has less than 10% of the required nutrition personnel available in the county, less than 10% of health workers trained on minimum essential nutrition package and only 50% of active Community Health Volunteers (CHVs)

have capacity in basic health and nutrition actions.

In the financial year 2015/2016, the County allocated 5.6million towards nutrition actions however; this is still inadequate to operationalize the County nutrition action plan.

Information management: The County has experienced challenges concerning data and information management. Nutrition data reporting is inadequate in both timeliness and quality; data collection tools are not adequate at health facility level, ownership of the nutrition component,

There are infrastructural challenges, which include poor road network, long distance to health facilities as well as poor network coverage, which affect service delivery.

Weak linkages between nutrition specific and nutrition sensitive interventions in the County due to limited multi-sectoral coordination forums. There are also weak linkages between the community and health facilities limiting referrals and access to health services.

Knowledge, attitude, beliefs and practices (KABP) are key challenge contributing to adoption of best practices in maternal, infant and young child nutrition (MIYCN) practices.

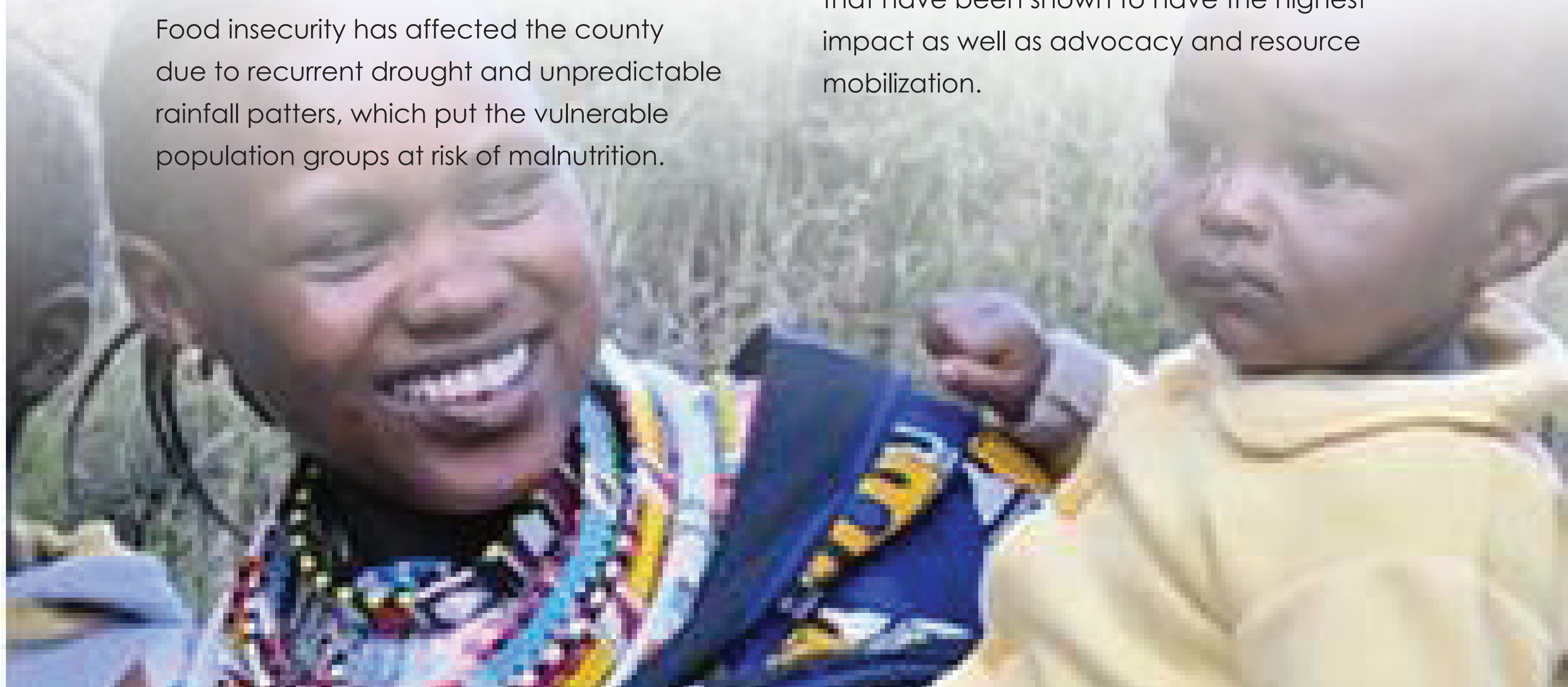
Food insecurity has affected the county due to recurrent drought and unpredictable rainfall patters, which put the vulnerable population groups at risk of malnutrition.

1.4 Policy framework and linkage

Development and implementation of Kajiado CNAP anchors to different National policy and policy guidelines including MIYCN policy, micronutrient supplementation policy, Iron Folic Acid supplements (IFAs) and Integrated Management of Acute Malnutrition (IMAM) guidelines. Furthermore, the CNAP has aligned itself the County Health Strategic and Investment Plan (CHSIP) and Kajiado County Integrated Development Plan (CIDP) 2013-2017. CHSIP is a critical element in planning process that provides a guide for Government budgeting of resources. Furthermore, the CNAP is linked to Kenya Vision 2030, which focusses on social, economic and political pillars.

1.5 Purpose of CNAP

This CNAP will operationalize strategies outlined in National Nutrition Action Plan (NNAP). It will serve as a road map for coordinated implementation of nutrition and dietetics interventions by the government, nutrition stakeholders, development agencies, private sector, and institutions of higher learning/research institutes for maximum impact in the county. It will act as a platform for implementation of cost effective nutrition activities and interventions that have been shown to have the highest impact as well as advocacy and resource mobilization.



CHAPTER II
COUNTY NUTRITION ACTION PLAN

2.1 The strategic objectives

This section highlights the 11 strategic objectives that will need to be addressed in order to achieve the goal of promoting and improving nutrition status of the people of Kajiado County.

These objectives are:

1. Improve nutritional status of women of reproductive age (15-49 years)
2. Improve nutrition status of children under-five years of age
3. Reduce the prevalence of micronutrient deficiencies in the population.
4. Prevent deterioration of nutritional status and save lives of vulnerable groups in emergencies
5. Improve access to quality curative nutrition services
6. Improve prevention; management and control of diet related Non Communicable Diseases (NCDs)
7. Improve nutrition in schools and other institutions
8. Improve knowledge, attitudes and practices on optimal nutrition
9. Strengthen the nutrition surveillance, monitoring and evaluation systems
10. Enhance evidence-based decision-making through operations research
11. Strengthen coordination and partnerships among the key nutrition actors

Table 2.1 below identifies County priority areas under each strategic objectives as well as the expected outcome, per objective

Table 2: Priority areas

Objectives	Priority Implementation strategy	Expected outcome
SO1: To improve the nutritional status of women of reproductive age (15-49 years)	Advocacy, Communication and Social Mobilization (ACSM) to promote consumption of healthy diets in WRA	Improved nutrition status of WRA
	Capacity building of health workers and CHVs on MIYCN	
SO2: To improve nutritional status of children under 5 years of age	ACSM to promote consumption of healthy diets in children under 5	Improved nutritional status of children Under 5 years of age
	Capacity building of health workers and CHVs on MIYCN and IMAM	
	Promote exclusive breastfeeding for the first six months and optimal complementary feeding practices with continued breastfeeding up to two years and beyond	
	Strengthening growth monitoring for children under five years of age	
	Supply chain management of nutritional commodities for management of acute malnutrition	
SO3: To reduce the prevalence of micronutrient deficiencies in the population	ACSM to promote consumption of fortified foods and dietary diversification	Reduced prevalence of micronutrient deficiencies
	Capacity building of health workers and CHVs on micronutrient prevention and control	
	Supply chain management of nutritional commodities	
SO4: To prevent deterioration of nutritional status and save lives of vulnerable groups in Emergencies	Capacity building of MOH and partners to develop and activate contingency and response plans	Timely and coordinated response to minimize consequences of emergency on health and nutrition status of affected populations
	Conduct regular surveillance of nutrition indicators	
	Develop and periodically review health and nutrition contingency and response plans and activation when necessary	
	Resource mobilization for timely response	

SO5: To improve access to quality curative nutrition services	Strengthen management of acute malnutrition among children under five years, PLW and other vulnerable groups e.g. HIV, cancers	Improved access to quality nutrition care services
	Capacity building of Health Care Providers (HCPs) to offer optimal curative nutrition services	
	Procure and distribute therapeutic nutrition commodities and equipment	
	Strengthen storage and nutrition supply chain management	
SO 6: Halt and reverse the prevalence of diet related NCDs	Capacity building of HCPs on prevention, management and control of NCDs	Improved prevention management and control of diet related NCDs
	ACSM on healthy dietary practices and physical activity	
	Activate and strengthen reporting, monitoring and evaluation systems for diet related NCDs	
	Strengthen routine weight and waist circumference monitoring for adults at health facility (HF) level	
SO7: To improve nutrition in schools, public and private institutions	Conduct situation analysis on school/institutional feeding program	Improved nutrition status of the population in schools and other institutions
	Establish and strengthen monitoring and evaluation of school feeding and health program	
	Strengthen coordination mechanism for schools and institutional feeding program	
	Advocacy for nutrition integration within school co-curricular activities e.g. kitchen gardening	
SO8: To improve nutrition knowledge, attitudes and practices on optimal nutrition among the population	Develop, disseminate, implement and monitor County Communication for Development (C4D) strategy	Improved knowledge, attitudes and practices in the general population
	Capacity building of HCPs and focal community persons on ACSM	
	Periodically assess dietary practices to inform programming	
	Mark key health and nutrition awareness days	
SO9: To strengthen nutrition surveillance monitoring and evaluation systems	Capacity building of MOH and partners on surveillance, use of DHIS, analysis and interpretation of M&E information	Enhanced quality and timeliness of data collected for effective decision making
	Conduct nutrition assessments(annual SMART surveys and others)	
	Strengthen nutrition reporting	
	Conduct regular data quality audits	
	Strengthen feedback and information sharing mechanism among nutrition stakeholders	

SO10: To enhance evidence based decision making through research	Conduct regular operational research to inform program design and implementation	Enhanced evidence based decision making through research in program design and implementation
	Capacity build MOH and partners on evidence based planning and budgeting	
	Prepare documentation of good practices, human interest stories and lessons learnt	
SO 11: To strengthen coordination and partnerships among the key nutrition actors	Strengthen nutrition sector and multi sector coordination through NTFs, CSGs and working groups	Increased human, financial and material allocation for nutrition interventions
	Maintain an updated partner 'who works where' matrix for nutrition sensitive and nutrition specific partners	
	Advocate and leveraging for increased and equitable budgetary allocation	
	Establish and strengthen SUN networks within the county	

2.2. Implementation matrix

Outcome indicator	Output indicator	Activity		Lead agency	Other agencies
% Reduction of micronutrient deficiencies (Iron, Iodine and Vitamin A) and malnutrition (over nutrition and undernutrition) overweight among women of reproductive age	% of pregnant women who take iron and folic acid supplements throughout pregnancy.	Provide IFA supplements to adolescent girls and pregnant women.	HF and Community	County Department of Health (CDH)	Ministry of Agriculture (MOA), Development and implementing partners, Media
		Conduct nutrition education on Iron rich foods	Community		
	% of households using Iodized salt	Conduct Community education on use of Iodized salt in each sub-county	Community		
	% of post-partum mothers receiving vitamin A supplement.	Provide Vitamin A supplement for post-partum mothers.	HF		
	% of households using Vitamin A fortified food products.	Conduct Community education on use of Vitamin A fortified food products & Vitamin A rich foods at sub-county level	Community		
		Conduct supportive supervisory visits to health facilities	HF		
		Hold quarterly stakeholder review and planning meetings	County and sub-county		
	Number of overweight and obese women successfully managed for weight.	Conduct community nutrition education on healthy dietary practices	Community		
	Proportion of health facilities with nutrition commodities and equipment for maternal nutrition interventions	Procure and distribute nutritional commodities and equipment to health facilities including Supplementary foods	County		
	% of pregnant women monitored for their weights.	Conduct routine weight monitoring and appropriate counselling for pregnant women.	HF		
	% of pregnant and Lactating women with MUAC < 21cm receiving supplementary food,	Procure and provide supplementary food to pregnant and Lactating women with MUAC < 21cm.	County		
	% of health workers trained on nutrition in pregnancy and lactation including logistics and supply chain management.	Train health workers on nutrition in pregnancy and lactation including logistics and supply chain management	County		

% Reduction of malnutrition (stunting, wasting, underweight, obesity) in children < 5 years	% of Health facilities certified as Baby Friendly.	Scale up Baby Friendly Hospital Initiative (BFHI), assess and certify H/facilities.	HF	CDH	Ministry of Education (MOE), Development and implementing partners, Media
	% of community units that are implementing Baby Friendly Community Initiative	Sensitize community units on implementation of Baby Friendly Community Initiative (BFCI)	Community		
	% of infants who are breastfed within one hour of birth	Educate ANC and post-natal mothers on importance of breastfeeding within the first one hour after birth.	Community/HF		
	% of children < 5years whose growth is monitored	Train HWs, CHEWs and CHVs on nutrition tools (CHANIS etc)	HF		
	% of children < 5 years screened at community level and referred for nutrition management				
	Proportion of Health facilities equipped with anthropometric equipment and reporting tools	Equip Health facilities and community units with anthropometric equipment and Monitoring & reporting tools.	HF		
	% of children < 6 months who are exclusively breastfed for 6 complete months	Conduct community education on importance of exclusive breastfeeding	Community/ HF		
	% of children < 2 years who continue breastfeeding and receive appropriate complementary foods up to 2 years.	Conduct community education on importance of appropriate IYCN	Community/HF		
		Conduct supportive supervisory visits to H/ facilities.	HF		
	% of children<5 years dewormed routinely	Conduct routine deworming	HF / community		
	% of households practicing proper hand washing with safe, clean water and soap	Promote proper hand washing & other hygiene practices, and timely seeking of health care.	Community	CDH	
	% of children < 5years with diarrhea who are treated with zinc supplements	Upscale advocacy on use of zinc Sulphate in the treatment of diarrhea	HF		
	% of health care personnel trained on HINI	Train health workers and community units on HINI (including IMAM, IYCN and BFHI/BFCI)	HF/ community		
	% of children with acute malnutrition managed	Provide therapeutic and supplementary foods to malnourished children according to IMAM protocol	HF		

% reduction in prevalence of micronutrient deficiencies in the population	% of children 6-59 months receiving routine vitamin A supplementation twice a year	Scale up vitamin A supplementation for children < 5 years with 2 doses a year.	HF	CDH	Ministry of Education (MOE), Development and implementing partners, Media
	% of children aged 6-23 months receiving multiple micronutrient powders as per current policy	Provide multiple micronutrients powder for children 6-23 months as per current policy	Community		
	% of HWs trained on prevention, management and control of micronutrient deficiencies.	Train service providers on micronutrients deficiency, prevention & control strategies including logistics and supply chain management.	HF		
	No. of micronutrient intervention campaigns (Radio, TV, Community etc) launched.	Advocate and create public awareness on food fortification, supplementation and dietary diversification at all levels	Community		
	% of WRA receiving IFAS and VAS	Procure and ensure timely distribution of micronutrient supplements (VAS, and IFAS).	County		
	No. of supervisory visits conducted at the health facility	Conduct M&E of micronutrient deficiency, prevention and control strategies.	Community		
	% of CHEWs and CHVs trained on micronutrient deficiency, prevention and control strategies.	Train CHEWs and CHVs on micronutrient deficiency, prevention and control strategies.	HF		

Improved nutritional status of vulnerable groups in emergencies	Emergency nutrition response plans put in place.	Build the capacity of the county on Nutrition in emergencies and develop nutrition response plans.	County	CDH	Kenya Red Cross Society; National Drought Management Authority; Development and implementing partners, media
	% of health workers with capacity on BMS violation guidelines and IMAM	Disseminate and distribute of BMS violation guidelines to health workers	County		
		Disseminate and distribute of guidelines for management of malnutrition in emergencies	County		
	No. Of nutrition situation reports developed	Conduct nutrition surveillance in emergency affected areas.	Community		
	No. of co-ordination meetings held.	Mapping of partners, Review and develop TORs.	County		
		Hold and document regular joint planning & review meetings.			
	% of affected populations receiving food and non-food support in emergencies	Timely provision of food and non-food items (logistics in emergencies)	HF		
	No. of integrated outreaches carried out in emergencies	Carry out integrated outreaches to scale up delivery of essential nutrition services (HINI).	County		
	% of health workers trained on provision of nutrition care during emergencies	Capacity building of all health workers to provide nutrition care and support at all levels during emergencies (sensitization)	County		
	No. of sub-counties implementing the nutrition commodities monitoring plan used during emergencies.	Mobilize resources for emergency response.	County		
		Develop, disseminate and implement the county monitoring plan for nutrition commodities in emergency.	Health Facility		
		Monitor food safety of nutrition commodities for use in emergencies.			

% increase in population accessing curative nutrition services	Proportion of resources committed to nutrition care services.	Mobilize resources for clinical nutrition care and treatment for common diseases.	County	CDH	Development and implementing partners,
	Number of health workers trained on curative/clinical nutrition services.	Train health workers on clinical nutrition care and management.	Health Facility		
	Proportion of health facilities providing curative/clinical nutrition services	Procure and distribute essential therapeutic nutrition commodities (Therapeutic feeds; F75 and F100, micronutrient supplements, ORS/Resomal etc) and equipment (anthropometric and others).	HF		
	Commodities monitoring plan disseminated and implemented by the health facilities and sub-county	Disseminate and implement nutrition commodities monitoring plan at health facility level	HF		
		Monitor food safety of nutrition commodities.	County		
		Conduct M& E of Curative/clinical nutrition services plus quarterly clinical nutrition audit for health facilities.			
	Proportion of children with malnutrition receiving care.	Procure and distribute essential therapeutic and supplementary commodities and equipment.	HF		
		Screen and enroll patients into Nutrition programmes (over and under nutrition)			

% reduction of incidences of diet related non-communicable diseases overweight	Proportion of sub-counties implementing nutrition guidelines on NCDs.	Disseminate NCD guidelines at all levels	County	CDH	Development and implementing partners,
	Proportion of the health workers trained on prevention, management and control of diet related NCDs.	Train service providers on prevention, management and control of diet related NCDs.	HF		
	Proportion of sensitization meetings conducted on healthy diets and physical activity at health facility level.	Create public awareness on the importance of prevention; management and control of diet related NCDs at all levels	Community		
	No. of coordination meetings held	Map partners, review and develop TORs	County		
		Hold regular joint planning and review meetings.	County		
	Proportion of population screened and referred for management of diet related NCDs	Scale up screening (BMI and Waist circumference).and referral for diet related NCDs at health facility and community levels.	Community/HF		
	No. of M&E sessions conducted on diet-related NCDs	Conduct M&E of diet related NCDs.	County		

% of school-going children with good nutrition status	Situation analysis on school/ institutional feeding conducted, documented and disseminated.	Conduct situation analysis on school/ institutional feeding including ECD centers and day care centers.	Schools	CDH	County Department of Education (CDE); MOA, Development and implementing partners,
	% of ECDs providing school meals to pupils	Implement school meals programmes in ECDs	Schools		
	% of schools implementing healthy learning and nutrition support to school going children	Implement healthy learning in schools and other institutions.	Schools		
		Periodically deworm and provide micronutrient supplements and conduct nutrition screening and referrals for school going children			
	Proportion of sub-counties monitoring nutrition interventions in schools and institutions.	Mobilize resources to sustain optimal institutional feeding programmes.	County		
		Conduct M&E of nutrition interventions in schools and other institutions.	Schools		
	No. of coordination meetings held	Hold and document regular stakeholder meetings	County		
	% of school health management team sensitized	Sensitize school health management team on school health policy and guidelines	School		

% of population adopting healthy diets and lifestyles	Proportion of service providers trained on nutrition communication and advocacy skills.	Train service providers on communication and advocacy skills.	HF	CDH	Development and implementing partners,
	Number of nutrition communication materials reviewed and disseminated.	Review, print, disseminate and distribute IEC materials.	County		
		Promote optimal nutrition through all channels of communication at all levels.	Community		
	No. of nutrition days marked per year.	Mark national/international nutrition days (World breastfeeding day, Iodine Deficiency Disorders day, Malezi Bora among others).	County		
	County nutrition ACSM developed	Develop and operationalize county nutrition ACSM strategy			
% Improved nutrition surveillance, monitoring and evaluation system	Number of coordination meetings held	Hold feedback meetings among nutrition stakeholders.		CDH	Development and implementing partners, Media
		Integrated data quality review meetings			
	Number of monitoring visits conducted by the health management teams	Conduct support supervision at county and sub-county levels by health management teams			
	% of health facilities with adequate reporting tools.	Equip all health facilities with data collection and reporting tools	HF		
	% of health managers and service providers trained on DHIS	Train all health managers and service providers on DHIS	County		
	Number of nutrition bulletins developed and disseminated	Develop and disseminate quarterly county nutrition bulletins			

Strengthened evidence based decision making	No. of coordination meetings held	Map partners, review and develop TORs	County	CDH	Development and implementing partners, media
		Disseminate research findings to key stakeholders at all levels			
		Hold regular joint planning and review meetings to align the annual nutrition planning process to the nutrition action plan			
		Mobilize resources to address critical gaps in research (advocacy meetings)			
	No. of MoUs signed for operational research	Develop MoUs with national/international institutions of higher learning for operational research			
	No. of nutrition surveys conducted	Conduct nutrition surveys (yearly)			
	% of HCPs trained on operational research	Train HCPs on operational research			
	No. of nutrition bulletins disseminated	Regularly document and share programme specific best practices/lessons learnt at county and sub-county level			
Coordination and information exchange strengthened among nutrition stakeholders.	No. of nutrition stakeholders meetings held.	Map partners using 3W matrix, review and develop TORs/MoUs	County	CDH	Development partners
		Hold Nutrition Technical Forums (NTFs) to strengthen feedback mechanisms			
		Strengthen linkage with other nutrition sensitive forums such as CSGs, WESCOORD etc.			
		Hold regular joint planning and review meetings to align the annual planning process with key county documents (CIDP, CHSSP, AWP)			
		Establish with clear TORs and operationalize key nutrition working groups e.g. MIYCN, Information and response			
	% of the resource mobilized for nutrition activities from government and partners against the budget activities.	Mobilize financial and human resources for nutrition interventions			

2.2. Coordination for implementation of Kajiado CNAP

The sector will strengthen coordination mechanisms at the county and sub-county level to ensure smooth flow of activities and improved partnerships. The DOH will take lead in coordination through use the existing coordination structures such as the County Nutrition Technical Forum (NTF), County Steering Group (CSG), Water and Environmental Sanitation Coordination (WESCOORD) and Health Stakeholders Forum. In addition, with clear terms of references, technical working groups (Information working group, Capacity Working group, MIYCN working group), will be operationalized. At all levels the nutrition stakeholders will establish coordination with other sectors by guided MOUs and actions spelt out in joint work plans. Nutrition stakeholders will play a crucial role in the execution of the Kajiado CNAP through the above established coordination structures.

The coordination activities will entail but not limited to:

- Providing enabling environment for the implementation of Kajiado CNAP by the stakeholders
- Monitoring and evaluation of the implementation of Kajiado CNAP
- Receiving progress report on the implementation of the plan
- Provide feedback to all other coordination forums of health and county steering group
- Strengthen linkages to all other coordination forums of health and county steering group.
- Strengthen inter-sectoral linkages to ensure multi-sectoral approach is achieved to fighting malnutrition

CHAPTER III

MONITORING AND EVALUATION FRAMEWORK

A system for monitoring and evaluation (M&E) is a critical component of the implementation of this Action Plan; as such, a system will enable tracking of programme implementation. The objective of M&E is to inform decision-making in the areas of accountability, activity implementation, allocation of resources and policy at County, sub-county and Health facility level. In order to achieve this objective various stakeholders in the implementation of the Plan of Action, will be encouraged to;

- Ensure timely availability of the data
- Analyze the data, disseminate and promote use of the findings
- Ensure proper storage, reliable access and ease retrieval by different users and utilizes both National and County M & E systems including District Health Information software (DHIS), Kenya Demographic Health Surveys (KDHS) and other surveys (e.g. SMART, Micronutrient, KAPB, short and long rains assessments) to ensure adequate provision of more disaggregated data so as to facilitate monitoring and evaluation at all levels
- Collect and analyze qualitative information and increase participatory monitoring

Operational research and analysis programs to evaluate changes towards desired outcomes and targets will guide this

3.1 Monitoring and evaluation Matrix

Outcome Indicators	Output indicators	Baseline year	Baseline Value				Source of data
				2015/2016	2016/2017	2017/2018	
% Reduction of Iron, Iodine and Vitamin A deficiency among women of reproductive age	% of pregnant women who take iron and folic acid supplements during pregnancy.	2012	54% (For ANC Iron supplementation)- Sept-2012	60%	65%	70%	Kajiado County SMART Survey data
	% of households using Iodized salt	2012	No Baseline data	40%	50%	60%	SMART survey
% Reduction of overweight and obesity among women of reproductive age	% of post-partum mothers receiving vitamin A supplement.	2014	20(% of PP women supplemented with vit. A).	50%	55%	60%	Health Facility Data
	% of households using Vitamin A fortified food products.		-No baseline data	40%	50%	60%	Survey
% Reduction of underweight among women of reproductive age.	% of overweight and obese women successfully managed for weight.		No baseline data	30%	50%	60%	Health Facility Data
	Proportion of health facilities with nutrition commodities and/or equipment for maternal nutrition interventions	2015	60%	65%	.70%	75%	Health Facility Data
	% of pregnant women monitored for their weights.	2014	38%	50%	70%	90%	Health Facility Data
	% of pregnant and Lactating women with MUAC < 21cm receiving supplementary food	2012	2.6% (% of women with MUAC <21 cm).	2%	1.5%	1%	SMART survey
	% of health workers trained on nutrition in pregnancy and lactation including logistics and supply chain management	2015	10%	20%	30%	40%	Training reports/Matrix

% Reduction of children < 5years with malnutrition (stunting, wasting, underweight, obesity)	% of Health facilities certified as Baby Friendly.	2015	2 health facilities	2	3	4	Health Facility Data
	% of community units that are implementing Baby Friendly Community Initiative	2015	0	2	4	6	Health Facility Data
	% of infants who are breastfed within one hour of birth	2012	76.1% (Timely Initiation to Breastfeeding)	79%	82%	85%	Survey
	% of children < 5years whose growth is monitored	2014	30%	30%	27%	24%	Health Facility Data
	% of children < 5 years screened at community level and referred for nutrition management	2014	3% (Prevalence of GAM)	3%	2.5%	2%	KDHS 2014
	Proportion of Health facilities equipped with anthropometric equipment and reporting tools	2015	80%	85%	90%	90%	Health Facility Data/ Supervision reports
	% of children < 6 months who are breastfed exclusively	2012	44.7% (Rate of exclusive breast-feeding).	50%	55%	60%	SMART Survey
	% of children U2 who continue bf and receive app complementary food upto 2years	2012	72.4% (Children receiving Minimum Dietary Diversity)	75%	78%	82%	SMART Nutrition Survey
	% of U5 dewormed routinely	2012	46.9%	55%	60%	65%	As above
	% of households practicing proper hand washing with safe, clean water and soap	2011	56.8%	60%	65%	70%	SMART Nutrition Survey
	% of children < 5years with diarrhea who are treated with zinc supplements	2012	52.4%	55%	60%	65%	Health Facility Data
	% of HW trained on HINI	2014	10%	20%	30%	40%	RRI March 2015 and KDHS 2014

% reduction in prevalence of micronutrient deficiencies in the population	% of children 6-59 months receiving routine vitamin A supplementation twice a year	2012	46.9% (6-59 months -vitamin A supplementation twice a year	50%	60%	70%	Smart Survey
	% of children 6-59 months receiving routine vitamin A supplementation twice a year	2012	46.9% (6-59 months -VAS twice a year.	50%	60%	70%	Survey
	% of children aged 6-23 months receiving multiple micronutrient powders as per current policy	2012	40%	40%	50%	60%	Survey
	% of HWs trained on prevention, management and control of micronutrient deficiencies.	2014	10%	20%	30%	40%	RRI Mar 2015
	No. of micronutrient intervention campaigns (Radio, TV, Community etc) launched.	2014	3 per year	3	4	6	County data
	% of WRA receiving IFAS and VAS	2014	40%	60%	70%	80%	DHIS
	No. of supervisory visits conducted at the health facility	2015	4 per year	4	4	4	M&E report
	% of CHEWs and CHVs trained on micronutrient deficiency, prevention and control strategies.	2015	0	50%	55%	60%	RRI March 2015
Improved nutritional status of populations in emergencies .	Emergency nutrition response plans put in place.	2014	1 per year	1	1	1	Meeting reports
	% of health workers with capacity on BMS violation guidelines and IMAM	2013	10%	40%	50%	60%	Training reports
	No. Of nutrition situation reports developed	2014	1 per quarter	1 per quarter	1 per quarter	1 per quarter	Meeting minutes
	No. of co-ordination meetings held.	2014	1 per quarter	1 per quarter	1 per quarter	1 per quarter	Meeting minutes
	% of affected populations receiving food and non-food support in emergencies	2014	80%	85%	90%	100%	Stock reports
	Proportion. of integrated outreaches carried out in emergencies	2014	80%	85%	90%	100%	Outreach reports
	% of health workers trained on provision of nutrition care during emergencies	2014	10%	40%	60%	80%	Training reports
	% of sub-counties implementing the nutrition commodities monitoring plan used during emergencies.	2014	100%	100%	100%	100%	Stock reports

Proportion of population accessing curative nutrition services	Proportion of resources committed to nutrition care services.	2015	4.4%	10%	15%	20%	Sector budget
	% of health workers trained on curative/ clinical nutrition services.	2012	10%	20%	50%	70%	
	Proportion of health facilities providing curative/clinical nutrition services	2012	58%	65%	80%	100%	
	Commodities monitoring plan disseminated and implemented by the health facilities and sub-county	2014	No data	20 %	40%	60%	
% reduction of incidences of diet related non-communicable diseases overweight	Proportion of sub-counties implementing nutrition guidelines on NCDs.	2014	No data	10%	20%	40%	
	Proportion of the health workers trained on prevention, management and control of diet related NCDs.	2014	<10%	20%	30%	50%	
	Proportion of sensitization meetings conducted on healthy diets and physical activity at health facility level.	2014	No data	20%	40%	60%	
	Proportion of population screened and referred for management of diet related NCDs	2014	No data	30%	40%	50%	
	% of M&E sessions conducted on diet-related NCDs	2014	No data	20%	30%	60%	
% of school-going children with good nutrition status	Situation analysis on school/institutional feeding conducted, documented and disseminated.	2014	No data	20%	40%	60%	
	% of ECDs providing school meals to pupils	2014	21%	50%	60%	80%	
	% of schools implementing healthy learning and nutrition support to school going children	2014	34%	50%	60%	80%	
	Proportion of sub-counties monitoring nutrition interventions in schools and institutions.	2014	-	20%	40%	60%	
	% of school health management team sensitized on nutrition	2014	-	40%	60%	70%	

% of population adopting healthy diets and lifestyles	Proportion of service providers trained on nutrition communication and advocacy skills.	2014	0%	20%	40%	50%	
	Number of nutrition communication materials reviewed and disseminated.	2014	0	4	4	4	
	%. of nutrition days marked per year.	2015	30%	50%	70%	90%	
	County nutrition ACSM developed and disseminated (annual county policy meetings)	2014	0	1	1	1	
% Improved nutrition surveillance, monitoring and evaluation system	% of monitoring visits conducted by the health management teams	2015	25%	50%	75%	100%	
	% of coordination meetings held	2015	50%	75%	100%	100%	
	% of health facilities with adequate reporting tools.	2014	50%	75%	90%	100%	
	% of health managers and service providers trained on DHIS	2014	40%	60%	80%	90%	
Strengthened evidence based decision making	No. of coordination meetings held (quarterly)	2014	1	4	4	4	
	No. of nutrition surveys conducted (need based)	2014	2	1	1	2	
Coordination and information exchange strengthened among nutrition stakeholders.	No. of nutrition bulletins disseminated	2015	1	2	3	4	
	Number of nutrition bulletins developed and disseminated (quarterly)	2014	1	2	4	4	

CHAPTER IV
RESOURCE MOBILIZATION FRAMEWORK

This section provides a summary estimated budget of KES 406 M to implement Kajiado County Action plan for the 3-year period.

Activities	Annual Resources Kshs			
	2015-2016	2016-2017	2017-2018	Total
Strategic objective 1: Improve nutritional status of women of reproductive age (15-49 years)				
Provide IFAS to adolescent girls and pregnant women	3,920,628	5,533,230	7,256,858	16,710,715
Provide VAS to post-partum mothers	768,689	994,844	1,236,250	2,999,783
Train health workers on the new IFA policy; micronutrients deficiency prevention and control strategies including logistic and supply chain management	830,800	830,800	830,800	2,492,400
Conduct community education on healthy dietary practices	500,000	500,000	500,000	1,500,000
Treatment of moderate acute malnutrition (MAM) - PLW	5,683,397	7,493,817	9,427,222	22,604,436
Production and distribution of IFAS materials to health facilities and communities	250,000	250,000	250,000	750,000
Total resources SO1	11,953,514	15,602,691	19,501,130	47,057,334
Strategic objective 2: Improve nutrition status of children under-five years of age				
Training health workers on BFHI	1,500,000	1,500,000	1,500,000	4,500,000
Assess and certify health facility as Baby friendly	48,000	48,000	48,000	144,000
Sensitize community units on BFCI implementation	600,000	600,000	600,000	1,800,000
Train HWs on nutrition tools (CHANIS etc)	4,899,000	4,899,000	4,899,000	14,697,000
Equip HF and CU's with anthropometric equipment (MUAC tapes, baby scale, height boards and weighing scales, stadiometer, BMI wheel)	2,037,000	1018500	1018500	4,074,000
Scale up VAS for children <5 years with 2 doses a year	2,413,700	3,123,757	3,881,846	9,419,303
Train health workers and community units on IMAM and MIYCN	5,651,000	0	5,651,000	11,302,000
Promote hand washing and other hygiene practices and timely seeking of health care	960,000	960,000	960,000	2,880,000

Deworming (Children)	2,352,119	2,924,154	3,534,327	8,810,600
Therapeutic Zinc supplementation with ORS	15,056,646	16,094,153	17,186,846	48,337,645
Management of severe acute malnutrition (SAM) - Inpatient and outpatient	10,170,744	13,103,861	16,234,982	39,509,587
Treatment of moderate acute malnutrition (MAM)	30,559,184	34,723,119	39,147,253	104,429,555
Production and distribution of BCC/IEC materials to health facilities and communities - IMAM, MIYCN	1,600,000	1,600,000	1,600,000	4,800,000
Provide multiple micronutrient powder for children aged 6-23 months	3,837,547	4,838,041	5,905,597	14,581,184
Total resources (SO2)	81,684,939	85,432,584		269,284,874
Strategic Objective 3: Reduce the prevalence of micronutrient deficiencies in the population				
Advocate and create public awareness on food fortification, supplementation and dietary diversification at location level.	860,000	860,000	860,000	2,580,000
Total resources (SO3)	860,000	860,000	860,000	3,440,000
Strategic objective 4: Prevent deterioration of nutritional status and save lives of vulnerable groups in emergencies				
Build the capacity of the county on Nutrition in emergencies and develop nutrition response plans.	600,000	600,000	600,000	1,800,000
Sensitize health workers on emergency response	400,000	400,000	400,000	1,200,000
In liaison with the national Government, ensure dissemination of guidelines for management of acute malnutrition.	250,000	250,000	250,000	750,000
Hold and document regular joint planning & review meetings.	180,000	180,000	180,000	540,000
Scale up delivery of essential nutrition services (High Impact Nutrition Interventions) - outreaches	3,850,000	3,850,000	3,850,000	11,550,000
Capacity building of all health workers to provide nutrition care and support at all levels during emergencies (sensitization)	500,000	500,000	500,000	1,500,000
Total resources (SO4)	5,780,000	5,780,000	5,780,000	17,340,000
Strategic objective 5: Improve access to quality curative nutrition services				
Train health workers on clinical nutrition care and management.	2,000,000	0	0	2,000,000
Total resources SO4	2,000,000	0	0	2,000,000
Strategic objective 6: Improve prevention; management and control of diet related NCDs				

In liaison with the national Government, ensure dissemination of guidelines on NCDs	220,000	0	220,000	440,000
Train service providers on prevention, management and control of diet-related NCDs.	1,200,000	1,200,000	1,200,000	3,600,000
Create public awareness on the importance of prevention; management and control of diet related NCDs at location level.	600,000	600,000	600,000	1,800,000
Total resources (SO6)	2,020,000	1,800,000	2,020,000	5,840,000
Strategic objective 7: Improve nutrition in schools and other institutions				
Conduct situation analysis on school/institutional feeding including ECD centers and day care centers.	531,000	0	0	531,000
Periodically deworm children aged 6-12 years in public and private primary schools	2,947,716	2,947,716	2,947,716	8,843,148
Sensitize primary school management on school health policy and guidelines	300,000	300,000	300,000	900,000
Total resources (SO7)	3,778,716	3,247,716	3,247,716	10,274,148
Strategic objective 8: Improve knowledge, attitudes and practices on optimal nutrition				
Train service providers on ASCM	870,000	870,000	870,000	2,610,000
Operationalize county nutrition advocacy plan	500,000	500,000	500,000	1,500,000
Mark national/international nutrition days (World breastfeeding day, Iodine Deficiency Disorders day, Malezi Bora, diabetes among others).	7,500,000	7,500,000	7,500,000	22,500,000
Total resources (SO8)	8,870,000	8,870,000	8,870,000	26,610,000
Strategic objective 9: Strengthen nutrition surveillance, monitoring and evaluation systems				
Conduct support supervision at County and Sub-County levels by CHMT and SCHMT(quarterly)	1,200,000	1,200,000	1,200,000	3,600,000
Equip all health facilities with data collection and reporting tools.	1,350,000	1,350,000	1,350,000	4,050,000
Data quality review meetings (integrated)	800,000	800,000	800,000	2,400,000
Conduct data quality assessments	1080000	1080000	1080000	3,240,000
Develop and disseminate quarterly County nutrition bulletin	300,000	300,000	300,000	900,000
Total resources (SO9)	4,730,000	4,730,000	4,730,000	14,190,000
Strategic objective 10: Enhance evidence-based decision-making through research				
Conduct nutrition surveys	3,000,000	3,000,000	3,000,000	9,000,000
Mobilize resources to address critical gaps in nutrition research (advocacy meetings)	200,000	200,000	200,000	600,000
Disseminate research findings to key stakeholders at all levels	100,000	100,000	100,000	300,000
Train HCPs on operational research	200,000	200,000	0	400,000

Total resources (SO 10)	3,500,000	3,500,000	3,300,000	10,300,000
Strategic objective 11: Strengthen coordination and partnerships among the key nutrition actors				
Hold NTF meetings	850,000	850,000	850,000	2,550,000
Operationalize key nutrition working groups	200,000	200,000	200,000	600,000
Hold regular joint planning and review meetings to align the annual nutrition planning process to key county documents (AWP, CIDP, CHSSP, CNAP)	200,000	200,000	200,000	600,000
Total resources (SO 11)	1,250,000	1,250,000	1,250,000	3,750,000
TOTAL RESOURCES REQUIRED IN KAJIADO COUNTY (KSH)	126,427,168	131,072,991		406,336,355

**Published by the
County Government of Kajiado,
Supported by FEED**

© 2016