Acknowledgement

The Wajir county department of Health acknowledges the valuable contributions of various stakeholders in the development of the County Nutrition Action Plan 2019-2023. We express our sincere gratitude and indebtedness to United Nations Children Fund (UNICEF) for the significant technical and financial contribution in the various stages of the CNAP development processes. The contribution of Save the Children international, World Vision International, International Livestock Research Institute, Kenya Red Cross Society, World food programme and County government departments (Water, Education and Agriculture) for the technical and financial support in developing and finalizing of this action plan. Further, we highly appreciate the county management teams (CHIRO, WASH, EPL, HEU, CHPO, HME and the Sub county Health Management Teams (SCNUT and SCHIRO) from Wajir South, Wajir East, Wajir West, Tarbaj, Wajir North, and Eldas for their commitment.

This action plan started with review of previous CNAP, formation of secretariat, inception meeting/workshop and dissemination of Kenya National Nutrition Action Plan (KNAP) key result areas to county stakeholders which provided guidance on key areas of focus and contributed to the development of this nutrition action plan. During development phase of action plan, teams were formed to facilitate the development of key result and indicators which were further consolidated with support from UNICEF and National Division of Nutrition.

The following persons are specially appreciated for drafting and final editing of the action plan: UNICEF: Sicily Matu, Janet Ntwiga, Edward Kutondo, Tom Amollo and Oliver Kamar; MoH-DND: Betty Samburu and Leila Akinyi; SCI: James Njiru, Abdi Omar and Josephat Ogeto, KRCS: Abdia Adan Manya and County department of Health staff in all the sub counties:- Mahat Dahir, Yusuf Adow, Fatuma Hajji, Hassan Irobe, Ibrahim Issack, Hassan Abdi, County Health Management Team; Nuria Ibrahim, Hassan Ibrahim, Sahara Adow, Nimo Golo, Ibrahim Hassan, Mohamed Salat, Department of Agriculture: Simon Kamwenje and Department of Education

Last, but not the least, I applaud County Nutrition Coordinator, Nuria Ibrahim Abdi for taking the lead in ensuring the whole process, and finalization of this County Nutrition Action Plan 2019/2023.

Dr. Dahir Ibrahim Somow
Director, Department of Health
Wajir County Government

Foreword

Malnutrition in Wajir remains a big public health problem. It affects thousands of Wajir people in various ways but it's particularly devastating in women and children. It impairs education achievements and economic productivity, costing the government and families enormous amounts of money to treat related illnesses. The high burden of malnutrition in the county is not only a threat to achieving Vision 2030 but is also likely to impede our progress to realize Sustainable Development Goals. Wajir County government is committed to fulfilling the constitutional obligation of ensuring food and nutrition security for all her people. The renewed commitment to nutrition is well articulated in the Wajir County integrated development plan and County health strategic plan

The Constitution of Kenya article 43 (1) gives every person the right to: the highest attainable standard of health, freedom from hunger and access to adequate food of acceptable quality. The government is committed to creating an enabling environment for citizens to realize these rights as evidenced in the Vision 2030, Kenya Health Policy (2014–2030) and the National Food and Nutrition Security Policy, 2012.

The Wajir CIDP and health sector plan outline some of the key measures the county government will put in place for the realization of the Vision 2030. This is to be achieved through supporting the provision of equitable, affordable and quality health and related services at the highest attainable standards to all people of Wajir. The County's commitment to providing a high quality of life to all its citizens was further affirmed by HIS Excellency Ambassador Governor Mohamed Abdi Mohamud in realization of the "Big Four Agenda" in which universal health coverage (UHC) by the year 2022 is prioritized.

Ismail Sheikh Issack
County Executive Committee- Health
Wajir County Government

List of Abbreviations and Acronyms

ACSM	Advocacy Communication and Social Mobilization
ANC	Ante Natal Care
ASAL	Arid and Semi-Arid Land
BFCI	Baby friendly community initiative
BFHI	Baby friendly hospital initiative
CDH	County department of health
CECM	County Executive Committee Member
CIDP	County Integrated Development Plan
CNAP	County Nutrition Action Plan
CRAF	Common Results and Accountability Framework
DALF	Department of Agriculture livestock and fisheries
DALYs	Disability adjusted life years
DRNCDs	Diet-related non-communicable diseases
EDE	Ending drought in Emergencies Framework Medium Term Plan
FBO	Faith Based Organization
GAM	Global Acute Malnutrition
HCW	Health Care workers
HMIS	Health Management Information System
IEC	Information Education and Communication
IFAS	Iron folic Acid Supplementation
IMAM	Integrated Management of Acute Malnutrition
IQ	Intelligence Quotient
KABP	Knowledge Attitude Beliefs and Practices
KCSP	Kenya Climate Smart Agriculture Project
KEMSA	Kenya Medical Supplies Agency
KHIS	Kenya Health Information System
KIRA	Kenya Inter-agency Rapid Assessment
KNAP	Kenya Nutrition Action plan
KRA	Key Result Area
LMIS	Logistics Management Information System
MCA	Member of County Assembly
MEAL	Monitoring, Evaluation and Accountability and learning framework
MIYCN	Maternal Infant and Young Child Nutrition
MIYCN-E	Maternal Infant and Young Child Nutrition in Emergencies
MOE	Ministry of Education
MoH	Ministry of Health
MTP	Medium Term Plan
NDMA	National Drought Management Authority
NTD	Neural Tube Defects
SBCC	Social Behavior Change and Communication
SFP	Supplementary Feeding Program
SFSP	Sustainable Food Systems
SMART	Standardized Monitoring and Assessment in Relief and Transition
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USD	United States Dollar
WASH	Water Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization

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Figures and Tables

Preface

The process of development of the CNAP 2018–2022 was driven by the department, through a sector-wide approach that involved broad-ranging consultations within and across the sector. Critical to note is the engagement of sub counties in the development of county nutrition action plans (CNAPs). A series of dedicated meetings were held with sub counties and their leadership during the entire development process. Further, the process brought together a broad range of actors that included the UN agencies, local partners, county government line departments and national government.

Key priorities to be implemented during the five years from 2019 to 2023 have been identified. It is my expectation that in working together, the overall objectives of the CNAP will be achieved.

Executive summary

The County Nutrition Action Plan (CNAP) 2019–2023 is a framework that provides for a coordinated implementation of nutrition interventions within the county. This action plan builds on the success, limitations and opportunities of the first action plan 2017-2019. The objective of the CNAP is to accelerate and scale up efforts towards the elimination of malnutrition in Wajir County in line with Kenya's Vision 2030 and sustainable development goals, focusing on specific achievements by 2022. Inadequate multisectoral engagement and weak monitoring were identified during review of the first action plan as one of the major challenges in development and implementation of the previous plan. CNAP development that was led by the department of health involved both nutrition sensitive and specific partners within the county during its review, sensitization and write-up workshops with support from national government-Division of nutrition.

CNAP has been organized into five chapters as follows: Chapter one, the introduction and national frameworks, which CNAP is anchored, nutrition situation and trends for Wajir County. Chapter two cover the framework of CNAP which includes, mission, core values, guiding principles, overall objective, development process and target audience of CNAP. Chapter three cover key result areas, strategies and interventions whereas chapter four looks at monitoring, evaluation, accountability and learning. The last chapter presents resource mobilization and costing framework.

CNAP further prioritizes 11 key result areas (KRA) categorized into three broad areas; nutrition-specific, nutrition-sensitive and enabling environment. KRA 1. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up, KRA 2. Nutrition of older children and Adolescent Promoted, KRA 3. Nutrition of older persons promoted, KRA 4. Prevention, control and management of Micronutrient Deficiencies Scaled up, KRA 5. Clinical nutrition and dietetics in disease management strengthened, KRA 6. Integrated Management of Acute Malnutrition Strengthened, KRA 7. Nutrition in Emergencies Strengthened, KRA 8. Nutrition in agriculture and food security, education, WASH and social protection scaled up, KRA 9. Sectoral and multisectoral nutrition governance including coordination, legal framework, nutrition information and research strengthened. KRA 10. Advocacy, Communication and Social Mobilization (ACSM) strengthened and KRA 11. Supply chain for nutrition commodities and equipment's strengthened.

The Department of Health shall be directly in charge of coordinating the execution of this action plan with support from nutrition stakeholders. The M&E framework present targets to be achieved for each strategic objective's expected outcomes and outputs.

This action plan also provides an estimate of the total resources required to achieve the results outlined. The cost estimates cover 2019-2023 implementation period. The projected total cost for implementing the activities of the plan for four fiscal years (2019/20 to 2022/23) is **KES 1,851,339,134.00**

CHAPTER 1
INTRODUCTION

Background information

This chapter gives the background information on the socio-economic and infrastructural information that has a bearing on the development of the county. The chapter provides a description of the county in terms of the location, size, physiographic, natural conditions and demographic profiles as well as the administrative and political units. In addition, it provides information on infrastructure and access; land and land use; community organizations/non-state actors; crop, livestock and fish production; forestry, environment and climate change; mining; tourism; employment and other sources of income; water and sanitation; health and nutrition access, education and literacy, trade, energy, housing, transport and communication, community development and social welfare.

Location and size

Wajir County is located in the North Eastern region of Kenya. The county lies between latitudes 3° N 60'N and 0° 20'N and Longitudes 39° E and 41° E and covers an area of 56,685.9 Km2. It borders Somalia to the East, Ethiopia to the North, Mandera County to the Northeast, Isiolo County to the South West, Marsabit County to the West and Garissa County to the South. The map below shows the location of Wajir County in the country.

Demographic profile

The Kenya 2019 Population and Housing census indicate that the county had a total population of 781,214. Males comprise 53 per cent of the population whereas female population account for 47 percent. Table 1 below shows the population of the county by constituency

Table 1: 2019 Census population description by constituency

Population description by constituency	2019 (Census)		
	Male	Female	Total
Wajir South	159,560	131,369	290,929
Wajir North	58,786	53,297	112,083
Wajir East	59,359	51,292	110,651
Tarbaj	26,856	29,776	56,632
Wajir West	65,785	56,037	121,822
Eldas	45,028	44,069	89,097
Total	**415,374**	**365,840**	**781,214**

Facility distribution per Sub County

There are 10 public hospitals and 2 private hospitals, 105 public primary facilities, and 2 FBO facilities. This totals to 117 primary health care facilities, which translates to 162 facilities in the county.

Table 2: Distribution of health facilities in Wajir County

Sub County	No. of health facilities
Eldas	13
Tarbaj	19
Wajir East	20
Wajir South	26
Wajir North	18
Wajir West	24
TOTAL	**119**

National policy and legal framework for CNAP 2

Wajir health sector has used the Key strategic guidance documents in the development of CNAP 2. The main documents are;

i) Vision 2030

Kenya has given legislative force to some key aspects of nutrition interventions. These include prevention and control of iodine deficiency disorders through mandatory salt iodization and control of other micronutrient deficiencies by mandatory food fortification of cooking fats and oils and cereal flours, through the Food Drugs and Chemical Substances Act. The benefits of breastfeeding are protected through the Breast Milk Substitutes (Regulation and Control Act) 2012. The Food, Drugs and Chemical Substances Act (food labelling, additives, and standard (amendment) regulation 2015 on trans fats) is also key legislation central to the control of DRNCDs. Additionally, Nutritionists and Dieticians Act 2007 (Cap 253b) has been set up to determine and set up a framework for the professional practice of nutritionists and dieticians; set and enforce standards of professional practice and ethics on nutrition and dietetics; enforce a programme of quality assurance for the nutrition and dietetic profession; research into and provide public education on nutrition and dietetics; and design programmes and methods for sensitization on suitable dietary and nutritional habits through capacity-building, competency oriented trainings and specialization in nutrition service delivery. Monitoring compliance is even more critical in the light of devolution. Counties' ability to implement and monitor the regulations is crucial, and hence is considered within the KNAP. Further, the KNAP identifies areas where the development of legislation is still necessary

ii) Kenya Health Policy 2013-2030

The Wajir County Health Policy document, 2014–2030 gives directions to ensure significant improvement in overall status of health in Kenya in line with the Constitution of Kenya 2010, the country's long-term development agenda, Vision 2030 and global commitments. It demonstrates the health sector's commitment, under the government's stewardship, to ensure that the country attains the highest possible standards of health, in a manner responsive to the needs of the population.

The county goal is adopted from the national health goal that was first defined in 2015 in the Ministry of Health's document, Transforming Health: Accelerating the Attainment of Universal Health Coverage. This document is an adaption of the national health policy and addresses health management, service delivery, and burden of disease related needs that are unique to Wajir County towards attaining 2030 goal.

iii) Food and Nutrition Security Policy 2012 and Food and Nutrition Security Policy Implementation Framework 2017-2022

The National Food and Nutrition Security Policy 2012 and the National Food and Nutrition Security Policy Implementation Framework 2017–2022 provides the framework and strategies for addressing nutrition and food security. The two policies address issues of food security using the value chain approach recommending specific interventions at various nodes. The NASEP policy also contributes towards the improved transfer of technology and management for higher agricultural sector productivity, a key prerequisite for poverty reduction and enhanced nutrition and food security. The objectives of the mentioned policies are well anchored in the revised Wajir County Agriculture Sector plan 2013-2022, 2018-2022 CIDP and the annual work plans. To achieve the desired results, the county government of Wajir is implementing various resilience building programmes namely; Sustainable Food Systems [SFSP] in partnership with WFP, Kenya Climate Smart Agriculture Project [KCSP], and Agriculture Sector Development Project II [A SDSP II] among others. If the above is well implemented, the county will attain food and nutrition security

iv) Health Sector Strategic Plan 2018-2022

Wajir Health Sector Strategic plan is guided by the overall Vision 2030 that aims to "transform Wajir into a nationally competitive and prosperous county with a high quality of life by 2030" through health for all. Its actions are anchored in the principles of the 2010 constitution, specifically aiming to attain the right to health, and to decentralize health services management through a devolved system of Governance. This strategic focus has been defined in the Kenya health policy, which has elaborated the long-term policy directions the county intends to achieve in pursuit of the imperatives of the Vision 2030, and the 2010 constitution. The strategic plan provides the health sector medium term focus, objectives and priorities to enable it move towards attainment of the Kenya health policy directions. The Health Sector refers to all the health and related sector actions needed to attain the health goals in the county. It is not restricted to the actions of the county department of health, but includes all actions in other related sectors that have an impact on health and nutrition. It will guide both County and sub county Governments on the operational priorities they need to focus on in health and nutrition

v) Kenya Nutrition Action Plan (KNAP) 2018-2022

This Kenya Nutrition Action Plan (KNAP) 2018–2022 seeks to address malnutrition in Kenya in all its forms and for all ages. It is anticipated that when fully implemented it will contribute to an improvement in nutritional status for the population of Kenya. The KNAP 2018–2022 applies a multisectoral approach and promotes collaboration to address the social determinants of malnutrition sustainably.

In the light of devolution and the functions ascribed to the two levels of government, KNAP 2018–2022 provides an umbrella framework and guidance to counties. County Nutrition Action Plans (CNAPs) will align with the KNAP's strategic framework. KNAP will also define the national government roles relating to the provision of technical support, advocacy, guidance and development of capacity for nutrition for the county governments, so the counties can concentrate on implementation. The KNAP will provide a critical catalyst for enhancing accountability, multisectoral collaboration and coordination, linking national and county actions, and tracking progress of both the KNAP and the CNAPs' results. This is more so in relation to the principle of ONE plan, ONE coordinating mechanism, and ONE monitoring, evaluation and accountability and learning framework (MEAL).

vi) Ending Drought in Emergencies (EDE) Framework

The Constitution places on the state obligations to protect the vulnerable and progressively realize a portfolio of rights, including the right to be free from hunger. Government policy is that drought should not become a disaster. The Government has therefore committed itself to ending drought emergencies in Kenya by 2022. This commitment is clearly spelt out in the Second Medium Term Plan (MTP) for Vision 2030, in which Ending Drought Emergencies (EDE) is recognized as one of the key foundations for national development. The EDE initiative reflects two significant changes in our understanding of drought emergencies in Kenya.

- The first is that they have their roots in poverty and vulnerability, and in the fact that Kenya's drought prone areas are among those which have benefited least from past investment; drought emergencies will not end until the essential foundations for development (principally security, infrastructure and human capital) are in place.

- The second is that drought emergencies are complex challenges which can only be managed by strong and competent institutions, able to draw on new streams of finance as well as the skills and resources of all actors.

This common programme framework operationalizes EDE commitments through an approach that strengthens collaboration and synergy across sectors, agencies and counties. EDE framework was a product of extensive discussion between the national and county governments and their development partners and it revolves around six pillars namely; (i) Peace and Security, (ii) Climate-Proofed Infrastructure,(iii) Human Capital (iv) Sustainable Livelihoods, (v) Drought Risk Management, and (vi) Institutional Development and Knowledge Management.

In line with the objective of EDE, the County Government of Wajir has a directorate in the Governor's office, to coordinate drought and emergency related issues. Wajir County has continued to invest in human capital, construction of social infrastructure, and implementation of sustainable resilience building programmes at the same time strengthening the relationship with development partners towards ending drought emergencies by 2022.

vii) County Integrated Development Plan (CIDP)

The second generation CIDP 2018-2022 for Wajir County provides comprehensive guidelines in budgeting, project funding, monitoring and evaluation of all the projects for the next five years. It also facilitates proper coordination with the national government and other stakeholders in order to improve the well-being of the county citizens. The Kenya Vision 2030 and its Medium-Term Plans provided the foundation for the preparation of the second CIDP for Wajir County. The integrated development-planning framework is formulated to enhance linkage between policy, planning and budgeting.

The process of project identification was consultative as provided for in the County Governments Act, 2012. Various consultative forums were organized at the county, sub-county and ward levels to identify the projects and programmes for the next five years. The information gathered was complemented with the views received during MTP III consultations as well as the consultations on the county Medium Term Expenditure Framework.

Trends in nutrition and health situation in Kenya

Kenya is characterized by the co-existence of undernutrition as manifested by stunting, wasting, underweight, micronutrient deficiencies, overweight, obesity and diet-related non-communicable diseases (DRNCD). All three forms of malnutrition occur within individuals, households and populations throughout the life course – pregnant women, children, adolescents, adults and older persons – throughout the country at different levels of public health significance. Undernutrition, including micronutrient deficiencies, affects mainly children and women especially during the first 1,000 days of life due to their high nutrient requirement, while obesity and DRNCDs affect mainly women of reproductive age and adults in general. Because of the ageing of body organs and systems, older people too are at a very high risk of malnutrition.

The nutrition situation in Kenya is very similar to the global one. Out of 7.22 million children under five years of age, nearly 1.8 million are stunted (26 per cent); 290,000 are wasted (4 percent); 794,200 (11 per cent) are underweight. However, there are geographical and social demographic variations in the severity of malnutrition.

Trends in health and nutrition situation in Wajir

Malnutrition remains a significant public health problem in Wajir County with prevalence of stunting and wasting at 26.4 and 14.2 percent respectively compared to national average of 26.0 and 4.1 percent, respectively as per 2014 demographic health survey. Data generated through annual SMART survey shows that underweight and stunting has consistently remained stable in the past four years as shown in figure 1. However, for acute malnutrition there has been cyclic fluctuations, with a high GAM of 16 percent which is classified as very high as per WHO/ UNICEF threshold. Recent nutrition survey showed an increase of global acute malnutrition from 12.0 percent (weighted) in 2018 to 16.4 percent in 2019 indicating a fluctuating situation.

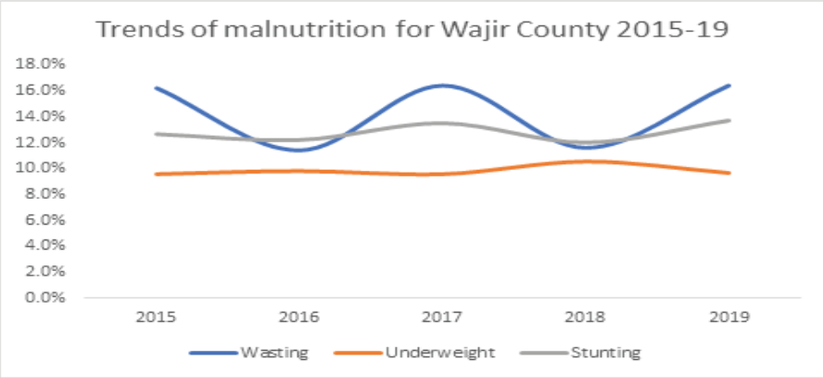


Figure 2: Trends of malnutrition in Wajir County between 2015-19

Maternal and Young Infant Nutrition status

The first two years of life are critical stages for a child's growth and development. Damage caused by nutritional deficiencies during this period could lead to impaired cognitive development, compromised educational achievement and low economic productivity. In Wajir, 87.6 percent of the children have the best start in life by being introduced to breast milk within the first hour of birth whereas 7 in every 10 children are exclusively breastfeed for the first six months of life. However, the County is not doing well on complementary feeding indicators. Timey introduction of complementary feeds at 65.2 percent whereas minimum dietary diversity and minimum meal frequency for children aged 6 – 23 months is 25.7 and 27.6 respectively. Approximately one child in every 10 children receive minimum acceptable diet (KABP, 2017). Maternal indicators are poor with majority (77 percent) of the women consuming less than five food groups according to 2019 survey. Pregnant women are recommended to consume iron folic acid for 270 days however, in Wajir they consume for an average of 50 days.

Wajir County health status

Wajir County is among 15 Counties that account for over 60 percent of maternal deaths in Kenya. The latest estimate of the county's maternal mortality ratio is 1683 deaths per 100,000 live births. Child death rates in Wajir County mirrors the national trend although the neonatal death rate (24/1000) is slightly higher and the infant and under-five death rates (44/1000) are slightly lower. High maternal and child death rates are linked to high birth rates and limited access to life saving maternal and child health interventions. Wajir County's total fertility rate (7.8) is twice as high as the national rate of 3.9 and also means that Wajir County has a high birth rate. The adolescent birth rate is also high – more than 1 in every 10 babies is born to an adolescent girl aged 15-19 (129/1000)

Contraceptive use and unmet need

Use of contraceptives for prevention of unintended pregnancies averts 30 percent of maternal deaths and improves child survival. Only 2 percent of currently married women aged 15-49 in Wajir County use a modern contraceptive method compared to the national rate of 53 percent. Unmet need for contraceptives, refers to the proportion of women who would like to avoid pregnancy but are not using a modern contraceptive method. About one in five (20%) of currently married women age 15-49 in Wajir County have an unmet need for contraceptives, which is slightly higher than the national rate of 17 percent.

Child immunization

Universal immunization of children against common vaccine-preventable diseases (tuberculosis, diphtheria, pneumonia, whooping cough (pertussis), tetanus, polio, and measles) is crucial to reducing infant and child mortality. The vaccination coverage in Wajir County is not yet universal and is generally lower than the national coverage as shown in figure 2. The measles vaccination has the lowest coverage (50%) and the tuberculosis vaccination has the highest (70%).

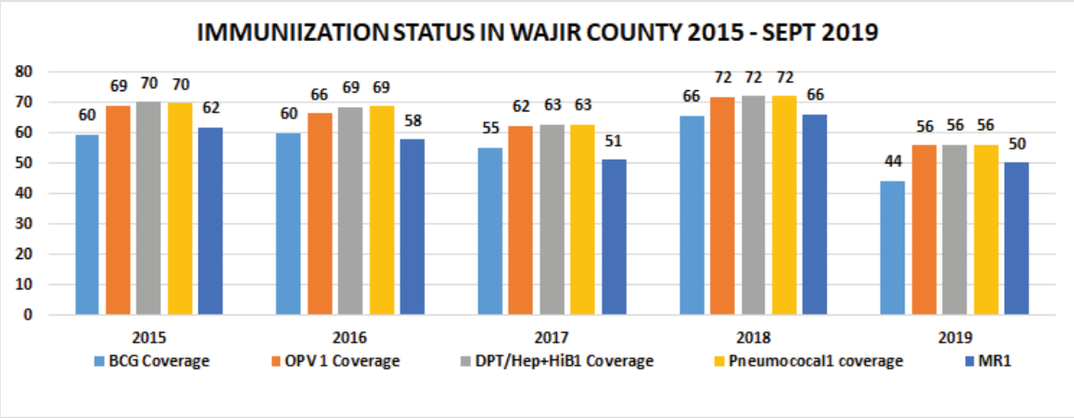


Figure 3: Wajir County immunization trends for 2015-19

Water Sanitation and Hygiene

The underlying determinants of acute malnutrition include an unhealthy environment such as access to water, sanitation, and hygiene. Treatment of drinking water by any method at household level is very low at 23 percent despite high (87%) proportion of water sources such as shallow wells and earth pans being prone to feacal contamination. Hand washing with soap and water at the critical times stands at 20 percent despite high (79%) awareness of hand washing. Open defecation is at 43 percent. The general latrine coverage in the county is as low as 31 percent with proper use of latrines at 23 percent. Poor sanitation and hygiene practices observed could be attributed to an outbreak of waterborne diseases majorly cholera and high diarrheal cases observed.

Human resource for nutrition

The largest proportion (26.0%) of the nutrition workforce are nurses followed by the clinical officer (14.7%), nutritionists (14.3%) and CHV/CHW (non-professionals) at 11.3% and Medical doctors (8.2%), as shown in figure 3 below. Majority (92%) of nutritionists have been recruited post devolution era, with a good retention in the last four years. Over the years no health workers have been trained on clinical nutrition and it draws little attention from nutrition workforce.

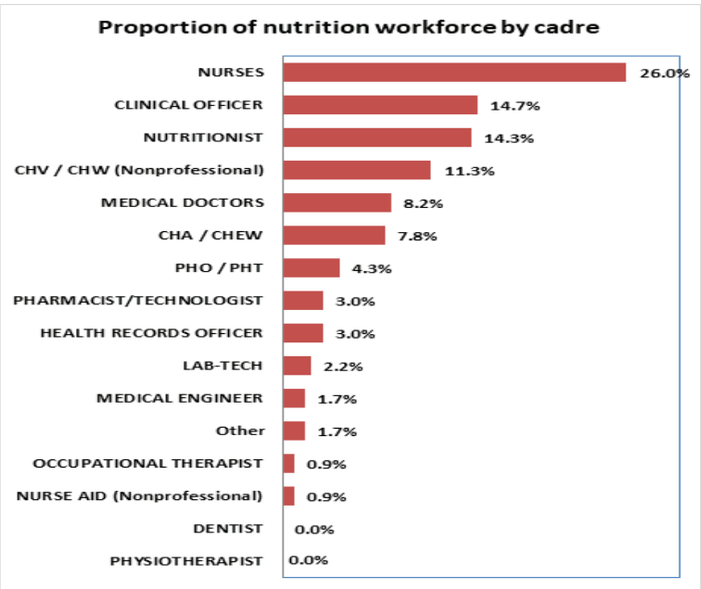


Figure 4: Proportion of Nutrition workforce by cadre

CHAPTER 2
COUNTY NUTRITION ACTION PLAN (CNAP) FRAMEWORK

Introduction

The Wajir County Nutrition action plan is an implementation roadmap for the period 2019-2023. The plan addresses the triple burden of malnutrition in the county, characterized by undernutrition as manifested by stunting, wasting, underweight, micronutrient deficiencies, and other diet-related non-communicable diseases (DRNCD). Wajir County experiences perennial emergency situations resulting from drought and sporadic flooding worsening the nutrition situation.

Overall Vision, Mission, goal and Core Values and Guiding principles

This CNAP represents the first Medium Term Plan of the health sector to support attainment of the Kenya Vision 2030. It is designed to provide an overall framework into which a set of priorities and actions are derived. Its strategic focus is as follows:

VISION

To Achieve Good Nutrition For All

MISSION

To reduce the burden of malnutrition in Wajir county through multi-sectoral and community-centered approaches to achieve optimal health and economic development.

OVERALL GOAL

To have a healthy and prosperous population in Wajir County

CORE VALUES AND GUIDING PRINCIPLES

• Professionalism	• Ethics
• Integrity	• Equity
• Accountability	• Efficiency and effectiveness
• Partnership	• Quality
• Teamwork, Collaboration	• Risk management
• Innovativeness	• Sustainability and ownership

Rationale

Wajir County second nutrition action plan will focus on 11 key result areas which are grouped into nutrition specific, nutrition sensitive and enabling environment thematic areas. A cost–benefit analysis conducted in Kenya in 2016 by UNICEF, the World Bank and Ministry of Health reported that every USD1 invested in scaling up high-impact nutrition interventions has the potential return of USD 22, higher than the global estimates of USD16–18. It is estimated that the costs and benefits of implementing 11 critical nutrition-specific interventions will avert more than 455,000 disability adjusted life years (DALYs) annually, save over 5,000 lives, and avert more than 700,000 cases of stunting among children under five.

The county nutrition action plan encompasses the 11 high impact nutrition interventions captured in well-stipulated strategies and interventions to help curb undernutrition, micronutrient deficiencies and other diet related non-communicable diseases in the county. It also focuses on emergency response and mitigation measures to aid in timely response and management of emergencies.

CNAP Overall Objective/purpose

The objective of the CNAP is to accelerate and scale up efforts towards the elimination of malnutrition in Wajir County in line with Kenya's Vision 2030 and sustainable development goals, focusing on specific achievements by 2023. The expected result or desired change for this action plan is that 'all the people of Wajir county achieve optimal nutrition for a healthier and better quality of life and improved productivity for the country's accelerated social and economic growth'.

CNAP development process

The process was driven by the county government, national government (Nutrition and Dietetics Unit of the Ministry of Health) and partners. It was widely consultative, involving all key nutrition stakeholders through a multisectoral process that was open, inclusive and built on existing and emerging alliances, institutions and initiatives. Key nutrition-sensitive and specific sectors, development partners and civil society organizations, NGOs. At the sub-county level, all the sub counties were involved. The process ensured that the plan is evidence-informed and recognized successes, challenges and lessons learnt from the implementation of the 2012–2017 CNAP. The process also ensured that CNAP is results-based and provides for a common results and accountability framework for performance-based M&E. Evidence was gathered through desk reviews of relevant documents and information from key sectors.

Target audience for CNAP

While many constituencies will benefit from the CNAP, the target audience includes health care planners and policy makers at both county and sub county level, county decision makers, nutrition-sensitive sectors, nutrition officers and managers at all levels, donors, development partners, civil society organizations, faith-based organizations, the private sector, academia, research institutions, the media and the Wajir public at large. This will enable them to understand what the county government of Wajir is doing to ensure optimal nutrition for all.

CHAPTER 3

KEY RESULT AREAS STRATEGIES AND INTERVENTIONS

KRA 1: Maternal, infant and young child nutrition scaled up

Context

Maternal malnutrition increases the risk of poor pregnancy outcomes such as obstructed labour, premature or low-birth weight babies and postpartum hemorrhage. Severe anemia during pregnancy is also linked to increased mortality during labour and delivery. On the other hand, sub optimal child feeding practices including poor breastfeeding and complementary feeding practices contribute greatly to child undernutrition.

Optimal infant and young child feeding practices – which include early initiation of breastfeeding, exclusive breastfeeding for the first six months of life and continued breastfeeding up to two years or beyond in addition to timely introduction of adequate, appropriate and safe complementary foods are crucial to ensure good physical and mental development and also contribute to long-term health benefits to the child. Research has shown that breastfeeding improves the health, development and survival of infants, children and mothers. According to Lancet 2013, exclusive breastfeeding could reduce child mortality by up to 13 percent and when combined with optimal complementary feeding could avert up to 19 percent preventable deaths. In addition, optimal breastfeeding would prevent 20,000 cases of cancer among mothers annually in low middle income countries and reduce hospitalization by half of diarrhea episodes (54%) and one third of respiratory infections (32%) cases hospitalized. Further, breastfeeding would reduce hospital admissions of all diarrhea and respiratory infection by 72 and 57 percent respectively. Longer breastfeeding is associated with a 13 percent reduction in the likelihood of overweight and/or prevalence of obesity and a 35 per cent reduction in the incidence of type 2 diabetes

In Wajir County average consumption of IFAS among pregnant women is 50 days (SMART survey 2019) out of the recommended 2 days. In addition, majority of women begin first ANC attendance after 4 months. The county has continuously experienced very low skilled birth attendance with home deliveries accounting for 57.6 percent of all live births while exclusive breastfeeding currently stands at 69.9 percent (KABP 2017). According to the report only 12.4 percent of children aged 6 – 23 months receive minimum acceptable diet. The poor maternal infant and young child nutrition (MIYCN) practices are caused by inadequate knowledge and skills among health care workers, community health volunteers and women of reproductive age. This is exacerbated by low literacy levels as shown by SMART survey indicating 70 percent of respondents had no education with 4 and 8 percent having attained primary level and secondary level respectively. Other MIYCN issues in the county include low growth monitoring services utilization, low vitamin A and Deworming coverage coupled with inadequate nutrition workforce, poor health worker attitude and inadequate nutrition equipment.

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

Expected Outcome.

Strengthened care practices and services for improved maternal, infant and young child nutrition

Output 1

Improved capacity of health care workers on MIYCN

Strategies

Strengthen the Capacity of health care workers on MIYCN.

Interventions

1. Capacity build HCWs, CHVs and other stakeholders on MIYCN.
2. Strengthen reporting and documentation reporting of MIYCN data

Output 2

Improved MIYCN care practices at the county level

Strategies

Scale up MIYCN Interventions in the County

Interventions

1. Hold key opinion leaders and influencers meeting on MIYCN issues.
2. Strengthen linkages and referral systems for MIYCN related issues.
3. Increase advocacy and communication on MIYCN
4. Finalize and implement SBCC strategy

Output 3

Improved maternal infant and young child feeding practices

Strategies

Interventions

1. Rollout Baby friendly community initiative implementation
2. Roll Out BFHI implementation in all level four hospitals
3. Roll out PD hearth in selected communities
4. Monitoring and enforcement of BMS Act, 2012

Output 4

Scaled up BFCI implementation

Strategies

Capacity building of HCW and CHVs on BFCI

Interventions.

1. Train health workforce on BFCI.
2. Train CHV on BFCI

KRA 2: Nutrition of older children and adolescent promoted

Context

These cohorts are faced with social and nutrition challenges. Children aged 5–9 years are very active. This stage is characterized by a slow, steady rate of physical growth, but a high rate of cognitive, social and emotional development. From the age of seven, there is rapid increase in weight and height of a child in preparation for adolescence. During Adolescence the cohort in this group have increased nutrient needs for their accelerated growth spurt, and for the emotional and social transition from childhood to adulthood. Many adolescents between 14 and 19 years of age are in boarding schools and may not have control over the foods they are served. Therefore, collaboration with other stakeholders, including the Ministry of Education, is key when addressing the nutrition needs of this age group. In addition, they are vulnerable to peer pressure and media, especially in relation to body image and marketing of foods, which could result in consumption of foods with excess salt, sugar and/or fats. The age group is also exposed to other risky health behaviours such as anorexia nervosa, exposure to and engaging in habits such as smoking, drugs and alcohol use. Often adolescents adopt dietary behaviours and lifestyles that they will continue into adulthood of which may affect the health and nutrition practices of the families they will eventually have.

In Wajir County the older children (5-9 years) and adolescents 10-18 cumulatively account for 33% of the total population. This is a significant proportion of the population whose nutrition needs cannot be ignored. The Issues identified among this group in Wajir County include: early marriages which might result in early pregnancy, poor eating habits (eating a lot of sugary and junk foods), drug and substance abuse and iron deficiency anemia among adolescent girls as a result of poor dietary intake of iron and onset of menstrual cycles. There is very little documented information on the nutrition status of this age group which makes it challenging to provide targeted interventions.

Expected Outcome

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

Output 1:

Improved capacity of MoH and MoE staff to implement healthy diet and lifestyle guidelines for older children (5-9 years) and adolescents (10-19 years).

Strategies

Implement healthy diet and lifestyle guidelines for older children (5-9years) and adolescents 10-19 years

Interventions

1. Capacity-build stakeholders on healthy diets and physical activity
2. Disseminate and distribute IEC materials healthy diet and lifestyle guidelines for older children (5-9years) and adolescents 10-19 years

Output 2

Improved health status of children 5-9 years and adolescents aged 10 – 19 years

Strategies

Promote health diets and lifestyle among children 5-9 years and adolescents 10-19years

Interventions

1. Sensitize community on healthy diet and lifestyle
2. Integrate messaging on healthy diet and physical activity in the school health programs
3. Implement weekly iron folic supplementations for adolescent 10-15 years

KRA 3: Nutrition of elderly persons promoted

Context

The elderly population in the county is projected to increase to over 68,000 in the next few years and it is important to note that the elderly face several nutritional challenges including inadequate energy and micronutrient intake due to poverty, inadequate dietary diversity, poor access to nutrition information as well may have health problems that cause a loss of appetite or make it hard to eat. This could include conditions such as dementia and other chronic illnesses. They may also have dental problems that make it hard to chew or swallow food.

Programmes are majorly designed to assess nutrition situations are often targeting children and women. Although no nutrition assessment has been done on the elderly population, malnutrition prevalence is believed to be high. Matters are made worse because of persistent drought and insecurity. In some areas, the population can totally depend on food aid. When the young adults go to look for new pasture or to urban centers for employment, the old people are left behind taking care of younger children. Social disintegration, economic problems, natural calamities and man-made conflicts may not only affect nutritional status but also the life expectancy of the elders. Most of the interventions done by government agencies and organizations operating in the county do not have any targeted intervention for the elderly. The elderly receives general ration as the younger adult. Given the severity of the drought, the loss of animals, absence of farming, insecurity make them more vulnerable to malnutrition.

While older people are commonly accepted as being a vulnerable group, at present, very little is done to meet their needs. This key result area is therefore introduced to look into these issues and provide a guide during interventions

Expected Outcome

Improved nutrition status of older persons

Output 1

Improved linkage of elderly persons to social protection programs and general food distribution

Strategies

Strengthen linkage of elders to social protection program

Interventions

1. Advocate for the linkage of older person to social protection program and general food distributions.

2. Mapping and assessment of nutritional needs of elderly persons in the county

Output 2

Improve capacity of health workers on geriatric nutrition

Strategies

Strengthen the capacity of health workers to provide nutrition services for older persons

Interventions

1. Train health workers on health and nutrition of older persons

2. Develop/adopt IEC materials on nutrition for older persons

KRA 4: Prevention, control and management of micronutrient deficiencies scaled up

Context

Micronutrient deficiencies are becoming more prevalent especially in ASAL counties in the country. Micronutrient malnutrition also referred as hidden hunger affects huge numbers of people across the county. Nutritional deficiencies have become more prevalent following persistent droughts and food insecurities affecting many in the county. Most at risk groups include children less than 5 years of age, adolescents and women of childbearing age, particularly pregnant and lactating.

Vitamin A, iodine and iron deficiencies are of major public health importance in the country and beyond and have been the cause of widespread mortality and morbidity in children, adolescents and women of not only this county but the whole country at large as well folic acid deficiency in pregnancy is a risk factor to Neural Tube Defects (NTD) in newborns and iodine deficiency during pregnancy is the commonest risk factor for preventable brain damage in the newborns.

Despite the consensus that food-based approach is the recommended strategy for the prevention of micronutrient deficiency limited access and availability of various food /fruits and vegetable has limited the effectiveness of diet diversification as a means of delivering Vitamin A and other micro nutrients.

Supplementation of micro-nutrients has been the strategy the county engaged for quite some time however, the coverage is still low for both Vitamin A supplementation and IFAS, the strategy involved periodic distribution of high dose Vitamin A supplements which is the most widely applied intervention with proven effectiveness for treatment, prevention and control of Vitamin A deficiency, however low uptake of VAS has been noted thus lowering the coverage.

The traditional approach to combating iron deficiency is supplementation particularly during pregnancy. However, coverage and compliance rates are usually very poor. Daily supplementation for pregnant women and women of childbearing age with iron tablets has been found effective provided that compliance is adequate.

Therefore, to achieve the desired outcome a number of strategies and interventions with related outputs will be employed in this plan for adoption.

Expected Outcome

Improved micronutrient status for children, women of reproductive age and other persons.

Output 1

Strengthened routine micronutrient supplementation for targeted groups

Strategies

Strengthen systems for delivery of micronutrient supplementation and enhance uptake

Interventions

1. Develop county SBCC strategy on micronutrient intake
2. Increase micronutrient among women of reproductive age (IFAS)
3. Increase twice supplementation of vitamin A among children 6 to 59 month
4. Document good practices from champions to advocate for behavior change
5. Train CHVs on SBCC strategy on MIYCN
6. Train health workers and community units and volunteers on micronutrient deficiency
7. Deworming Strengthen deworming among school going children

Output 2

Increased dietary diversity and Bio-fortification of food

Strategies

Enhance uptake of diversified and bio-fortified foods

Interventions

1. Monitor compliance on food fortification in the market.
2. Sensitize community members on identifying fortified foods in the market
3. Sensitize health workers on food fortification

KRA 5: Clinical nutrition and dietetics in disease management strengthened

Context

Non-communicable diseases (NCDs)—mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes—are the world's biggest killers. Low- and middle-income countries already bear 86 percent of the burden of these premature deaths, resulting in cumulative economic losses of USD $7 trillion over the next 15 years and millions of people trapped in poverty. In Wajir data on NCDs is limited except those seen at hospital and reported through KHIS which is showing an upward trend.

Prevalence of HIV in Wajir stands at1 percent, which is low compared with other regions in Kenya but stigma is still very high and this a barrier to accessing health care services. Tuberculosis (TB) is the world's top infectious killer diseases today. According to World Health organization (WHO), TB is the ninth leading cause of death worldwide. Prevalence of TB in Wajir as per 2015 survey is 87/ 100,000. TB being a catabolic disease disposes high proportion of TB cases to malnutrition affecting treatment outcomes.

Clinical nutrition services are limited to counselling at the main referral hospital. However, TB and HIV nutrition services are provided in tier 4 facilities, with erratic supply chain for nutrition commodities. There are no specialized in-patient feeding programs established in of the four hospitals within the county.

Expected Outcome

Improved clinical nutrition and dietetics management in Wajir County

Output 1

Scale-up quality and timely provision of nutrition interventions for diet related non – communicable disease

Strategies

Strengthen capacity of the county to provide to prevent and manage DRNCD

Interventions/activities

1. Capacity building of health managers and health workers on DRNCD
2. Sensitization of community and stakeholder on DRCND
3. Scale up screening for Diet related NCDs

Output 2

Improved capacity of the county to provide clinical nutrition and dietetics services

Strategies

Strengthen capacity of the county to provide clinical nutrition and dietetics management services

Interventions

1. Capacity building of health care providers on basic essential clinical nutrition and dietetics care package.
2. Establish nutrition screening, assessment and triage areas/stations in outpatient and inpatient services
3. Procurement of nutrition commodities for feeding and management of special conditions based on inpatient feeding protocols

Output 3:

Improved capacity of the county to provide Nutrition in TB and HIV management services

Strategies

Strengthen Nutrition interventions in HIV and TB prevention and management

Interventions

1. Capacity building of health care providers on Nutrition in HIV and TB prevention and management
2. Scale up nutrition assessment and counseling for TB and HIV clients
3. Avail nutrition commodities for undernourished TB and HIV clients

KRA 6: Integrated Management of Acute Malnutrition Strengthened

Context

Acute malnutrition results from inadequate dietary intake and/or disease as the two immediate causes. A deadly vicious cycle is often created between acute malnutrition and infection, whereby children with acute malnutrition are predisposed to infection, and vice versa. Children with acute malnutrition are at a five to nine time's higher risk of death when compared to well-nourished children.

Prevalence of acute malnutrition has at all times remained above 12% with the latest survey showing a prevalence above WHO emergency threshold of 15%, with high caseloads for children aged 6 – 59 months and pregnant and lactating mothers. Access for treatment acute malnutrition is through 107 public and FBO health facilities and integrated outreach services when funding is available. Coverage of IMAM services has remained relatively low (44.6% and 45.6% for OTP and SFP respectively) mainly due to distance from health facilities, stock out of nutrition commodities, poor health-seeking behaviours by the community, migration of families leading to high defaulter rates, and little or no IMAM program awareness.

Capacity assessment revealed that most health workers are trained on IMAM. However, IMAM performance is still very poor in some facilities due to poor adherence to IMAM protocol (high defaulters, long length of stay, wrong admission and discharge criteria). Regular capacity building either through class room training, mentorship, on the job training and supervision is envisioned to improve performance.

Expected Outcome

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

Output 1

Scaled-up access and utilization of IMAM services

Strategies

Strengthen access and utilization of IMAM services by caregivers

Interventions

1. Active case finding and periodic mass screening for identification of malnutrition cases
2. Routine integrated health and nutrition outreach in hard to reach areas

3. Community sensitization and awareness raising on importance of IMAM program
4. Scale up roll out of surge across the County
5. Strengthen the CU and support groups

Output 2

Improved IMAM program performance in the county

Strategies

Capacity development of health workforce for delivery of IMAM services

Interventions

1. Capacity building of health care providers and CHVs on IMAM and HMIS
2. Strengthen supply chain for IMAM commodities and anthropometric tools
3. Conduct routine IMAM data quality audit and data review meetings
4. Strengthen the provision of IMAM reporting tools and registers.

KRA 7: Nutrition in emergencies strengthened

Context

Wajir County experiences frequent cyclic emergencies such as drought, floods, outbreak of disease and insecurity, among others, that often causes disruption and affects the health and nutrition status of the vulnerable groups including pregnant and lactating women, infants, young children, older persons as well as persons with disabilities. Efforts made at county level to put mechanisms in place for disaster risk reduction / management as well as emergency response and recovery. The County Nutrition Action Plan (CNAP 1) 2013–2017 was considered risk-informed and had a strategic objective that included emergency preparedness and response which guided the sector over the five-year period. Emergency coordination was scaled up over the period and credited for improvements over the years in emergency preparedness, response and recovery efforts.

To achieve the desired outcome, a series of strategies and interventions with related outputs are prioritized for implementation over the plan period in order improve multi-level and multisectoral capacity for risk preparedness, reduction and mitigation against the impact of disasters

Expected Outcome

Improved multi-level and multisectoral capacity for risk preparedness, reduction and mitigation against impact of disasters

Output 1

Strengthened coordination and partnerships for integrated preparedness and response initiatives

Strategies

Integrate risk reduction and mitigation in all planning

Interventions

1. Establish emergency preparedness and risk reduction coordination structures
2. Strengthen supply chain for nutrition commodities in emergencies
3. Capacity build Health managers, HCWs, CHVs and communities on response preparedness during emergencies
4. Support timely nutrition assessment and response in times of emergencies
5. Advocate for review of KIRA assessment tools to in-cooperate more MIYCN-E indicators
6. Map partners in preparedness and emergency risk reduction

Output 2

Strengthened preparedness capacity for nutrition sector

Strategies

Enhance risk analysis and articulation

Build capacity of systems and individuals to undertake preparedness functions

Interventions

1. Support Joint planning, resource mobilization and implementation meetings with other stakeholders
2. Review disaster preparedness and response plan
3. Capacity build different stakeholders on disaster risk reduction
4. Procure contingency commodities and avail contingency systems in place at the county level
5. Conduct, review and disseminate early warning information

Output 3

Improved access to timely multisectoral high impact interventions to avert excess morbidity and mortality during emergency

Strategies

Roll out a package of high-impact interventions to affected population

Interventions

1. Activate emergency coordination for health and nutrition response planning
2. Conduct nutrition needs assessment during emergencies to adapt response
3. Optimize nutrition service delivery approaches including outreach services in hard-to-reach areas

KRA 8: Nutrition in agriculture and food security, education, WASH and social protection scaled up

Context

The entire food system from production to consumption has an influence on the nutritional status of a population. Challenges in food production, storage, processing, marketing, consumer demand and preparation, consequently result in dietary inadequacy that leads to nutritional problems at household level. In Wajir county safe and adequate nutritious diets are not easily accessible and adequately utilized by most households due to prevailing conditions like food taboos, small scale production of food locally, climatic conditions unfavorable for crops and livestock production, low investment and adoption of production technologies, knowledge gap on dietary diversity at household level, poor road infrastructure, insecurity among other challenges.

Undernourished children in early childhood have lower performance in Intelligence Quotient (IQ) and other tests. In addition, poor child nutrition is associated with poor school enrolment, low attendance and high school dropout. Nutrition education in schools is known to foster healthy eating habits in the children themselves and their families in the short and longer terms. School meals ensure children are well nourished and healthy and are able to learn. Home-grown school meals program are implemented in select counties in arid and semi-arid areas. However, not all schools offer school meals supported by the government, and there is inadequate integration of nutrition in the school curriculum – especially for adolescents

In Wajir county school curriculum does not promote nutrition and physical activity. Functional health clubs are not in place, hence leading to minimal emphasis on nutrition issues in school curriculum activities. Moreover, lack of personnel trained on nutrition in schools is a major challenge in schools hence minimal periodic nutritional assessments in schools

Access to safe drinking water, sanitation and hygiene (WASH) services is a fundamental element of healthy communities and has an important positive impact on nutrition. Lack of access to WASH can affect a child's nutritional status in many ways. Existing evidence supports at least three direct pathways: via diarrhoeal diseases, intestinal parasite infections and environmental enteropathy. Hand washing with soap and water has been shown to reduce the risk of diarrhoea in the general population by 42–44 per cent. In addition, the treatment and safe storage of drinking water in the household reduces the risk of diarrhoeal disease by 30–40 per cent and safe disposal of faeces reduces the risk of diarrhoeal disease by 30 per cent or more.

The Kenya national social protection policy No. 56 defines social protection as 'policies and actions, including legislative measures that enhance the capacity and opportunities for the poor and vulnerable to improve and sustain their lives, livelihoods and welfare. It must also enable income-earners and their dependents to maintain a reasonable level of income through decent work, and ensure access to affordable health care, social security, and social assistance.' The policy proposes three policy measures which have a bearing on nutrition: (i) social assistance, (ii) social security, and (iii) health insurance. It also adopts four approaches to social protection, which have implications for nutrition: (i) Provision, (ii) Prevention, (iii) Promotion, and (iv) Transformation.

Social protection policies and programmes hold immense potential for improving the nutrition situation of vulnerable populations. To ensure that these policies holistically combat malnutrition, a nutrition-sensitive approach needs to be employed in their design and implementation. Nutrition and social protection are linked by their relevance for building resilience and linking emergency and development approaches. Social protection can positively affect nutrition by: (a) improving dietary quality, (b) increasing income and (c) improving access to health services

Expected Outcomes

1. Linkages between Nutrition, agriculture and food security strengthened
2. Nutrition mainstreamed in education sector policies, strategies and action plans.
3. Nutrition integrated into WASH policies, strategies, plans and programmes
4. Integration of nutrition in social protection programmes strengthened

Output 1

Production and Consumption of safe, diverse, and nutritious foods promoted

Strategies

- Promote increased consumption of safe, diverse, nutritious foods
- promote production of diverse nutritious food
- Promote/uptake of new technologies in agriculture (kitchen gardens)

Interventions

1. Sensitize communities on diversified food production and consumption
2. Support uptake and use of food composition tables and recipes for decision making
3. Advocate for the development of county specific food safety regulations and enforcement mechanisms
4. Develop Social Behaviour Change and Communication (SBCC) strategy for increased consumption of nutritious foods and improved dietary diversity (including fortified foods
5. Promote uptake of modern technologies in food production, processing, preservation, storage and utilization.

Output 2

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

Strategies

- Improved school curriculum to reinforce and promote nutrition and physical activity Integrate nutrition and physical activity in curricular and co-curricular frameworks
- Promote health and safe and nutritious food in schools and other learning institutions.

Interventions

1. Develop and advocate for nutrition and physical activity content for school curriculum.
2. Advocate for inclusion of nutrition and physical activity themes in co-curricular school activities (drama, music, talent shows, contests, symposia, health clubs)
3. Establishing health and nutrition clubs at schools
4. Identifying nutrition ambassadors from the school health clubs and using them to promote good nutritional practices
5. Sensitize and develop tools and manuals for nutrition assessment in schools
6. Create awareness among stakeholders including, curriculum support officers, food service providers and handlers, Parent–Teacher Associations (PTA) on healthy and safe and nutritious food

Output 3

Improved access to safe and adequate WASH services

Strategies

Promote establishment of WASH facilities and provision of safe drinking water at the household level, work place, institutions and market places

Interventions

1. Sensitization of communities on sanitation and hygiene promotion at household level, institutions, workplace and public places
2. Advocate for the protection of water sources, water treatment at user level and water quality surveillance
3. Support the development of mechanisms that strengthen coordination, linking nutrition to WASH
4. Advocacy for WASH/Institutional triggering to enhance good political will

Output 4

Nutrition promoted and linkages enhanced in social protection programmes including in crisis

Strategies

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

Interventions

1. Advocate for inclusion of targeting criteria for nutrition in social protection programmes; cash transfers, hunger safety nets, and others
2. Advocate for inclusion of nutrition indicators in the M&E of social protection interventions
3. Train stakeholders in social protection programmes on good nutrition practices
4. Advocate for resources for social protection nutrition programmes

KRA 9: Sectoral and multisectoral nutrition governance including coordination, legal framework, nutrition information and research strengthened

Context

Coordination in Kenya for nutrition has been credited as a key enabler of success in programming, a factor that is validated by the 2014 Kenya Demographic Health Survey, which showed a steady improvement in the nutritional status of children. Efforts on coordination in Wajir have their roots in emergency programmes that require stakeholder alignment and coherence given the cyclical nature of disasters and resulting high levels of acute malnutrition in certain areas of the county.

Monitoring and Evaluation Systems

The current nutrition monitoring and evaluation (M&E) is built on the existing infrastructure that collects collates and analyses surveillance and service delivery data from various facilities. The county M&E framework developed to define the performance indicators for tracking the 2019–2023. CNAP implementation has been a key enabler in strengthening the nutrition surveillance, monitoring and evaluation systems in the county.

Expected Outcome

Strengthened coordination, partnerships and collaboration of multi-sectoral nutrition activities

Output 1

Enhanced existing nutrition coordination and collaborating mechanisms and linkages within the county

Interventions

1. Advocate for meetings with county policy makers and political leaders to strengthen and support multi-sectoral coordination meetings
2. Enhance representation of nutrition at sectoral forums at all levels
3. Set up a coordination committee for monitoring and enforcement of national legislation on nutrition linked to the national committees

Output 2

Strengthened partnerships and collaboration for nutrition

Strategies

Strengthen and diversify partnerships in nutrition

Interventions

1. Develop a strategy and framework for enhancing public–private partnerships
2. Develop and update nutrition sector/ multisectoral partnership to guide collaboration at all levels

Output 3

Nutrition resource mobilization and accountability tracked

Strategies

Develop and implement a resource mobilization strategy for nutrition covering all aspects of resources – financial, human and organizational

Interventions

1. Create coordinating mechanism for resource mobilization at all levels
2. Develop costed nutrition plans
3. Support participation and representation of nutrition sector in public-participation forums at all levels.

Expected Outcome

Sectoral and multisectoral nutrition information systems, learning and research strengthened

Output 4

Strengthened nutrition sector capacity and evidence-based decision-making

Strategies

Improve capacity for quality nutrition data collection, analysis and dissemination

Interventions

1. Develop and use a nutrition multi sectoral nutrition scorecard to monitor key CNAP indicators quarterly
2. Routine Data review and feedback meetings with Sub counties
3. Conduct M&E capacity needs assessment and action plan for findings

Output 5

Improved access to and use of nutrition information to inform program quality, adjustment and learning

Strategies

Timely generation, dissemination and utilization of nutrition situation updates to inform programme planning and response

Interventions

1. Develop nutrition dashboards, scorecards and desktop reviews
2. Systematic utilization of nutrition information to inform program quality improvement
3. Conduct nutrition situation analysis, generate information products, and disseminate to all levels for planning and response

Output 6

Quality nutrition data generated for evidence based programming

Strategies

Integrate data quality into the County M&E framework

Interventions

1. Conduct Integrated Nutrition SMART Surveys, MIYCN,KAP and coverage assessment
2. Conduct Data Quality Audits for all the facilities in the county.

Output 7

Improved decision making through research evidence

Strategies

Enhanced evidence-based decision making through research.

Interventions

1. Advocate for research prioritization at county and sub county levels
2. Advocate and strengthen formation and coordination of sub-committees for research at the county
3. Strengthen systematic review of nutrition sensitive and nutrition-specific research
4. Promote knowledge sharing forums such as conferences, workshops and meetings
5. Establish an effective mechanism for knowledge management and learning Knowledge sharing through publications and bulletins

KRA 10: Advocacy, Communication and Social Mobilization (ACSM) strengthened

Context

Nutrition status improvement requires political goodwill for increased investment and raising population level awareness. Advocacy is an important key result area if a good nutrition outcome is to be achieved in the county. The result area aims to improve and strengthen governance, capacity to deliver, increased awareness, demand and adoption of nutrition services and practices at all levels in the continuum of health. Wajir has developed social behavior change and communication action plan to promote infant feeding practices. Through advocacy Wajir County has funded approximately 50% of SMART survey budget for 2018 and 2019.

Despite the various gains on advocacy, gaps still exist. Human resource numbers and the capacity for advocacy has persistently been identified as a gap during capacity assessments at national and county level. Other identified gaps are weak community engagement, weak community participation and weak feedback mechanisms that result in poor or weak social accountability. Health seeking behaviours and service awareness is a major barrier for uptake of health and nutrition services.

County budget analysis indicates that nutrition is underfunded; therefore, advocacy is required to lobby for nutrition positioning at the county levels and increased financial allocation. Currently, a huge share of funding even for nutrition actions goes towards curative actions in nutrition.

There is evidence that nutrition-sensitive actions have a big role to play if we are to improve the nutrition indicators. This requires advocacy actions to have line sectors mainstream nutrition in their policies and actions.

Expected Outcome

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

Output 1

Political commitment and prioritization of nutrition at the county level enhanced

Strategies

Strengthen in high-level nutrition advocacy within the county

Interventions

1. Conduct high level advocacy meetings with MCAs and County executive on the importance of prioritizing nutrition
2. Sensitize county assembly health committee on nutrition
3. Establish multi-sectoral platform for nutrition
4. Advocate for recruitment of nutritionist
5. Capacity build journalist and media people on nutrition for better and informed coverage

Output 2:

1. Improved uptake of nutrition services by the community
2. Improved Behaviour on nutrition

Strategy

Build and maintain stronger relationships with channels of communication and other means of social mobilizations.

Interventions

1. Strengthened channels of communication and social mobilization.
2. Develop IEC materials targeting different audience
3. Train local media houses on nutrition for improved coverage.
4. Train health workers on communication skills.
5. Document and disseminate best practices, case studies, research findings and success stories.
6. Sensitization of CHAs and CHVs on key nutrition priorities
7. Marking of nutrition calendar days and events

Output 3

Empowered community to demand for their rights on nutrition

Strategies

Strengthen community advocacy on nutrition services and interventions

Interventions

1. Develop, communicate and disseminate county ACSM strategy document
2. Strengthen community awareness on nutrition activities to create demand

KRA 11: Supply chain for nutrition commodities and equipment's strengthened

Context

Nutrition commodities and equipment are a key component for prevention and management of malnutrition along the life course. The key objective is to ensure uninterrupted supply by facilitating integration into a single more effective and efficient Government led supply chain system with KEMSA as the key warehousing and distribution agency of nutrition commodities directly to the health facilities. The need for continuous supply of adequate and good quality nutrition commodities and equipment is paramount to the success of the treatment of these conditions and the success of UHC agenda.

Expected Outcome

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

Output 1

Increased government budget allocation for nutrition commodities and allied tools

Strategies

Advocate for increased government budget allocation for nutrition commodities and allied tools.

Intervention

Advocate for a standing budget line for nutrition commodities and equipment and increased allocation for procurement and distribution of nutrition commodities at county level

Output 2

Strengthened coordination and management capacity of supply chain of nutrition commodities and equipment

Strategies

Optimize functioning of County and Sub county Nutrition Commodity Steering Committees

Interventions

1. Support and advocate for establishment of Joint quarterly meetings for all Nutrition Commodity Steering Committee -
2. Conduct Annual County Forecasting and quantification exercise across the nutrition programs
3. Capacity build HCWs on LMIS and KHIS

Output 3

Quality of all nutrition commodities and equipment ensured.

Strategies

Develop a feedback mechanism to monitor quality of nutrition supplies.

Interventions

1. Conduct nutrition commodity data quality audits and data review meetings
2. Develop and provide tools for quality assurance including data collection and summary
3. joint support supervision and end user monitoring
4. Support regular end-user monitoring of nutrition commodities on a regular basis.

CHAPTER 4
MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING

Introduction

The monitoring, evaluation, accountability and learning (MEAL) framework will facilitate tracking and evaluation of performance of set targets, as well as serving as an accountability and learning framework for the various nutrition stakeholders in the county. In addition to supporting results and financial tracking, the MEAL framework will also guide a common reporting approach for the county. The CNAP elaborates required investments to strengthen the nutrition system and scale up coverage of nutritional interventions, to attain set nutrition objectives for the county. The MEAL framework further provides a summary of select results and indicators that will be mutually tracked and reported on by all sectors responsible for the implementation of CNAP. The summary is referred to as the Common Results and Accountability Framework (CRAF).

The CNAP M&E system will therefore ensure:

- Continued progress monitoring, reporting through regular and systematic tracking of the progress of implementation of the CNAP.
- Alignment of all stakeholders' resources and actions to strengthen nutrition interventions in the county.
- Evidence-based decision making through ensuring timely availability of good-quality evidence that is effectively disseminated.
- That operational research capacity is strengthened to generate evidence to inform decision making and policy formulation.
- Documentation of lessons learnt in CNAP implementation to promote learning, institutional memory and linking of nutrition programmes with research and training.

COMMON RESULTS AND ACCOUNTABILITY FRAMEWORK (CRAF)

CNAP has identified results expected upon full implementation of the action plan, together with indicators that will measure the progress of achievement of the strategies outlined. Important to note is a set of key indicators and targets that are referred to as the CRAF that have been agreed upon. The CRAFT uses a logical results framework process at three levels (impacts, out

The key element to be monitored in CNAP include: Resources (inputs); service data, service coverage/Outcomes, Client/Patient outcomes (behavior change, morbidity), Investment outputs, access to services and impact assessment. In order to achieve effective monitoring system, operational policies, guidelines and tools should be in place and sufficiently disseminated.

Table 3: CNAP adopted Common Results and Accountability Framework (CRAF)

No	KNAP expected results (Global targets used where applicable)	Indicator	Baseline 2014	Data Source	Target 2023	Framework for targets
1	Reduce prevalence of stunting among children under five years by 40%		13.7%	(SMART)	8%	WHA target 1 NFNSP-IF
2.	Reduce the prevalence of anemia in women of reproductive age by 30%	Prevalence of Anaemia in women 15-49 years (%)	36%	KDHS 2014	18%	WHA target 2 NFNSP-IF
3.	Reduce the prevalence of low birthweight by 30%	Prevalence of birth weight of 2.5 kg and below (%	8%	KDHS Report	4%	WHA target 3
4	Increase the rate of exclusive breastfeeding in the first six months by 20% and above	Prevalence of exclusive breastfeeding in children 0-6 months (%)	69%	Survey	83%	WHA target 5 & NFNSP-IF
5.	Reduce and maintain childhood wasting to less than 5%	Prevalence of wasting (W/H >2SD) in children 0-59 months (%)	16%	Survey	12%	Reduce and maintain childhood wasting to less than 5%
6.	Reduce and maintain childhood underweight to less than 10%	Reduce and maintain childhood underweight to less than 10%	13.7%	Survey	10%	Reduce and maintain childhood underweight to less than 10
7.	Maintain mortality rates at below 3% for MAM and 10% for SAM	Maintain mortality rates at below 3% for MAM and 10% for SAM	0.2	KHIS	< 3%	NFNSP-IF
8.	Reduce anaemia in pregnant women by 40% or more	Reduce anaemia in pregnant women by 40% or more	36%	KDHS	15%	KNAP
9.	Reduce anaemia in adolescent girls by 30%	Reduce anaemia in adolescent girls by 30%	21%	KNMS	10%	KNAP
10	Reduce vitamin A deficiency in children by 50%	Reduce vitamin A deficiency in children by 50%	39%	KNMS	15%	KNAP
11	10% of population accessing health services screened and assessed for nutritional status	Proportion of population screened and assessed for nutrition status while accessing healthcare services	0	Hospital Data	7%	Clinical Nutrition target 2b
12	Increased nutrition health budget	Increased nutrition health budget	1,8M		15M	KNAP

Overall progress review will be conducted at end term. During implementation, performance and progress will be monitored quarterly and annually, while the overall progress review will be conducted through both quantitative and qualitative assessments. The monitoring and evaluation framework will guide this process, through monitoring of the inputs against outputs, outcomes and impacts.

The monitoring processes will involve the following:

Data Generation

- The different data are collected through routine data, surveys, sentinel surveillance and periodic assessments data will be collected from different sources to monitor different indicators on the implementation progress.
- The Routine data will be generated using the existing tools and uploaded to the DHIS2 monthly at the facility level
- Multi-sectoral teamwork with nutrition sensitive actors
- Timely reporting at all levels.
- Data Validation
- Data quality audit through Annual and Quarterly verification process should be carried out, to review the data across all the indicators both at county and sub county level

Data analysis

- This step ensures monthly transformation of data into information which can be used for decision making at all levels.
- Information dissemination
- Information collected during the surveys will be routinely disseminated to key sector stakeholders to get feedback on the progress and plan for corrective measures.
- Stakeholder Collaboration
- There is need to effectively engage other relevant Departments and Agencies and the wider private sector in the health sector M&E process.
- Each of these stakeholders generates and requires specific information related to their functions and responsibilities.
- The information generated by all these stakeholders is collectively required for the overall assessment of sector performance.

Monitoring Reports

Quarterly Reporting

- Monitoring of indicators will be carried out through quarterly and biannual reporting from routine data collection, like the HIS, nutrition scorecard, and feedback during CNTF

Assessment Report

- The report developed during periodic surveys by the county and nutrition stakeholders will be presented both at the county and the national (NIWG) for review, recommendations and for decision both at the county and national levels. Best practices that arise will also be documented for shared learning.

CNAP Evaluation process

Evaluating implementation of the CNAP is intended to determine whether the interventions suggested achieved the expected results. The evaluation will provide credible evidence on the performance of the CNAP and document what worked and did not work. Beyond answering the evaluation questions, it will test the effectiveness of the suggested interventions, against practices in the region with similar challenges.

A midterm review and an end evaluation will be undertaken to determine the extent to which the objectives of the action plan are met. Trends will be assessed, together with the results of the various assessments and surveys across the different indicator domains – inputs/processes; outputs; outcomes and expected results.

Mid -term review

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

End term evaluation

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

Evaluation Criteria

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

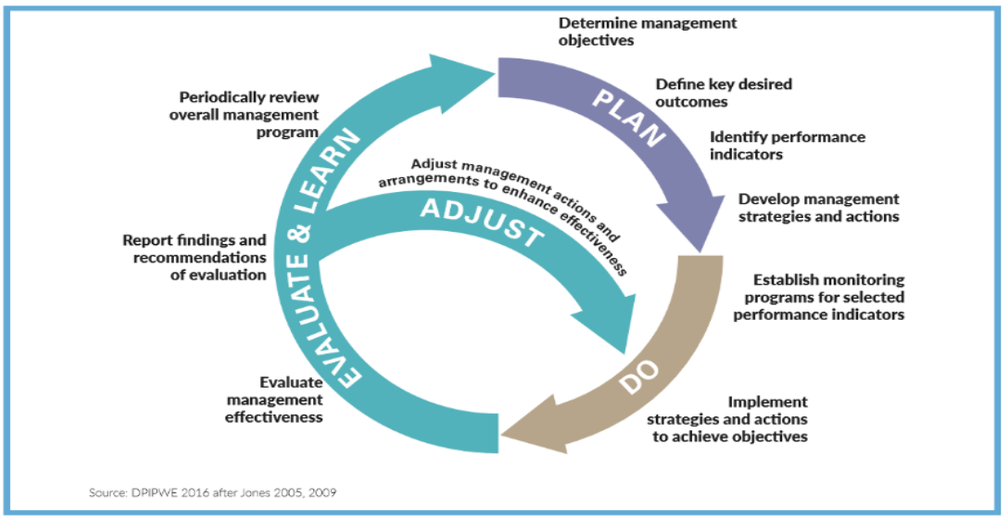
Evaluation criteria will highlight the following aspects of the interventions: (i) Effectiveness, (ii). Efficiency, (iii) Sustainability, (iv) Relevance, (v) Impact, (vi) Gender and (vii) Human Rights

CNAP Accountability process

The accountability process of CNAP will be anchored in to the Monitoring, Evaluation, Accountability and Learning (MEAL) plan and accountability framework and this shall be strengthened to existing coordination platforms within sectors and across sectors. The CECMs from nutrition sensitive and specific departments will commit to MEAL with overall stewardship from the office of the Governor.

CNAP learning process

Figure 6: Learning Cycle below indicates the learning cycle involved.



The Wajir County CNAP2 learning process will follow an adaptive management cycle approach, which involves improving outcomes through learning. Identification of the key nutrition issues facing the county have been outlined in the situation analysis and strategies and interventions outlined to address the issues. This followed by the actual implementation, and monitoring of the inputs, outputs, outcomes, achieved and evaluation against the expected results, adjusting accordingly.

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

The following initiatives will guide learning:

1. Compare results across time to determine which ones contribute to achieving the mission and expected results.

2. Facilitation of both formal and informal learning and reflection meetings of all stakeholders, by sharing learning experiences (positive and negative) with partners, communities and other stakeholders, in response to their needs. This will strengthen accountability and transparency.

3. Documentation of processes and reports (paper based, photos, videos, etc.); and appropriate storage (filing – electronic, paper based) of MEAL outputs to keep learning within the organization even when key staff leave.

4. Mentoring of staff with a focus on specific issues or identified needs and helping individuals reflect and question existing practice. v.

5. Training courses in response to feedback.

6. Development of innovative tools for MEAL including nutrition indicator monitoring dashboard

Financial tracking and budget analysis

Investment in nutrition by both the national and county government is crucial in achieving outcomes outlined in this document. Thus, an important aspect in measuring the performance of the CNAP is to be able to track the nutrition investments regularly and transparently. This will help in better use of financial data (allocations vs expenditures) to mobilize increased resources for improved nutrition and for purposes of advocacy and better planning. Governments invest in nutrition through budgetary allocation to various sectors, e.g., health, agriculture, education, WASH and social protection, and the CNAP has incorporated nutrition targets in these sectors to ensure these budgets work harder for nutrition impact. Kenya has developed a nutrition financial tracking tool and will be used in this step, whereas the executive has been sensitized on it, there is a need for continuous sensitization and institutionalization of this tool.

Institutional arrangement for M&E

Wajir County is implementing Integrated Monitoring Evaluation System (CIMES), which track all departmental programmes, Kenya Vision 2030 through its medium-term plans (MTP) and County Integrated Development Plans (CIDPs), which will provide department with reliable policy implementation feedback to help it efficiently allocate resources over time.

At the County level, there is an established Division of Standards, Quality assurance and M&E unit within the MoH whose functions are to:

1. Provide strategic direction for M&E in the health department

2. Coordinate M&E activities as well as supporting programmes in their M&E needs; and

3. Work with the County Bureau of Statistics (KNBS) to collect health information and vital statistics required for County development. In Wajir, the division of Standard and Quality assurance/M&E and the Nutrition and Dietetics Unit has a nutrition information and management programme.

Role of national and county government in implementation of CNAP

The Government of Kenya has developed policies and programmes and has also established institutions to address the very complex nature of nutrition problems, these initiatives largely contributes to the implementation of KNAP and CNAP . However, fluctuating rainfall patterns, recurrent widespread droughts and the economic situation have continued to adversely affect the country's food security posing resource challenge and making implementation of CNAP activities a bit difficult, the national also helps in ,Developing the capacity of the health workforce to deliver integrated services including nutrition, Mainstream, Nutrition in School curriculum, support Nutritional research, capacity build Counties for implementation of CNAP, and provide enabling environment for implementation.

The role of the County government in Implementation of the CNAP will be and not limited to;

1. Coordination of the CNAP Activity implementation.
2. Develop capacity of the health workforce to deliver integrated services including nutrition and enhance the implementation of CNAP
3. Resource allocation to enable implementation of the CNAP activities.
4. Resource mobilization from development partners and collaborations for implementation of CNAP.
5. Employment of nutrition human resources in nutrition relevant Sectors
6. Monitor, evaluate and review of the CNAP activities
7. Adopt, disseminate and implement nutrition policies, guidelines and manuals
8. Develop CNAP joint implementation framework

Data management for nutrition M&E

The role of the health and nutrition information system is a collection of health and nutrition data, collation, conveyance and management of the data to information for decision-making. The data is collected from the service delivery points (SDP) and uploaded into the KHIS by the data manager at the sub county level and the information should be complete and timely. To support health and nutrition information systems strengthening, the department has developed various policy documents.

Research

Implementation research is a subset of health system research and critical for successfully implementing evidence-based interventions and policies it will also help us to test and develop solutions to tackle barriers to effective implementation of outlined intervention in the document.

The department of health has a research unit headed by a director of research, currently conducting assessment on the effectiveness of the ambulance referral system. The research office will foresees all the research work carried out in the department from the design, methodology and research execution. Therefore the objective of considering implementation research in the document is to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of chosen interventions. In the context of the document and the structure of implementation will also be subjected to implementation research.

Limitation of the data source

Department of health has Kenya health Information System (KHIS) for data collection, storage and retrieval. However, data not routinely collected through KHIS will be a challenge and therefore need for periodic surveys or tools to collect. The assumption is that there will be resources both technical and financial to conduct periodic assessments

Cost of MEAL

MEAL will be allocated between 5 and 10 per cent of the CNAP budget. However, specific activities involved in MEAL will be costed, including assessments, baselines, routine monitoring, ongoing reflection and learning, and periodic evaluations

CHAPTER 5

CNAP RESOURCE MOBILIZATION AND COSTING FRAMEWORK

Introduction

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

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

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

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

Costing of the CNAP

Financial resources need for the CNAP was estimated by costing all the activities necessary to achieve each of expected outputs in each of Key Result Area (KRA). The costing of the CNAP used result-based costing to estimate the total resource need to implement the action plan for the next four years. The action plans were costed using the Activity-Based Costing (ABC) approach. The ABC uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve Strategic plan targets. ABC is a process that allocates costs of inputs based on each activity, it attempts to identify what causes the cost to change (cost drivers); · The CNAP overall budget captures all the activities that will be implemented and aligned to planned outputs for the next five years.

Summary of resource need by Key Result Area

Category	KRA	2019/2020	2020/21	2021/2022	2022/23	Total KSH	Total USD
Nutrition Specific	**KRA 1**. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up	5,044,400.00	5,284,400.00	5,284,400.00	5,284,400.00	20,147,600.00	201,476.00
	KRA 2. Nutrition of older children, Adolescent, Adults and Older persons promoted	6,824,788.00	8,697,776.00	10,570,764.00	12,443,752.00	38,537,080.00	385,370.80
	KRA 3. Prevention, control and management of Micronutrient Deficiencies Scaled up	559,500.00	4,247,500.00	3,670,500.00	3,670,500.00	12,148,000.00	121,480.00
	KRA 4. Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs)	3,914,500.00	5,201,500.00	3,914,500.00	4,439,500.00	17,470,000.00	174,700.00
	KRA5. Clinical nutrition and dietetics in disease management strengthened	20,780,372.00	36,264,650.00	32,588,824.00	28,308,259.00	117,942,105.00	1,179,421.05
	KRA 6. Integrated Management of Acute Malnutrition Strengthened	341,473,080.00	358,776,995.00	377,062,842.00	387,407,408.00	1,464,720,325.00	14,647,203.25
	KRA7. Nutrition in Emergencies Strengthened	12,223,900.00	11,323,900.00	10,823,900.00	10,823,900.00	45,195,600.00	451,956.00
Nutrition Sensitive	**KRA 9**. Strengthen and promote nutrition in Agriculture & Food security, Education, WASH and social protection sectors	14,970,806.00	15,000,806.00	14,970,806.00	14,970,806.00	59,913,224.00	599,132.24
Enabling environment/ Crossing Cutting	**KRA 10**. Sectoral and multisectoral Nutrition Governance, Nutrition Information system, Learning and Research Strengthened	9,947,000.00	10,520,000.00	7,747,000.00	7,447,000.00	35,661,000.00	356,610.00
	KRA 11. Nutrition Capacity, Advocacy, Communication and Social Mobilization (ACSM) strengthened	4,091,050.00	4,091,050.00	4,091,050.00	4,091,050.00	16,364,200.00	163,642.00
	KRA 12. Supply chain management for nutrition commodities and equipment strengthened	8,260,000.00	4,860,000.00	4,860,000.00	5,260,000.00	23,240,000.00	232,400.00
TOTAL BUDGET TO IMPLEMENT THE CNAP		428,089,396.00	464,268,577.00	475,584,586.00	484,146,575.00	1,851,339,134.00	18,513,391.34

Implementation resources

The Strategic plan costed using the Activity Based Costing (ABC) approach. The ABC uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve planned targets for the financial years of 2019/20 – 2022/23. The cost over time for all the Key Result Areas provides important details that will initiate debate and allow County health management and development partners to discuss priorities and decide on effective resource allocation.

The KRAs provided targets to be achieved within the plan period and the corresponding inputs to support attainment of the targets. Based on the targets and unit costs for the inputs, the costs for the strategic plan were computed. According to the Activity Based Costing, to fully actualize the strategic plan, KES 1,846,961,134.00 / USD 18,469,611.34 is required as shown in the figure below. Further annual breakdown of cost requirement (s) is also presented.

Funding opportunities and sustainability of CNAP

In order to realize the objective of the CNAP it is paramount that all sectors (Nutrition specific and sensitive departments) operating in the county both government and nongovernmental actors pull together resources for the implementation of planned interventions. The county department of health will major finance the nutrition sensitive interventions in KRA 1 to KRA 7 whereas the nutrition sensitive sectors including department of Agriculture, Water sanitation and hygiene(WASH) education will support the realization of KRA 8. KRA 9. The action plan has heavily relied on the County integrated development plan 2017-2022 and other sectoral strategic plan to make it easy to raise the budget required for its implementation.

Furthermore once the action plan is finalized it will be made available to any state and non-state development partner who might want to invest in nutrition specific and sensitive nature. The document has also made provisions for advocacy communication and social mobilization as a tool for resource mobilization. During the implementation cycle the advocacy efforts will be geared to petitioning the county executive and assembly to increase budgetary allocation for nutrition interventions.

Appendices

Output	Expected Results	Indicator	Baseline 2018/ 2019	2019/20	2020/21	2021/22	2022/23	Means of verification	Lead	Associated
KRA 1 Maternal, Infant and Young Child, older Children and adolescent Nutrition (MIYCAN) Promoted										
Output 1.1 capacity of health care workers strengthened on MIYCN	Health care Workers Capacity on MIYCN built	Number of health workers trained on MIYCN	60	120	180	240	300	Training reports	CDH	Other partners , SCI, UNICEF
		Number of MIYCN Trainings Conducted	2	4	6	8	10	Training report , Signed pax list	CDH	Save the children , World vision
Improved MIYCN care practices at the county level.	County level MIYCN care practice improved	Finalized SBCC strategy in use No of engagement held at county level	0 0	1 2	1 4	1 6	1 8	Finalized SBCC strategic Plan.	CDH	Save the children, UNICEF, KRCS
Improved maternal infant and young child feeding practices	Maternal infant and young child feeding practices improved	No of sub county hospitals implementing BFHI.	0	1	2	3	4	Assessment report	CDH	UNICEF , SCI, KRCS
Scaled up BFCI implementation	BFCI scaled up	No of Trained health work force on BFCI. No of Trained CHV on BFCI	22 102	57 202	92 302	127 402	162 502	Training report Training report	CDH CDH	Save the children , KRCS
KRA 2: Nutrition of older children and adolescent promoted										
Output 1: Improved capacity of MoH and MoE staff to implement healthy diet and lifestyle guidelines for older children (5-9 years) and adolescents (10-19 years).	Capacity of MOH staff to implement healthy diets and physical activity developed	Number of MOH staff trained on health diets sand physical activity	0	25	25	25	25	Training report	CDH	Health and nutrition partners

Output	Expected Results	Indicator	Baseline 2018/ 2019	2019/20	2020/21	2021/22	2022/23	Means of verification	Lead	Associated
	Capacity of MOE staff on healthy diets and physical activity developed	Number of MOE staff trained on health diets sand physical activity	0	25	25	25	25	Training report	CDH/ MOE	Health and nutrition partners
	IEC materials on healthy diet and lifestyle guidelines for older children (5-9years) and adolescents 10-19 years distributed	Number of health facilities with healthy diet and lifestyle guidelines for older children (5-9years) and adolescents 10-19 years disseminate	0	25	25	25	25	Distribution lists/ photos/supervision reports	CDH	Health and nutrition partners
Output 2 Improved health status of children 5-9 years and adolescents aged 10 – 19 years	Community sensitized community on healthy diets and physical activities	Number of community level sensitization meetings conduct on healthy diets and physical activities	0	4	4	4	4	Activity reports	CDH	Health and nutrition partners
	messaging on healthy diet and physical activity integrated in the school health programs	Proportion of public primary schools integrating messages on healthy diets and physical activity in the school health programs	0	10	20	30	40	Activity report/ supervision reports	MOE/ MOH	Health and nutrition partners
	Increased proportion of adolescent receiving weekly Iron and folic supplementations	Percentage of adolescent girls receiving Weekly iron and folic supplementation	0	25	50	75	100	Progress reports	MOE/ MOH	Health and nutrition partners

KRA 3 Nutrition of older persons promoted										
1.1 Improved linkage of elderly persons to social protection programs and general food distribution.	Improved nutrition status of older persons	No of older persons linked to social protection programmes supported with food and nutrition commodities	0	60	120	240	360	Beneficiaries list or Registers	CDH	Social services,NDMA
1.2 Improved capacity of health workers on geriatric nutrition	Improved knowledge of health workers on Geriatric nutrition	No of health workers trained on geriatric nutrition	0	30	60	90	120	Training reports	CDH	SCI,Unicef.
KRA 4. Prevention, control and management of Micronutrient Deficiencies Scaled up										
4.1 Strengthened routine micronutrient supplementation for targeted groups	Improved micronutrient status for children, women of reproductive age and other persons.	Proportion of children aged 6-59 months receiving Vitamin A supplements at least two doses annually.	37.1%	55%	60%	75%	86%	Smart survey	CDH	SCI UNICEF,
		Proportion of pregnant women who take iron and folate supplements for at least 180 days	53%	65%	75%	85%	100%	KHIS	CDH	SCI/UNFPA/UNICEF
		Percentage of children aged 6-23 months provided with multiple micronutrient powders	4.4%	25%	35%	55%	75%	Survey report	CDH	

4.2 Increased dietary diversity and consumption of Bio-fortified food	Enhance uptake of diversified and bio-fortified foods	Proportion of fortified food in the local market	0%	15%	30%	45%	60%	Survey report	CDH	SCI,Unicef,WFP,CDA,FAO
		Proportion of household consuming fortified products(maize and wheat flour, salt, fats/oils)	3.7%	25%	35%	55%	75%	Survey report	CDH	SCI,Unicef,WFP,CDA,FAO
		Proportion of the population accessing adequate micro-nutrient intake	No baseline data	25%	35%	50%	65%	Survey reports/ Smart/	CDH	SCI,UNICEF,WFP,CDA,FAO

KRA 5: Clinical nutrition and dietetics in disease management strengthened										
Scale-up quality and timely provision of nutrition interventions for diet related non – communicable disease	Quality and timely provision of nutrition intervention for DRNCDs scaled up	proportion of patients managed for DRNCDs	O	10	20	30	40	DHIS	CDH	NONE
Improved capacity of the county to provide clinical nutrition and dietetics services Improved	Capacity of the county to provide clinical nutrition improved	Number of health workers trained on Clinical Nutrition care process	1	10	20	30	40	Training data base	CDH	
		Number of Clinical Nutrition policy guidelines printed and Distributed to Facilities	0	50	100	150	200	Availabiliyof policy guidelines	CDH	DON
capacity of the county to provide Nutrition in TB and HIV managements services	Capacity of the county to provide nutrition in TB and HIV improved	no of patients screened for malnutrition and received nutrition interventions	0	50	100	150	200	250	CDH	NHP
		number of nutrition service delivery points for TB and HIV patients	1	2	4	6	8	10	CDHNHP	
		proportion of HIV/ TB patients receiving nutrition care for malnutrition	38	48	58	68	78	DHIS/TIBU	CDH	NHP

KRA 6 : Integrated Management of Acute Malnutrition Strengthened										
Scaled-up access and utilization of IMAM services	IMAM services coverage improved	1. Coverage of OTP	45%		60%		75%	Coverage reports	CDH	SCI, KRCS, UNICEF
		2. No. of hard to reach communities accessing IMAM services through outreach services						Activity reports	CDH	SCI, KRCS, UNICEF
		3. Proportion of health facilities with surge approach rolled out	59%	65%	70%	75%	80%	Surge dashboard	CDH	SCI, UNICEF
Improved IMAM program performance in the county	IMAM program performance improved	1. Number of health workers trained on IMAM	25	50	100	150	200	Training data base	CDH	SCI, KRCS, WFP, UNICEF
		2. No of IMAM data quality audits carried out	0	4	8	16	20	Activity reports	CDH	SCI, KRCS, WFP, UNICEF
		3. Proportion of children admitted into OTP and SFP program who are discharged as defaulters	10%	9%	8%	7%	6%	KHIS monthly reports	CDH	SCI, KRCS, WFP, UNICEF
		No of health facilities reporting zero stocks for more than 14 days	5%	5%	5%	3%	2%	LMIS report	CDH	UNICEF, WFP

KRA 7 Nutrition in Emergencies Strengthened										
Strengthened coordination and partnerships for integrated preparedness and response initiatives	Fully-functional multi-level and multisectoral capacity for risk preparedness, reduction and mitigation against impact of disasters	No. of Functional county emergency preparedness coordination structures	1	2	3	5	7	No. of meetings	CDH	SCI,NDMA&Unicef/KRCS

KRA 7 Nutrition in Emergencies Strengthened										
Strengthened preparedness capacity for the nutrition sector	Nutrition sector representation in multi sectoral coordination forums for preparedness and risk reduction	Proportion of multi sectoral coordination forums for emergency preparedness with nutrition sector representation annually	No. baseline data	50%	70%	80%	100%	Meeting minutes	CDH	SCI,NDMA&Unicef/KRCS
Improved access to timely multi-sectoral high impact interventions to avert excess morbidity and mortality during emergency	Nutrition integrated in Disaster preparedness and response plan at County level	Number of facilities implementing IMAM surge	62	77	92	107	115	Surge Reports	CDH	SCI &UNICEF/KRCS
		Number of sub counties with integrated contingency, preparedness and response plans	0	2	4	6		Updated integrated plan	CDH	NDMA&Unicef/KRCS
Output	Expected Results	Indicator	Baseline 2018/2019	2019/20	2020/21	2021/22	2022/23	Means of verification	Lead	Associated

KRA 9: Nutrition in agriculture and food security, education, WASH and social protection scaled up										
Consumption of safe, diverse, and nutritious foods promoted	Increased number of Households consuming safe, diverse and nutritious food	Proportion of farm households utilizing 4-5 food groups in a day	5	10	20	25	30	Reports survey	CDH DALF	SAVE THE CHILDREN UNICEF WFP
	county specific regulations to promote consumption of diverse and nutritious food formulated	Number of county specific regulations formulated	0	1	0	1		Specific regulations formulated	CDH DALF COUNTY ASSEMBLY	SAVE THE CHILDREN UNICEF WFP WORLD VISON
Production of diverse nutritious food increased	Increased supplementing of school meals with locally produced fruits and vegetables “	Percentage of schools supplementing school meals with locally produced fruits and vegetables	0	10	20	30	50	Assessment Reports	CDH DALF	SAVE THE CHILDREN UNICEF WFP WORLD VISON
	Sensitization and dissemination meeting for both Sub-county and county heads	Number of sensitization meetings held at both sub county and county levels	0	8	16	32	48	SENSITIZATION MEETING REPORT	CDH DALF	SAVE THE CHILDREN UNICEF WFP WORLD VISON
	Conducting community action days.	Number of community action days conducted	0	8	16	24	32	Community dialogue day report	CDH DALF	SAVE THE CHILDREN UNICEF WFP WORLD VISON

KRA 9: Nutrition in agriculture and food security, education, WASH and social protection scaled up										
	Promote uptake of technologies in food production ,processing ,preservation and storage	Number of Agri-nutrition technologies that have been disseminated	2	3	4	5	6	Reports	CDH DALF	SAVE THE CHILDREN UNICEF WFP WORLD VISON
Improved school curriculum to reinforce and promote nutrition and physical activity Integrate nutrition and physical activity in curricular and co-curricular frameworks	Develop and advocate for nutrition and physical activity content for school curriculum	number of nutrient and physical activities integrated in the curricular and co-curricular frameworks	0	10	20	25	0	REORTS	CDH EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON
	Establishing health and nutrition clubs at schools	Number of health and nutrition clubs established	0	60	120	200	0	REORTS	CDH DALF, EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON
	Identifying nutrition ambassadors from the school health clubs and using them to promote good nutritional practices	Number of nutrition ambassadors in schools identified to promote good nutrition practices	0	100	200	300	0	REORTS	CDH DALF, EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON
	Develop tools and manuals for nutrition assessment in schools	Proportion of schools where nutrition assessment is done						REORTS	CDH DALF, EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON

KRA 9: Nutrition in agriculture and food security, education, WASH and social protection scaled up										
Promote health and safe and nutritious food in schools and other learning institutions	Sensitize and develop tools and manuals for nutrition assessment in schools	Percentage of schools using customized tools and manuals for nutritional assessment.		30	60	80	0	REPORTS	CDH DALF, EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON
	Create awareness among stakeholders including, curriculum support officers, food service providers and handlers, Parent–Teacher Associations (PTA) on healthy and safe and nutritious food	Percentage of schools offering safe and nutritious foods	0	30	60	80	0	REPORTS	CDH DALF, EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON
Improved access to safe and adequate WASH services	Improved access to safe and adequate WASH services.	proportion of household using improved sanitation facilities and practice proper handwashing at the critical times		30	50	75	90	REPORTS	CDH DALF, EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON
	Advocate for the protection of water sources ,water treatment at user level and water quality surveillance	Proportion of households with access to an improved water source and practice water treatment		30	50	75	90	REPORTS	CDH DALF, EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON
	Support the development of mechanisms that strengthen coordination, linking nutrition to WASH	Coordination mechanism linking WASH and nutrition strengthened.						REPORTS	CDH DALF, EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON

KRA 9: Nutrition in agriculture and food security, education, WASH and social protection scaled up										
	Advocacy for WASH/Institutional triggering to enhance good political will	Enhanced political good will towards WASH activities	0	8	16	24		REPORTS	CDH DALF, EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON
Nutrition promoted and linkages enhanced in social protection programmes including in crisis	Advocate for inclusion of targeting criteria for nutrition in social protection programmes; cash transfers, hunger safety nets, and others	Percentage of Nutritional status of social protection safety nets intended beneficiaries considered during targeting	0	20	40	60		REPORTS	CDH DALF, EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON. NDMA
	Advocate for inclusion of nutrition indicators in the M&E of social protection interventions	No of meetings held to advocate for Nutritional indicators incorporated in the social protection safety nets M&E system	0	1	2	3		REPORTS	CDH DALF, EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON. NDMA
	Train stakeholders in social protection programmes on good nutrition practices	The number of Stakeholders in trained on good nutrition practices	0	4	6	10	4	REPORTS	CDH DALF, EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON. NDMA
	Advocate for resources for social protection nutrition programmes	No of advocacy meetings to advocating for resources allocated to advocate social protection	0	2	2	3	1	REPORTS	CDH DALF, EDUCATION	SAVE THE CHILDREN UNICEF WFP WORLD VISON. NDMA

KRA 10: Sectoral and multisectoral nutrition governance including coordination, legal framework, nutrition information and research strengthened										
Enhanced existing nutrition coordination and collaborating mechanisms and linkages within the county	Strengthened coordination, partnerships and collaboration of multi-sectoral nutrition activities	Number of functional nutrition coordination technical forums held	4	4	4	4	12	Reports and Minutes	CDH	SCI&Unicef
Strengthened partnerships and Collaboration for nutrition	Strengthened partnerships for nutrition	Public Private Partnership strategy developed	0	1	1	2	5	MOU	CDH	
Nutrition resource mobilization and accountability tracked	Developed resource mobilization strategy for nutrition	Number of resource mobilization strategy meetings held	0	1	2	3	4	Reports	CDH	UNICEF
Strengthened nutrition sector capacity and evidence-based decision-making	Enhanced nutrition planning and performance monitoring and evaluation	Number of Wajir Nutrition Action Plan evaluation conducted	0	1	0	0	0	CNAP document	CDH	SCI&Unicef
Quality nutrition data generated for evidence based programming	Strengthen nutrition capacity and evidence based decision making	Number of trainings conducted on HMIS	35	70	100	130	165	Training reports	CDH	CDH

	Timely generation and dissemination of nutrition situation updates to inform programme planning and response	Number of nutrition situation reports (SRA/ LRA) generated	2	2	4	6	8	SRA/LRA reports	CDH	NDMA
		Number of population-based survey	3	3	6	9	12		Survey reports	UNICEF/SCI/NDMA
Improved decision making through research evidence	Enhanced evidence-based decision making through research	No. of new research priorities identified annually	0	1	0	1	2	Minutes of TWG	CDH	Partners
Improved access to and use of nutrition information to inform program quality, adjustment and learning	Improved access to and use of nutrition information to inform programme quality improvement	Number of Nutrition dashboard developed	0	1	1	1	3	Dashboards	CDH	CDH

KRA 11. Advocacy, Communication and Social Mobilization (ACSM) strengthened										
Political commitment and prioritization of nutrition at the county level enhanced	Enhanced political commitment and continued prioritization of nutrition in the county agenda.	1 Number of high-level nutrition meetings held	0	2	3	4	4	REPORT	MOH SAVE THE CHILDREN UNICEF	WASH PATNERS AGRI
		2 No. of dissemination meeting conducted	0	2	6	10	14	Community advocacy meeting report		
Improve uptake of nutrition services at the community	Number of nutrition sensitization meetings conducted	Number of community units sensitized	0	2	6	10	14	Activity report	CDH SAVE THE CHILDREN UNICEF	WASH PATNERS
		Number of nutrition sensitization meetings conducted	0	2	6	10	14	Sensitization meetings Meetings		
		Number documents on best practices and case studies produced and disseminated	0	2	6	10	14	Best practices and case study report		

KRA 12: Supply chain for nutrition commodities and equipment's strengthened										
Increased County budget allocation for nutrition commodities and allied tools	County prioritizing procurement of nutrition commodities and equipment	Proportion of budget for nutrition commodities and equipment in the county	0	25%	50%	75%	100%	Budget Report	CDH	CDH
Strengthened coordination and management capacity of supply chain of nutrition commodities and equipment	Enhanced integrated supply chain management system for nutrition commodities and equipment	Number of HCWs trained on supply chain management	100	130	160	190	220	Training reports	CDH	SCI/JSI

Detailed Costing Template by Output and KRA

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 1 Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up	Improved capacity of HCWs on MIYCN	Capacity building of health care workers on MIYCN	96,000.00	456,000.00	456,000.00	456,000.00	**1,464,000.00**	**14,640.00**
		Strengthen reporting and documentation reporting of MIYCN data	30,000.00	30,000.00	30,000.00	30,000.00	**120,000.00**	**1,200.00**
		Monitoring and enforcement of BMS Act, 2012	30,000.00	30,000.00	30,000.00	30,000.00	**120,000.00**	**1,200.00**
	Improved MIYCN care practices at the county level.	Finalize and implement SBCC strategy	120,000.00	-	-	-	**120,000.00**	**1,200.00**
		Commemorate national health action days (WBW, Malezi bora) at the county level.	40,000.00	40,000.00	40,000.00	40,000.00	**160,000.00**	**1,600.00**
		Strengthen linkages and referral systems for MIYCN related issues	8,400.00	8,400.00	8,400.00	8,400.00	**33,600.00**	**336.00**
		Engage key opinion leaders and influencers on MIYCN issues	24,000.00	24,000.00	24,000.00	24,000.00	**96,000.00**	**960.00**
		Use of media to pass MIYCN messages	30,000.00	30,000.00	30,000.00	30,000.00	**120,000.00**	**1,200.00**
	Improved capacity of Health work force on BFHI	Train Health work force on BFHII.	456,000.00	456,000.00	456,000.00	456,000.00	**1,824,000.00**	**18,240.00**
		Establish workplace support for Breastfeeding mothers	1,440,000.00	1,440,000.00	1,440,000.00	1,440,000.00	**5,760,000.00**	**57,600.00**
		Train Health workforce on BMS Act 2012.	456,000.00	456,000.00	456,000.00	456,000.00	**1,824,000.00**	**18,240.00**
	Roll out of PD Hearth in selected communities	Train health workers of PD Hearth	456,000.00	456,000.00	456,000.00	456,000.00	**1,824,000.00**	**18,240.00**
		Train CHVs and Mother to mother support groups	576,000.00	576,000.00	576,000.00	576,000.00	**2,304,000.00**	**23,040.00**
		Implementation of PD Hearth in selected communities	250,000.00	250,000.00	250,000.00	250,000.00	**250,000.00**	**2,500.00**
	Scaled up BFCI implementation	Train health work force on BFCI.	456,000.00	456,000.00	456,000.00	456,000.00	**1,824,000.00**	**18,240.00**
		Train CHV on BFCI	576,000.00	576,000.00	576,000.00	576,000.00	**2,304,000.00**	**23,040.00**

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 2: Nutrition of older children and adolescent promoted	Improved capacity of MoH and MoE staff to implement healthy diet and lifestyle guidelines for older children (5-9 years) and adolescents (10-15 years).	Capacity-build stakeholders on healthy diets and physical activity	3,779,800	3,779,800	1,889,900	1,889,900	15,119,200	151,192.00
		Disseminate and distribute IEC materials healthy diet and lifestyle guidelines for older children (5-9years) and adolescents 10-19 years	524,000	524,000	524,000	524,000	2,096,000	20,960.00
	Improved health status of children 5-9 years and adolescents aged 10 – 19 years	Integrate messaging on healthy diet and physical activity in the school health programs	324,000	324,000	324,000	324,000	1,296,000	12,960.00
		Implement weekly iron folic supplementations for adolescent 10-15 years	1,872,988	3,745,976	5,618,964	7,491,952	18,729,880	187,298.80
KRA 3: Nutrition of elderly persons promoted	Improved linkage of elderly persons to social protection programs and general food distribution.	Advocate for the linkage of older person to social protection programmes and general food distributions.	313,500.00	313,500.00	313,500.00	313,500.00	1,254,000.00	12,540.00
		Mapping and assessment of nutritional needs of elderly persons in the county	246,000.00	-	-	-	246,000.00	2,460.00
	Improve capacity of health workers on geriatric nutrition	Train health workers on health and nutrition of older persons	-	3,357,000.00	3,357,000.00	3,357,000.00	10,071,000.00	100,710.00
		Develop/adopt IEC materials on nutrition for older persons	-	577,000.00	-	-	577,000.00	5,770.00

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 4: Prevention, control and management of micronutrient deficiencies scaled up	Strengthened routine micronutrient supplementation for targeted groups	Develop county SBCC strategy on micronutrient intake	-	762,000.00	-	-	762,000.00	7,620.00
		Increase micronutrient among women of reproductive age (IFAS)	876,000.00	876,000.00	876,000.00	876,000.00	3,504,000.00	35,040.00
		Increase twice supplementation of vitamin A among children 6 to 59 month	1,328,500.00	1,328,500.00	1,328,500.00	1,328,500.00	5,314,000.00	53,140.00
		Document good practices from champions to advocate for behavior change	50,000.00	50,000.00	50,000.00	50,000.00	200,000.00	2,000.00
		Train CHVs on SBCC strategy on MIYCN	1,410,000.00	1,410,000.00	1,410,000.00	1,410,000.00	5,640,000.00	56,400.00
	Increased dietary diversity and Bio-fortification of food	Monitor compliance on food fortification in the market.	250,000.00	250,000.00	250,000.00	250,000.00	1,000,000.00	10,000.00
		Sensitize community members on identifying fortified foods in the market	-	525,000.00	-	525,000.00	1,050,000.00	10,500.00

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 5: Clinical nutrition and dietetics in disease management strengthened	Output 1 Scale-up quality and timely provision of nutrition interventions for diet related non – communicable disease	Capacity building of health managers and health workers on DRNCD	2,637,360.00	2,637,360.00	2,637,360.00	2,637,360.00	10,549,440.00	105,494.40
		Sensitization of community and stakeholder on DRCND	239,760.00	239,760.00	239,760.00	239,760.00	959,040.00	9,590.40
		Scale up screening for Diet related NCDs	2,647,852.00	147,852.00	147,226.00	148,296.00	3,091,226.00	30,912.26
	Improved capacity of the county to provide clinical nutrition and dietetics services	Capacity building of health care providers on basic essential clinical nutrition and dietetics care package	-	2,372,026.00	2,372,026.00	2,379,147.00	7,123,199.00	71,231.99
		Establish nutrition screening, assessment and triage areas/stations in outpatient and inpatient services	-	4,083,852.00	147,852.00	148,296.00	4,380,000.00	43,800.00
		Procurement of nutrition commodities for feeding and management of special conditions based on inpatient feeding protocols	-	9,028,400.00	5,000,000.00	5,000,000.00	19,028,400.00	190,284.00
		Capacity building of health care providers on Nutrition in HIV and TB prevention and management	15,255,400.00	15,255,400.00	16,274,200.00	15,255,400.00	62,040,400.00	620,404.00
	Improved capacity of the county to provide Nutrition in TB and HIV managements services	Avail nutrition commodities and equipment for undernourished TB and HIV clients	-	2,500,000.00	5,770,400.00	2,500,000.00	10,770,400.00	107,704.00

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 6: Integrated Management of Acute Malnutrition Strengthened	Output 6.1 Scaled-up access and utilization of IMAM services	Active case finding and periodic mass screening for identification of malnutrition cases	6,560,000.00	6,560,000.00	6,560,000.00	6,560,000.00	26,240,000.00	262,400.00
		Routine integrated health and nutrition outreach in hard to reach areas	7,800,000.00	7,800,000.00	7,800,000.00	7,800,000.00	31,200,000.00	312,000.00
		Community sensitization and awareness raising on importance of IMAM program	3,000,000.00	3,000,000.00	3,000,000.00	3,000,000.00	12,000,000.00	120,000.00
		Scale up roll out of surge across the County	1,896,000.00	1,896,000.00	1,896,000.00	1,896,000.00	7,584,000.00	75,840.00
	Output 6.2	Capacity building of health care providers and CHVs on IMAM and HMIS	3,635,000.00	3,635,000.00	3,635,000.00	3,635,000.00	14,540,000.00	145,400.00
	IMAM program performance improved	Strengthen supply chain for IMAM commodities	1,285,000.00	1,285,000.00	1,285,000.00	1,285,000.00	5,140,000.00	51,400.00
		Procurement of nutrition commodities for children under-five and PLWs	309,229,080.00	326,532,995.00	344,818,842.00	355,163,408.00	1,335,744,325.00	13,357,443.25
		Conduct routine IMAM data quality audit and data review meetings	8,068,000.00	8,068,000.00	8,068,000.00	8,068,000.00	32,272,000.00	322,720.00

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 7 Nutrition in Emergencies	Strengthened coordination and partnerships for integrated preparedness and response initiatives	Establish emergency preparedness and risk reduction coordination structures	157,500.00	157,500.00	157,500.00	157,500.00	**630,000.00**	**6,300.00**
		Strengthen supply chain for nutrition commodities in emergencies	750,000.00	750,000.00	750,000.00	750,000.00	**3,000,000.00**	**30,000.00**
		Capacity build Health managers,HCWs,CHVs and communities on response preparedness during emergencies	7,016,400.00	7,016,400.00	7,016,400.00	7,016,400.00	**28,065,600.00**	**280,656.00**
		Support timely nutrition assessment and response in times of emergencies	1,000,000.00	1,000,000.00	1,000,000.00	1,000,000.00	**4,000,000.00**	**40,000.00**
		Advocate for review of KIRA assessment tools to in-cooperate more MIYCN-E indicators	-	500,000.00	-	-	**500,000.00**	**5,000.00**
		Map partners in preparedness and emergency risk reduction	200,000.00	-	-	-	**200,000.00**	**2,000.00**
	Strengthened preparedness capacity for the nutrition sector	Support Joint planning, resource mobilization and implementation meetings with other stakeholders	200,000.00	200,000.00	200,000.00	200,000.00	**800,000.00**	**8,000.00**
		Review disaster preparedness and response plan	100,000.00	100,000.00	100,000.00	100,000.00	**400,000.00**	**4,000.00**
		Capacity build different stakeholders on disaster risk reduction	1,200,000.00	-	-	-	**1,200,000.00**	**12,000.00**
		Conduct, review and disseminate early warning surveys	300,000.00	300,000.00	300,000.00	300,000.00	**1,200,000.00**	**12,000.00**
	Improved access to timely multi-sectoral high impact interventions to avert excess morbidity and mortality during emergency	Activate emergency coordination for health and nutrition response planning	100,000.00	100,000.00	100,000.00	100,000.00	**400,000.00**	**4,000.00**
		Conduct nutrition needs assessment during emergencies to adapt response	200,000.00	200,000.00	200,000.00	200,000.00	**800,000.00**	**8,000.00**
		Optimize nutrition service delivery approaches including outreach services in hard-to-reach areas	1,000,000.00	1,000,000.00	1,000,000.00	1,000,000.00	**4,000,000.00**	**40,000.00**

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 9: Nutrition in agriculture and food security, education, WASH and social protection scaled up	Consumption of safe, diverse, and nutritious foods promoted	Increase number of Households consuming safe, diverse and nutritious food	616,706.00	616,706.00	616,706.00	616,706.00	**2,466,824.00**	**24,668.24**
		Formulate county specific regulations to promote consumption of diverse and nutritious food formulated	3,479,400.00	3,479,400.00	3,479,400.00	3,479,400.00	**13,917,600.00**	**139,176.00**
	Production of diverse nutritious food increased	Increase supplementing of school meals with locally produced fruits and vegetables	824,850.00	824,850.00	824,850.00	824,850.00	**3,299,400.00**	**32,994.00**
		Sensitization and dissemination meeting for both Sub-county and county heads on nutritional diversity	589,500.00	589,500.00	589,500.00	589,500.00	**2,358,000.00**	**23,580.00**
		Conduct community action days.	507,000.00	507,000.00	507,000.00	507,000.00	**2,028,000.00**	**20,280.00**
		Promote uptake of technologies in food production ,processing ,preservation and storage	1,689,750.00	1,689,750.00	1,689,750.00	1,689,750.00	**6,759,000.00**	**67,590.00**
	Improved school curriculum to reinforce and promote nutrition and physical activity Integrate nutrition and physical activity in curricular and co-curricular frameworks services at the community	Develop and advocate for nutrition and physical activity content for school curriculum	565,000.00	565,000.00	565,000.00	565,000.00	**2,260,000.00**	**22,600.00**
		Establishing health and nutrition clubs at schools	247,500.00	247,500.00	247,500.00	247,500.00	**990,000.00**	**9,900.00**
		Identifying nutrition ambassadors from the school health clubs and using them to promote good nutritional practices	-	30,000.00	-	-	**30,000.00**	**300.00**
		Develop tools and manuals for nutrition assessment in schools	3,258,000.00	3,258,000.00	3,258,000.00	3,258,000.00	**13,032,000.00**	**130,320.00**

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
	Improved access to safe and adequate WASH services	Improve access to safe and adequate WASH services.	1,857,900.00	1,857,900.00	1,857,900.00	1,857,900.00	**7,431,600.00**	**74,316.00**
		Advocate for the protection of water sources ,water treatment at user level and water quality surveillance	487,500.00	487,500.00	487,500.00	487,500.00	**1,950,000.00**	**19,500.00**
		Support the development of mechanisms that strengthen coordination, linking nutrition to WASH	112,500.00	112,500.00	112,500.00	112,500.00	**450,000.00**	**4,500.00**
		Advocate for WASH/Institutional triggering to enhance good political will	135,000.00	135,000.00	135,000.00	135,000.00	**540,000.00**	**5,400.00**
	Output 1.5	Advocate for inclusion of targeting criteria for nutrition in social protection programmes; cash transfers, hunger safety nets, and others with M&E indicators	465,200.00	465,200.00	465,200.00	465,200.00	**1,860,800.00**	**18,608.00**
	Nutrition promoted and linkages enhanced in social protection programmes including in crisis	Train stakeholders in social protection programmes on good nutrition practices and lobby for more resources	135,000.00	135,000.00	135,000.00	135,000.00	**540,000.00**	**5,400.00**

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 9: Sectoral and multisectoral nutrition governance including coordination, legal framework, nutrition information and research strengthened	Enhanced existing nutrition coordination and collaborating mechanisms and linkages within the county	Advocate for meetings with County policy makers and political leaders to strengthen and support multi-sectoral coordination meetings	500,000.00	500,000.00	500,000.00	500,000.00	**2,000,000.00**	**20,000**
		Enhance representation of nutrition at sectoral forums at all levels	100,000.00	100,000.00	100,000.00	100,000.00	**400,000.00**	**4,000**
		Set up a coordination committee for monitoring and enforcement of national legislation on nutrition linked to the national committees	100,000.00	-	-	-	**100,000.00**	**1,000**
	Strengthened partnerships and collaboration for nutrition	Develop a strategy and framework for enhancing public–private partnerships	300,000.00		300,000.00		**600,000.00**	**6,000**
		Develop and update nutrition sector/ multi-sectoral partnership to guide collaboration at all levels	200,000.00	200,000.00	200,000.00	200,000.00	**800,000.00**	**8,000**
	Nutrition resource mobilization and accountability tracked	Create coordinating mechanism for resource mobilization at all levels	100,000.00	-	-	-	**100,000.00**	**1,000**
	Strengthened nutrition sector capacity and evidence-based decision-making	Develop and use a nutrition multi sectoral nutrition scorecard to monitor key CNAP indicators quarterly	20,000.00	20,000.00	20,000.00	20,000.00	**80,000.00**	**800**
		Routine Data review and feedback meetings with Sub counties	1,414,000.00	1,414,000.00	1,414,000.00	1,414,000.00	**5,656,000.00**	**56,560**
		Conduct M&E capacity needs assessment and action plan for findings	2,000,000.00	-	-	-	**2,000,000.00**	**20,000**
	Improved access to and use of nutrition information to inform program quality, adjustment and learning	Develop nutrition dashboards, scorecards and desktop reviews	10,000.00	10,000.00	10,000.00	10,000.00	**40,000.00**	**400**
		Conduct nutrition situation analysis, generate information products, and disseminate to all levels for planning and response	300,000.00	300,000.00	300,000.00	300,000.00	**1,200,000.00**	**12,000**
	Quality nutrition data generated for evidence based programming	Conduct Integrated Nutrition SMART Surveys, MIYCN,KAP and coverage assessment	2,500,000.00	2,500,000.00	2,500,000.00	2,500,000.00	**10,000,000.00**	**100,000**
		Conduct Data Quality Audits for all the facilities in the county.	1,803,000.00	1,803,000.00	1,803,000.00	1,803,000.00	**7,212,000.00**	**72,120**

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
	Improved decision making through research evidence	Advocate for research prioritization at county and sub county levels	-	3,073,000.00	-	-	**3,073,000.00**	**30,730**
		Advocate and strengthen formation and coordination of sub-committees for research at the county	100,000.00	100,000.00	100,000.00	100,000.00	**400,000.00**	**4,000**
		Strengthen systematic review of nutrition sensitive and nutrition-specific research	500,000.00	500,000.00	500,000.00	500,000.00	**2,000,000.00**	**20,000**
KRA 11. Advocacy, Communication and Social Mobilization (ACSM) strengthened	Output 1.1 Enhanced capacity for implementation of MIYCN at all levels.	Enhance political commitment and continued prioritization of nutrition in the county agenda.	273,250.00	273,250.00	273,250.00	273,250.00	1,093,000.00	10,930.00
	Improve uptake of nutrition services at the community	Conduct nutrition sensitization meetings at the community	3,817,800.00	3,817,800.00	3,817,800.00	3,817,800.00	15,271,200.00	152,712.00
KRA 11: Supply chain for nutrition commodities and equipment's strengthened	Increased government budget allocation for nutrition commodities and allied tools	Advocate for a standing budget line for nutrition commodities and equipment and increased allocation for procurement and distribution of nutrition commodities at national and county level	400,000.00			400,000.00	**800,000.00**	**8,000**
	Strengthened coordination and management capacity of supply chain of nutrition commodities and equipment	Support and advocate for establishment of Joint quarterly meetings for all Nutrition Commodity Steering Committee	1,200,000.00	1,200,000.00	1,200,000.00	1,200,000.00	**4,800,000.00**	**48,000**
		Conduct Annual County Forecasting and quantification exercise across the nutrition programs	300,000.00	300,000.00	300,000.00	300,000.00	**1,200,000.00**	**12,000**
		Capacity build HCWs on LMIS and KHIS	1,600,000.00	1,600,000.00	1,600,000.00	1,600,000.00	**6,400,000.00**	**64,000**
		Develop and provide tools for quality assurance including data collection and summary	3,000,000.00				**3,000,000.00**	**30,000**
		joint support supervision and end user monitoring	1,760,000.00	1,760,000.00	1,760,000.00	1,760,000.00	**7,040,000.00**	**70,400**